NOTICE OF BOARD MEETING
WEDNESDAY 29 APRIL 2015
TO COMMENCE AT 1.00 PM IN THE CONFERENCE ROOMS A & B,
RESEARCH & DEVELOPMENT CENTRE, KINGSWAY, DERBY DE22 3LZ

Item	Time	AGENDA	Enc Ref	Discussion led by
1.	1:00	Chairman's Welcome and Opening Remarks and Strategic Theme	**-**	Mark Todd
2.	1:05	My Recovery Journey	-	
3.	1:30	Apologies for Absence Declarations of Interest		Mark Todd
4.	1:35	Minutes of Board of Directors meeting, held on 25 March 2015	**A**	Mark Todd
5.	1:45	Matters arising – Actions Matrix	**B**	Mark Todd
6.	2:00	Chairman's Report	**C**	Mark Todd
7.	2:10	Chief Executive's Report	**D**	Steve Trenchard
FINANCE, STRATEGY AND GOVERNANCE				
8.	2:25	Information Governance Update	**E**	Ifti Majid
9.	2:35	Workforce Strategy Update	**F**	Jayne Storey
10.	2:45	Trust Sealings	**G**	Jenna Davies
11.	2:50	Annual Review of Register of Interests	**H**	Jenna Davies
B R E A K 3:00				
12.	3:15	Corporate Governance Framework	**I**	Jenna Davies
13.	3:25	Committee Summary Reports: - Audit Committee - Quality Committee - Safeguarding Committee (verbal)	**J**	Committee Chairs
OPERATIONAL PERFORMANCE REVIEW				
14.	3:35	Finance Director's Report Month 11 – *this paper will be available on the Trust website on the afternoon of Friday, 24 April and a printed copy will be available at the meeting.*	**K To follow**	Claire Wright
15.	3:45	Integrated Performance and Activity Report and Safer Staffing – *this paper will be available on the Trust website on the afternoon of Friday, 24 April and a printed copy will be available at the meeting-*	**L To follow**	Ifti Majid
16.	3:55	Financial Performance Report	**M**	Claire Wright
17.	4:05	Deep Dive – County CAMHS Staff Levels and Capacity	**N**	Ifti Majid
CONCLUSION				
18.	4:35	I. Board Forward Plan II. Identification of any issues arising from the meeting for inclusion or updating of the Board Assurance Framework III. Deep Dive selection IV. Strategic theme for next meeting V. Comments from observers on Board performance and content of meeting	**O**	Mark Todd

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. On this occasion the special reason applies to information which is likely to reveal the identities of an individual or commercial bodies.

The next meeting is to be held on 27 May 2015, at 1.00 pm in Conference Rooms A & B, Centre for Research and Development, Kingsway, Derby DE22 3LZ

Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board. Participation in meetings is at the Chairman's discretion. `

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Wednesday, 25 March 2015

MEETING HELD IN PUBLIC

Commenced: 1:00 pm Closed: 4:10 pm

Prior to resumption, the Board met to conduct business in confidence where special reasons applied

PRESENT:	Mark Todd	Chairman
	Steve Trenchard	Chief Executive
	Caroline Maley	Senior Independent Director
	Maura Teager	Non-Executive Director
	Tony Smith	Non-Executive Director
	Jim Dixon	Non-Executive Director
	Phil Harris	Non-Executive Director
	Ifti Majid	Chief Operating Officer/Deputy Chief Executive
	Claire Wright	Executive Director of Finance
	Carolyn Green	Executive Director of Nursing and Patient Experience
	Dr John Sykes	Executive Medical Director
	Jayne Storey	Director of Transformation
	Mark Powell	Director of Business Development and Marketing
IN ATTENDANCE:	Anna Shaw	Deputy Director of Communications
	Sue Turner	Executive Administrator and Minute Taker
For item DHCFT 2015/051	David Tucker	General Manager, Specialist Services
For item DHCFT 2015/051	Kaydia Allen	Acting Senior Nurse, Kedleston Unit
For item DHCFT 2015/051	Amy Ramful	Lead Nurse, Kedleston Unit
VISITORS:	John Morrissey	Council of Governors
	Carole Riley	Derbyshire Voice Representative
	Timothy Proctor	Volunteer Chaplain Kingsway Hospital and member of the public
APOLOGIES:	Graham Gillham	Director of Corporate and Legal Affairs

DHCFT 2015/035	**CHAIRMAN'S OPENING REMARKS, APOLOGIES, DECLARATIONS OF INTEREST** The Chairman opened the meeting by welcoming all present and explained that the strategic theme for the meeting would be how to prepare for an integrated health system.

	Declarations of Interest: No declarations were noted.
DHCFT 2015/036	**MY STORY** This item was not discussed. The service user concerned hoped to be able to provide the Board with a written statement describing her journey through to discharge.
DHCFT 2015/037	**MINUTES OF DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST BOARD MEETING, HELD ON 25 FEBRUARY 2015** The minutes of the Derbyshire Healthcare NHS Foundation Trust Board meeting, held on 25 February 2015 were accepted and approved.
DHCFT 2015/038	**MATTERS ARISING** **ACTION MATRIX** All green completed items to be removed and updates were noted directly on the matrix.
DHCFT 2015/039	**MATTERS ARISING** Maura Teager referred to DHCFT2015/029 Position Statement on Quality (third bullet point) and asked if the Trust was in a position to take a proactive approach to nurse recruitment using the new recruitment pathway for nurse training. A neighbouring trust is recruiting into basic HCA roles with a 'built in' opportunity to access nurse training within 9 months at one of the local universities. She felt it would be good to learn from this exercise and Carolyn Green agreed to consider the relevance of this approach for our Trust. The Chairman asked Carolyn Green to pursue this further with Maura Teager outside of the meeting. **Corporate Governance Framework:** The Corporate Governance Framework document would now be submitted to the April Board, after further comments and review at the Audit Committee. *(Although this wasn't stated the Chairman originally intended to mention this under matters arising.)*
DHCFT 2015/040	**CHAIRMAN'S REPORT** The Board noted the Chairman's report which summarised his meetings and visits during the month. **RESOLVED: The Board received and noted the Chairman's report.**
DHCF/ 2015/041	**CHIEF EXECUTIVE REPORT** The Chief Executive presented his regular monthly report to the Board that provided an update on achievements in the last month. Steve Trenchard explained he was working with Anna Shaw, Deputy Director of Communications to produce a very clear message on mental and physical healthcare for Derby and Derbyshire with the aim for it to be collectively signed

	up by key stakeholders. Maura Teager asked for clarification regarding the themes and lessons learnt from NHS investigations into matters relating to Jimmy Saville. Steve Trenchard pointed out that the Trust had reviewed its policy and he was not aware that the Trust had any contact with celebrities that might place it in a vulnerable position. He made it clear that anyone who held celebrity status would have to go through rigorous checks. Carolyn Green thought it necessary to carry out a review of DBS (Disclosure and Barring Service) checks on staff within the Trust's employ including anyone within a voluntary capacity in addition to the volunteer's service. The Chairman was concerned that there were gaps in assurance relating to DBS checks. These checks apply to all people the Trust partnered with including the third sector workforce. It was agreed that Governors would also be required to undergo a DBS check and Anna Shaw was asked to undertake this exercise in relation to checks on all Governors. A clear ownership and wider audit regarding DBS checks would also be undertaken under the lead of Ifti Majid and Jayne Storey and would be referred to the Employee Strategy and Engagement Committee (ESEC). DBS checks would also apply to contractual relationships to ensure that the Trust is fully compliant. Jim Dixon asked whether extra funding would be made available for children's mental health. Steve Trenchard replied that the Government had announced that £2.5bn would be released over the next five years, some of which would be released into the CCG and the Trust was working with commissioners to ensure it would receive as much uplift as possible in order to be compliant with IAPT in psychosis and trauma. Delegated authority for the Information Governance was given to Ifti Majid to sign off this year's information governance toolkit submission. The Trust was aiming for 96% compliance and an excess of 95% of staff trained **ACTION: Anna Shaw to lead the Governors' DBS exercise.** **ACTION: An audit of CRB checks to be undertaken under the lead of Ifti Majid and Jayne Storey and referred to the Employee Strategy and Engagement Committee (ESEC).** **RESOLVED: The Board of Directors received and noted the Chief Executive's Report.**
DHCFT 2015/042	**<u>FINANCE DIRECTORS REPORT MONTH 11</u>** The Month 11 Report provided the Trust Board with an update on current financial performance against the operational financial plan as at the end of February 2015. • Current financial performance remains significantly ahead of plan. The Trust has a risk rating of four (the best rating), both now and forecast for the end of the year. • It is expected that the final month of the year would differ significantly to that

	of the previous months. Higher expenditure will reduce some of the surplus built up during the year and the Trust is expected to end the year approximately £1.2m ahead of plan. • In essence, this meant the Trust delivered on its operational plan without using its contingency reserve. This was illustrated by the graph on page 5 of the report. Claire Wright pointed out that normal year-end operational matters and day to day processes were taking place. Ifti Majid wished to reinforce the impact vacancies had on financial results. Although he did not think this was ideal he felt it was important to clarify that the Trust was not purposefully holding vacancies and he wanted to ensure this was recognised by the Board. **RESOLVED: The Board of Directors received assurance on the Trust's current financial performance in 2014/15.**
DHCFT 2015/043	**INTEGRATED SERVICE DELIVERY** Kate Majid, Head of Transformation and Patient Involvement attended the meeting to provide the Board with assurance of progress against the Strategic Outcomes with respect to Integrated Service Delivery. The report provided an update against several key advances in the development of neighbourhood and campus services and reflected the work in progress against strategic outcomes: • Outcome 2 - People receive care that is joined up and easy to access; Pillar 2: Integrated Care Pathways, Pillar 3: Service Delivery & Design • Outcome 4 - Care is Delivered by Compassionate and Empowered Teams; Pillar 7: Workforce and Leadership Kate Majid highlighted the significant work completed on neighbourhood boundaries based on GP populations and illustrated how the Trust's neighbourhood boundaries would cross over with CCG boundaries. The Chairman asked for clarity on clustering. Kate Majid replied that Mark Ridge had identified over recording on cluster 4 whilst carrying out an audit. Further checks were being carried out with clinical teams and a manual adjustment would be made to rectify this. Sensitivity tests had been carried out and she was confident this had now been corrected. Maura Teager asked if there were any significant outliers that related to the workforce profile and GP practices contained within the neighbourhood boundaries. Kate Majid replied that GP's relationships and linking with primary care would be enhanced and it was envisaged that this would maximise smooth transitions for patient transfers between primary and secondary care. There were no significant outliers in this sense and it was hoped these could be identified during budget setting and checks were being carried out to ensure the numbers were correct. Significant work had taken place to establish the correct workforce profile and this would be in place in April. Ifti Majid concluded that this programme was implemented to focus on neighbourhoods and communities. It was recognised that these communities were changing and the Trust would need to keep up with this changing

	landscape. As a Board it was important to recognise this as the biggest change ever instigated by this organisation and the Trust would have to ensure it had the capacity to initiate this successfully. **RESOLVED: The Board of Directors received assurance from the paper in respect to achievement of and alignment to the Trust's Strategic Outcomes regarding the development of a Model of Integrated Service Delivery.**
DHCFT 2015/044	**<u>UPDATE ON STRATEGY IMPLEMENTATION 2013 – 2016 QUARTER 3</u>** This paper was presented to provide the Trust Board with assurance of progress made against the strategic outcomes. The strategy set plans for 2013 to 2016 and has at its heart the people who use our services, their families and carers. The report reflected the current position across the organisation with regard to achievement of the strategic outcomes and pillars of delivery. The current position is; 22 are 'on plan' (green) compared to 23 in Q2, 0 are 'ahead of plan' (blue) and 7 are 'behind plan' (red) compared to 6 Q2. Areas that have had an impact on the position include the decision not to reduce beds on the Hartington Unit from 23 to 20 due to the recognised pressures within the Urgent Care system. This decision will help avoid a detrimental impact on Patient experience. The report also provided examples of evidence of progress against all strategic outcomes: • People receive the best quality care • People receive care that is joined up and easy to access • The public have confidence in our healthcare and developments • Care is delivered by empowered and compassionate teams Carolyn Green highlighted the fact that some population changes were having an adverse effect on the Trust's ability to manage the flow of people into and out of beds. The demand to meet population needs of people with potential mental health issues has meant bed numbers would be stretched and there would also be a demand on capacity. In response to this, Tony Smith agreed out of area beds had an adverse effect on patient experience and seeking to achieve improvement would be key to obtaining assurance. Caroline Maley highlighted the neighbourhood model and asked about the staff engagement sessions. Kate Majid explained that there had been a variety of opportunities for staff to engage and everyone had been invited to help build the model. Tony Smith was concerned to know how local champions were engaging through leadership management programmes and whether champions were being utilised correctly. In response, Kate Majid said she could give some clear examples and the direct result of their input had impacted on changes to the model. She believed the model was successful because the Trust had listened to what its people were saying. The Board of Directors felt that to be assured the plan was sustainable it required the following additional assurances: To understand there was a reliable communication plan in place To see a structured approach to the relationship plan To see learning development flowing through

	Jim Dixon believed this was a good paper and asked when some of the critical stakeholders, such as the police and social services would get to share some of the analysis bearing in mind this is a community solution. Kate Majid replied that this was currently very much in progress and Sara Bains was leading on mapping the programme within the communities and third sector. **RESOLVED: The Board of Directors noted the content of the report and received partial assurance on progress to date.**
DHCFT 2015/045	**<u>BOARD ASSURANCE FRAMEWORK UPDATE</u>** The purpose of the report is to meet the requirement for the Board to produce an Assurance Framework. The Board Assurance Framework (BAF) is a high level report which enables the Board of Directors to demonstrate how it has identified and met its assurance needs, focused on the delivery of its objectives, and subsequent principal risks. This was the third and final update report of the BAF submitted to the Audit Committee and Board of Directors for 2014-15. Since the last update of the 2014/15 BAF by the Board of Directors in Oct 2014, the following developments have taken place: • A 'Deep Dive' review and challenge by the Audit Committee of all the risks under three of the four strategic outcomes has been completed. The deep dive for risks identified under the fourth strategic outcome was undertaken at the Audit Committee on 18 March. Each deep dive was led by the Executive Director with overall responsibility for the risk. Feedback to date has been positive, with the Audit Committee reporting that it received assurance that each of the risks presented was appropriately managed and mitigated. For 2015-16, the Audit Committee has recommended that deep dive reviews and challenges be focused on those risks contained in the BAF rated as high, with the lower graded risks reviewed by the relevant named responsible committee. • Although a "named responsible committee" for overseeing each of the principal risks has been identified over the last 6 months, not all committees have explicitly referenced assurances received to the BAF. This was a gap identified by the audit undertaken by PwC for 2014-15 Governance Arrangement, Structures and Processes. This is being resolved and the committees are following guidance and explicitly referencing the BAF at each of their meetings. The BAF continues to be reviewed by Executive Directors on an approximately monthly basis. Interim updates on actions due for review are provided by the responsible Director via the DATIX Web: Risks database which details all risk assessments within the Trust. Caroline Maley informed that Board that some amendments were made to the BAF when it was reviewed by the Audit Committee on 18 March and these amendments would be carried through to the next version of the BAF that would be presented to the Board. The Board was comfortable that the BAF deep dive process was taking place within the named committees that feed into the Audit

	Committee. Steve Trenchard wished the Board to extend thanks to Rachel Kempster for her work on the BAF. The Board recognised this is an onerous and evolving task and it appreciated the supportive way in which she held executives to account. **RESOLVED: The Board of Directors:** **1) Approved the updated and final Board Assurance Framework for 2014/15** **2) Agreed that the Board and Audit Committee would continue to receive a formal update on the BAF three times a year during 2015-16.** **3) Supported the 'deep dive' review and challenge by the Audit Committee of only risks graded high, with lower graded risks being reviewed by the relevant named responsible committee.**
DHCFT 2015/046	**<u>COMMITTEE SUMMARY REPORTS</u>** Members of the Board considered the summary reports of the Quality Committee and Mental Health Act Committee **I. Mental Health Act Committee:** Tony Smith commended John Sykes' work with the commissioning team in conducting the audit projects. He also acknowledged the work of the Associate Hospital Managers on behalf the Non-Executive Directors for the training and support event taking place later in the year. The Chairman noticed the partial assurance contained in the report in relation to the clinical audits and recognised this was because they were still in progress. Tony Smith assured the Chairman that there was a specific action plan behind each audit and appropriate methods were in place to manage this process. Steve Trenchard requested that as assurance was not obtained with Section 58 Consent to Treatment this should be identified on the risk register. John Sykes added that clinical teams were supported to check where the gaps were and plans are in place to develop their understanding and minimise clinical variation. Ifti Majid asked the Chair of the Mental Health Act Committee to be aware of the lack of attendance at Section 136 groups as there should be two representatives who attend and this was not happening currently. **II. Quality Committee:** Maura Teager, Chair of the Quality Committee reported that she had received assurance on the progress from the Physical Healthcare Progress report provided by Haley Darn. She was surprised at the high number of suicides taking place in the home setting and was assured that this was being reported through the SIRI process. The work being carried out by Carrina Gaunt and Brenda Rhule on Health and Safety and Ligature Risk Reduction/Bariatric Patient Evacuation was considered an extremely good pairing. Carolyn Green assured the Board of the competency systems to be put in place to address the limited assurance obtained on the Medication Incidents report. This is being developed and monitored through the Nurse Leadership group. **III. Finance & Performance Committee:** Jim Dixon, Chair of the Committee, gave a verbal update on matters discussed at the meeting held on 17 March and assured the Board on matters relating to the risks within the

	Committee's governance. **IV. Audit Committee:** A written report of the meeting held on 18 March will be submitted to the April Board. **RESOLVED: The Board of Directors was assured by the contents of the Committee Summary Reports.**
DHCFT 2015/047	**<u>RAISING CONCERNS</u>** The Purpose of this report is to provide the board of directors with details of the content of the review undertaken by Robert Francis QC following continuing disquiet about the way NHS organisations deal with concerns raised by NHS staff and the treatment of some of those who have spoken up when exposing poor standards of patient care and treatment. • Robert Francis QC published the review, Freedom to Speak Up. In his report Robert Francis QC sets out 20 Principles and Actions which aim to create the right conditions for NHS staff to speak up, share what works across the NHS and get all organisations up to the standard of the best and provide redress when things go wrong in the future. • The aim of the review is to provide advice and recommendations to ensure that NHS staff feel it is safe to raise concerns, be confident that they will be listened to and their concerns acted upon. • The report has drawn lessons from the experiences of those involved in raising and handling concerns, including from staff who have suffered as a result of raising concerns Jayne Storey wanted the Board to understand that whilst there was a recognised process for raising concerns it was important that the culture of the organisation supported that process. A small task group would meet in April to map across the principles to understand how the Trust compared in practice and an action to address as appropriate. The Chairman drew attention to principle number 11 as there was discussion at the last meeting of the Council of Governors on how difficult it was to have a member of staff talk to an individual. It was recognised that it may not be easy to approach a member of the executive team who may also be the guardian of 'speaking up' and Jayne Storey acknowledged that this principle required further work. Steve Trenchard clarified that this would be covered through ESEC and agreed there was more work to be done to help people understand that everyone has a responsibility to speak up. He also felt it important to demonstrate that the Trust is listening to people when they raise concerns. Additional communication would be considered via the website and a screensaver could be developed to promote the process. These matters would be taken to ESEC at the next meeting in May and a further report on progress will be submitted to the Board in June. Carolyn Green reminded Non-Executive Directors and Executives to ask if people knew how to raise concerns when carrying out quality visits and to revisit

	the different ways that are possible. A**CTION: Principles of speaking up to be reviewed at ESEC and a further Raising Concerns report would be brought to the Board in June.** **RESOLVED: The Board of Directors:** **1) Noted the recommendations of the report** **2) Noted the responsibilities of the Board** **3) Noted the Principles and Actions required**
DHCFT 2015/048	**<u>POSITION STATEMENT ON QUALITY</u>** The purpose of this report is to provide the Board of Directors with an update on the Trust's continuing work to improve its quality of services in line with the Trust's Strategy, Quality Strategy and Framework and our strategic objectives. Carolyn Green wished to draw attention to the media work and staff engagement and she shared some aspects of clinical performance for assurance purposes. The Chairman thanked the Quality Committee for circulating the details of the CAMHS study. New guidance published on access and waiting time standards for mental health has introduced three new standards where access to services is important. The new standards have been discussed with the Trust's commissioners at the joint provider and commissioner Quality Assurance Group, and will be discussed in further detail at the Quality Committee in April to address how to meet the challenging stand on waiting times and access. Ifti Majid made the point that it is possible that data might have to be reported from May onwards from Q3 and he wanted the Board to note the limited assurance on this point. **RESOLVED: The Board of Directors noted the Quality Position Statement.**
DHCFT 2015/049	**<u>QUALITY FRAMEWORK AND STRATEGY</u>** The Board of Directors was asked to approve the contents of the Quality Framework and Strategy document and support its implementation. Carolyn Green referred to the evidence contained within framework that explained what makes Quality work and she outlined the key quality priorities: • Suicide prevention • Think! Family • Physical Healthcare • Friends and Family test • Clinical outcomes including – Payment by results • Positive and Safe including safe ward • Recovery principles These priorities would be reviewed annually in partnership with the Trust's Senior Clinical leaders and Quality Assurance Group members: • Each year we will define our outcomes

	• We will measure that our staff are aware them • Work towards and deliver on these key priorities This will define for 2015 the key areas of work for the Quality Committee and its sub-groups and will be reflected on and adjusted throughout the life of this strategy. Maura Teager pointed out that there were 11 sub-committees to the Quality Committee. Caroline Maley pointed out that the Audit Committee did not meet on a bi-monthly basis and asked for the graph to be corrected. Other minor amendments to the framework were fed through to Carolyn Green. Carolyn Green asked the Board to accept the Quality Framework Strategy and confirm its approval of the quality priorities. The Chair and members of the Board agreed to delegate approval of the Quality Framework Strategy to the Quality Committee. **ACTION: Maura Teager as Chair of the Quality Committee will receive the refined version of the Quality Framework and Strategy for agreement at the Committee's next meeting in April.** **RESOLVED: The Board of Directors noted the Quality Framework and Strategy and delegated approval to the Quality Committee.**
DHCFT 2015/050	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT AND SAFER STAFFING** The purpose of this report is to define the Trust's performance against its Key Performance Indicators (KPIs) plus any actions in place to ensure performance is maintained. Compliance with the Trust's performance indicators is being actively monitored and corrective actions are put in place where appropriate. Areas covered in this report include, the Main Performance Indicators, Health Visitors, IAPT (Improving Access to Psychological Therapies) and Ward Safer Staffing. • The recording of PbR (Payment by Results) Clusters and HONOS (Health of the Nation Outcome Scores) 12 month reviews continue to be challenging • The rate of Trust cancellations and DNAs (Did Not Attend) in outpatients is still causing concern • Health Visiting and IAPT both continue to stay above their targets Ifti Majid wished to assure the Board that all items relating to the data completion indicator were now resolved. The Chairman asked whether a more robust approach should be taken with DNAs. Ifti Majid explained that "texting" reminders to patients had a positive impact. Furthermore, his view was that DNAs showed that the Trust was not delivering services to people in a meaningful way for them. Until the Trust delivers a service in neighbourhoods an increasing or flat trend on DNAs will continue to be seen. Ifti Majid wanted to assure the Board that when a person "DNAs" a process is followed to ensure that someone from the team always attempts to contact the person who did not attend an appointment.

	Carolyn Green was impressed with the work she had seen carried out to reduce DNAs at the Hartington Unit reception during their quality visit. Since using this process there has been a significant improvement in attendance. She had asked the teams to measure effectiveness and track the response and explained that the results would be available next year for their next quality visit. She expressed a wish to hold an administration excellence event to demonstrate this work and hoped to receive funding from the Training Board or HEEM to do this. She hoped to use support from organisations such as the Samaritans or other voluntary helpline agencies or experts in this area to help administrators develop their skills in dealing with difficult calls. She expressed the need to develop administration excellence and to champion an exchange of ideas and skills. She would propose holding this event to the Training Board and the Chairman agreed this would be a very valuable exercise. The Chairman referred to the continual evidence contained in the Safer Staffing Report that services are incredibly stretched and wished to state that the Board recognised what was contained the report. In response Carolyn Green added that a very successful recruitment event had been held that had resulted in 16 candidates applying for Band 5 and 6 positions and some very positive interviews had been held. Claire Wright thought it would have been useful for the executive summary of the report to have been expanded to cover finance and activity to illustrate how these were integrated. **ACTION: Carolyn Green to propose holding an administration excellence event to the Training Board.** **RESOLVED: The Board acknowledged the current performance of the Trust and noted the actions in place to ensure improved/sustained performance.**
DHCFT 2015/051	**<u>DEEP DIVE KEDLESTON LOW SECURE UNIT</u>** David Tucker, General Manager, Specialist Services and his colleagues from the Kedleston Unit, Kaydia Allen, Acting Senior Nurse and Amy Ramful, Lead Nurse, attended the meeting to carry out in depth discussions on their view of staffing, activity and performance relating to the Kedleston Unit based at the Kingsway site. The key difficulties were listed as follows: • Significant difficulties experienced in recruiting to inpatient nursing posts • High levels of sickness absence • Difficulties are experienced in covering vacancies with temporary staff due to Bank fill rates • Action plans are in place to try and address the staffing issues • These issues have had an impact on performance • Overall, feedback received through the various feedback mechanisms available has been very good David Tucker wished to assure the Board of the actions being taken to minimise risk and address the staffing level shortfalls and assured the Board that the Unit continues to perform well despite the staffing pressures. He added that the

	division was working more efficiently across its services and difficulties were discussed amongst staff and then staff moved to support under staffed areas. This had created a sharing of resources and support was being provided from other areas to acquire a better qualified workforce although each unit could only manage a certain number within its preceptorship at any given time and this was being shared out. Nurses introduced from Cherry Tree Close had helped significantly to have qualified registered nurses working at all times. Ifti Majid asked what morale was like on the unit. In response, Kaydia Allen said she believed that morale had been affected by long term sickness. Leadership had improved recently and staff felt more supported. Teams were working very flexibl, things were improving and were not as bad as they had been. Steve Trenchard asked whether the Trust had provided enough support to develop their roles as leaders and what could the Trust to do to help staff carry out their roles better. Kaydia Allen felt fortunate to have received support to develop as a clinician and she now had opportunities to develop her leadership through many different educational opportunities. She thought managers needed to be developed to draw talent out of staff. In response to this the Chairman said he thought an adequate appraisal system should be established to utilise the development of staff. Amy Ramful said she had learnt so much from Kaydia Allen and Richard Morrow and from having a more visible leadership of people around her who she felt comfortable with. This had helped her develop. Maura Teager asked the team what they considered to be the biggest risk to the unit. Kaydia Allen said the biggest risk was staffing as there were not enough qualified nurses to cover long term sickness and it was difficult to know what to do when these issues arose. Amy Ramful reported on a successful recruitment event held recently and that experienced staff had been enrolled. Jim Dixon asked how the team wished to be known in the community and whether preparation was being made to challenge any stigma that might arise from the new housing development on Kingsway due to its close proximity to the unit. Kaydia Allen felt there was a stigma held with the Kedleston Unit and this was felt by both service users and nurses. The staff work with mentally ill service users who have been through the criminal justice system and some people might not like to know this is happening on their door step. Nurses see these people as service users and do not judge them and it is best to think like this to be effective in their work. John Sykes also asked about the stigma associated with the Kedleston Unit and wondered if there was an opportunity to engage with the community that is moving closer to the site. He felt it would be a good idea to attend meetings in the community so new residents would be aware of the type of service users being cared for in the Kedleston Unit. Caroline Maley asked what could help the unit's service users and staff. Kaydia Allen felt it would be useful to have improvements made to the visitors' area facilities. She realised this was a big development to ask for but it would make a huge difference to the visiting area for families and carers and would have a positive impact on the service users. She would also like to work towards Royal

	College of Psychiatrists accreditation (AIMS) and move into accreditation status. Carolyn Green asked if there was there anything that could be done to help staff have a more resilient way of working in a pressured area. Kaydia Allen believed specific training in forensic care would help and added that lack of extended training might have been the reason why staff moved out of the service as in the past when she had carried out appraisals staff had wanted to develop but had struggled to access extended education that was key to their service. This was, in part, due to the realities of the Learning Beyond Registration restrictions. She also felt staff were not fully utilising their skills and they should be developed more for degree and master level study in this area of mental health work in the hope that this would improve retention of staff and their clinical competence. Ifti Majid pointed out that the Board had asked questions relating to morale, leadership, sickness and recruitment and in return had heard about the ambitions of the unit and the obstacles that were getting in the way. He asked members of the Board if they had received a level of assurance. The Board agreed that strong assurance was obtained on the leadership and management of the unit and wished to see sustainability of the actions put in place. Carolyn Green said she would like to see a CPD retention training plan for staff to make sure that today's discussions were carried through. The Chairman felt it important to increase the capacity and competence of staff and to look at how long term sickness and absence is addressed and deal with this in terms of the Trust's values. Jim Dixon requested that the Board looked at improving the visitors' facilities at the Kedleston Unit. Steve Trenchard praised the team for their outstanding work and for thanked them for attending the meeting and discussing their opinions. **ACTION: Ongoing review of the quality of the appraisal system to continually focus on staff development** **ACTION: The Education team to work actively with the Kedleston Unit leadership team on a CPD retention training plan.** **RESOLVED: The Board of Directors reviewed and discussed the contents of the Staffing Levels Solutions report and endorsed the steps taken to address the issues raised.**
DHCFT 2015/052	**<u>FOR INFORMATION</u>** **I. Board Forward Plan** Claire Wright pointed out that the Board Forward Plan would need to be updated for two items that would transfer responsibility from Claire Wright to Mark Powell .Carolyn Green suggested that the Safeguarding Committee summary report would also need to be added to the forward plan. **II. Deep Dive Selection** It was agreed that County CAMHS staff levels and capacity would be the subject of the Deep Dive.

DHCFT 2015/053	**CLOSE OF THE MEETING** The Chairman thanked all of those present for their attention and comments and closed the public meeting at 4:10 pm.

DATE OF NEXT MEETING

The next meeting of the Board in public session is scheduled take place on Wednesday, 29 April 2015 at 1.00 pm. in Conference Rooms A & B, R&D Centre, Kingsway Site, Derby, DE22 3LZ (confidential session to commence earlier at 10.30 am).

BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - APRIL 2015						Enc B
Date	**Minute Ref**	**Action**	**Lead**	**Status of Action**	**Current Position**	
24.9.2014	DHCFT 2014/149	Committee Reports	ALL	Committee reports to follow a consistent model with a strong emphasis on evidence of assurance obtained.	29.10.2014 Actions from internal audit, revised report front sheet and Terms of Reference and Scheme of Delegation will be brought to the January Audit Committee and then the January Board meeting. 26.11.2014 Revised front sheet report and ToR and SOD to be brought to January Audit Committee and then January Board meeting. 14.1.2015 On agenda for both January Audit Committee and January Board. 28.1.2015 Actions from internal audit, revised report front sheet and Terms of Reference and Scheme of Delegation would be now be covered in the March meeting of the Audit Committee and then to the Board. 25.2.2015 Actions from internal audit, revised report front sheet and Terms of Reference and Scheme of Delegation would be covered in the April meeting of the Audit Committee and scheduled to be brought to the Board in May.	Green
28.1.2015	DHCFT 2015/002	Patient Story - Experience with CAHMS.	Carolyn Green	Quality Committee to pursue inequalities within autism services. Coaching in communication difficulties within autism to form part of medical staff's professional development programme.	16.2.2015 The agenda is pressured at this time, this work will be scheduled for May 2015. 25.2.2015 - Quality Committee to pursue inequalities within autism services. Coaching in communication difficulties within autism to form part of medical staff's professional development programme and an update to be provided by John Sykes to the Board in May.	Yellow
28.1.2015	DHCFT 2015/006	Chief Executive's Report	ALL	Anna Shaw and the Comms Team to be informed of changes within the neighbourhood services.	16.2.2015 Ongoing. 25.3.2015 Turned green at March Board	Green
28.1.2015	DHCFT 2015/008	Corporate Governance Framework	Jenna Davies	Agenda item for April.	Was reviwed at Audit Committee on 18 March and planned for April Board.	Yellow
28.1.2015	DHCFT 2015/010	Committee Summary Reports	Jenna Davies	Actions to address consistency and level of detail of the summary reports would form part of the governance framework exercise.	16.3.2015 Discussed at Board Development on 11 March and agreed to trial a new model. Additionally short life task and finish group to be established to review integrated options for some Board Committees. 20.4.2015 The short life working group will need to complete its review of board governance before the final framework is completed for ratification by the Board. Initial date has now been set and the June Board is realistic timeframe for this work to be competed.	Green
28.1.2015	DHCFT 2015/016	Integrated Performance and Activity Report and Safer Staffing	Jayne Storey	Jayne Storey to monitor/analyse attendance at inductions. Ifti Majid and Jayne Storey to hold discussions on the position of the workforce dashboard.	17.1.2015 Inductions will be monitored and reported back to ESEC. Workforce Dashboard to be concluded. 25.2.2015 A date would be agreed for discussions and an update brought to the next Board meeting. 16.4.2015 Key Metrics included within April Board report	Green

25.2.2015	DHCFT 2015/030	NHS National Staff Survey Results	Jayne Storey	The results of the survey would be submitted to the next ESEC meeting in May and transparency of actions would be submitted to	On plan for ESEC and Board in May. Forward Plan reflects this.	Yellow
25.3.2015	DHCFT 2015/041	Chief Executive's Report	Anna Shaw	Governors are required to undergo DBS checks. Anna Shaw to lead the Governors' DBS exercise.	Governors have all been requested to complete the DBS documentation. Action ongoing.	Orange
25.3.2015	DHCFT 2015/041	Chief Executive's Report	Ifti Majid/Jayne Storey	An audit of CRB checks to be undertaken under the lead of Ifti Majid and Jayne Storey and referred to the Employee Strategy and	To be circulated prior to the April Board.	Green
25.3.2015	DHCFT 2015/050	Integrated Performance and Activity Report and Safer Staffing	Carolyn Green	Carolyn Green to propose holding an administration excellence event to the Training Board	Not completed as yet. Up-date will be available in June	Orange
25.3.2015	DHCFT 2015/051	Deep Dive Kedleston Low Secure Unit	Ifti Majid	Ongoing review of the quality of the appraisal system to continually focus on staff development	Briefing completed through Divisional structures reminding of importance of picking up staff development as part of PADR process. We have also just agreed to check all of the governors and Jayne Davies has the forms for processing.	Green
25.3.2015	DHCFT 2015/051	Deep Dive Kedleston Low Secure Unit	Jayne Storey and Education	The Education team to work actively with the Kedleston Unit leadership team on a CPD retention training plan.	Temporary staffing (Bank) are compliant through the temporary staffing office and we audit this, the key piece of work will be to track agency staff where we have had to use agencies not provided through the temporary staffing office. Action ongoing.	Orange

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

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 29 April 2015

Chairman's Report

Background

It has been agreed that the Chair submits a written report to the Board.

Key Themes

The following substantial meetings/visits have been made during the month:

- Attended the Interview for Consultant Community Paediatrician on 26 March
- Presentation by Laurence Baldwin - Children and Adolescent Mental Health Service (CAMHS) and Q&A (Erewash South) on 31 March
- Non-Executives' Quarterly meeting on 1 April
- Attended Integrated Service Delivery Board meeting on 2 April
- Met with Moosa Patel from Capsticks to discuss Consultancy Services on 7 April
- Attended the Governor Finance & Strategy meeting on 7 April
- Met with Karen Richie and John Simmons from Healthwatch Derbyshire 7 April
- Attended Quality Committee Meeting on 9 April
- Attended a Quality Visit to the A&E Liaison Services North on 13 April
- Attended the Board Development Session on 15 April
- Attended Richard Morrow Mindfulness presentation and Q&A Derby East on 16 April
- Attended and chaired the 4Es Stakeholder Meeting on 21 April
- Attended the Quality Visit at Audrey House, Derby on 22 April
- Attended the Quality Visit at ATSS Specialist Business Unit on 22 April
- Attended the Patient Participation Group meeting on 23 April
- Attended the Quality Visit at School of Nursing Services on 24 April
- Attended the Leadership Event on 28 April

I also held some appraisal sessions for NEDs.

Key points were:
1. Our external advisers on transformation have produced data relating to our future service options with in some cases superficially surprising results. I have encouraged some further exchanges with them.
2. A useful meeting with Healthwatch Derbyshire confirming our strong but appropriate relationship with them.
3. Well-attended meetings in Derby and Erewash to showcase aspects of the Trust's work and recruit members and governors. There has been good interest in most of the vacancies.
4. Good evidence that, to slightly varying degrees, teams are utilising the CQC-oriented model for Quality Visits.

Legal Issues
There are no legal issues arising from this Board report.

Equality Delivery System
There are no specific impacts on REGARDS groups arising directly from this report.

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

Recommendation

The Board of Directors are requested:
1) To note the paper and challenge me on any item.

Report Prepared by: **Mark Todd**
Chairman

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 25th March 2015

Chief Executive's Report

1. Introduction

This is my regular monthly report to the Derbyshire Healthcare NHS Foundation Trust Board of Directors. It provides a context to the issues the Board will be considering at the meeting, a brief résumé of what we have been working on in the month, and a guide to the agenda and papers. It is written as a communication aide for those reading our papers online or attending the meeting in person.

2. Context, strategy (vision and execution) and updates from the month

National Context

2.1 There is continued discussion in the run up the general election about parity of esteem, funding for mental health services and the need to identify funding for future investment against reported funding reduction of 8% over the last parliament.

2.2 The financial performance of the NHS provider sector continues to be a cause for national debate both within the political sphere and by the Health Think-Tank The Kings Fund.

2.3 A summary of the health pledges within the manifestos released by the Conservatives, Labour and Liberal Democrats, with an overview of the Green Party and UKIP policies, is available to read at http://www.nhsproviders.org/resource-library/general-election-manifestos-april-2015/

2.4 A Mental Health Taskforce has been established to develop a new five year national strategy for mental health covering services for all ages which will be published in autumn 2015. This will be the first time there has been a NHS England-led strategic approach to designing mental health services for all ages spanning the health and care system. The terms of reference for the work of the taskforce can be found at http://www.england.nhs.uk/wp-content/uploads/2015/03/mh-tor-fin.pdf

Local Context

2.5 The Trust was actively involved as a partner in a visit to Erewash by the national Vanguard team on 20 and 21 April. We joined Derbyshire Community Health Services NHS FT, Derbyshire Health United and Erewash Commissioners and General Practitioners in setting out the vision and ambition for this new pilot.

2.6 Our services remain very busy due to the demand on them and the weekly operational meetings have continued in response to the increased demand, the

need to manage staffing shortfalls and to ensure that services are maintained at safe levels.

2.7 I opened the 'Borderline Arts' Art Exhibition at The Quad on Monday 20 April. Borderline Arts are a small charity striving to breakdown stigma in mental health.

2.8 On 24 April I opened the Care Co-ordination Association national conference titled 'Stronger Code, Better Care? Exploring and Considering Implementation of the New Mental Health Act Code of Practice'.

2.9 The Health Visiting Service has been awarded the Baby Friendly Initiative (Stage 3) which is an excellent achievement. The standards have been designed to support pregnant women to recognise the importance of breastfeeding and early relationships for the health and well-being of their baby. Our thanks and congratulations go to Susan Earnshaw and David Tucker for their leadership and to all Health Visitors who participated in the external assessment.

3. Key issues before the Board today

I ask that our Board challenge each other on all aspects relating to the issues before it today in order to gain necessary assurance on items pertaining to safety (particularly our response to increased demand and service pressures), effectiveness (such as information governance), and responsiveness in delivering NICE compliant services (through the deep dive of CAMHs in the County).

Legal Issues

There are no legal issues arising from this Board report at this time.

Equality Delivery System

None specifically.

Consultation

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

Recommendation

The Board of Directors are requested:

1) To note and discuss the paper and challenge me on any item.

Report Prepared by: **Steve Trenchard**
Chief Executive

Derbyshire Healthcare NHS Foundation Trust
Report to Public Board 29th April 2015

Information Governance- Quarter 4 report

This report provides our performance update on our Quarter 4 progress towards meeting the requirements of the 2014-15 Version 12 Information Governance Toolkit as well as the work of the Information Governance Committee and Information Governance breach monitoring.

Executive Summary

- The IG Toolkit was submitted on 31st March 2015 at 96% and satisfactory. This keeps DHCFT at the forefront of our category as the highest scoring Mental Health and Community Trust
- The IGC continues to progress the agreed work programme
- There has been a marked decrease in the number of reported IG incidents and no new reportable incidents this quarter

Strategic considerations

- To maintain high level of organisational performance

(Board) Assurances

- Full assurance on our IGT V 12 Toolkit submission
- Full that we continue to progress the IG agenda
- Full assure that IG breaches are monitored and responded to appropriately including any actions required

Consultation

- This report will be presented at Aprils Information Governance Committee

Governance or Legal issues

- Compliance with the IG Toolkit forms an important pillar of assurance around data protection (The Data Protection Act), confidentiality and information security

Equality Delivery System

- A high level of compliance I the IG Toolkit supports improved practice around data collection that enables analysis of activity supporting improving outcomes for all REGARDS Groups

Recommendations

The Board of Directors is requested to:

- To acknowledge the successful completion of the IG Toolkit
- To acknowledge the progress made with the IG workplan

Report presented by: Ifti Majid

Report prepared by: Audrey Sirrel

INFORMATION GOVERNANCE Q4 (Jan- March 2015) Report

INTRODUCTION

This report provides information on our Version 12 Information Governance Toolkit submission demonstrating we have met all the requirements for 2014-15 at level 2 or above. We have met our target of 96% and Satisfactory and remain top in our category.

BACKGROUND

- The annual cycle of Information Governance (IG) implementation starts with the publication of the IG Toolkit which enables organisations to self- assess baseline compliance and develop plans to achieve improvements in-year, prior to the final annual return submitted at year end.
- V12 of the toolkit requires the 3-stage reporting process requiring organisation's to carry out the following stages:
- Baseline assessment on 31st July 2014.
- Performance update on 31st October 2014. This was submitted showing 65% attainment and Not Satisfactory.
- Final submission by 31 March 2014. The Annual Return to be submitted on line as in previous years with our IG Statement of Compliance (IGSOC). We have achieved 96% and Satisfactory

1. To be considered "satisfactory" a Trust must obtain level 2 for all IG criteria. We have obtained level 3 for 40/45 criteria This includes the requirement for Trust Board involvement at the "highest level" in reviewing specified IG policies and the IG Management framework.

FINAL SUBMISSION STATUS

Assessment	Stage	Overall Score	Self-assessed Grade	Reviewed Grade	Reason for Change of Grade
Version 12 (2014-2015)	Baseline	65%	Not Satisfactory	n/a	n/a
	Performance Update	65%	Not Satisfactory	n/a	n/a
	Published	96%	Satisfactory	n/a	n/a

PROGRESS OF THE 2014-15 IG WORK PROGRAMME

The following planned priorities were agreed for 2014-15: these have all been achieved

2. To complete the IG Toolkit so that all relevant (45) standards were achieved at a minimum level 2 or above producing a score of 96% compliance. This will produce an overall rating of "Satisfactory" allowing us to submit our annual IGSOC. It should be noted that one Information Governance requirement (11-112) states that all staff (95%) are fully trained in IG awareness. Our final submission was at 95.3% compliance. This

is a significant undertaking for the Trust especially given the increase in staff with the acquisition of new services. We continue to address the issues we have capturing new starters, manual updating from face to face training and unavailable staff.

To continue to review and update policy in line with National Guidance. To continue to promote IG awareness.

INFORMATION GOVERNANCE COMMITTEE

The IGC has met twice this quarter. The IGC has reviewed and ratified a number of IG and IT policies to ensure that they incorporate any legal changes or guidance provided by the ICO. The focus has been to ensure that all policies reflect the introduction of Electronic Patient Records and Caldicott 2. The IG policy dashboard for year end shows us at 100% with no policies out of date. The IGC has ratified a number of new applications and Information Sharing Agreements.

INFORMATION GOVERNANCE BREACHES

During this quarter we have had no new level 2 reportable SIRIS The table below shows this quarters incidents broken down by outcome with no major or catastrophic breaches. We continue to get a number of incidents reported which have originated outside the Trust which the Information Standards Manager liaises on. We also continue to liaise with Patient Experience as required.

	Insignificant	Minor	Moderate	Total
Breach of Confidentiality - Verbal	1	2	0	3
Electronic Record - Incorrect address or other personal details	1	1	0	2
Electronic Record - Other electronic breach	1	3	5	9
Electronic Record - Unsafe e-mailing of confidential information	0	2	0	2
Paper Record - Breaches related to faxing	0	1	0	1
Paper Record - Incorrect address or other personal details	4	4	0	8
Paper Record - Missing/Lost document(s)	1	1	0	2
Paper Record - Missing/Lost record(s)	0	1	0	1
Paper Record - Other paper record breach	1	5	3	9
Paper Record - TNT unable to locate	0	1	0	1
Paper Record - Unauthorised access to clinical record (Actual or Potential)	0	1	0	1
Total	9	22	8	39

RISKS

The main risks remain:

- IG Breaches which are SIRI reportable to the ICO at Level 2

Year End Benchmark Position

Derbyshire Healthcare's attainment level of 96% and Satisfactory maintains our position as the highest achieving Trust within the Mental Health and Community category.
Benchmarking report attached as enclosure 1

Audrey Sirrel

Assessment Version 12 (2014-2015)

Organisation Name	Level 0	Level 1	Level 2	Level 3	Not Relevant	Total Req'ts	Overall Score	Self assessed Grade
Derbyshire Healthcare NHS Foundation Trust	0	0	5	40		45	96%	Satisfactory
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	0	1	6	38		45	94%	Not Satisfactory
TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST	0	0	8	37		45	94%	Satisfactory
SOUTH STAFFORDSHIRE AND SHROPSHIRE HEALTHCARE NHS FOUNDATION TRUST	0	2	4	38	1	45	93%	Not Satisfactory
BRADFORD DISTRICT CARE TRUST	0	0	10	34	1	45	92%	Satisfactory
EAST LONDON NHS FOUNDATION TRUST	0	0	11	34		45	91%	Satisfactory
SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	0	0	12	33		45	91%	Satisfactory
CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST	0	0	13	32		45	90%	Satisfactory
LEICESTERSHIRE PARTNERSHIP NHS TRUST	0	0	13	32		45	90%	Satisfactory
LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	0	1	10	33	1	45	90%	Not Satisfactory
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	0	0	12	32	1	45	90%	Satisfactory
KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	0	0	16	29		45	88%	Satisfactory
SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST	0	0	16	29		45	88%	Satisfactory
TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	0	0	16	29		45	88%	Satisfactory
CAMDEN AND ISLINGTON NHS FOUNDATION TRUST	0	0	17	27	1	45	87%	Satisfactory
CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	0	0	18	27		45	86%	Satisfactory
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	0	0	18	27		45	86%	Satisfactory
2GETHER NHS FOUNDATION TRUST	0	0	21	23	1	45	84%	Satisfactory
MERSEY CARE NHS TRUST	0	0	22	22	1	45	83%	Satisfactory
OXLEAS NHS FOUNDATION TRUST	0	0	22	22	1	45	83%	Satisfactory
GREATER MANCHESTER WEST MENTAL HEALTH NHS FOUNDATION TRUST	0	0	23	22		45	82%	Satisfactory
NOTTINGHAMSHIRE HEALTHCARE NHS TRUST	0	0	23	22		45	82%	Satisfactory
OXFORD HEALTH NHS FOUNDATION TRUST	0	0	23	21	1	45	82%	Satisfactory
SOUTHERN HEALTH NHS FOUNDATION TRUST	0	0	24	21		45	82%	Satisfactory

DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST	0	0	25	20		45	81%	Satisfactory
HUMBER NHS FOUNDATION TRUST	0	0	25	19	1	45	81%	Satisfactory
LANCASHIRE CARE NHS FOUNDATION TRUST	0	0	24	20	1	45	81%	Satisfactory
Worcestershire Health and Care NHS Trust	0	0	24	20	1	45	81%	Satisfactory
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	0	0	26	19		45	80%	Satisfactory
CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	0	0	26	18	1	45	80%	Satisfactory
NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	2	0	20	23		45	80%	Not Satisfactory
CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	0	0	27	17	1	45	79%	Satisfactory
HERTFORDSHIRE PARTNERSHIP UNIVERSITY FOUNDATION NHS TRUST	0	0	27	17	1	45	79%	Satisfactory
AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	0	0	30	14	1	45	77%	Satisfactory
BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	0	0	30	14	1	45	77%	Satisfactory
Solent NHS Trust	0	0	31	14		45	77%	Satisfactory
5 BOROUGHS PARTNERSHIP NHS FOUNDATION TRUST	0	0	31	13	1	45	76%	Satisfactory
DEVON PARTNERSHIP NHS TRUST	0	0	32	12	1	45	75%	Satisfactory
LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	0	0	33	11	1	45	75%	Satisfactory
SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	0	0	33	11	1	45	75%	Satisfactory
WEST LONDON MENTAL HEALTH NHS TRUST	1	1	28	15		45	75%	Not Satisfactory
Black Country Partnership NHS Foundation Trust	0	0	34	11		45	74%	Satisfactory
MANCHESTER MENTAL HEALTH AND SOCIAL CARE TRUST	0	0	34	10	1	45	74%	Satisfactory
SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST	0	0	34	11		45	74%	Satisfactory
NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	0	0	36	8	1	45	72%	Satisfactory
NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	0	0	36	8	1	45	72%	Satisfactory
CALDERSTONES PARTNERSHIP NHS FOUNDATION TRUST	0	0	37	7	1	45	71%	Satisfactory
COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	0	0	39	6		45	71%	Satisfactory
NORTH ESSEX PARTNERSHIP NHS FOUNDATION TRUST	0	0	39	5	1	45	70%	Satisfactory
DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	0	0	41	4		45	69%	Satisfactory
NORTH EAST LONDON NHS FOUNDATION TRUST	0	0	40	4	1	45	69%	Satisfactory
PENNINE CARE NHS FOUNDATION TRUST	0	0	41	3	1	45	68%	Satisfactory
Rotherham Doncaster and South Humber NHS Foundation Trust	0	0	44	1		45	67%	Satisfactory

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	0	0	45	0		45	66%	Satisfactory
Sheffield Health & Social Care NHS Foundation Trust	0	0	45	0		45	66%	Satisfactory
SOMERSET PARTNERSHIP NHS FOUNDATION TRUST	0	0	45	0		45	66%	Satisfactory
SOUTH WEST YORKSHIRE PARTNERSHIP FOUNDATION NHS TRUST	0	0	44	0	1	45	66%	Satisfactory

Grade key

Not Satisfactory	Not evidenced Attainment Level 2 or above on all requirements (Version 8 or after)
Satisfactory with Improvement Plan	Not evidenced Attainment Level 2 or above on all requirements but improvement actions provided (Version 8 or after)
Satisfactory	Evidenced Attainment Level 2 or above on all requirements (Version 8 or after)

Version 12 reports are not available for the following organisations:

African and Caribbean Mental Health Services
BEDFORDSHIRE AND LUTON MENTAL HEALTH AND SOCIAL CARE NHS TRUST
BUCKINGHAMSHIRE MENTAL HEALTH NHS TRUST
COUNTY DURHAM AND DARLINGTON PRIORITY SERVICES NHS
EAST KENT NHS AND SOCIAL CARE PARTNERSHIP TRUST
EAST SUSSEX COUNTY HEALTHCARE NHS TRUST
NEWCASTLE, NORTH TYNESIDE AND NORTHUMBERLAND MENTAL HEALTH TRUST
NORTH WEST SURREY MENTAL HEALTH NHS PARTNERSHIP TRUST
NORTHGATE AND PRUDHOE NHS TRUST
OXFORDSHIRE LEARNING DISABILITY NHS TRUST
Richmond General Practice Alliance Ltd
SOUTH OF TYNE AND WEARSIDE MENTAL HEALTH NHS TRUST
SUFFOLK MENTAL HEALTH PARTNERSHIP NHS TRUST
Surrey and Hampshire Borders NHS Trust
SURREY OAKLANDS NHS TRUST
TEES AND NORTH EAST YORKSHIRE NHS TRUST
WEST KENT NHS AND SOCIAL CARE TRUST
WEST SUSSEX HEALTH AND SOCIAL CARE NHS TRUST
WORCESTERSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors

People Strategy Update

The purpose of this report is to share with the Board our planned approach to delivering on our People Strategy, with particular focus on our values

We deliver excellence
We involve our people in making decisions
We focus on our people
We put our patients at the centre of everything we do

Areas focussed on within this update include the building blocks to delivering the strategy, the approach to developing our leaders, our planned activities following the publication of the National annual staff survey and the key People metrics, which continue to be monitored.

Executive Summary

- The **People Strategy** 2011-2015 has five primary aims, these have been translated into a number of **building blocks** and will form the basis of the strategy review for 2016 onwards
- **Collective Leadership**: There will be more focus on our leaders, delivering better patient care through competent, caring and compassionate staff. An initial 'Spotlight on our Leaders' event will be taking place in early June that will focus on our role as leaders and equipping for the challenging times ahead.
- **Engagement**: Following the results of the staff survey, a number of 'conversations' across the Trust are taking place to understand the 'why' behind the responses, these will be collated and presented back to the People Forum, Board and wider organisation as an 'annual health check'
- **The Employment Relationship / Getting the Basics right**: A number of consultations are taking place to implement rotation of shifts and across ward areas to enhance skills and personal development in addition to building a more **flexible workforce**. There continues to be a fairly high number of both disciplinary and grievance cases. We are continuing a monthly rolling programme of generic **recruitment** for qualified nursing posts across the organisation. We successfully recruited 16 nurses from the February/March events with a further planned event in April. **Partnership working** with collective staff side, this is an improving relationship, with both JNCC and LNC working well and are working on a formal partnership agreement. HR policy development has improved the position in relation to current employee related policies and procedures.
- Our **key People metrics** demonstrate how we compare to our Trust targets and national / local benchmark data where available. It is proposed that a more detailed review of key metrics supported by the annual health check is received by the People Forum and reported back to Board. The metrics demonstrate the challenging environment that we are facing and even more imperative to support staff through these times. It is critical that our workforce planning becomes more dynamic to anticipate the workforce needs and movement over the coming few years.

Strategic considerations

- How do we continue to engage and energise staff during a period of large scale change whilst maintaining business as usual?

(Board) Assurances

- People metrics
- A building block framework to support the strategy refresh
- A refocused ESEC –with emphasis on our values 'We focus on our People'

Consultation

- The detail behind this report will be discussed at the People Forum.

Governance or Legal issues

There are no legal issues arising from this Board Report.

Equality Delivery System

The detailed analysis of the staff survey by protected groups will be analysed and any issues raised as a result will be explored at the People Forum.

Recommendations

The Board of Directors is requested to:

1) Acknowledge the continuing delivery of the People Strategy with particular emphasis on leadership and staff engagement within this update.

2) To note the key metrics and proposed actions

Report presented by: **Jayne Storey**
Director of Transformation

Report prepared by: **Jayne Storey**
Director of Transformation

People Strategy - update

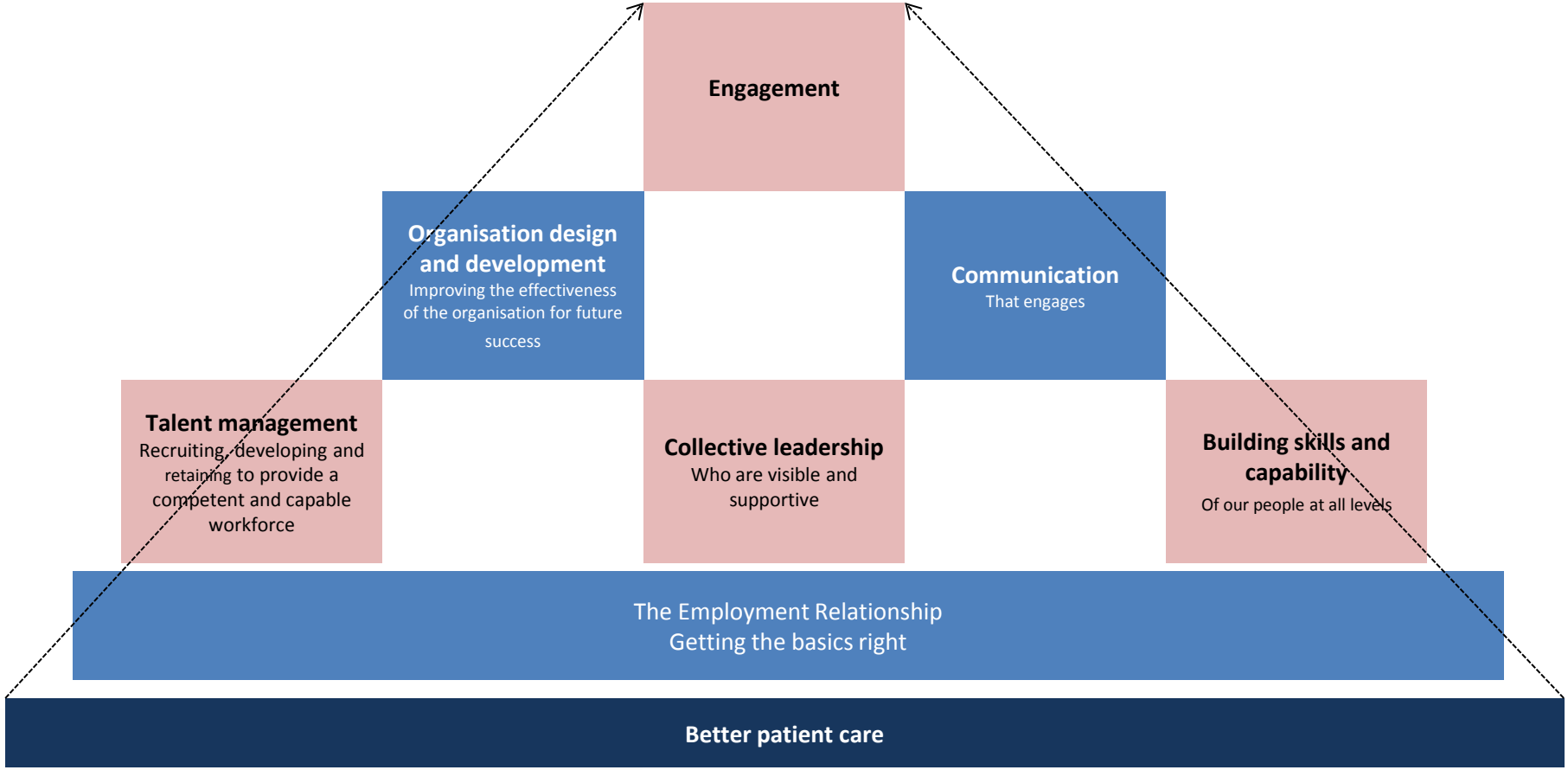
April 2015

People Strategy Building Blocks

Derbyshire Healthcare NHS
NHS Foundation Trust

The strategy consists of five primary aims:

- Engaging our people
- Educating and developing our people
- Maximising the potential of our people
- Our peoples' working environment
- Management of change.

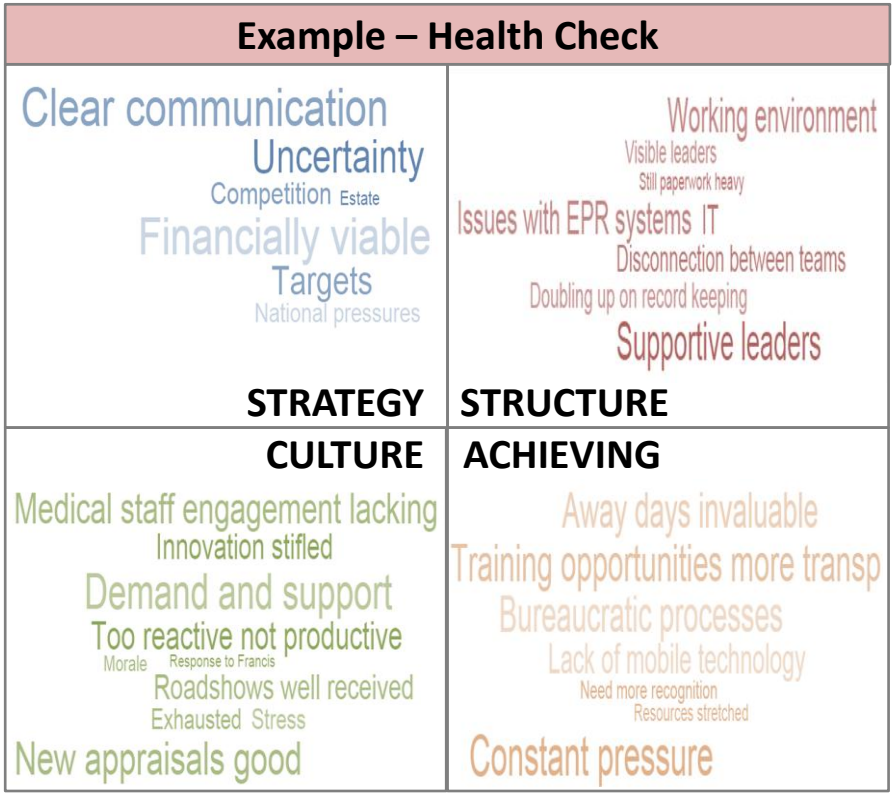


Involving and engaging our People

Derbyshire Healthcare NHS
NHS Foundation Trust

Diagnostic - hard data	Health check - conversational	Building a Better Future Together - involving and listening to our people	Leader led Programme of Engagement	'You said - we heard - we did'
Staff Survey 2014 results - Trust and Service Line Previous 12 months key KPI's Trust / SL Action Planning Meeting - scheduled 26th March **Outcomes:** Clear road map of activities for the next 12 months	Focus Groups Exit data Identify the 'push pull factors (barriers/enablers) Define what we mean by engagement and high performance leading to better patient care **Outcomes:** Visual Health check Regular effective 2-way communication Defined brand: Building a Better Future Together 'Shared Purpose'	Re-focus ESEC to reflect People Forum Spotlight on our Leaders Collective leadership Emphasis on visible leadership Effective communication Revisit behaviors to support values	Sub group of People Forum - tasked to lead and develop Team sessions Removing un-necessary activities Focus on our People etc Detailed review of staff survey results at a local level **Outcomes:** A series of 'branded ' team sessions Indicative timeline	Invited to Board/Board development People Forum / champions invited to Board development Feedback to teams on progress since Health check Key two way communication - the journey so far, understanding our culture, 'you said, we heard, we did' **Outcomes:** Key comms to organisation – the journey so far, evidence of shifting the culture
March	April/May	May/June	June/July	August

Example – Health Check



WE FOCUS ON OUR PEOPLE

Better together

Collective Leadership

Derbyshire Healthcare NHS
NHS Foundation Trust

Visible Leadership

Supporting Change		Building Capacity		Engagement & Inclusion
Leadership	**Coaching**	**Talent Management**	**Workforce Planning**	**Widening Participation**
Understanding the corporate issues & Leadership Challenges	Skills To Develop Staff	Personal Achievement & Development Review	Context - Trust & National	Engaging Bands 1-4
Personal Impact - Leadership skills development offer for all staff	Team Coaching	Talent Management Process and Protocols	Workforce Trends and Implications	Apprenticeships
Management Technical Skills	Coaching Training	Succession Planning	Impact of Transformation	Community Engagement & Work Experience
	Internal Coaching Network	Creating Development Opportunities	LETB requirements	Wider Workforce Funding
	Crucial Conversations			
	Derbyshire Networking			

Derbyshire H&SC Community Integrated Systems

Key People Metrics

Derbyshire Healthcare NHS
NHS Foundation Trust

	Mar 2014		Feb 2015	Mar 2015	Target	Benchmark
Annual Staff Turnover	9.44%	Regularly review hot spot areas	9.29%	9.51%	10%	NHS **8.89%** National MH&LD **11.63%** East Mids MH&LD **10.98%**
Compulsory Training	81.18%	Continued focus and improved access	81.13%	82.48%	95%	East Mids MH&LD **80%**
Appraisal Compliance	73.01%	Live Workforce Dashboard and ESR MSS	78.73%	76.95%	90%	NHS **83%** National MH&LD **88%** East Mids MH&LD **87%**
Sickness Absence	4.43% M 4.57% A	Leaders receive alerts and reports via FirstCare	4.98% M 4.81% A	5.18% M 4.92% A	3.9%	NHS **4.26%** A National MH&LD **4.81%** A East Mids MH&LD **4.86%** A
Active Recruitment	14 posts	Establishment Control Group	78 posts	55 posts		
Variance from Funded Establishment	15.33%	5% tolerance against target	13.49%	13.65%	90% staff in post	

Compulsory Training Dec 2014 Benchmark source: ***East Mids Streamlining Prog***

Annual Staff Turnover Dec 2014 & Sickness Absence Nov 2014 Benchmark source: ***HSCIC NHS iView***

Appraisal Compliance Oct 2014 Benchmark source: ***NHS Staff Survey 2014***

Feb 2015 V Mar 2014

Mar 2015 V Feb 2015

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Within Trust Target Parameters

Outside Trust Target Parameters

WE FOCUS ON OUR PEOPLE

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Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors –29th April 2015

Register of Trust Sealings 2014-15

Purpose of Report

This report provides the Trust Board with an account of the authorised use of the Foundation Trust Seal during 2014-15.

Executive Summary

- In accordance with the Standing Orders of the board of directors the Foundation Trust Seal is affixed to legal transactions, including deeds, transfer and letting of contracts over £100,000.
- These transactions will apply where the board has previously approved the business through the Capital Expenditure Plan or the Estates and Agile Working Strategy.

Governance or Legal issues

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

Equality Delivery System

This report has a neutral impact on REGARDS groups

Recommendations

The Board of Directors are requested to:

1) Note the authorised use of the Foundation Trust Seal during 2014-15

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

Report prepared by: **Sue Turner**
Executive Administrator, Corporate & Legal Affairs

Derbyshire Healthcare NHS Foundation Trust

Register of Sealings 2014-15

CONSECUTIVE NUMBER	DATE OF SEAL	DESCRIPTION OF DOCUMENT SEALED
DHCFT36	30.07.14	ICT Agreement (dated 19 July 2012) between Derbyshire Healthcare NHS Foundation Trust and Civica UK Ltd relating to clinical information systems – Civica UK Ltd registered 1628868; with associated schedules and signed side letter. Electrical Patient Record System (PARIS) (executed in duplicate).
DHCFT37a	10.12.14	Intermediate building contract 204 JCT between Derbyshire Healthcare NHS Foundation Trust and Peter Baines Ltd in the sum of £171,684. Work to first floor, Ripley Library, Grosvenor Street, Ripley.
DHCFT38	10.12.14	Richmond Letcombe Ltd and Derbyshire Healthcare NHS Foundation Trust. Deed of variation relating to development adjoining former Aston Hall Hospital, Aston on Trent, Derby. Schedule 1 Deed of Convenant, Covenantor agreed to enter deed prior to taking disposition
DHCFT37b	05.01.15	Intermediate Building Contract 2011 - duplicate contract (as DHCFT37a above)
DHCFT38a	05.01.15	JCT minor works building contract 2011 between Derbyshire Healthcare NHS Foundation Trust and Peter Baines Ltd. Alteration of toilet accommodation, stores etc at St. Andrews House, London Road, Derby in the sum of £219,422 in duplicate.
DHCFT39	03.02.15	Lease relating to Erewash House, Ilkeston. Land transaction return for HM Revenue and Customs.
DHCFT40	03.02.15	Deed of Variation relating to land at Aston Hall Hospital

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors - 29th April 2015

Corporate Governance
Register of Directors' Interests 2014-15

Purpose of Report

This report provides the Trust Board with an account of directors' interests during 2014-15.

Executive Summary

- It is a requirement that the Chairman, Board members and Board-level Directors who regularly attend the Board and current members, should declare any conflict of interest that may arise in the course of conducting NHS Business.
- The Chairman and Board members should declare any business interest, position of authority in a charity or voluntary body in the field of health and social care, and any connection with a voluntary or other body contracting for NHS services. These should be formally recorded in the minutes of the Board, and entered into a register, which is available to the public.
- Directorship and other significant interests held by NHS Board members should be declared on appointment and kept up to date.

Board Assurances

Directors are asked to disclose to the meeting any changes to the Register of Directors' Interests during the course of the year.

When reviewing their disclosures, each Board member has personally reaffirmed in writing their agreement to comply with the NHS Codes of Conduct and Accountability, and the Seven Principles of Public Life (Nolan), and to state whether there is any relevant audit information of which the Trust's Auditors are unaware.

Governance or Legal issues

The disclosure and statements referenced within this report are subject to the NHS Code of Conduct and Accountability and Licence Conditions of the Foundation Trust.

Equality Delivery System

This report has a neutral impact on REGARDS groups

Recommendations

The Board of Directors are requested to:

1) Approve and record the declarations of interest as disclosed. These will be recorded in the Register of Interests which is accessible to the public at the Trust Head Office and will be listed in the Trust's annual report and accounts for 2015-15.
2) Record that all directors have signed as to compliance with the NHS Codes of Conduct and Accountability and Nolan principles; no relevant audit matters have been declared.

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

Report prepared by: **Sue Turner**
Executive Administrator, Corporate & Legal Affairs

Declaration of Interests Register 2014-15

NAME	INTEREST DISCLOSED	TYPE
Jenna Davies	Nil	-
Jim Dixon	Trustee – Heritage Lottery Fund / National Heritage Memorial Fund Director – Jim Dixon Associates Patron – Accessible Derbyshire	(a) (a) (d)
Graham Gillham	Nil	-
Carolyn Green	Nil	-
Phil Harris	Director – Phormative Ltd	(a)
Ifti Majid	Nil	-
Caroline Maley	Director – C D Maley Ltd Non-Executive Director – Employer First Ltd (until 18 February 2015) Trustee – Vocaleyes Ltd.	(a, b) (a) (a, d)
Lee O'Bryan (up to 3 November 2014)	Director – The Camden Partnership Ltd Non-Executive Director – Avon and Wiltshire Mental Health Partnership Trust	(b) (d)
Mark Powell	Nil	-
Tony Smith	Panel Member (Assessor) – Judicial Appointments Commission (from 26 March 2012 to 31 March 2015)	(d)
Jayne Storey	Director of Workforce – Nottinghamshire Cricket Board Ltd	(a)
John Sykes	Nil	-
Maura Teager	Non-Executive Director – Ripplez social enterprise and NHS provider of the Family Nurse Partnership	(a)
Lesley Thompson (up to 30 October 2014)	Director – Beyond Consultants Ltd Associate Consultant – Libra, CMZ[2]	(a,b,c) (e)
Mark Todd	Chair of Trustees – Motor Neurone Disease Association	(d)
Steve Trenchard	Nil	-
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
Report to Board of Directors 29th April 2015

Corporate Governance Framework

Purpose of Report
The purpose of this report is to discuss and approve the refreshed Corporate Governance Framework.

Executive Summary
Following the advisory internal audit undertaken by PWC on the Trusts governance framework a piece of work was undertaken to review the existing governance framework. Graham Gilham, Director of Corporate and Legal Affairs led the review of the existing framework. In so doing it has been presented for discussion at a Board development meeting, the Executive Leadership team and a sub group comprising Mark Todd, Caroline Maley and Claire Wright on behalf of the Board have coproduced the attached framework.

Consultations
This information has been shared with the Board of Directors and the Executive Leadership Team.

Governance or Legal Issues
The Governance Framework sets out the key decision making and terms of delegated authority for all Board Committees which will enable the Trust to comply with its statutory and legal obligations set out in the Health and Social Care Act (2012), the Monitor Compliance Framework and the Care Quality Commission Fundamental Standards for health and social care providers.

Equality Delivery System
This report has a neutral impact on REGARDS groups in so far that it applies equally to processes of governance, system stewardship and financial probity.

Recommendations
The Board of Directors is asked to:
1) Approve the Corporate Governance Framework

Report prepared and presented by:

SteveTrenchard
Chief Executive

Derbyshire Healthcare NHS Foundation Trust

D R A F T

CORPORATE GOVERNANCE FRAMEWORK DOCUMENT APRIL 2014

Appendices:

1. BOARD OF DIRECTORS – ROLES AND RESPONSIBILITIES

1. This Document

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

2. Role and Purpose

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

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

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

The Board leads the trust by undertaking three key roles:

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

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

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

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

3. General Responsibilities

The general responsibilities of the Board are:

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

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

3.2 Leadership

The Board provides active leadership to the organisation by:

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

3.3 Quality

The Board:

- Ensures that the Trust's quality of service responsibilities for clinical effectiveness, patient safety and patient experience, are achieved.
- Has an intolerance of poor standards, and fosters a culture which puts patients first.

- Ensures that it engages with all its stakeholders, including patients and staff on quality issues and that issues are escalated appropriately and dealt with.

3.4 Strategy

The Board:

- Sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives, taking into account the views of the Council of Governors.

- Determines the nature and extent of the risk it is willing to take in achieving its strategic objectives.

- Monitors and reviews management performance to ensure the Trust's objectives are met.

- Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required.

- Develops and maintains an annual business plan, with due regard to the views of the Council of Governors, and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders.

- Ensures that national policies and strategies are effectively addressed and implemented within the Trust.

3.5 Culture, Ethics and Integrity

The Board:

- Is responsible for setting values, ensuring they are widely communicated and adhered to and that the behaviour of the board is entirely consistent with those values.

- Promotes a patient-centred culture of openness, transparency and candour.

- Ensures that high standards of corporate governance and personal integrity are maintained in the conduct of Foundation Trust business.

- Establishes appeals panels as required by employment policies particularly to address appeals against dismissal and final stage grievance hearings.

- Ensures that Directors and staff adhere to any codes of conduct adopted or introduced from time to time.

- Ensures the application of appropriate ethical standards in areas such as research and development

3.6 Governance/Compliance

The Board:

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

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

- Ensures compliance with the principles, systems and standards of good corporate governance and has regard to guidance issued by Monitor and appropriate codes of conduct, accountability and openness applicable to Foundation Trusts.

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

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

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

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

3.7 Risk Management

The Board:

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

- Ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement in the development of care plans, the review of quality of services provided and the development of new services.

- Ensures there are appropriately constituted appointment and evaluation arrangements for senior positions such as consultant medical staff and those reporting to Executive Directors.

3.8 Committees

The Board:

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

3.9 Communication

The Board:

- Ensures an effective communication channel exists between the Trust, its Governors, members, staff and the local community.
- Meets its obligations in respect of the council of governors and members and ensures Governors are equipped with the skills and knowledge they need to undertake their role.
- Ensures the effective dissemination of information on services, strategies and plans and also provides a mechanism for feedback.

  Shares the agenda and minutes of board meetings with the Council of Governors and ensures that those board proceedings and outcomes that are not confidential are communicated publically, primarily via the Trust's website.
- Ensures that the business of the Board is conducted openly in public, except where special reasons apply.
- Holds an annual meeting of its members which is open to the public.
- Publishes an annual report and annual accounts.

3.10 Finance

The Board:

- Ensures that the Trust operates effectively, efficiently, economically.
- Ensures the continuing financial viability of the organisation.
- Ensures the proper management of resources and that financial responsibilities are achieved.
- Ensures that the Trust achieves the targets and requirements of stakeholders within the available resources.
- Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

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

4. Role of the Chairman

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

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

- The Chairman is responsible for ensuring that the board and the council of governors play their part in the development and determination of the Trust's strategy and overall objectives, and ensuring they work well together.

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

5. Role of the Chief Executive

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

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

- The CEO is responsible for implementing the decisions of the board and its committees and providing information and support to the board and Council of Governors.

6. Accountability

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

- The Director of Corporate and Legal Affairs shall support the Chairman on matters relating to induction, Board development, and training for Directors.

7. Other Matters

The Trust Board shall be supported by the Trust Secretary whose duties in this respect will include:

- Agreement of the agenda, for Board and Board Committee meetings, with the relevant Chairman, in consultation with the Chief Executive, or the lead

Executive Director for that Committee.

- Collation of reports and papers for Board and committee meetings.
- Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward.
- Ensuring that Board procedures are complied with.
- Supporting the Chairman in ensuring good information flows within and between the Board, its committees, the Council of Governors and senior management.
- Advising the Board and Board Committees on governance matters.

A full set of papers comprising the agenda, minutes and associated reports and papers will be sent within the timescale set out in standing orders to all directors and others as agreed with the Chairman and Chief Executive from time to time. The agenda and minutes of Board meetings will be shared with the Council of Governors.

The Board and all Board Committees shall self-assess its performance following each Board meeting.

2. STRUCTURE AND PROCESSES FOR ASSURANCE AND ESCALATION

Board Committees

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

These Board Committees are established in accordance with the FT Constitution and Standing Orders of the Board, also in support of the Monitor License, FT4:

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

Roles of the Committees

The Audit Committee

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

The Finance and Performance Committee

- The prime purpose of the Committee is to oversee and gain assurance on all aspects of financial management and operational performance, including contract compliance, commercial decisions and cost improvement reporting. The Committee also oversees the Trust's business development, commercial and marketing strategies and its approach to helping workforce engagement and development.
- The Finance and Performance Committee is responsible for agreeing terms of reference and annual work programmes for its supporting sub-committees. It also receives agreed assurance and escalation reports as defined in the forward plan for the Committee.

The Quality Committee

- The prime purpose of the Committee is to obtain assurance that high standards of care are provided and that adequate and appropriate governance structures, processes and controls are in place to promote safety and excellence in patient care. The Committee monitors risks arising from clinical care and ensures the effective and efficient use of resources through evidence-based clinical practice.

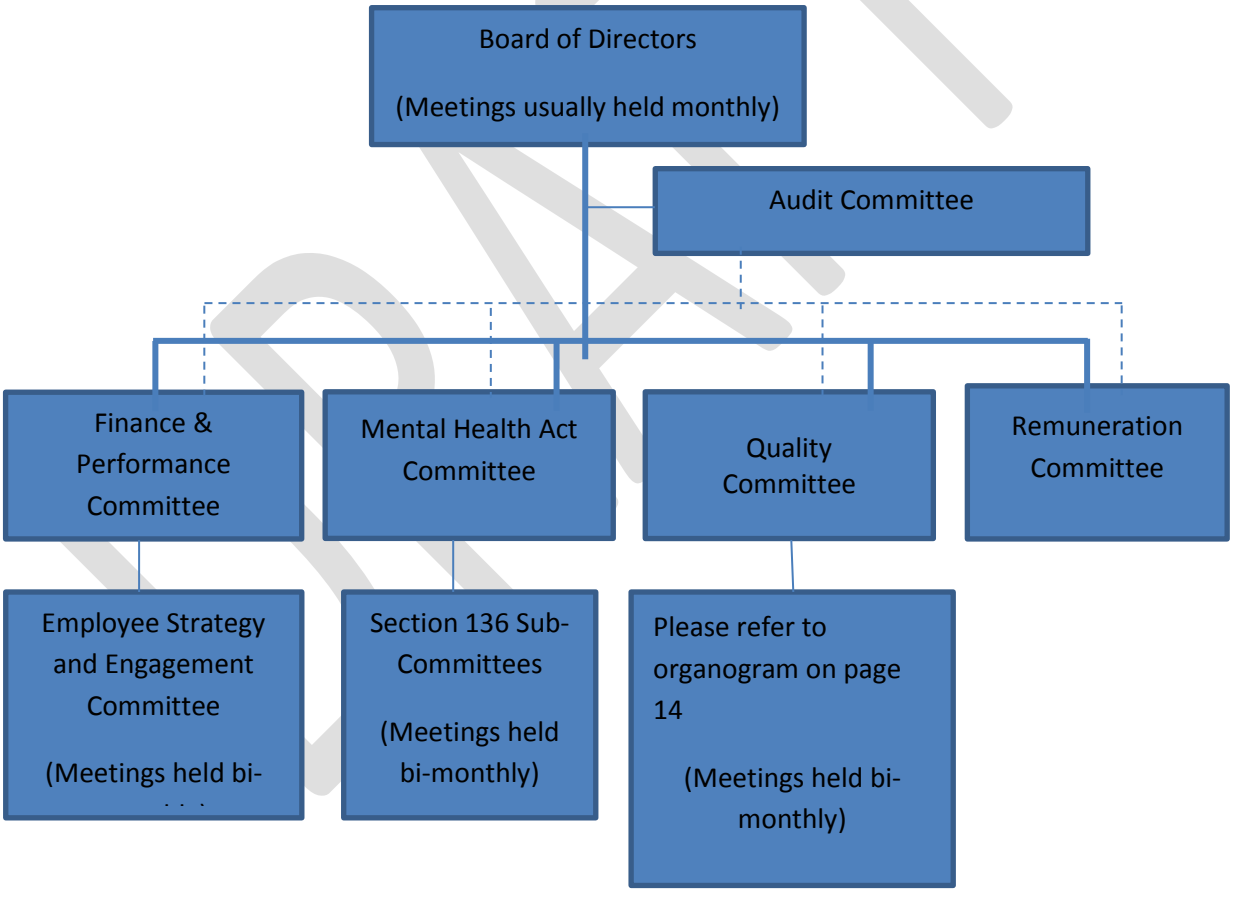
- The Quality Committee is responsible for agreeing Terms of Reference and annual work programmes for its supporting sub-committees. It also receives agreed assurance and escalation reports as defined in the forward plan for the Committee.

The Mental Health Act Committee

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

Structure

The current Board Committee structure is shown below:-



Assurance and Escalation

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

- The BAF supports the Board in identifying and managing all its strategic risks. The Trust will continue to develop and review the Trusts Risk Register to ensure all significant strategic, clinical, financial risks are identified and actively managed within the resources available.

- The Trust Risk Register is a 'live' database of all significant risks to the Trust. The process for review of the Risk Register is primarily within the remit of the Quality Committee. This is discussed every month at the Quality Committee meeting and top risks, both strategic and operational, are identified and itemised.

- In addition, the BAF is reviewed by the Audit Committee three times per year prior to submission to the Board, in order to provide independent assurance. Issues for escalation may include matters which could incur reputational risk or undermine public confidence, those which may affect the Trust's continuity of services rating and financial risk rating, and risks to the achievement of the Trust's strategy or forward plan.

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

Each committee :-

- Reviews at the outset of each meeting any relevant BAF item specifically assigned to the Committee
- Considers at each meeting any new issue which needs to be identified for inclusion in the BAF
- Co-operates with any request from the Audit Committee regarding a risk-related matter, and provides assurance as appropriate
- Provides a summary of the business conducted at each Committee meeting to the following Board meeting, including any specific areas requiring escalation, significant exception reports or other gaps in assurance
- Maintains and keep under review a forward plan for the business of the Committee
- Conducts an annual self-effectiveness review, against its Terms of Reference, taking into account the Audit Committee's view on the effective operation and co-operation of each respective Committee
- Provides to the Board an annual review of the scope of the Committee's business, including the setting of key objectives for the coming year

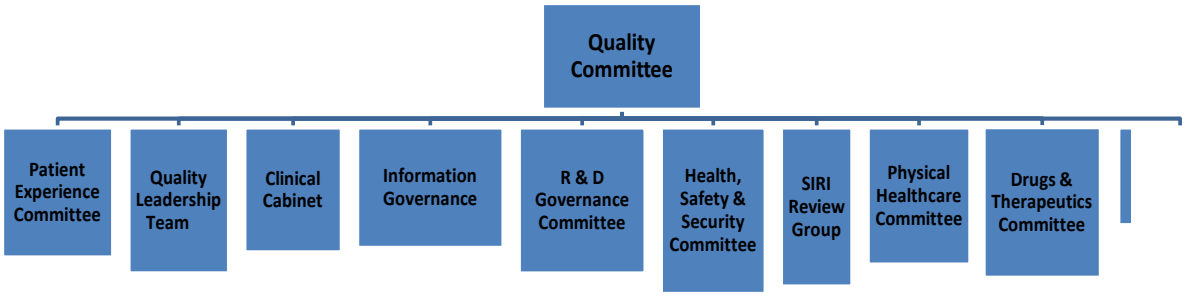
The remit of each Committee is set out in terms of reference approved by the Board (see scheme of delegation). These are reviewed each year to ensure robust governance and assurance arrangements are in place.

Systems for Assurance and Escalation

The process for monitoring performance, receiving assurance and escalating concerns is illustrated in the pyramid diagram below. The Corporate Governance structure of the Trust Board and its Committees is informed and supported by the Quality Committee sub-committee structure and divisional quality leadership teams. Therefore, an issue which requires escalation can start in any part of the organisation and this process ensures that managers and Executive Directors provide assurance, or escalate issues if necessary, through the ward to Board organisational structure. Issues identified through this process may relate to quality of services delivered, performance targets, service delivery or achievement of strategic objectives.

Assurance and Escalation Pyramid

Quality Committee Structure



3. Part One : Scheme of Delegation Decisions Reserved to the Board

REF	DECISIONS RESERVED TO THE BOARD
	General Enabling Provision The Board may determine any matter, for which it has delegated or statutory authority, in full session within its statutory powers.
	Regulations and Control 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chairman and Chief Executive in public session in accordance with Standing Orders. 5. Approve a scheme of delegation of powers from the Board to Committees**.** 6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determine the extent to which that member may remain involved with the matter under consideration. 7. (Not used). 8. Approve arrangements for dealing with complaints. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto, i.e. the structure and composition of the Board and its Committees. 10. Receive reports from Committees including those required by Monitor or other regulator to establish and to take appropriate action. 11. Confirm the recommendations of the Trust's Committees where the Committees do not have delegated powers. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on Trust. 13. Establish Terms of Reference and reporting arrangements of all Committees and Sub-committees that are established by the Board. 14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property. 15. Authorise use of the Seal. 16. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with Standing Orders.
	Appointments/ Dismissals 1. Appoint and dismiss Committees (and individual members) that are directly accountable to the Board. 2. Ensure all appointments are timely, all board members are annually appraised and that any disciplinary issues are in line with trust policy. . 3. Confirm appointment of members of any Committee of the Trust as representatives on outside bodies.

REF	DECISIONS RESERVED TO THE BOARD
S.F.Is 3.2.3i S.F.Is 3.2.3ii	*Strategy, Business Plans and Budgets* 1. Define the strategic aims and objectives of the Trust. 2. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by Monitor. 3. Approve the Trust's policies and procedures for the management of risk. 4. Approve Outline and Final Business Cases for Capital Investment through the approval of the Capital Programme. 5. Approve budgets and Annual Plan. 6. Approve annually the Trust's proposed organisational development proposals. 7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 8. Approve PFI proposals. 9. Approve proposals on individual contracts. Authority to authorise any one revenue order shall be limited to: • Over £500,000 – Board of Directors • £200,000 to £500,000 – Chief Executive or Director of Finance • £50,000 to £200,000 – Deputy Chief Executive or Deputy Director of Finance • £30,000 to £50,000 – Board Level Directors • £10,000 to £30,000 – Divisional Directors and General Managers • £1,000 to £10,000 – Heads of Operational Service Areas (or lower limit for individual budget holders as set by the Chief Executive) Authority for planned expenditure of capital resources shall be limited to: • Expenditure on individual project up to £100,000 – approved by the Capital Action Team • Expenditure on an individual project up to £1,000,000.00 – jointly signed by the Director of Finance and one other Executive Director (as member of Agile Working and Asset Planning Board) • Project in excess of £1,000,000.00 – Board signature required 10. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance (for losses and special payments). 11. (Not used). 12. Approve proposals for action on litigation against or on behalf of the Trust. 13. Review use of NHSLA risk pooling schemes (LPST/CNST/RPST) to cover insurable risk 14. To approve the Integrated Business Plan and such other business plan, budgeted and capital programmes submitted by the CEO on an annual basis, including the approval of cost improvement programmes. 15. To review proposals on service policies and priorities as negotiated with commissioners. 16. To consider advice from any such professional Advisory Committees as the Board may establish or recognise. 17. To approve written evidence on behalf of the Trust to be submitted to statutory or other official bodies. Where urgent action is required, the

REF	DECISIONS RESERVED TO THE BOARD
	CEO should act on behalf of the Trust and consult with the Chairman (or Deputy Chairman in his/her absence), and report action taken at the next meeting of the Board. 18. To receive reports on the legally binding contracts entered into with commissioners. 19. To approve business cases requiring additional resources as set out within the investment policy. 20. To identify key strategic risks, evaluate them and ensure adequate responses are in place and are monitored. 21. Ensure Governors are appropriately consulted on matters deemed to be a significant transaction.
	Human Resources 1. To approve pay and terms and conditions of employment for Trust employees (except where covered by national agreements). 2. To receive decisions on disciplinary and grievance appeal panels in respect of senior positions 3. To receive updates on Speaking Up and Whistleblowing cases.
	Policy Determination 1. Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff.
	Audit 1. Consider the Annual Report from the Audit Committee and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. 2. Receive an annual report from the auditor and agree action on recommendations where appropriate by the Audit Committee. 3. To consider the Audit reports on the affairs and accounts of the Trust.
	Annual Reports and Accounts 1. Adoption of the Annual Report, Annual Accounts and Annual Quality Account – unless delegated to the Audit Committee.
	Monitoring 1. Receive such reports as the Board sees fit from Committees in respect of the exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust by the Board as set out in management policy statements. All monitoring returns required by Monitor shall be approved by the Board. 3. Receive reports from DoF on financial performance against plan. 4. Receive reports from DoF on actual and forecast income from service contracts. 5. To receive reports from the CEO and DoF upon the implementation of, and variances from, agreed business plans, service level agreements, budgets and capital programmes, and where appropriate take necessary action. 6. To make such directions regarding internal financial control and control of income/expenditure as required by Monitor. 7. To authorise payments which require the prior approval of the Board under the SOs and SFIs. 8. To receive reports on external and internal issues affecting the services within the Trust from the CEO and other directors, and take action where necessary. 9. To make arrangements for the investigation of complaints.

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

3. Part Two : Responsibilities Delegated to Board Committees

Audit Committee Terms of Reference

1. Authority

1.1 The Audit Committee is constituted as a standing committee of the Foundation Trust's Board of Directors. Its constitution and Terms of Reference shall be as set out below, subject to amendment at future Board of Directors meetings. The Audit Committee shall not have executive powers in addition to those delegated in these Terms of Reference.

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

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

2. Membership

2.1 The Committee shall be composed of at least three independent Non-Executive Directors, at least one of whom should have recent and relevant financial experience. One of the members shall be appointed Chairman of the Committee by the Board of Directors. The Foundation Trust Chairman shall not be a member of the Audit Committee (but may attend by invitation as appropriate).

2.2 A quorum shall be two Non-Executive Directors.

3. Attendance

3.1 Only members of the Audit Committee have the right to attend meetings, but the Chief Operating Officer, Director of Finance and Executive Director with responsibility for risk and quality assurance shall generally be invited to attend routine meetings of the Audit Committee.

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

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

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

3.5 A representative of the Local Counter Fraud Service will attend at least two meetings of the Audit Committee.

3.6 Foundation Trust Directors and/or staff and executives shall be invited to attend those meetings in which the Audit Committee will consider areas of risk or operation that are their responsibility.

3.7 Governors may be invited to attend meetings of the Audit Committee.

3.8 The Director of Corporate and Legal Affairs shall be the secretary to the Audit Committee and will provide administrative support and advice to the Chairman and the Committee members.

3.9 The External Auditor shall be afforded the opportunity at least once per year to meet with the Audit Committee without Executive Directors present.

4. Access

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

5. Frequency of meetings

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

6. Required frequency of attendance by members

6.1 Members of the Audit Committee must attend at least three of all meetings each financial year but should aim to attend all scheduled meetings.

7. Duties and Responsibilities

7.1 The Committee's duties and responsibilities are as follows:

Integrated governance, risk management and internal control

7.2 The Audit Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Foundation Trust's activities, clinical and non-clinical, that supports the achievement of the Trust's objectives.

7.3 In particular the Committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the Governance statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board of Directors;

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

- the policies and procedures in respect of all counter-fraud and security work as required by NHS Protect.

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

7.5 As part of its integrated approach, the Committee will ensure appropriate information flows to the Audit Committee from executive management and other Board Committees, principally the Quality Committee and Finance and Performance Committee, in relation to the Trust's overall internal control and risk management position. However, these other Committees must not usurp the Audit Committee's role.

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

7.7 To develop and use an effective assurance framework to guide the Audit Committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from Directors and Managers and other investigatory outcomes so as fulfil its functions in connection with these Terms of Reference.

Internal audit

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

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

Adequate resourcing;
Its co-ordination with external audit;
Meeting the Public Sector Internal Audit standards 2013;
Providing adequate independent assurances;
Having appropriate standing within the Foundation Trust; and
Meeting the internal audit needs of the Foundation Trust.

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

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

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

External audit

7.13 To make a recommendation to the Council of Governors in respect of the appointment, re-appointment and removal of an external auditor and related fees as applicable. To the extent that the recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

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

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

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

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

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

7.19 To consider the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal of the auditors.

Annual accounts review

7.20 To review the annual statutory financial statements, before they are presented to the Board of Directors, in order to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes;
- Changes in, and compliance with the accounting policies, practices and estimation techniques;
- Areas where judgment has been exercised;
- Explanation of estimates or provisions having material effect;
- Explanations for significant variances;
- The schedule of losses and special payments;
- Significant adjustments in the preparation of the financial statements and any un-adjusted statements; and
- Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

7.21 To review each year the accounting policies of the foundation trust and make appropriate recommendations to the Board of Directors.

7.22 To review the annual report and annual governance statement before they are submitted to the board of directors to determine completeness, objectivity, integrity and accuracy.

7.23 To review all accounting and reporting systems for reporting to the Board of Directors, including in respect of budgetary control.

7.23a Where formally delegated by the Board, to adopt the annual financial statements and Annual Report.

Whistleblowing

7.24 To review the adequacy of and provide assurance to the Board the Foundation Trust's arrangements by which Foundation Trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

Standing orders, standing financial instructions and standards of business conduct

7.25 To review on behalf of the Board of Directors the operation of, and proposed changes to the standing orders and standing financial instructions, the constitution, codes of conduct and standards of business conduct; including maintenance of registers.

7.26 To examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension.

7.27 To review the Scheme of Delegation.

Other

7.28 To review performance indicators relevant to the remit of the Audit Committee.

7.29 To examine any other matter referred to the Audit Committee by the Board of Directors and to initiate investigation as determined by the Audit Committee.

7.30 To consider the outcomes of significant reviews carried out by other bodies which Include, but are not limited to regulators and inspectors within the health sector and professional bodies with responsibilities that relate to staff performance and functions.

7.31 To review the work of all other Foundation Trust Committees in connection with the Audit Committee's assurance function.

7.32 The Committee may also request specific reports from individual functions within the Foundation Trust (for example, clinical audit).

7.33 To conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

8. Reporting

8.1 The minutes of all meetings of the Audit Committee shall be formally recorded and submitted, together with recommendations where appropriate, to the Board of Directors. The submission to the Board of Directors shall include details of any matters to be escalated in respect of which actions or improvements are needed. This will include details of any evidence of potentially *ultra vires*, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters. To the extent that such matters arise, the Chairman of the Audit Committee shall present details to a meeting of the Board of Directors in addition to submission of the minutes.

8.2 The Audit Committee will report annually to the Board of Directors in respect of its work in support of the annual governance statement, specifically commenting on:

- the assurance framework and its fitness for purpose;
- the effectiveness of risk management within the Foundation Trust;
- the integration of and adherence to governance arrangements;
- the appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements relating to its existence as a functioning business.
- the robustness of the processes behind the quality accounts; and any pertinent matters in respect of which the Audit Committee has been engaged.

8.3 This annual report should also describe how the Committee has fulfilled its Terms of Reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

8.4 The Foundation Trust's annual report shall include a section describing the work of the Audit Committee in discharging its responsibilities, taking into account the comments on the effectiveness from members of the Board and other Committees.

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9. Administrative Support

9.1 The Committee shall be supported by the Director of Corporate & Legal Affairs whose duties in this regard include, but are not limited to:

- Agreement of the agenda with the Chairman of the Audit Committee and attendees;
- Preparation, collation and circulation of connected papers in good time;
- Ensuring that those required to attend are invited to the meeting in good time;
- Ensuring that the minutes are taken and keeping a record of matters arising and issues to be carried forward;
- Manage the forward plan of the Committee's work;
- Arranging meetings for the Chairman with Directors and advisers as necessary;
- Advising the Audit Committee as appropriate on pertinent issues / areas of interest / policy developments;
- Enabling training and development of Committee members as appropriate
- Reviewing every decision to suspend the standing orders.

10. Review

The Terms of Reference of the Audit Committee shall be reviewed at least annually.

Finance & Performance Committee Terms of Reference

1. Authority

1.1 The Board of Directors approved the establishment of a Finance and Performance Committee as a Committee of the Board. The prime purpose of the Committee is to gain assurance on all aspects of financial management and operational performance, on behalf of the Board. The Committee may refer specific issues to the Board, Audit Committee and other Committees and make recommendations as appropriate. Matters formally delegated to the Finance and Performance Committee by the Board of Directors are:

a. Cost Improvement Plan (CIP) reporting
b. Contractual compliance performance reporting
c. Treasury Management – to approve policy, procedures, controls and monitoring of policy implementation
d. Working Capital Facility – to approve

1.2 Aside from those specific matters listed, the Committee otherwise gains assurance on matters through reports and exceptions provided to it.

The constitution and Terms of Reference, as set out below, are as approved by the Board. They may be subject to amendment at a future Board meeting.

2. Membership

2.1 The membership of the Committee shall comprise:-

- Chairman of Committee – Non Executive
- Two other Non-Executive Directors
- Chief Executive
- Executive Director of Finance
- Chief Operating Officer
- Medical Director/Chief Nurse (either to attend, as available)
- Director of Corporate and Legal Affairs

If the Chairman is not present, one of the Non-Executive Directors will chair the meeting. Other members of Directorate teams may be required to attend, at the invitation of the committee.

3. Quorum

3.1 A quorum shall be four members, including at least one Executive Director and one Non-Executive Director.

4. Frequency

4.1 Meetings should be held bi-monthly with additional meetings if required.

Key Responsibilities

a. To provide detailed oversight of financial performance, forward projections and assumptions which underpin forward plans.

b. To receive regular reports on performance, for detailed scrutiny against agreed targets and key performance indicators – together with action plans where required.

c. To receive twice-yearly, and by exception, strategic level reports on workforce movements, trends and projections

d. To monitor delivery of the cost improvement programme.

e. To oversee progress of all contract negotiations.

f. i. To keep under review the Foundation Trust's capability and capacity to meet the commercial and marketing requirements of potential business opportunities and any other service and strategic developments including tender submissions

ii. In respect of the above, to consider outline business cases and proposals and make recommendations to Board accordingly

g. To receive regular reports from Committees and other meetings relevant to the work of this Committee.

h. The agenda for the Committee will be informed by a forward plan of regular items but will also receive reports on relevant financial and performance issues requiring additional scrutiny and assurance pertaining to actual and anticipated performance and/or when required by Trust Board or Audit Committee.

i. To keep under review as a standing item at each meeting the Board Assurance Framework and high level risks, insofar as they relate to the remit of the Committee; and to comply with any request from the Audit Committee for assurance in relation to the Board Assurance Framework and the Risk Register.

j. To conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

5. Minutes and Reporting

5.1 Minutes of meetings of the Committee shall be taken and formally recorded. The Committee will produce a written report to the next full Board highlighting assurances received, actions requested, and referring issues for full Board discussion where appropriate. The Committee will report annually to the Audit Committee describing how the Committee has fulfilled its remit and giving details of significant issues and how they have been addressed.

6. Review

6.1 The Terms of Reference shall be subject to review at least annually.

Quality Committee Terms of Reference

1. Authority

1.1 The Board of Directors has approved the establishment of a Quality Committee as a Committee of the Board in accordance with standing orders. The prime purpose of the committee is to enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to:

- Promote safety and excellence in patient care;
- Identify, prioritise and manage risk arising from clinical care;
- Ensure the effective and efficient use of resources through evidence-based clinical practice; and
- Protect the health and safety of Trust employees

2. Membership

2.1 The membership of the Committee shall comprise:-

- Non-Executive Director – Chairman of the Committee
- Non-Executive Director (2)
- Service Receiver representatives from Derbyshire Voice (2) with an additional named representative in reserve
- Carer representative
- Executive Director of Nursing and Patient Experience
- Medical Director or a nominated Deputy
- Deputy CEO
- Director of Finance
- Director of Workforce and OD
- Director of Corporate and Legal Affairs
- Director of Transformation
- Head of Quality & Performance
- Head of Effectiveness
- Head of Patient Safety
- Head of Patient Experience
- Chairman or Deputy Chairman of Divisional level Quality Leadership Teams
- The Divisional Clinical Directors (2)
- Chief Pharmacist
- Research and Clinical Audit Manager
- Risk and Assurance Manager
- Senior Psychologist

- The named links between the Mental Health Act Committee and the Quality Committee to ensure consistency and cross Board Committee discussion are the Medical Director and the Director of Corporate and Legal Affairs.

- The named link between the Training Board and the Quality Committee to lead on clinical standards led training is currently named as the Director of Transformation.

Also may attend:

- Chief Executive Officer
- Chairman
- Assistant Director Education
- Head of Transformation & Patient Involvement

If the Committee Chairman is not present, the meeting shall be chaired by another Non-Executive Director.

3. Quorum

3.1 A quorum shall be four members, including at least one Executive Director and two Non-Executive Directors.

4. Frequency

4.1 Meetings shall be held monthly.

Key Responsibilities

In respect of general governance arrangements:

4.2 To ensure that all statutory elements of risk and quality governance are adhered to within the Trust including the requirements of our regulators, Monitor and the Care Quality Commission (regulations).

4.3 To provide a clear link with the Trust's Strategy and Quality framework when agreeing quality governance priorities.

4.4 To provide direction to the quality governance activities of the Trust's services and divisions. This will include setting strategy, delegating activities and monitoring clinical performance against this strategy or quality priorities.

4.5 To scrutinise and approve the Trust's Quality Position Statements and Integrated Risk and Quality Governance Annual Reports before submission to the Board.

4.6 To have final sign off of the Trust Quality Account prior to Board approval

4.7 To approve the Terms of Reference and membership of its reporting sub-Committees, known as the Quality Leadership Teams at Divisional level; and to oversee the work of those sub-committees, receiving reports from them, reviewing their work plans and clinical escalation issues.

4.8 To agree to refer specific issues to the Board and make recommendations as appropriate.

4.9 To receive and approve the annual Clinical Audit Programme consistent with the audit needs of the Trust and consistent with the Quality priorities.

4.10 To oversee the Trust's policies and procedures with respect to the use of clinical data and patient identifiable information to ensure that this is in accordance with all relevant legislation and guidance including the Caldicott Guidelines and the Data Protection Act 1998.

4.11 To make recommendations to the Audit Committee concerning the annual Internal Audit plan, to the extent that it applies to matters within these Terms of Reference; and to comply with any request from the Audit Committee for assurance in relation to the Board Assurance Framework and the Risk Register.

4.12 On behalf of the Board, to have overview responsibility for all regulations and standards as described by the Care Quality Commission as part of our responsibilities under the Care Quality Commission (Registration) Regulations 2009 and **Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.**

4.13 To promote within the Trust a culture of open and honest reporting of any situation that may threaten the quality of patient care in accordance with the Trust's policy on raising concerns and monitoring the implementation of that policy. This will include an approach that enables an open patient safety culture.

4.14 To oversee the system within the Trust for obtaining and maintaining any licences relevant to clinical activity in the Trust.

4.15 To ensure that risks to patients are minimised through the application of a comprehensive risk management system, known as the Board Assurance Framework, clinical risk registers, risk registers and associated monitoring.

4.16 To oversee the processes within the Trust to ensure that appropriate action is taken in response to adverse clinical incidents, complaints and litigation and those examples of good practice are disseminated within the Trust and beyond if appropriate.

4.17 To ensure a clear link with the Mental Health Act Committee.

4.18 To maintain a forward plan of regular agenda items.

a. To ensure a clear link with the Commissioners Quality Assurance Group, and that escalated clinical concerns, gaps in commissioning and patient safety concerns are discussed and monitored.

b. In addition to the Divisional Quality Reference Groups. To monitor the work of the Trust-wide groups which report the Quality Committee, currently the Quality Leadership Teams, Clinical Cabinet, Serious Incident Requiring Investigation (SIRI) group, Information Governance, Research and Development, Health Safety and Security Committee, the Physical Health Care Committee, Drugs and Therapeutics Committee, Patient Experience Sub Committee and any short term named task and finish groups established to design or develop Trust Clinical Strategy.

To co-operate with and assist the work of other Trust wide groups which report or scrutinise the work of the Quality Committee

c. To receive Board assurance on how the Trust has developed and planned for all clinical service re-design with sign off of any associated clinical safety plan to mitigate changes in service, which have been designed and developed by the Quality Leadership Team.

d. To conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

5. Minutes and Reporting

5.1 Minutes of meetings of the Committee shall be taken and formally recorded. A summary of the Committee's business will be presented to the Trust board and the Committee will present to Audit Committee, prior to (Board), an Annual Report on its activities for the previous year.

6. Review

6.1 The Terms of Reference shall be subject to review at least annually.

Mental Health Act Committee Terms of Reference

1. Authority

1.1 The Board of Directors has approved the establishment of a Mental Health Act Committee as a Committee of the Board. The purpose of the Committee is to obtain assurance, on behalf of the "Hospital Managers" and the Trust as the detaining authority, that the safeguards and provisions of the Mental Health Act are appropriately applied; to take account of the provisions of related statute and guidance, such as Mental Capacity Act, Deprivation of Liberty Safeguards (D.o.L.S.) and Human Rights Act.

1.2 The Committee will exercise its responsibilities by fulfilling a scrutiny and monitoring role from receipt of regular activity data, and inspection reports; by obtaining assurance that best practice is deployed across the Trust.

2. Membership

2.1 The Core membership shall comprise one Non-Executive Director of the Trust, (Committee Chairman) and two other Non-Executive Directors, the Medical Director, (or his nominated representative), the Executive Director of Nursing and Patient Experience, (or nominated representative) and the Director of Corporate and Legal Affairs.

The associated membership shall comprise:-

- Mental Health Act Manager
- Representative of Associate Hospital Managers
- Representative of Consultant Medical Staff
- Local Authority Leads for Approved Mental Health Practitioners (AMHPs)
- Representative of Medical Staff in Training

- Head of Pharmacy
- Head of Patient Experience
- Other senior management/professional leads may be invited at the discretion of the Committee Chairman.

3. Quorum

3.1 A minimum of three core members including at least one Non-Executive Director.

4. Frequency of Meetings

4.1 Meetings will be held quarterly.

Key Responsibilities

4.2 To receive information, and review if necessary, the number of patients subject to detention under each section of the Mental Health Act for the previous quarter.

4.3 To consider matters of recommended good practice, and in particular the requirements of the Code of Practice (Revised): Mental Health Act (1983) as amended, approve policy changes and report to the Quality Committee.

4.4 To receive and review, as required, other activity reports e.g. the use of seclusion.

4.5 To receive the Care Quality Commission Inspection Reports and the management response.

4.6 (i) To review regularly the Trust's compliance with the statutory requirements of the Mental Health Act (1983).

(ii) With regard to Section 136, to monitor use of this section through the multi-agency Section 136 sub-committee.

4.7 To consider the implications of related legislation, principally the Mental Capacity Act, D.O.L.S., Human Rights Act guidance and other related ethical issues as appropriate.

4.8 To obtain assurances that training needs are met and in general help promote awareness of the requirements of the Mental Health Act and associated legislation.

4.9 When receiving information on Mental Health Act activity and reports, the Committee will pay due regard to the Trust's Equality and Diversity Agenda.

4.10 To regularly review the Trust's Policies and Procedures in relation to the Mental Health Act and Code of Practice requirements, and the duties of Associate Hospital Managers, including the protocols for the hearing of appeals and reviews.

4.11 To keep under review as a standing item at each meeting the Board Assurance Framework and high level risks, insofar as they relate to the remit of the Committee; and to comply with any request from the Audit Committee for assurance in relation to the Board Assurance Framework and the Risk Register.

5. Minutes and Reporting

5.1 Minutes of meetings of the Committee shall be taken and formally recorded. A summary of the Committee's business will be regularly presented to the Trust Board and the Committee will present to Board an Annual Report on its activities for the previous year.

6. Review

6.1 The Terms of Reference will be subject to annual review.

6.2 The Committee will present to Audit Committee, an Annual Report on its activities for the previous year.

Remuneration Committee Terms of Reference

1. Authority

1.1 The Remuneration Committee is constituted as a standing Committee of the Foundation Trust's Board of Directors. Its constitution and Terms of Reference shall be as set out below, subject to amendment at future Board of Directors meetings.

1.2 The Remuneration Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Remuneration Committee.

1.3 The Remuneration Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Foundation Trust with relevant experience and expertise if it considers this necessary for or expedient to exercise its functions.

1.4 The Remuneration Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2. Role

2.1 To decide and review the terms and conditions of office of the Foundation Trust's Executive Directors and senior managers on locally-determined pay in accordance with all relevant Foundation Trust policies, including:

- salary, including any performance-related pay or bonus;
- provisions for other benefits, including pensions and cars; and
- allowances.

2.2 To adhere to all relevant laws, regulations and NHS policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate executive directors whilst remaining cost effective.

2.3 To advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments.

2.4 To keep under review Executive Director development and succession planning.

2.5 To review periodically payments made to staff leaving the organisation under redundancy or other means

2.6 Where an exit package for any staff member is deemed to exceed contractual requirements, the approval of the Committee is required

3. Membership

3.1 The membership of the Remuneration Committee shall consist of:
- the Foundation Trust Chairman (who will Chair the Remuneration Committee); and
- all Non-Executive Directors on the Foundation Trust Board of Directors.

3.2 A quorum shall be three members.

4. Attendance

4.1 Meetings of the Remuneration Committee may be attended by:
- Chief Executive;
- Director of Transformation; and
- Director of Corporate and Legal Affairs; and
- Any other person who has been invited to attend a meeting by the Remuneration Committee so as to assist in deliberations.

5. Frequency of Meetings

5.1 Meetings shall be held annually or as required.

6. Minutes and Reporting

6.1 The minutes of all meetings of the Remuneration Committee shall be formally recorded. [These will be retained by the Chairman and not shared with Executive Directors.]

6.2 The Remuneration Committee will report to the full Board of Directors after each meeting.

6.3 The Remuneration Committee shall ensure that Board of Directors emoluments are accurately reported in the required format in the Foundation Trust's annual report.

6.4 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

APPENDIX B

BOARD FRONT SHEET TEMPLATE

Confidential/Public Session (DELETE AS APPROPRIATE)

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 25th June 2014 (**USE DATE FORMAT AS SHOWN WITH ACTUAL DATE)**

Title succinct, meaningful

Create a box around each of the areas - to make it easier to read / structure

Purpose of Report Expectation is for this to be a couple of sentences maximum

Why is the paper coming to the Board / the Committee?

In the content that follows - have a clear logical structure:
Aim for simple, elegant presentation so the fundamental message shines through
Preference not to embed documents, avoid that wherever possible.
Use Arial 12 font.

Use page numbers

Do not use unexplained abbreviations or jargon (i.e. do not rely on a glossary)

Executive Summary

- Clearly describe all that you want to draw attention to, if the reader were not to read the whole document
- Pull out the key messages/findings in report - don't expect the reader to extract it themselves
- Consider: What are the answers to the question "so what?"
- Openly disclose the key risks and issues to note, make any necessary explicit cross-reference to BAF, annual plan, specific strategy outcomes, CQC /Monitor/legislation /compliance risks etc
- Focus on trends and forward looking insight – not just the "here and now"
- Clarify the key next steps and actions being taken to correct or capitalise on the key risks and issues
- Does it have a potential financial implication? If so be explicit – do not say "Board to note potential resource implications" (NB business case will be needed and referenced for financial impact)
- Does it have a potential impact on quality? – if so be explicit
- Does it have workforce implications? - if so be explicit
- Does it have a transformation impact – if so be explicit
- Remember the audience, especially if this is public document – use appropriate accessible plain English, etc

Strategic considerations

- What is the wider context of this document (national/local/Trust)
- Draw out or build on the explicit *strategic* links – e.g. Trust strategy outcomes, other specific strategies, etc
- Include here any specific strategic questions that the board/committee should consider?
- NB: Distinguish between *assurance* considerations which should be included below and *strategic* considerations

(Board) Assurances

- What are the specific assurances that the board/committee can obtain from this paper? Be open and transparent on what is full assurance compared to partial assurance
- Note the key difference between board assurance and other organisational risks – note if the risk is on the risk register (which includes BAF risks) and include reference to Risk ID from Datix if at all possible.
- If this paper is to a committee which has specific responsibility for specific BAF risks –include an extract of the BAF risk affected, appropriately updated, to demonstrate how this responsibility is being discharged by this paper.
- If this paper is to Board and raises an issue that impacts on an existing BAF risk – include the relevant extract of the BAF

Consultation Include the following as relevant

- Include explicit dated reference here to where another committee/meeting (not just board committees – include ESEC and other meetings) has considered content from this or a draft of this paper
- Is this paper coming as a result of escalation to board by any other committee? If so explain
- If this is a follow up/update to a previous board/committee paper on the same topic - explicitly cross reference to last paper
- Include if relevant, whether Governors have been or should be involved, have Public Patients Involvement been involved, other stakeholders as relevant
- Has any technical advice been sought? – if so explain

Governance or Legal issues

Spell out any governance, compliance or legal issues relating to this report, or confirm there are none – e.g. CQC, regulatory framework, health and safety

Note to authors: it is highly unlikely that a paper going to Trust Board should have no governance, compliance or legal implications whatsoever

Equality Delivery System

Spell out any impact on REGARDS groups, or confirm none

Recommendations

The Board of Directors is requested to: What do you want the Board to do with this paper?

NB: Be explicit if certain wording needs to be minuted – put that *actual wording* in the recommendation

1) Approve…
2) Receive assurance from (scrutinise current performance/discharge responsibilities)…
3) Accept the proposal…
4) Decide/approve/endorse decision of/…
5) Note …

Report presented by: **Name, Role**

Report prepared by: **Name, Role**

Further context for authors and sponsors – delete before submission:

There is an expectation is that authors and sponsors use judgement as to when specific content needs to be included. One size does not fit all in front sheet /executive summary content! For shorter papers your executive summary may well be your whole paper, but use this framework to structure the content of your paper. For longer papers you will need all of the above content as well as your main paper content – but think about whether you can distil your paper further!

Consider, for reports that have similar main content each month/quarter – you may wish to think about introducing a new "topic of the month" or periodical additional information with a focus on something related but different – to expand the breadth and depth of understanding.

Bear this in mind when writing Board reports:

"Board reports need to contain highly relevant and insightful information and clearly analyse the issues to stimulate constructive dialogue amongst board members and stakeholders. The result of an effective dialogue should be commitment by the Board and stakeholders to the actions needed to drive the business to achieve or surpass its goals" *(Andrew Mosely – consulting director at Metapraxis (business intelligence consultancy) - CFO UK - published Oct 13)*

APPENDIX C

STANDING ORDERS

Derbyshire Healthcare NHS Foundation Trust

Standing Orders

Board of Directors

Standards of Business Conduct

CONTENTS

1. Introduction to Standing Orders

Who should read these Standing Orders?

1.1. You should read these Standing Orders and be aware of their relevance to you as you discharge your responsibilities if you:-

- Are a Director of the Trust
- Attend Board meetings
- Are a member of a committee or sub-committee established by the Board, or attend its meetings
- Are a senior officer of the Trust
- Are involved in letting contracts on behalf of the Trust
- Are responsible for any aspect of the procurement of goods and services on behalf of the Trust
- Have a pecuniary interest in a contract that the Trust is entering into
- Are required to sign any legal document on behalf of the Trust

Statutory Framework

1.2. The Derbyshire Healthcare NHS Foundation Trust is a public benefit corporation which was established under the 2006 Act on 1st February 2011, subject to its Constitution and Provider Licence.

1.3. The headquarters of the Trust is at Bramble House, Kingsway Site, Kingsway, Derby, DE22 3LZ.

1.4. NHS Foundation Trusts are governed by a regulatory framework that confers the functions of the Trust and comprises the 2006 Act, the Constitution and Terms of Authorisation. The powers of the Trust are set out in the 2006 Act subject to any restrictions in the Terms of Authorisation.

1.5. The Trust will be bound by such other statute and legal provisions or guidance which governs the conduct of its affairs.

1.6. As a public benefit corporation the Trust has specific powers to contract in its own name and to act as a corporate trustee. The Trust has a common law duty as a bailee for patients' property held by the Trust on behalf of patients. The Trust also has statutory powers to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

1.7. In accordance with paragraph 27 of the Constitution, the Standing Orders of the Board of Directors is to be set out in this Annex 7. The Trust adopts Standing Orders for the regulation of proceedings and business.

NHS Framework

1.8. In addition to the statutory requirements the Secretary of State (through the Department of Health) issues further requirements and guidance. These are normally issued under cover of a circulation or letter. Many of these are contained within the Trust's Model Corporate Governance documents. Codes of Conduct and Accountability make various requirements concerning possible conflicts of interest of Directors. The Codes (and the Constitution) also require the establishment of Audit and Remuneration Committees with terms of reference formally agreed by the Trust Board.

Delegation of Powers

1.9. The powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

1.10. Delegated powers are covered in a separate section (Reservation and Delegation of Powers).

1.11. Where officers are designated in these Standing Orders, they may designate their responsibility through approved Schemes of Delegation.

1. Interpretations and Definitions

2.1. At any meeting, the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (in which he should be advised by the Chief Executive of Secretary), except where this would contravene any statutory provision or direction made by the Secretary of State (applicable to NHS Foundation Trusts) or such authorisation as may be given by the Independent Regulator.

2.2. All references in these Standing Orders to the masculine gender shall be read equally applicable to the feminine gender.

2.3. For convenience and unless the context otherwise requires the terms and expressions contained within paragraph 40 of the Constitution relating to Interpretation are incorporated and are deemed to have been repeated here verbatim for the purposes or interpreting words contained in this document:

> *"COMMITTEE" means a Committee or Sub-Committee appointed by the Trust.*
>
> *"COMMITTEE MEMBERS" shall be persons formally appointed by the Trust to sit on or to Chairman specific Committees.*
>
> *"CONTRACTING AND PROCURING" means the systems for obtaining the supply of goods, material, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal or surplus and obsolete assets.*

"NOMINATED OFFICER" means an Officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

"OFFICER" means and employee of the Trust or any other person holding a paid appointment or office with the Trust.

"SFIs" means Standing Financial Instructions.

"SOs" mean Standing Orders.

2. BRIBERY ACT

3.1. It is a long established principle that public sector bodies, including the NHS, must be scrupulously impartial and honest in the conduct of their business and that as an employee of the Trust you should remain above suspicion.

3.2. The introduction of the Bribery Act 2010 places responsibility on the organisation to ensure robust procedures are in place to prevent bribery and corruption taking place within the Trust. The Trust believes it is the responsibility of all employees to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interest and their NHS duties.

3.3. All individuals within healthcare organisations are capable of being prosecuted for taking or offering a bribe. There is no maximum level of fines that can be imposed and an individual convicted of an offence can be imprisoned for up to ten years. The Bribery Act 2010 came into force on 1st July 2011 and creates five basis offences:

- Bribing another person with the intention of inducing that person to perform a relevant function or activity improperly or to reward that person for doing so
- Accepting a bribe with the intention that a relevant function or activity should be performed improperly as a result
- Bribing a foreign public official
- A Director, manager or officer of a commercial organisation allowing or turning a blind eye to bribery within the organisation (the question of whether any particular organisation falls within the definition of a 'commercial organisation' will be considered on the facts of individual cases. It is, however, reasonable to assume that an NHS Trust or NHS Foundation Trust could be deemed a 'commercial organisation' for the purpose of this Act).
- Failing to prevent bribery – where a person (including employees, agents and external third parties) associated with a relevant commercial organisation bribes another person intending to obtain or retain a business advantage. This is a strict liability offence which can be committed by the organisation unless it can show, in its defence, that it had adequate procedures in place to prevent bribery.

3.4. As an employee you have a responsibility to respond to other employees, patients and suppliers impartially, to achieve value for money from the public funds with which you are entrusted and to demonstrate high ethical standards of personal conduct. Recognising the statements of this nature cannot allude to every possible contingency, it is assumed that all employees are able to distinguish between acceptable and unacceptable behaviour in the conduct of their duties. Staff must not misuse or make official 'commercial in confidence' information to persons or organisations not reasonably needing access, particularly if its disclosure would prejudice the principle of a purchasing system for the Trust based on fair competition. If, however you are uncertain about the correctness or propriety of any proposed business transaction, or in relation to hospitality, declaration of interests or commercial sponsorship then you must seek advice from a senior Manager.

3.5. The aim of this policy is to:

Provide you as an employee of the Derbyshire Healthcare NHS Foundation Trust with clear guidance to ensure that you are aware of your responsibilities in relation to the conduct of business within the NHS and the consequences of failing to observe those responsibilities.

3.6. It is an offence for a person to offer, promise or give a financial or other advantage to another person in one or two cases:

- Case 1 applies to where that person intends the advantage to bring about the improper performance by another person of a relevant function or activity or to reward such improper performance
- Case 2 applies where the person knows or believes that the acceptance of the advantage offered, promised or given in itself constitutes the improper performance or a relevant function or activity

3.7. DHCFT staff must not:

- Abuse their past or present official position to obtain preferential rates for private deals
- Unfairly advantage one competitor over another or show favouritism in agreeing sponsorship
- Misuse or make available official 'commercial in confidence' information
- Accept any inducements or inappropriate hospitality or gifts

3.8. You should refer to the Trust Raising Concerns (Whistleblowing) Policy for guidance on how to report concerns that you do not feel able to raise though normal reporting channels.

4. Breaches of Policy

4.1. Alleged breaches of this policy will be investigated under the Terms of the Trust Disciplinary Procedure.

4.2. In accordance with the Trust's Fraud and Corruption Policy all suspicions of fraud and/or corruption occurring within the NHS will be referred to the Trust's Local Counter Fraud Specialist and/or NHS Counter Fraud Service for formal investigation. Should evidence of fraud or corruption be discovered the Trust may initiate disciplinary, criminal and civil sanctions as appropriate.

4.3. Under the Prevention of Corruption Act, 1906 and 1916, it is an offence for employees to corruptly to accept any gifts or consideration as an inducement or reward for:

- Doing, or refraining from doing, anything in their official capacity or
- Showing favour or disfavour to any person in their official capacity

Under the Prevention of Corruption Act 1916, any money, gift or consideration received by an employee in public service from a person or organisation holding or seeking to obtain a contract will be deemed by the courts to have been received corruptly unless the employee proves the contrary. (Refer to Trust Declaration of Interests, Hospitality and Sponsorship Policy for further information).

4.4. The Bribery Act creates the offence of offering or receiving bribes and if failure to prevent a bribe being paid on an organisation's behalf. It makes it an offence for a person to offer, promise or give a financial or other advantage to another person if:

- That person intends the advantage to bring about the improper performance by another person of a relevant function or activity or to reward such improper performance or
- That person knows or believes that the acceptance of the advantage offered, promised or given in itself constitutes the improper performance of a relevant function or activity

4.5. The maximum sentence for bribery committed by an individual is 7 to 10 years imprisonment. The offence applies to bribery relating to any function of a public nature, connected with a business, performed in the course of a person's employment or performed on behalf of a company or another body of persons. Therefore bribery in both the public and private sectors is covered by the Act.

You should be aware that breaches of these Acts renders you liable to prosecution which may also lead to loss of employment and pension rights in the NHS.

5. THE TRUST

5.1. **Composition of the Trust –** in accordance with the Constitution the composition of
the Board of the Trust shall comprise:

- A Non-Executive Chairman
- Up to 6 other Non-Executive Directors (one of whom may be nominated as the Senior Independent Director); and
- Up to 6 Executive Directors

The Board of Directors shall at all times be constituted so that at least half the Board, excluding the Chairman, shall comprise of the Non-Executive Directors.

5.2. The Board may appoint one of the Non-Executive Directors as the Senior Independent Director, in consultation with the Governors.

5.3. **Appointment of the Chairman and Directors** – The Chairman and Non-Executive Directors are appointed (and removed) by the Council of Governors. The Chief Executive will be appointed or removed by the Non-Executive Directors and the appointment (but not the removal) will be subject to approval by the Council of Governors. The Trust shall appoint an Appointments Committee and/or other nominated persons whose members shall be the Chairman, Non-Executive Directors and the Chief Executive whose function will be to appoint the other Executive Directors of the Trust.

5.4. **Terms of Office of the Chairman and Directors** – the provisions governing the period of tenure of the office of the Chairman and Directors and for the termination or suspension of office of the Chairman and Directors are set out in the Constitution and these Standing Orders. Non-Executive Directors, including the Chairman, shall be appointed by the Council of Governors for specified terms at intervals of no more than three (3) years. Any term beyond six years (e.g. two three year terms) shall be subject to rigorous review and shall take into account the need for progressive refreshing of the Board. Non-Executive Directors may be in exceptional circumstances serve longer than six (6) years but in such circumstances shall be subject to annual re-appointment.

5.5. **Appointment of Deputy Chairman** – for the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chairman, the Council of Governors may appoint a Non-Executive Director to be Deputy Chairman for such a period, not exceeding the remainder of his term as Non-Executive Director of the Trust, as they may specify on appointing him.

5.6. Any Non-Executive Director so elected may at any time resign from the office of Deputy Chairman by giving notice in writing to the Chairman and the Council of Governors may thereupon appoint another Non-Executive Director as Deputy Chairman in accordance with paragraph 2.4.

5.7. **Powers of Deputy Chairman** – where the Chairman of the Trust has ceased to hold office or where he has been unable to perform his duties as Chairman owing to illness, or any other cause, the Deputy Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes his duties.

5.8. **Joint Directors**

(1) Where more than one person is appointed jointly to a post of Director those persons shall count for the purposes of Standing Order 2.1 as one person.

(2) Where the office of Director of the Board is shared jointly by more than one person:

a) Either or both of those persons may attend or take part in meetings of the Board;
b) If both are present at a meeting they should cast one vote if they agree;
c) In the case of disagreements no vote should be cast;
d) The presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 6.26 Quorum

5.9. **Not Used**

5.10. **Role of Directors –** the Board will function as a corporate decision-making body within which all Directors will be equal. Their role as members of the Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory functions. In exercising these functions the Board will consider guidance from the Independent Regulator's "the NHS Foundation Trust Code of Governance" as amended from time to time.

1) **Executive Directors** Executive Directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

2) **Chief Executive** The Chief Executive shall be responsible for the overall performance of the Trust. He is the **Accounting Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under financial directions and in line with the requirements of the NHS Foundation Trust Accounting Officer Memorandum for Trust Chief Executives.

3) **Executive Director of Finance** The Executive Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant financial directions.

4) **Non-Executive Directors** The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of, or when chairing, a Committee of the Trust which has delegated powers.

5) **Chairman** The Chairman shall be responsible for the operation of the Board and Chair all Board meetings when present. The Chairman has certain delegated executive powers. The Chairman must comply with the terms of appointment and with these Standing Orders. The Chairman shall liaise with the Council of Governors over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance. The Chairman shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

5.11 **Corporate Role of the Board**

1) All business shall be conducted in the name of the Trust
2) All charitable funds received in the Trust shall be held in the name of Derbyshire Community Health Services NHS Foundation Trust, acting as corporate trustee on behalf of the Trust
3) The powers of the Trust shell be exercised by the Board meeting in private session except as otherwise provided in Standing Order (6.1).

5.12 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in “the Scheme of Delegation : decisions reserved to the Board.”

5.13 **Lead Roles for Directors**

The Chairman will ensure that the designation of Lead roles or appointments of Board members as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Director with responsibilities for Infection Control or Child Protection Services etc).

6. MEETINGS OF THE TRUST

6.1 Admission of the Public and the Press – The meetings of the Board of Directors shall be open to members of the public and press unless the Board decides otherwise in relation to all or part of a meeting for reason of confidentiality or on other proper grounds.

In the event that the public and press are admitted to all or part of a Board meeting the Chairman shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board business shall be conducted without interruption and disruption and the public will be required to withdraw upon the Board resolving that in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete its business without the presence of the public.

Nothing in these Standing Orders shall require the Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report or proceedings without permission granted by resolution of the Trust.

6.2. **Calling of Meetings** – Ordinary meetings of the Trust shall be held as such times and places as the Board determines.

6.3 One third or more members of the Directors may requisition a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of the requisition being presented, the Directors signing the requisition may forthwith call a meeting.

6.4 **Notice of Meetings** – Before each meeting of the Trust Board, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chairman or the Director of Corporate and Legal Affairs shall be delivered to every Director or sent by post to the usual place of residence of such Director, so as to be available to him at least three clear days before the meeting.

Lack of service of the notice on any Director shall not affect the validity of the meeting.

6.5 In the case of a meeting called by Directors in default of the Chairman, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

6.6 Failure to serve such a notice on more than three Directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

6.7 Before any meeting of the Board which is to be held in public, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's Headquarters at least three clear days before the meeting.

6.8 **Agenda and Supporting Papers** – The Agenda will be sent to Directors 3 days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three clear days before the meeting, save in an emergency.

6.9 A Director desiring a matter to be included on an agenda shall make his request in writing to the Chairman at least six clear days before the meeting subject to SO 6.3. Requests made less than six days before a meeting may be included on the agenda at the discretion of the Chairman.

6.10 At any meeting of the Trust, the Chairman, if present shall preside. If the Chairman is absent from the meeting the Deputy Chairman, if present shall preside. If the Chairman and the Deputy Chairman are absent such Non-Executive Director as the Directors present shall choose shall preside.

6.11 **Annual Members' Meeting** – The Trust will publicise and hold an annual meeting of its members by the end of September each year. The meeting must be open to members of the public.

6.12 **Chairman's Ruling** – The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

6.13 **Voting** – All questions put to the vote at a meeting shall be determined by a majority of the votes of the Directors present and voting on the question and, in the case of an equal vote, the person presiding shall have a second or casting vote.

6.14 All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

6.15 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any questions may be recorded to show how each Director present voted or abstained.

6.16 If a Director so requests, his vote shall be recorded by name.

6.17 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

6.18 An officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

6.19 **Minutes** – The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next meeting whereafter they will be signed by the Chairman. The names of the Directors present at the meeting shall be recorded in the minutes.

6.20 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

6.21 **Suspension of Standing Orders** – Except where this would contravene any provision in the Constitution, the Terms of Authorisation any statutory provision or authorisation by the Independent Regulator any one or more of the Standing Orders may be temporarily or permanently suspended at any meeting, provided that at least two thirds of the Board are present signifying their agreement to such suspension, including one Executive Director and one Non-Executive Director.

6.22 A decision to suspend SOs shall be recorded in the minutes of the meeting. A separate record of matters discussed during this suspension shall be made and shall be available to the Directors.

6.23 The Audit Committee shall review every decision to suspend SOs.

6.24 These Standing Orders shall be amended only if:

- At least half the total of the Trust's Non-Executive Directors present vote in favour of the amendment, and
- At least two-thirds of the Directors are present, and
- The variation proposed does not contravene any applicable statutory provision or direction;

6.25 **Quorum** – No business shall be transacted at a meeting of the Trust Board unless at least three of the whole number of the Directors are present including at least one Executive Director and one Non-Executive Director. Joint Directorships shall count as one post for the purpose of the Quorum.

6.26 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

6.27 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 9.5 *et seq*) he/she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

7. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

7.1. Subject to SO 7.1.1 below and subject to the Mental Health Act 1983, the Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO 8.1 or 8.2 below, or by an Executive Director of the Trust in each case subject to such restrictions and conditions as the Board thinks fit.

7.1.1. **Hospital Managers Powers to Discharge** – When the Trust is exercising the functions of the managers referred to in Section 45 of the Mental Health Act 2007 those functions may be exercised by any three or more persons authorised by the Board, each of whom is neither an Executive Director of the Board nor an employee of the Trust.

7.2. **Emergency Powers** – The powers which the Board has reserved to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chairman after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chairman shall be reported to the next formal meeting of the Board for ratification.

7.3. **Delegation to Committees** – Subject to SO 4.1 above, the Board shall agree from time to time to the delegation of executive powers to be exercised by committees and sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board.

7.4. **Delegation to Officers** – The Chief Executive is responsible for those functions of the Trust which have not been retained as reserved by the Board or delegated to a committee. The Chief Executive shall determine which functions he will perform personally and shall nominate officers to undertake the remaining functions for which he will still retain accountability to the Trust.

7.5. The Chief Executive shall prepare a Scheme of Delegation identifying his proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board.

7.6. Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Executive Director of Finance or other Executive Director to provide information and advise the Board in accordance with statutory requirements.

7.7. The Board shall comply with the arrangements set out in the "Decisions Reserved for the Board and Scheme of Delegation".

7.8. **Overriding Standing Orders** – If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

8. COMMITTEES

8.1. **Appointment of Committees** – Subject to the Constitution and any applicable statutory provision or direction the Trust may appoint Committees or Sub-Committees of the Trust, consisting wholly or partly of Directors of the Trust or wholly or partly of persons who are not Directors of the Trust. The Standing Orders of the Trust shall apply to committees and sub-committees of the Trust.

8.2. A Committee appointed under SO 5.1 may appoint Sub-Committees consisting wholly or partly of members of the committee (whether or not they include Directors of the Trust or other health service bodies in question); or wholly of persons who are not members of the Trust or other health service bodies or the Committee of the Trust or other health service bodies in question.

8.3. Each such Committee or Sub-Committee shall have such Terms of Reference and powers and be subject to such conditions (as reporting back to the Board), as the Board shall decide.

8.4. Committees may not delegate their executive powers to a Sub-Committee unless expressly authorised by the Board.

8.5. The Board shall approve the appointments to each of the Committees, which it has formally constituted. Where the Board determines and regulations permit, that persons, who are neither Directors nor Officers, shall be appointed to a Committee the Terms of such appointment shall be within the powers of the Board. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement of loss of earnings, and/or expenses in accordance where appropriate with national guidance.

8.6. Where the Board is required to appoint persons to a Committee and/or to undertake statutory functions, and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with any regulations and direction.

8.7. The Chief Executive will be appointed or removed by the Non-Executive Directors subject to approval by the Council of Governors.

8.8 Appointment of Executive Directors other than the Chief Executive –is for the Remuneration Committee, consisting of the Chairman, the Chief Executive and other Non-Executive Directors, to appoint or remove the Executive Directors.

8.9 In Considering any matter relating to the continuation in office of any board executive director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract.

8.10 Committees, Sub-committees and joint Committees established by the Board shall include:

Audit Committee

Remuneration Committee

Quality Committee

Finance and Performance Committee

Mental Health Act Committee

And any other such Committees as required by the Board to discharge its responsibilities.

8.11 **Confidentiality** - A member of a Committee shall not disclose a matter dealt with by, or brought before, the Committee without its permission until the Committee shall have reported to the Board or shall otherwise have concluded on that matter, or if the Board shall resolve that any matter will remain confidential.

8.12 Committee meetings of the Board will not be held in public unless expressly stated.

9 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

9.1 Policy statements: general principles

The Board of Directors will from time to time agree and approve Policy statements/procedures which will apply to all or specific groups of staff employed by the Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Board of Directors minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

9.2 Specific Policy statements

Notwithstanding the application of SO 9.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following policy statements:

- Declaration of Interests, Hospitality and Sponsorship Policy for the Trust staff
- The staff Disciplinary and Appeals Procedures adopted by the Trust.

9.3 Specific guidance

Notwithstanding the application of SO 9.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Independent Regulator and the Secretary of State for Health (applicable to NHS Foundation Trusts):

- Caldicott Guardian 1997
- Human Rights Act 1998
- Freedom of Information Act 2000

9.4 Declaration of Interests – The NHS Code of Accountability and the Constitution requires the Board of Directors to declare interests which are relevant and material to the NHS Board of which they are a Director. All existing Directors should declare such interest. Any Directors appointed subsequently should do so on appointment.

9.5 Interests which should be regarded as "relevant and material" are:

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.

f) Research funding/grants that may be received by an individual or their department.

g) Interests in pooled funds that are under separate management.

9.6 If any Director has any doubt about the relevance of an interest, this should be discussed with the Chairman or Director of Corporate and Legal Affairs.

9.7 Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

9.8 At the time Board of Directors' interest are declared, they should be recorded in the board minutes. Any changes in interests should be declared at the next board meeting following the change occurring.

9.8 Board of Directors' directorships of companies likely or possibly seeking to do business with the Trust should be published in the Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.

9.10 During the course of a Board meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

9.11 **Register of Interests** – The Director of Corporate and Legal Affairs will ensure that a Register of Interests is established to record formally declarations of interest of Directors. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Board of Directors.

9.12 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be included.

9.13 The Register will be available to the public and the Director of Corporate and Legal Affairs will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

10 DISABILITY OF DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

10.10 Subject to the following provisions of this Standing Order, if the Chairman, or a Director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

10.11 Not used.

10.12 The Trust shall exclude a Director from a meeting of the Trust while any contract, proposed contract or other matter in which he/she has a pecuniary interest, is under consideration.

10.13 Any remuneration, compensation or allowances payable to a Director by virtue of 2006 Act shall not be treated as a pecuniary interest for the purpose of this Standing Order.

10.14 For the purpose of this Standing Order the Chairman or a Director shall be treated, subject to SO 9.6, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

a) A nominee of his, is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

or

b) He is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

And in the case of married persons living together the interest of one spouse shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest to the other.

10.15 A Director shall not be treated as having a pecuniary interest in any contract or other matter by reason only:

a) Of his membership of a company or other body, if he/she has no beneficial interest in any securities of that company or other body;

b) Of an interest in any company, body or person with which he is connected as mentioned in SO 9.5 above which is so remote or insignificant that it cannot be reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

10.7 Where a Director:

a) Has an indirect pecuniary interest in a contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

b) The total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

c) If the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class, this Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his/her duty to disclose his/her interest.

10.16 Standing Order 8 applies to a Committee or Sub-Committee of the Trust as it applies to the Trust and applies to any member of any such Committee or Sub-Committee (whether or not he is also a Director of the Trust) as it applies to a Director of the Trust).

11 STANDARDS OF BUSINESS CONDUCT

11.10 **Policy** – Staff must comply with the national guidance contained in HSG(93)5' Standards of Business Conduct for NHS staff'. The following provisions should be read in conjunction with this document.

11.11 **Hospitality** – Staff shall decline all except modest hospitality offers by potential or actual suppliers to the Trust. For the purpose of this Standing Order, modest hospitality shall be defined as that which is similar to the scale of hospitality which the NHS as an employer would be likely to offer.

The Trust shall maintain a hospitality register, detailing both the hospitality accepted and that which has been offered but declined. The register will be held by the Director of Corporate and Legal Affairs.

11.12 **Interests of Officers in Contracts** – If it comes to the knowledge of a Director or an officer of the Trust that a contract in which he has any pecuniary interest not being a contract to which he himself is a party, has been, or is proposed to be, entered into by the Trust he shall at once give notice in writing to the Director of Corporate and Legal Affairs of the fact that he is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

11.13 An Officer must also declare to the Chief Executive any other employment or business or other relationship of his, or of a cohabiting partner, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

11.14 All Board Directors are required, upon appointment, to subscribe to the NHS Code of Conduct and Code of Accountability.

11.15 **Canvassing of, and Recommendations by, Directors in Relation to Appointments** – Canvassing of Directors of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in the application form or otherwise brought to the attention of candidates.

11.16 A Director of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

11.17 **Relatives of Directors or Officers** – Candidates for any staff appointment shall when making application disclose in writing whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.

11.18 The Directors and every Officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

11.19 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other Director or holder of any office under the Trust.

11.20 Where the relationship of an Officer or another Director to a Director of the Trust is disclosed, Order "Disability of Directors in proceedings on account of pecuniary interest" (SO10) shall apply.

12. CUSTODY AND SEALING OF DOCUMENTS

12.1 **Custody of Seal** – The Common Seal of the Trust shall be kept by the Director of Corporate and Legal Affairs in a secure place.

12.2 **Sealing of Documents** – The Seal of the Trust shall not be fixed to any document unless the sealing has been authorised by a resolution of the Board or of a committee, thereof or where the Board has delegated its power.

12.3 Attestation of Sealings – The Common Seal of the Trust shall be affixed in the presence of the Chairman and an authorised signatory.

12.4 **Register of Sealing** – An entry of very sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal.

13. SIGNATURE OF DOCUMENTS

13.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive or Director of Corporate and Legal Affairs as designated signatory.

13.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed), the subject matter of which has been approved by the Board or Committee or Sub-Committee to which the Board has delegated appropriate authority.

14. MISCELLANEOUS

14.1 **Joint Arrangements** – The Trust also has statutory powers under section 75 of the 2006 Act to enter into prescribed arrangements jointly planned with local authorities.

APPENDIX D

MONITOR NHS FOUNDATION TRUST GOVERNANCE ARRANGEMENTS CONDITION FT4

MONITOR LICENCE NUMBER 120334
DATE OF ISSUE: 1 April 2014

CONDITION FT4 – NHS FOUNDATION TRUST GOVERNANCE ARRANGEMENTS

1. This condition shall apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:

(a) have regard to such guidance on good corporate governance as may be issued by Monitor from time to time; and

(b) comply with the following paragraphs of this condition.

4. The Licensee shall establish and implement:

(a) effective Board and Committee structures;

(b) clear responsibilities for its Board, for Committees reporting to the Board and for staff reporting to the Board and those Committees; and

(c) clear reporting lines and accountabilities throughout its organisation.

5. The Licensee shall establish and effectively implement systems and/or processes:

(a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;

(b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations;

(c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;

(d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);

(e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;

(f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;

(g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and

(h) to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

(a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;

(b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;

(c) the collection of accurate, comprehensive, timely and up to date information on quality of care;

(d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;

(e) that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and

(f) that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate. Section 6 – NHS Foundation Trust Conditions

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

8. The Licensee shall submit to Monitor within three months of the end of each financial year:

(a) a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks; and

(b) if required in writing by Monitor, a statement from its auditors either:

(i) confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or

(ii) setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.

Audit Committee - feedback summary
Meeting held 18 March 2015 10:30am -1:30pm

Key issues linked to Strategy and Governance requirements:

Agenda item	Issue and actions	Assurance
Minutes and action matrix from meeting held on 23 January 2015	The minutes of the previous meeting were agreed. Action matrix updated.	Agreed
Board Assurance Framework	Rachel Kempster presented the 2014/15 update report. Members of the Committee reviewed and discussed the BAF in depth and noted that three risk gradings, 3e, 2c and 3b had been reduced from high to moderate severity following review by the Director lead.	Agreed that the Audit Committee and Board would continue to receive a formal update on the BAF three times a year Supported the 'deep dive' review and challenge of only risks graded high, with lower graded risks being reviewed and challenged by the relevant named responsible committee.
Deep Dive- Strategic Risks	Members discussed at length risk 4A; The organisation does not create the right environment for staff to be able to deliver compassionate care which could undermine quality of care for patients. Members had a transparent and open discussion around the partial assurance reported by the auditors. Carolyn Green specifically noted that the report would be referred to the Quality Committee, the Quality Leadership Teams and Clinical Reference Groups for information and feedback. Carolyn Green also highlighted to the Committee that Compassionate training was a key risk and would be referred to the Training Board and it was agreed that the use of language that people understood would be versed within the training module.	The Committee noted the audit report and received partial assurance on the risk mitigations and effectiveness of the risk that the organisation does not create the right environment for staff to be able to deliver compassionate care which could undermine the quality of care for patients.

Agenda item	Issue and actions	Assurance
Complaints, concerns and compliments report	The Audit Committee was asked to consider the contents of the report on complaints, concerns and compliments and was assured that; • Information is being collected and acted on to ensure learning informs changes in practice. • The Trust is promoting an open culture where complaints (many aspects, complex, requiring a written response) and concerns (straightforward and easily resolvable with an agreed solution, can sometimes include a written response but less likely) are welcomed and learnt from. • Compliments tell us what we are doing well and how we can put positive experiences at the heart of all we do	The Audit Committee agreed there was a vigorous system in place
Annual Report Narrative	The Committee noted that this year, the draft 2014/15 Annual Report will be circulated to the Board but the Audit Committee will have delegated authority to approve the final audited version.	The draft annual report will be circulated to the Board for comment

Issues to be escalated to Board, Audit Committee or other Board Committees
1. Risk Associated with the BAF fourth strategic outcome would be escalated to **Quality Committee** 2. Corporate Governance Framework would be escalated to the **Board of Directors** for approval 3. The draft Annual Report would be escalated to **Board of Directors** for Comment

Quality Committee - feedback summary
Meeting held 9 April 2015 2:15pm - 4:30pm

Key issues linked to Strategy and Governance requirements:

Agenda item	Issue and actions	Assurance
Minutes and action matrix from meeting held on 9 April 2015	Minor amendments and some adjustments to Physical health care actions to the minutes agreed. Action matrix updated.	Agreed
Staff Survey	Garry Southall, Principal Workforce & Organisational Development Manager attended the meeting to present the findings of the NHS National Staff Survey 2014. The survey covered 29 Key Findings (KFs). Compared against all Mental Health Trusts the survey breakdown for the Trust showed: 2 KFs in the top 20% 10 KFs above average 10 KFs average 6 KFs worse than average 1 KF in the worst 20%	Assurance on progress overall but limited assurance on some key aspects that were below average and one aspect in the worst percentile. Actions are being developed and monitored by the Employee Strategy and Engagement Committee (ESEC) raising concerns and whistleblowing policy was being reviewed and adjusted based upon this feedback. (ESEC) will lead the solutions to these findings and gaps in assurance. The Quality Committee received limited assurance on raising concerns and whistleblowing
Serious Incident Report	Committee received information relating to all Serious Incidents (SIs) occurring during March 2015. There had been a slight reduction in the number of incidents reported externally in March 2015 compared to February 2015. This brought the total for 2014-15 to 71 compared to 51 for 2013-14. There are currently 41 overdue actions from SIRI investigations. Approximately 25% of these actions became overdue on the 31st March 2015. There are no actions overdue that have been assessed as a high priority linked to a root cause of an incident. Duty of Candour – this was been reported on, both in the feedback from the individual investigations and from the Contractual Duty of Candour report to commissioners. There have been no breaches in discharging the Trust's statutory Duty of Candour reported in March 2015. Research findings from the second additional paper from the National Homicide, Suicide analysis were presented and discussed.	The Quality Committee received assurance on the detailed SIRI process, however it maintains a monitoring brief of clinical performance with an increase in serious incidents of a significant levels and continued analysis and close monitoring of our death rate. The Quality Committee received assurance on the process and scrutiny for reviewing Duty of candour

	Review of suicides from 2013: Wendy Henson informed the committee that this data was presented to the Mortality Group who would analyse the data in relation to diagnosis, how this was linked to the crisis team and home treatment as opposed to admission and it would also analyse transition issues within teams and multi-agencies. Risk factors would also be looked at. The Mortality Group also wanted to utilise learning opportunities in a pro-active sense and would look at protective factors to establish what keeps people safe.	Continued analysis and close monitoring of our death rate in relation to Suicide will be maintained. Awaiting further information and additional service development recommendations from the Suicide prevention group and Mortality group. John Sykes to escalate suicide prevention and recovery work training to the Training Board.
Infection Control Annual report presented in line with Health Act requirements	Performance against key standards of Infection Prevention & Control and related activities remains consistent. Reported cases of key alert organisms remains low Interruption to services related to infection control incidents remains low Cleanliness of clinical areas remains consistently good, as were PLACE inspection results Clinical compulsory training of identified staff remains consistent Recent Environmental Health inspections of our kitchens resulted in a five start rating by Derby City Council.	Report accepted and received Full assurance on progress overall Noted the reporting of key areas, such as surveillance of healthcare associated with infections – alert organisms, outbreaks of infection, staff training. Received assurance on standards of cleanliness of clinical areas and food preparation areas Approved this report in preparation of presentation to the Trust Board of Directors
Suicide patient safety planning	In the absence of John Sykes, Wendy Brown updated the Quality Committee on the work of the Suicide Prevention Group and the Clinical Risk Group that defined the Trust's approach to the prevention of self-harm and suicide and the assessment and management of risk.	Considered the position statements on suicide prevention and the principles outlined by Dr Bethan Davies including Positive Risk Taking Clarified the type and level assurances required around the Trust's approach to suicide prevention. Agreed the next steps and project roll-out of patient safety planning with regular up-dating from John Sykes and priority areas for roll-out to be considered.

Triangle of Care	The Triangle of Care is a national initiative supported by NHS, Carers and professional organisations. It aims to implement six simple standards for carers into mental health services, initially in acute services, but widening out to community services, and eventually to all Trust services. The committee noted that the Trust is due to present the progress report about the implementation process to the regional group for approval at the end of April.	Accepted the report on the Triangle of Care provided the report would be taken to the 4Es Group, Carers Group and Patient Experience Group Approved the report to be presented to the Regional Triangle of Care Group for review of the first year of membership Noted the gaps in performance in some clinical teams and further improvement in carers work is required.
Draft 1 of the Quality Report for 2014/15	Draft 1 of the Quality Report for 2014/15 was presented to the Quality Committee prior to the final version publication date of 30 June 2015. Clare Grainger asked that feedback on the content be sent to her by email before 30 April in order that a final draft can be submitted to the Audit Committee for approval on 22 May. Once complete the report will be professionally produced and formatted at the final version stage as required in the guidance for development.	The Quality Committee considered and scrutinised the content of the draft report.
Forward plan	The Audit Committee would review the Quality Committee's Terms of Reference to address any gaps and ensure it was fit for purpose and the forward plan would be updated accordingly.	Agreed

Any Other Business	No other business	Agreed and noted

Escalation issues
There were no issues to be escalated to the Board. The Board is requested to receive a copy of the Infection Control Annual report presented in line with Health act requirements to the public board. See attached annual report Cross committee and other governance group's actions to be noted. Training Board- Suicide prevention training, roll out of Patient Safety planning

The Trust Board are requested to receive this report and guide the Quality committee on its current work and work plan

Derbyshire Healthcare NHS Foundation Trust
Report to Quality Committee 9th April 2015

Infection Prevention & Control Annual Report 2014/15

Purpose of Report: This paper summarises the activity over the preceding 12 months

Executive Summary

- Performance against key standards of Infection Prevention & Control and related activities remains consistent.
- Reported cases of key alert organisms remains low
- Interruption to services related to infection control incidents remains low
- Cleanliness of clinical areas remains consistently good, as were PLACE inspection results
- Clinical compulsory training of identified staff remains consistent
- Recent Environmental Health inspections of our kitchens resulted in a five start rating by Derby City Council.

Strategic considerations

- **In order that standards remain high, organisational commitment is required**
- **Planning for transformation of services and buildings needs to include infection prevention and control as part of planning and delivery**
- **A commitment to supporting staff in delivery of high standards is required – attendance at training, supply of materials for example.**

(Board) Assurances

- A clinical audit programme is developed and delivered
- Cleanliness assurance mechanisms
- Surveillance of health care associated infections (HCAI) alert organisms
- Compulsory training standards and compliance

Consultation

- **Quality Committee April 2015, then as part of a report to the Trust Board of Directors.**

Governance or Legal issues

This paper brings update on regulatory aspects – around standards which may form part of a CQC inspection or enquiry. These would be around patient safety, leadership, responsiveness and effectiveness. Standards are set in the Healthcare Associated Infections Code of Practice for Infection Prevention & Control 2010.

Equality Delivery System

This paper and the work of the Committee do not consider they disadvantage any group identified by REGARDS.

Recommendations

The Quality Committee is requested to:

1) Note the reporting of key areas, such as surveillance of healthcare associated infections – alert organisms, outbreaks of infection, staff training.
2) Receive assurance on standards of cleanliness of clinical areas and food preparation areas
3) Approve this report in preparation of presentation to the Trust Board of Directors.

Report presented by: **Hayley Darn, Nurse Consultant.**

Infection Prevention & Control

Annual Report - 2014/15

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

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

1.0 Introduction

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

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

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

2.0 National context

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

3.0 Structures within Derbyshire Healthcare NHS Foundation Trust

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

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

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

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

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

4.0 Key achievements of 2014/15

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

- Replacement flooring at Brooklands (Erewash Recovery team base, Ilkeston)
- Replacement furniture across inpatient wards – namely Melbourne House
- Upgraded clinical facilities at the new Amber Valley Recovery team base at Ripley
- Replacement flooring at the OT Kitchen, Hartington Unit
- Purchase of replacement pressure relieving mattress systems.

4.2 The Infection Control team have been involved in the planning of the refurbishment of the Assessment Suite and Hope & Resilience Hub at the Radbourne Unit. These have been developed with infection control standards central to the planning and delivery, as have the works currently underway to convert the former Day Hospital site at London Road Community Hospital.

4.3 Continued delivery of a training programme for those clinical and support staff who are identified as requiring the training (target group March 2015 was 1747 staff) saw a compliance position on 30/03/15 of 83.06%. Training sessions are largely delivered in a ‘face to face’ taught session, in a variety of locations and via the ‘block’ training methodology. There is also an e-learning option for staff to access.

4.4 There has been 1 ward closure as a result of norovirus type illness in the period April 2014 – March 2015 – individual suspected cases have been well managed on wards with minimal clinical impact and no evidence of cross infection. Pleasley ward was closed to admissions in December 2014 for a period of 4 days

whilst patients and staff on the wards were symptomatic of Norovirus, with 1 laboratory confirmed case.

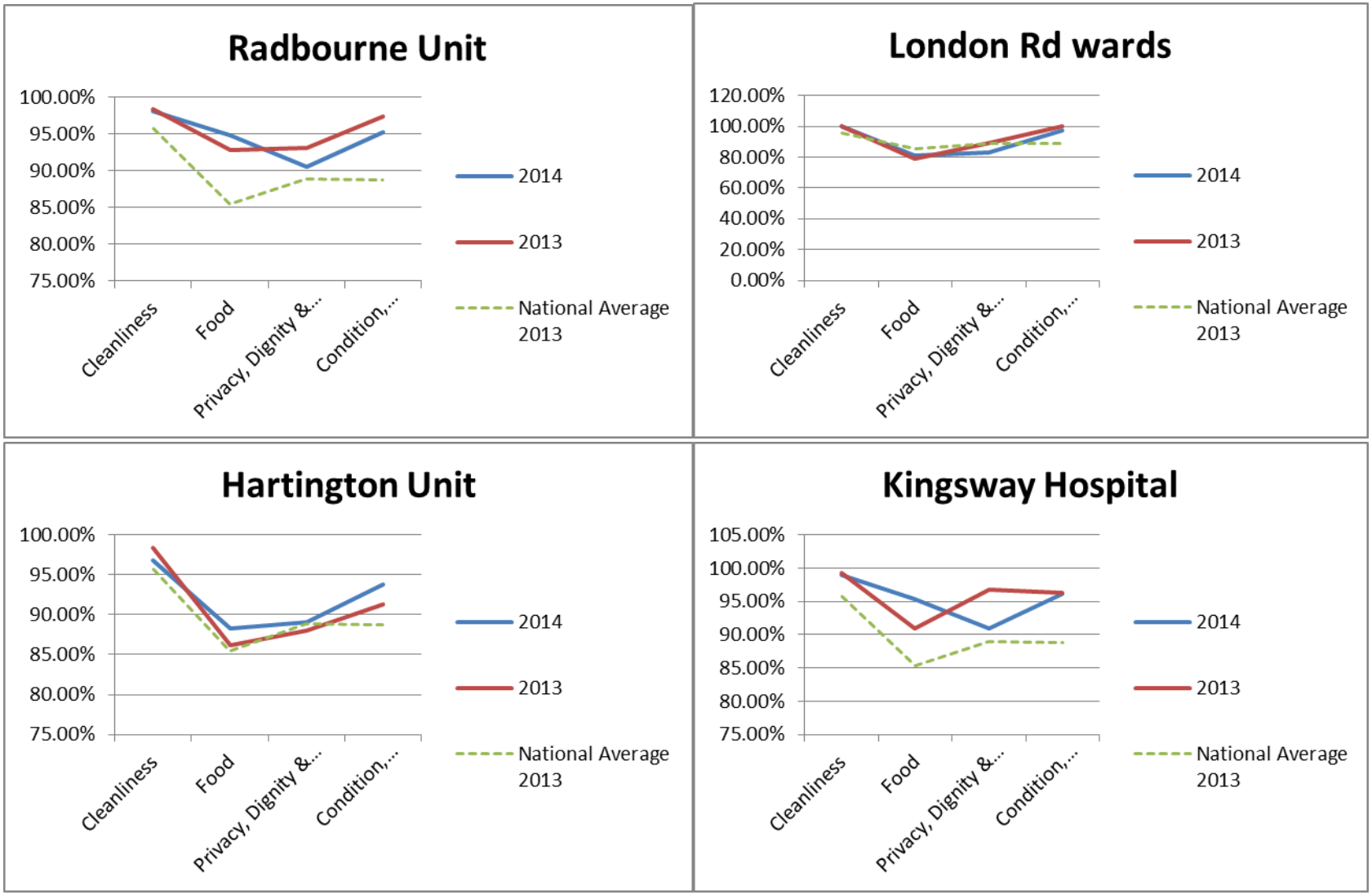
4.5 Surveillance of healthcare associated infections (HCAI alert organisms) have seen no cases of MRSA bacteraemia between April 2014 – March 2015 (0 reported in 2013/14) and 0 cases of *Clostridium difficile* in the same time period (0 in 2013/14).

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

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

4.8 Patient Led Assessment of the Care Environment (PLACE) inspections took place in Spring 2014, with continued strong performance. The 2015 inspection programme is underway at time of writing this report. (see graphs on following page). Our performance is largely in line with or exceeding national standards and results in each of the sections. The teams undertaking PLACE consist of Service User representatives, Estates, Nursing and Domestic Services as well as Infection Control representation. An action plan is drawn up after the assessments, which then feed into the allocation of capital funds, support for larger capital bids and in informing backlog maintenance priorities.

PLACE Assessment Results 2014

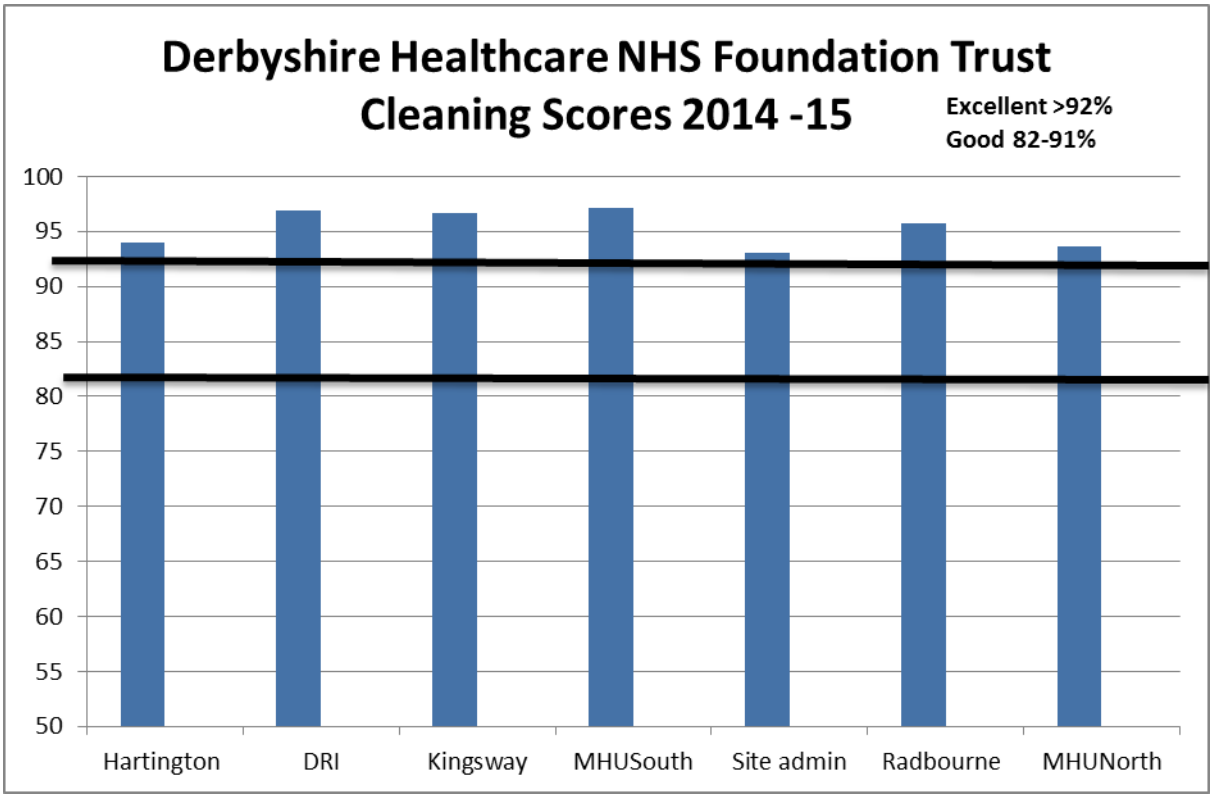


4.8 Continued development of the skills and leadership of the Infection Control Link Nurses programme brings a strong focus of clinical leadership and a conduit for information between the specialist team and clinical level. The link nurses meet twice a year to receive training and to share good practice.

5.0 Assurances

5.1 The Facilities team continue to deliver high standards of cleanliness, and the graph below (Graph 1) demonstrates the performance from April 2014 until March 2015. The highest standards and greatest cleaning services input are delivered in inpatient wards and patient facilities. Services to admin bases and bases where patients do not receive services have seen a reconfiguration of cleaning service, and the scores reflect their performance (MHU north, site admin).

Graph 1: Performance against National Standards of Cleanliness



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

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

Table 2: Surveillance of healthcare associated infection (HCAI)

2014/15	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MARCH
MRSA bacteraemia (trajectory = 5)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Clostridium Difficile (trajectory = 10)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Outbreaks of infection (Norovirus type)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**

5.4 During the winter season of 2014/15, there has been 1 ward closure as a result of diarrhoeal illness (confirmed Norovirus), with the wards seeing minimal impact on service. The proactive nature of the response, with swift activation of enhanced cleaning has ensured minimal opportunity for cross infection.

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

- Infection control general standards (hand hygiene, sharps, decontamination, equipment). Thematic review of the general infection control audit saw areas of work needed recording of cleaning of equipment. The audit tool has been revised and is now an electronic solution following feedback from Clinical teams and also from the Infection Control committee that the current system needed a refresh. Electronic system goes live in April 2015, which will produce ease of recording and thematic review.

- MRSA screening compliance. The data collection for this audit is now completed and shows inconsistent practice across ward areas. This will remain a feature of inpatient infection control training in the forthcoming year, and is being considered by the infection control link nurses as an area of practice development. Where screening is recorded is also a consideration which will be picked up via the electronic patient record development.

- Child health clinics standards the Health Visitor links have developed their own audit tool based on standards, which is being used now to monitor compliance and deficits in premises. Results are not yet fully available and will be reported to the Infection Control Committee in due course.

5.6 Clinical compulsory training continues to take place for those staff who are required to attend, as identified as part of the training framework, and administrated via the training passport system. Compliance is monitored via the Infection Control Committee at a strategic level, and attendance is managed by each of the Divisions. Frequency of attendance is currently agreed as every 2 years, and these are largely taught sessions via the 'block training' method. The compliance 'as at' 30/03/15 was 83.06% (this is a rolling 12 month figure). This method of delivery is also offered to Medical staff.

5.7 The development of the 'harm free care' agenda has meant that focus now is much more in prevention of harm, which is how the success in infection prevention has been achieved. Further developmental work, using the recent education of the infection control support nurse, has meant that plans for more detailed study of infectious conditions, the morbidity they cause and identification of risk factors can continue. Focussed work on the development of expertise in wound management continues through the maintenance of a Tissue Viability Link Nurse programme for inpatient wards, with targeted support to nursing staff to be able to assess, plan and care for a wound, thus preventing wound infection and promotion of healing. Support is contracted from Derby Hospitals NHS Foundation Trust in the form of training time and also clinical support for Tissue Viability with early success in partnership working.

5.8 Work to develop key practice standards with the Health Visitors and review the environments of the Child Health clinics has been undertaken. The health visitors link group for infection control have now developed an audit tool based on standards which they are currently using to audit their clinical standards and environments.

5.9 An influenza vaccination campaign was delivered for staff and patients who met the criteria. The final staff uptake figures are not yet know, with changes in reporting at NHS England level meaning that we do not have a final figure and benchmarks as yet. We delivered via in excess of 96 clinic sessions in a variety of locations. The sickness/ absence rate for staff reporting cold and flu like illness remained low, accounting for less than 1% of sickness / absence compared to last year.

5.10 The introduction of DATIXweb risk assurance and reporting modules has seen closer to real time reporting of incidents, including infection control and inoculation incidents) and the requirement for clinical teams to hold risk assessments in key areas such as hand hygiene, storage of alcohol hand rubs, sharps safety and provision of personal protective equipment (PPE). Incident reporting in a timely fashion has also meant that infection control have the increased ability to respond to reported incidents and emerging trends.

5.11 Hotel services continue to provide assurance on key service delivery areas, such as food hygiene, pest control, laundry and linen supplies, and the duty of care audits required

under the NHS Waste Management regulations. A full review of the laundry contract has taken place as a joint venture, with a single provider in place. The kitchens at Radbourne Unit & Kingsway sites have both had environmental health inspections and were both awarded 5star ratings by Derby City Council for the third year in succession. This is a very public method of demonstrating quality, as it is used across all food preparation establishments. We continue to gain additional assurance by using an independent Environmental Health officer to undertake inspections and guidance, as well as the local authority inspections. Pest control contractors call outs totalled 33, with planned inspections of kitchen areas taking place as a preventative measure.

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

5.13 Review of the DATIX Complaints system for 01/04/14 until 30/03/15 shows only 1 complaint related to cleanliness / infection risk, which has been dealt with by means of written response.

6.0 Next steps and priorities

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

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

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

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

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

6.6 A commitment to continue participation in local and national emergency planning exercises – work has been undertaken during this year to revise guidance on Viral Haemorrhagic Fever (Ebola, and other viral strains), and to procure appropriate personal

protective equipment (PPE). Guidance has been devised, and we have participated in a regional review process led by NHS England.

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

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

7.0 Potential risks in delivery

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

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

7.3 Continued operational support to achieve compliance with compulsory training.

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

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

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

Hayley Darn

30th March 2015.

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 29th April 2015

Finance Director's Report Month 12

Purpose of Report

This paper provides the Trust Board with an update on the end of year financial performance against our operational financial plan and is consistent with the information submitted in the quarter 4 Monitor return.

Also contained in the report for information is a summary of capital expenditure for the financial year.

Recommendations

The Board of Directors is requested to:

1) Consider the content of the paper and receive a good level of assurance on the outturn financial performance against the operational financial plan for 2014/15.

Executive Summary

- End of year underlying surplus achieved of £1.8m which is better than plan by £0.3m this is an adverse change of £0.9m. The change in outturn position mainly relates to the update of year end provisions.
- Actual net deficit achieved at end of year of £(0.2)m which was worse than plan by £0.5m which is due to higher impairments than in the plan.
- We ended the year with a risk rating of three as per the operational plan.
- The Cost Improvement Programme has been fully achieved this financial year, with a small amount £86k of savings being found non-recurrently. There are no revenue generation schemes, all schemes relate to cost reductions.
- Capital expenditure has exceeded the 2014/15 plan following additional revenue funding being received from the Nurse Technology Fund.
- Cash is ahead of plan by £3.6m which is mainly related to outstanding payments to other organisations.

Strategic considerations

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

Board Assurances

This report should be considered in relation to the financial risks contained in the Board Assurance Framework, namely:

- 3b: "*Risk to financial performance as a result of under delivery of savings from the efficiency programme or other inability to contain costs to budgeted levels*" and

- 3c: "*Risk that there is a material variance against planned income levels for services that are not funded through block income targets. This may lead to an adverse effect on Trust COSRR risk rating and could also increase the value of savings required from the CIP programme*"

Consultation

- Finance and Performance Committee challenges key strategic aspects of financial performance and financial risks.

- Performance and Contracts Overview Group regularly discuss many aspects of financial performance

- Asset Planning and Agile Working Board oversee the capital expenditure plan which is operationally managed by the Capital Action Team on a monthly basis.

- Financial information presented to all of these meetings is entirely consistent with financial information presented to Trust Board.

Governance or Legal issues

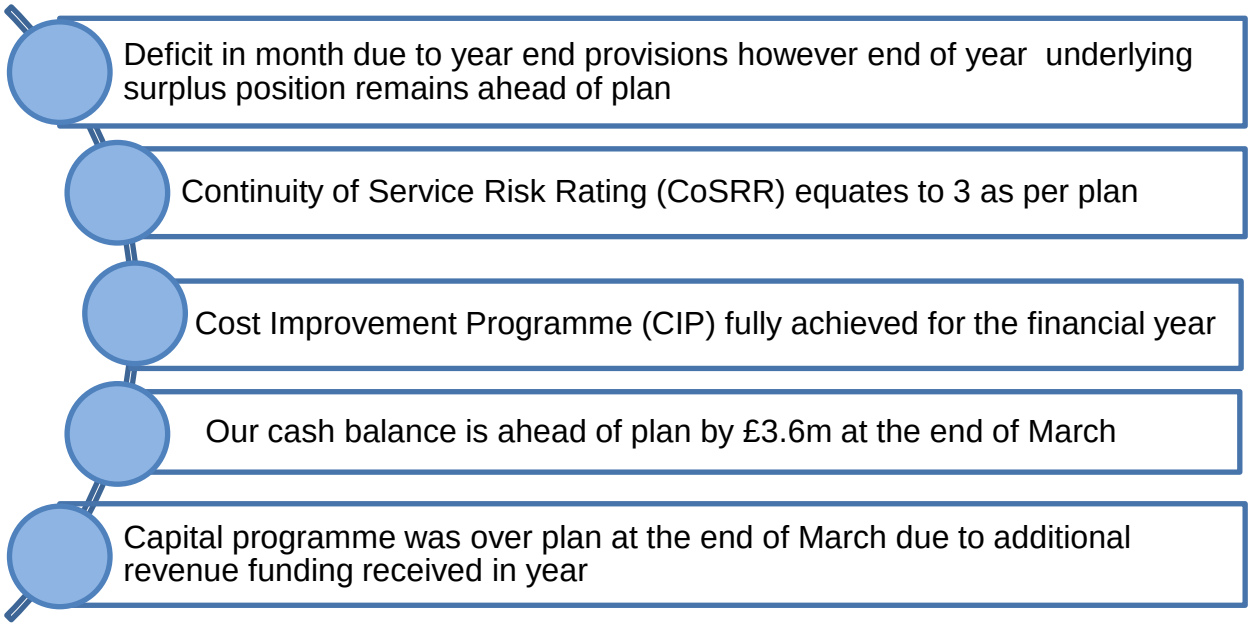
There are no governance or legal exceptions. Delivery of the operational plan is reported to Monitor the Regulator in our in-year submissions.

Equality Delivery System

This report has a neutral impact on REGARDS groups.

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

FINANCIAL OVERVIEW
MARCH 2015



1. Overall Financial Performance

Income & Expenditure – key statistics

In the month there was an underlying deficit of £(2.2)m which was worse than plan by £2.4m. EBITDA was worse than plan by £1.8m which equates to (9.8)% of income, against a plan of 6.8%. This has mainly been driven by various year end provisions, some of which were in the forecast previously. The approach to provisions has been discussed with auditors before being actioned.

At the end of the financial year the Trust achieved an underlying surplus of £1.8m which remained better than plan by £0.3m. EBITDA was £8.7m against a plan of £7.8m which equates to 6.6% of income compared to a plan of 6.1%.

STATEMENT OF COMPREHENSIVE INCOME	MARCH 2015					
	Current Month			Year to Date		
	Plan	Actual	Variance Fav (+) / Adv (-)	Plan	Actual	Variance Fav (+) / Adv (-)
	£000	£000	£000	£000	£000	£000
Clinical Income	9,889	10,155	266	117,966	119,634	1,668
Non Clinical Income	742	1,237	495	9,028	11,191	2,163
Pay	(7,908)	(8,212)	(305)	(94,607)	(95,079)	(472)
Non Pay	(2,004)	(4,244)	(2,239)	(24,579)	(27,071)	(2,492)
EBITDA	**719**	**(1,064)**	**(1,783)**	**7,807**	**8,675**	**867**
Depreciation	(275)	(321)	(46)	(3,300)	(3,337)	(37)
Impairment	(1,200)	(1,372)	(172)	(1,200)	(1,984)	(784)
Profit (loss) on asset disposals	0	3	3	0	347	347
Interest/Financing	(157)	(323)	(166)	(1,945)	(2,499)	(555)
Dividend	(83)	(452)	(369)	(1,000)	(1,369)	(369)
Net Surplus / (Deficit)	**(996)**	**(3,529)**	**(2,533)**	**363**	**(166)**	**(529)**
Technical adj - Impairment	(1,200)	(1,372)	(172)	(1,200)	(1,984)	(784)
UnderlyingSurplus / (Deficit)	**204**	**(2,157)**	**(2,361)**	**1,563**	**1,817**	**254**

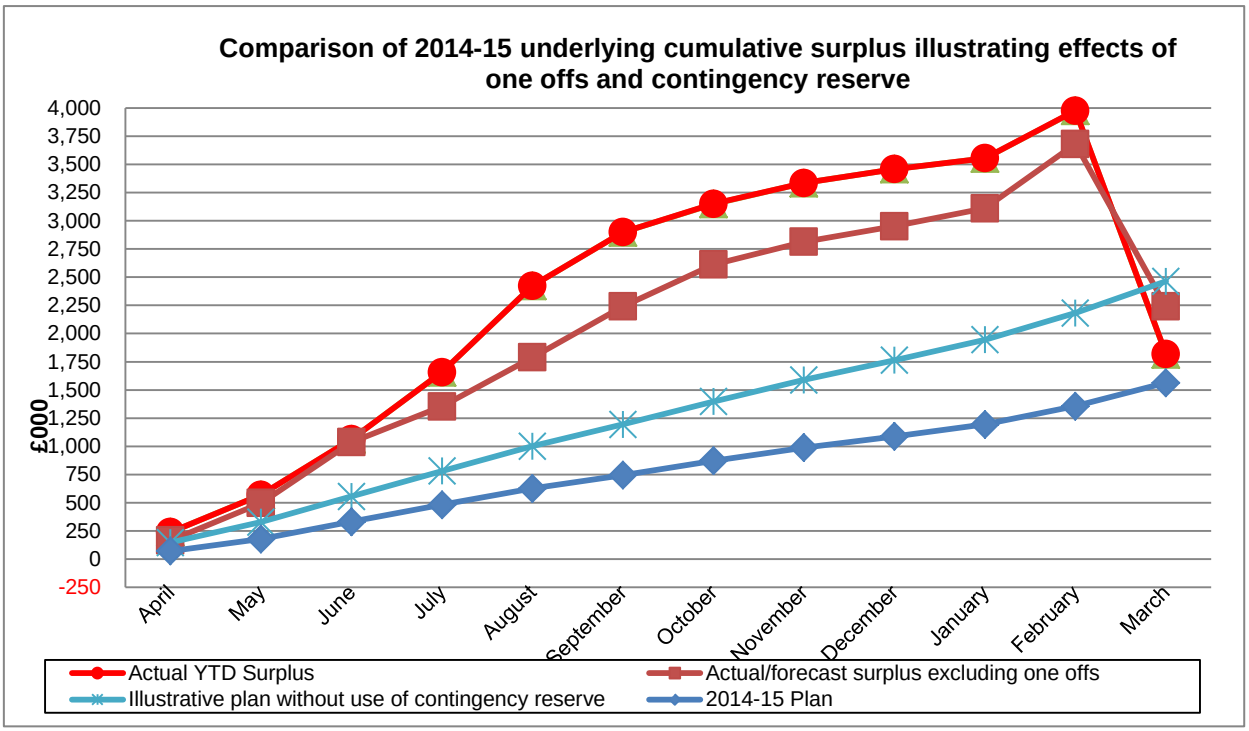
- At the end of the financial year clinical income is better than plan by £1.67m which is mainly driven by Service Developments that were not included in the original plan due to the timing of the plan submission and agreement of contracts, these have corresponding pay and non-pay expenditure.
  This was higher than previously forecast by £171k which has mainly been driven by some non-recurrent income in the last month of the year which has corresponding non-pay expenditure.

- Overall non-clinical income was better than plan by £2.2m which has been driven throughout the year by higher pharmacy recharges which has corresponding expenditure. There was also an increase in the last month due to additional income received from the Nurse Technology Fund which has been spent on capital items.
  This was £157k better than previously forecast last month difference being mainly due to the level of pharmacy recharges.

- Pay expenditure ended the financial year at £472k overspent which was slightly more than previously forecast by £31k. The overspend during the year mainly relates to Service Developments that were not included in the original plan as reported throughout the year.

- Non pay expenditure has overspent in the month by £2.2m increasing the previous small overspend to £2.5m, which has mainly been driven by year end provisions, some of which were already included in the forecast. In the previous month the forecast for the end of year position was an overspend of £1.4m, which has actually increased by £1.1m. The adverse movement relates to an increase in provisions along with smaller increases across the Trust on general non pay expenditure.

The graph below shows the cumulative underlying surplus for both actual and forecast compared to the plan. It also includes additional lines to illustrate what the underlying surplus would look like excluding the one-off costs and benefits this year, and what the financial plan surplus would be if expenditure related to the use of the general contingency had not been included in the plan.



The significant differences between the actual underlying surplus and adjusted underlying surplus relates to the release of an accrual in July and the profit on sale of a property August, as previously reported. The peak in February is mainly driven by higher income levels.
The significant drop in the last month of the year relates to the pensions discount factor, holiday pay ruling provision and other provisions along with the increase in Public Dividend Capital payment, some of these provisions have been one offs and have therefore been adjusted for in the 'actual/forecast surplus excluding one offs' line in the graph above.

2. Risk Rating

The Continuity of Services Risk Rating (CoSRR) is a 3 at the end of the financial year as per plan. Previously the Liquidity metric was forecast to end the year at a 4 however due to the changes in the operating expenditure the Liquidity metric out-turned at a 3.

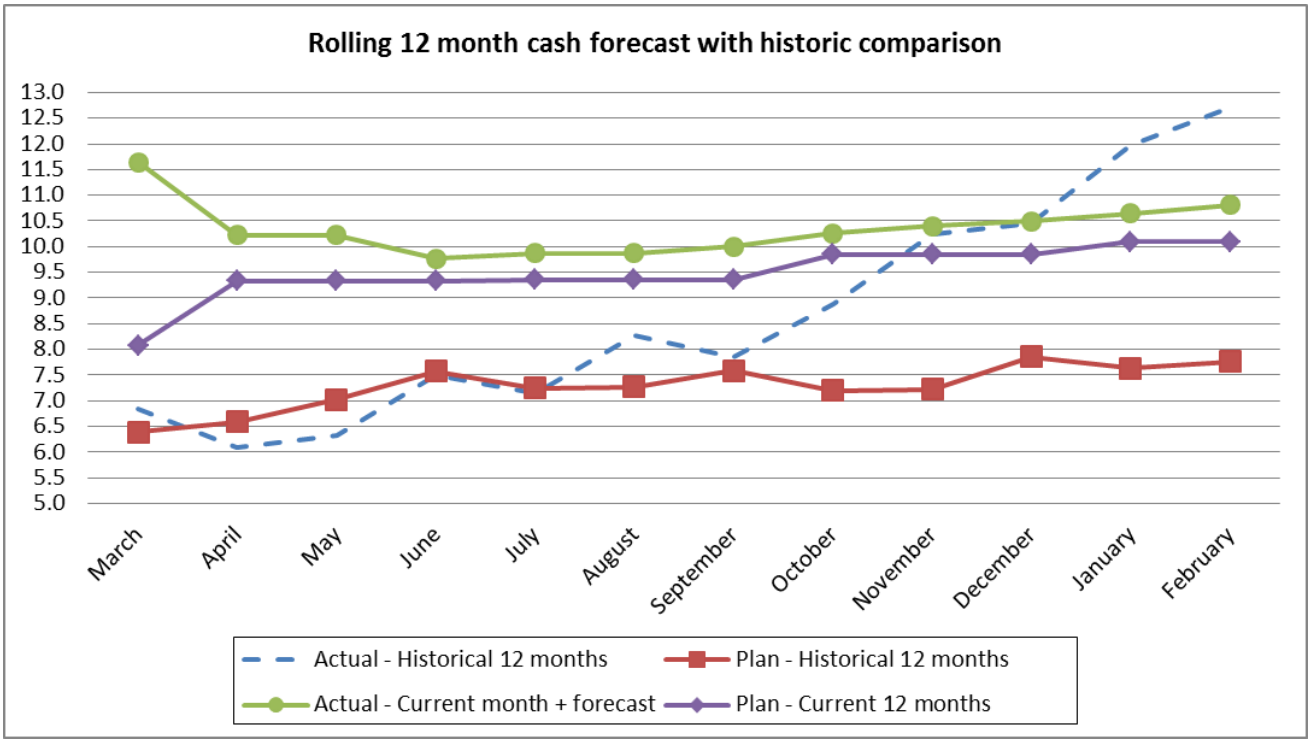
3. Efficiency / Cost Improvement Programme (CIP)

We have delivered all programmed savings in year and therefore delivered the full CIP programme of £4.3m. During the year £86k has been found non-recurrently and there have been no revenue generation schemes.

4. Cash Balances

The cash balance at the end of the financial year was £11.6m which is ahead of plan by £3.6m.
The cash being ahead of plan is driven by some outstanding payments to other providers which are on hold whilst contract issues are being resolved and capital creditors which were not fully paid at the end of the year.

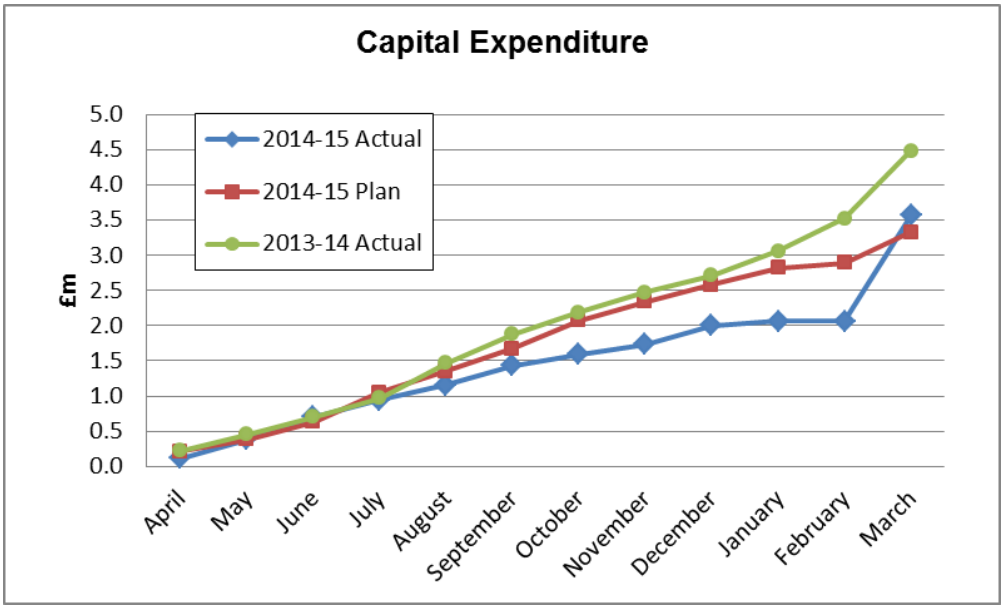
The forecast graph below assumes that the capital creditors will be paid in April along with some high invoices that have been paid in the month to date and that the other contract issue currently in discussion will be resolved by the end of June.



During quarter 2 of the financial year we improved into a net current asset position and maintained that throughout the year until the final month where we have reverted into net current liabilities; however this was still better than the plan. This change in the final month of the year has been driven by the increase in provisions.

5. Capital Expenditure

Capital Expenditure was £239k more than planned at the end of March. The reason for the expenditure being higher than plan was due to income (received as revenue) from the Nurse Technology Fund, which has been spent on mobile devices.



During the financial year each of the planned schemes are monitored on a monthly basis by the Capital Action Team (CAT). During this financial year CAT has reprioritised several schemes in order to fund urgent bids that have arisen in year. The table below contains a summary of the schemes including the original planned budgets and actual expenditure.

	Original Plan	Actual expenditure	Variance
	£'000	£'000	£'000
Estates			
Backlog Maintenance	400	393	7
Estates Staff	130	99	31
City Locality Refurbishment	250	256	(6)
Ripley Library Refurbishment	180	182	(2)
Recovery and Resilience Suite	-	124	(124)
Hartington Unit S136 Upgrade	36	36	0
Cubley Court Flooring	40	40	0
Kingsway Site Car Parking	55	127	(72)
Cherry Tree Bungalow	75	75	0
Refurbishment Day Hospital	-	90	(90)
OT Kitchen Cubley	-	39	(39)
Other Estate schemes	90	75	15
Sub-total Estates	**1,256**	**1,536**	**(280)**
IM&T			
Electronic Patient Records	1,348	1,119	229
PC and Server replacement	144	549	(405)
Other IT projects	309	283	26
Sub-total IM&T	**1,801**	**1,951**	**(150)**
Other			
Transformation	100	0	100
Environmental Works / Anti-Ligature	37	39	(2)
Infection Control	50	44	6
Other Miscellaneous	85	(2)	87
Sub-total Other	**272**	**81**	**191**
Total Capital Expenditure 2014-15	**3,329**	**3,568**	**(239)**

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 29th April 2015

Trust Performance Report – Key Performance Indicators Compliance

The purpose of this report is to define the Trust's performance against its Key Performance Indicators plus any actions in place to ensure performance is maintained. Compliance with the Trust's performance indicators is being actively monitored and corrective actions are put in place where appropriate. Areas covered in this report include, the Main Performance Indicators, Health Visitors, IAPT and Ward Safer Staffing

Executive Summary

- The recording of Payment by Result Clusters and Health of the Nation Outcome Scores 12 month reviews continue to be challenging.
- The rate of Trust cancellations and outpatients who Did not attend is still causing concern
- Health Visiting continues to stay above their targets

Strategic considerations

- To maintain high level of organisational performance

(Board) Assurances

- This report provides full assurance for;
  - Monitor Targets
  - Performance related elements of schedule 6
  - Heath Visitor Performance
  - IAPT Performance
- The report provides partial assurance for ;
  - Locally Agreed Targets
  - Performance related elements of schedule 4
  - Ward Staffing

Consultation

- This report isn't being considered at any other Committee or Meeting

Governance or Legal issues

There are no legal issues arising from this Board Report.

Equality Delivery System

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

Recommendations

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

Report presented by: **Ifti Majid**
Chief Operating Officer/Deputy Chief Executive

Report prepared by: **Ifti Majid**
Chief Operating Officer/Deputy Chief Executive

Derbyshire Healthcare NHS FT
Key Performance Indicators Compliance Report
Based on March 2015 Information

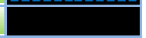
Introduction

The following Performance Compliance report is organised into the following sections;

1. Trust Performance Dashboard including exceptional items and specific areas of interest
2. Health Visitors Dashboard
3. IAPT Services Dashboard
4. Ward Safer Staffing Return

1 Trust Performance Dashboard

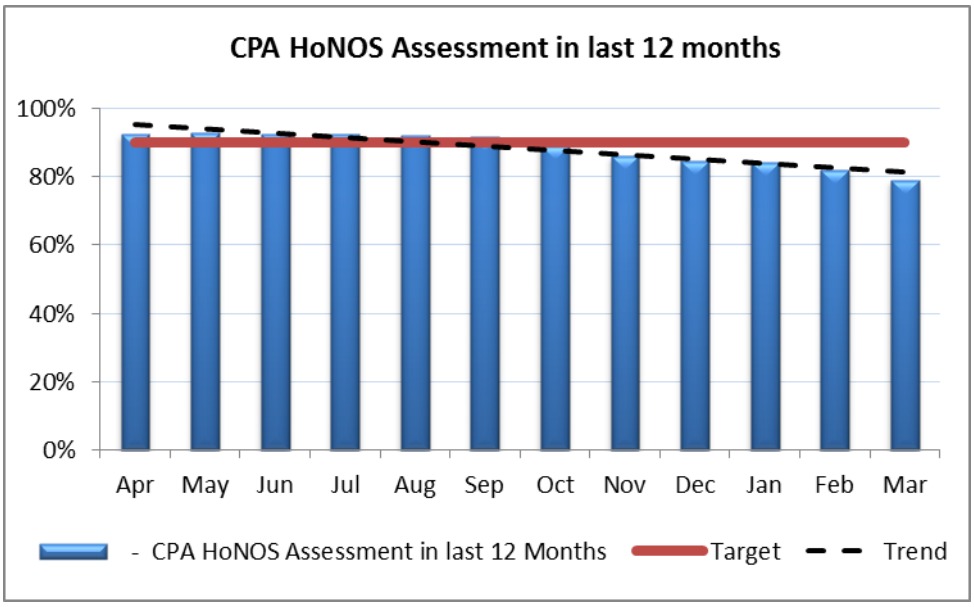
14-15 Performance Dashboard	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Trend
- Monitor Targets														
- CPA 7 Day Follow Up	95.00%	98.85%	100.00%	98.90%	97.03%	96.00%	98.61%	97.37%	96.20%	95.19%	96.77%	97.35%	97.80%	
- CPA Review in last 12 Months (on CPA > 12 Months)	95.00%	95.20%	95.78%	96.49%	96.87%	96.77%	97.67%	95.97%	95.43%	95.78%	96.83%	96.65%	95.88%	
- Delayed Transfers of Care	7.50%	1.94%	1.83%	1.70%	1.45%	0.98%	1.24%	2.65%	1.38%	1.32%	0.99%	1.30%	0.67%	
- Data Completeness: Identifiers	97.00%	99.34%	99.27%	99.20%	99.14%	99.10%	99.10%	99.04%	99.03%	99.03%	99.06%	99.03%	98.99%	
- Data Completeness: Outcomes	50.00%	97.84%	97.84%	97.75%	97.73%	97.69%	97.51%	96.74%	95.89%	95.41%	95.32%	94.52%	93.57%	
- Community Care Data - Activity Information Completeness	50.00%	90.42%	90.85%	91.12%	90.30%	89.79%	89.47%	89.58%	90.00%	89.85%	90.06%	90.00%	89.87%	
- Community Care Data - RTT Information Completeness	50.00%	92.31%	92.31%	92.31%	92.31%	92.31%	92.31%	92.31%	92.31%	92.31%	92.31%	92.31%	92.31%	
- Community Care Data - Referral Information Completeness	50.00%	72.87%	72.89%	72.73%	72.22%	73.86%	72.64%	72.02%	72.21%	71.27%	71.47%	71.03%	70.81%	
- 18 Week RTT Less Than 18 Weeks - Non-Admitted	95.00%	97.42%	94.54%	96.44%	96.36%	97.63%	97.20%	95.20%	96.74%	97.22%	95.44%	95.97%	95.27%	
- 18 Week RTT Less Than 18 Weeks - Incomplete	92.00%	94.69%	95.85%	95.85%	96.46%	96.73%	96.89%	98.21%	97.03%	95.71%	96.77%	95.47%	94.74%	
- Early Interventions New Caseloads	95.00%	100.00%	91.30%	108.80%	121.70%	103.50%	102.90%	105.00%	104.40%	100.00%	99.10%	103.20%	102.10%	
- Clostridium Difficile Incidents	7	0	0	0	0	0	0	0	0	0	0	0	0	
- Crisis GateKeeping	95.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
- Locally Agreed														
- CPA HoNOS Assessment in last 12 Months	90.00%	92.78%	92.86%	92.59%	92.53%	92.38%	91.76%	89.24%	86.28%	84.82%	84.56%	82.28%	79.26%	
- CPA Settled Accommodation	90.00%	99.88%	99.86%	99.84%	99.84%	99.83%	99.83%	99.79%	99.81%	99.71%	99.66%	99.45%	99.37%	
- CPA Employment Status	90.00%	99.88%	99.85%	99.85%	99.85%	99.88%	99.88%	99.82%	99.82%	99.81%	99.78%	99.65%	99.55%	
- Data Completeness: Identifiers	99.00%	99.34%	99.27%	99.20%	99.14%	99.10%	99.10%	99.04%	99.03%	99.03%	99.06%	99.03%	98.99%	
- Data Completeness: Outcomes	90.00%	97.84%	97.84%	97.75%	97.73%	97.69%	97.51%	96.74%	95.89%	95.41%	95.32%	94.52%	93.57%	
- Patients Clustered not Breaching Today	99.00%	89.48%	89.76%	91.16%	91.42%	90.00%	88.91%	85.49%	80.52%	75.96%	72.11%	69.29%	69.54%	
- Patients Clustered Regardless of Review Dates	100.00%	97.30%	97.35%	97.42%	97.36%	97.34%	97.13%	96.77%	95.52%	94.29%	93.18%	91.80%	90.28%	
- 7 Day Follow Up – All Inpatients	95.00%	98.25%	100.00%	98.32%	96.21%	94.74%	97.98%	97.25%	92.78%	95.52%	96.30%	97.67%	94.39%	

14-15 Performance Dashboard	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Trend
- Schedule 4 Contract														
- Consultant Outpatient Appointments Trust Cancellations (Within 6 Weeks)	5.00%	4.66%	2.51%	4.65%	3.94%	3.72%	3.63%	6.54%	5.37%	8.04%	8.22%	6.45%	7.14%	
- Consultant Outpatient Appointments DNAs	15.00%	14.52%	15.25%	15.83%	15.05%	15.41%	16.75%	17.28%	18.46%	18.34%	18.26%	17.37%	16.89%	
- Under 18 Admissions To Adult Inpatient Facilities	0	0	0	0	0	0	0	0	0	0	1	0	0	
- Outpatient Letters Sent in 10 Working Days	90.00%	81.86%	86.26%	85.80%	67.87%	54.67%	58.83%	36.40%	61.20%	66.67%	78.00%	73.71%	74.29%	
- Outpatient Letters Sent in 15 Working Days	100.00%	92.29%	95.40%	91.45%	89.30%	81.38%	84.28%	48.91%	78.68%	82.55%	83.85%	86.61%	87.09%	
- Average Community Team Waiting Times (Weeks)	N/A	6.43	6.57	6.78	6.44	6.75	6.63	6.15	6.34	6.34	6.07	5.03	4.28	
- Inpatient 28 Day Readmissions	10.00%	9.30%	6.82%	7.20%	7.69%	7.55%	5.56%	14.63%	6.73%	7.43%	8.06%	6.67%	6.56%	
- Crisis Home Treatments	0	136	145	127	140	132	108	110	110	88	115	115	94	
- CPA Review in last 12 Months	90.00%	95.20%	95.78%	96.49%	96.87%	96.77%	97.67%	95.97%	95.43%	95.78%	96.83%	96.65%	95.88%	
- Assertive Outreach Caseload	N/A	250	247	247	247	246	245	268	267	267	267	267	266	
- Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	
- MRSA Incidents	0	0	0	0	0	0	0	0	0	0	0	0	0	
- Discharge Fax Sent in 2 Working Days	98.00%	92.62%	98.36%	98.31%	97.12%	97.14%	100.00%	98.29%	99.00%	94.52%	98.25%	99.17%	98.11%	
- Schedule 6 Contract														
- CPA In Settled Accommodation	N/A	91.26%	91.08%	91.11%	91.36%	91.20%	90.28%	90.51%	90.68%	91.03%	90.75%	90.74%	90.42%	

1.1 Exception Items and Specific Areas of Interest

The following section reviews a number of indicators in more detail, identifying where actions are in place to address areas of performance.

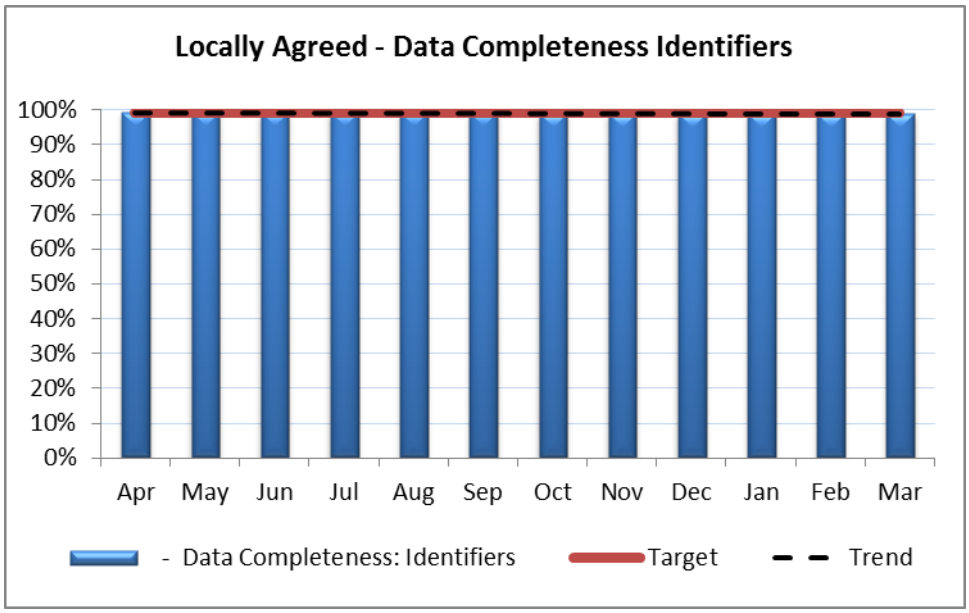
1.1.1 Locally Agreed – Care Programme Approach Health of the Nation Outcome Score Assessment in Last 12 Months



Health of the Nation Outcome Score assessments are part of clustering so by improving the clustering position we will improve the Health of the Nation Outcome Score assessments position by default (see below).

Action planned: Please see action plan in section 1.1.3

1.1.2 Locally Agreed – Data Completeness Identifiers

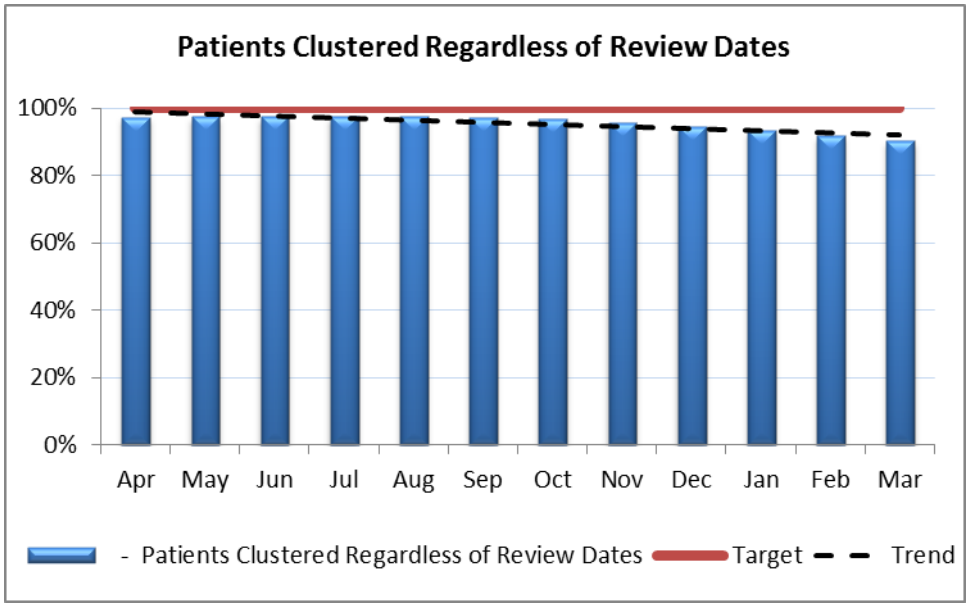


There have been some issues with staff not using Paris correctly when recording post codes. On Paris if the patient has been discharged, the referral must be re-opened before information can be updated. The way this is done has been communicated out to all teams. Once the information has been updated the referral must be re-closed.

Action planned:

- Staff advised that the Paris post code selector function must be used
- To continue to monitor and exception report to enable improvement

1.1.3 Locally Agreed – Patients clustered regardless of Review Dates



There has been little improvement in reported compliance with Payment by Results requirements. This is despite some people making significant inroads into their backlog of exceptions. The Payment by Results Advisor has continued working mostly with Consultants to identify strategies to clear the backlog of exceptions and to avoid future exceptions. This has included one-to-one sessions exploring Payment by Results related functions in PARIS, provision of exception/proposed action reports and manual inputting of paper assessments. Some of the recent changes within Paris, eg the ability to copy the previous Payment by Results assessment, have supported this work.

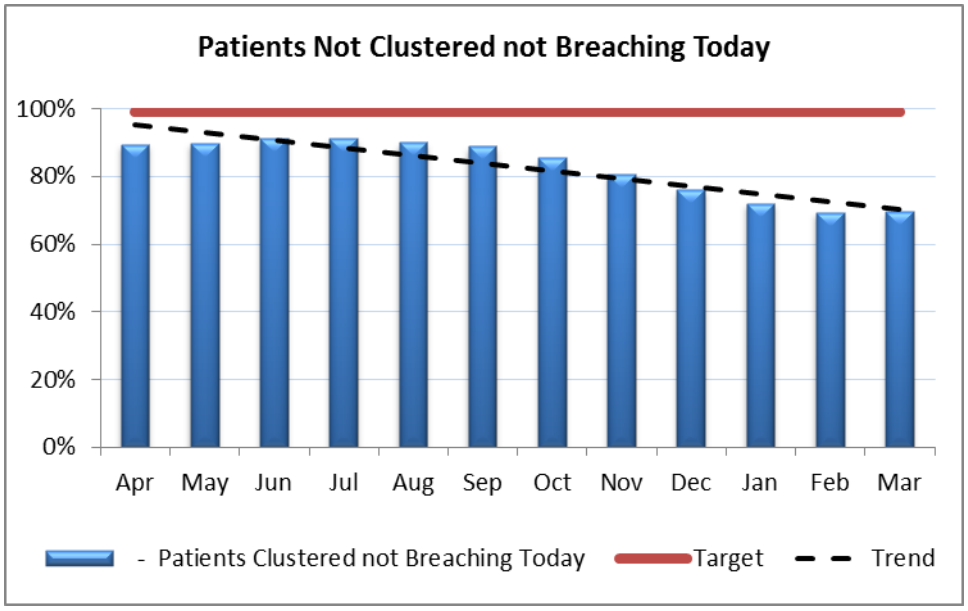
In March some admin support has been put in place to assist mainly with inputting of assessments. The admin worker has also started to contact individual non-medical staff in community teams with their list of exceptions. This admin support is only in place until the end of April.

The Payment by Results Advisor post has been extended until the end of June to continue to work with clinicians to improve the position.

Action planned:

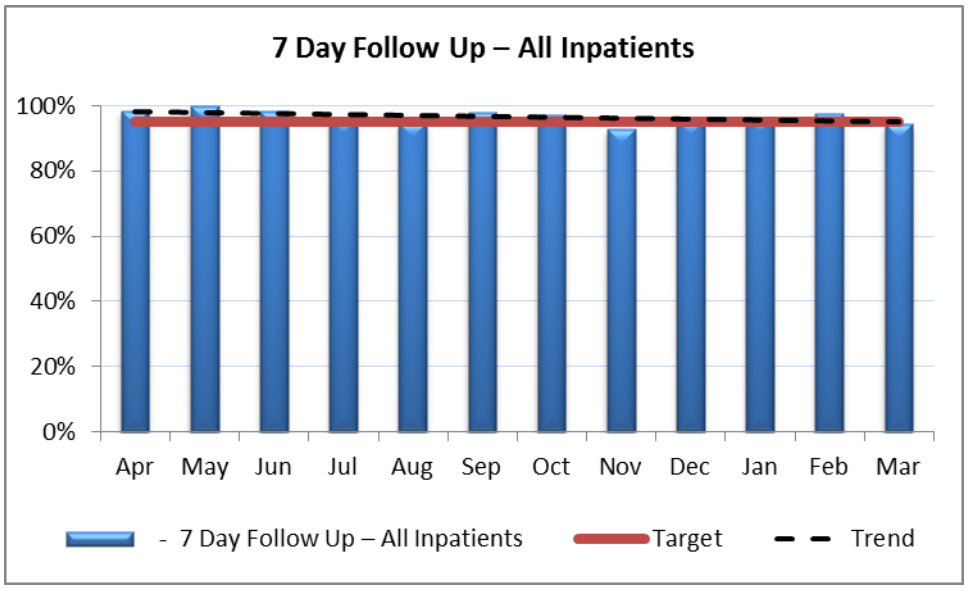
- Payment by Results Advisor to continue to work with individual clinicians

1.1.4 Locally Agreed – Patients clustered not Breaching Today



Please see comment and action plan in section 1.1.3

1.1.5 Locally Agreed – 7 Day Follow Up – All Inpatients

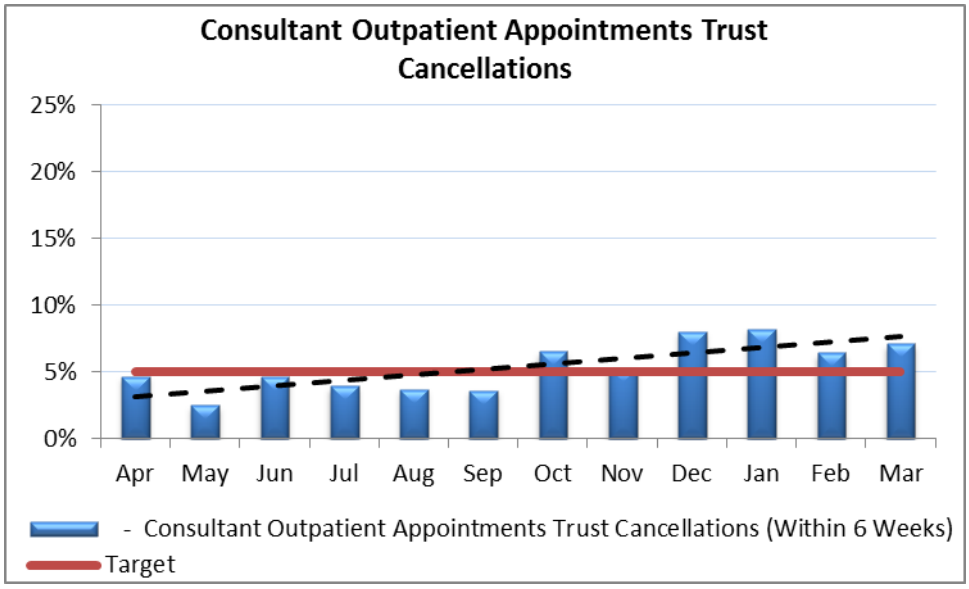


A number of patients did not attend their appointments and others were followed up by Social Workers employed by the Council.

Action planned:

- To continue to make every effort to follow-up all discharged patients within 7 days
- To address recording issues

1.1.6 Schedule 4 – Consultant Outpatient Trust Cancellations



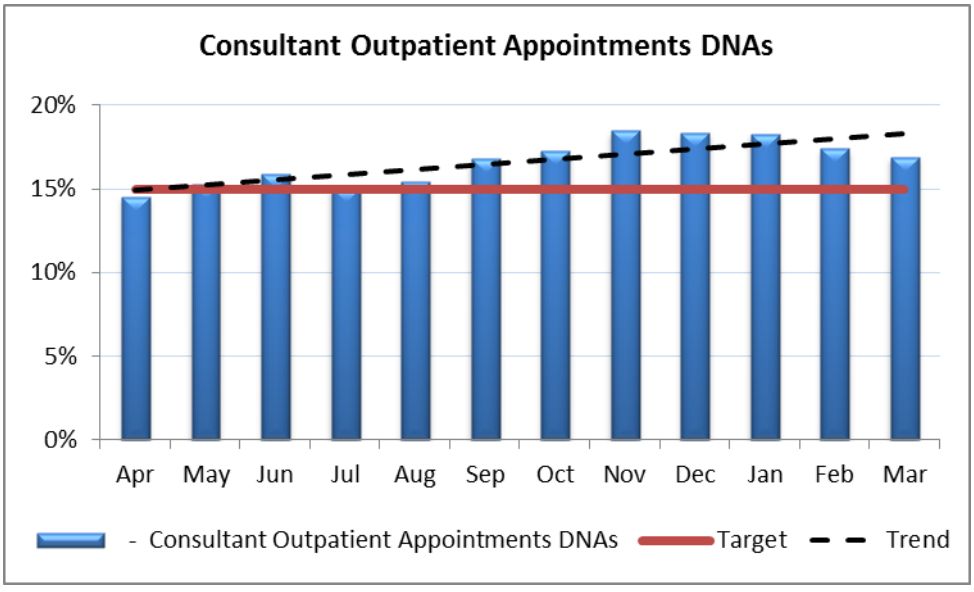
An audit of cancellation reasons found that only 4% of the cancellations in March inconvenienced patients, which is beneath the target threshold. The main reason for these cancellations was consultant sickness.

Where cancellations did not inconvenience patients, the main reasons included:

- Virtual appointment – patient not inconvenienced
- Appt changed to another doctor, same date, same time, same location
- Patient did actually attend this appointment
- Patient requested to reschedule the appointment.

Action planned: To tightly control actual cancellations by continuing to use the established clinic cancellation authorisation process.

1.1.7 Schedule 4 – Consultant Outpatient Did Not Attends



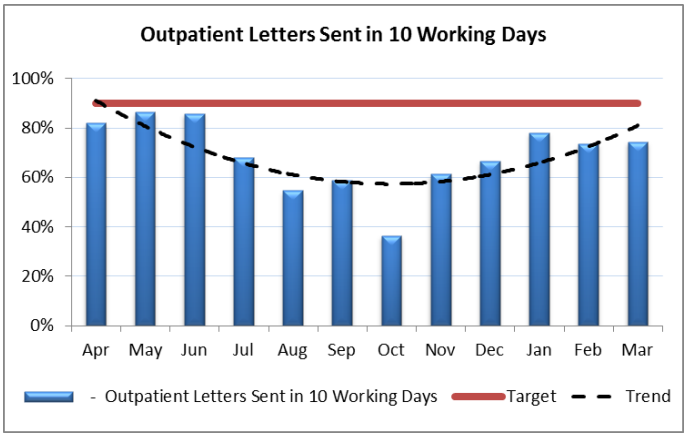
Recent study: http://qir.bmj.com/content/3/1/u202228.w1114.full

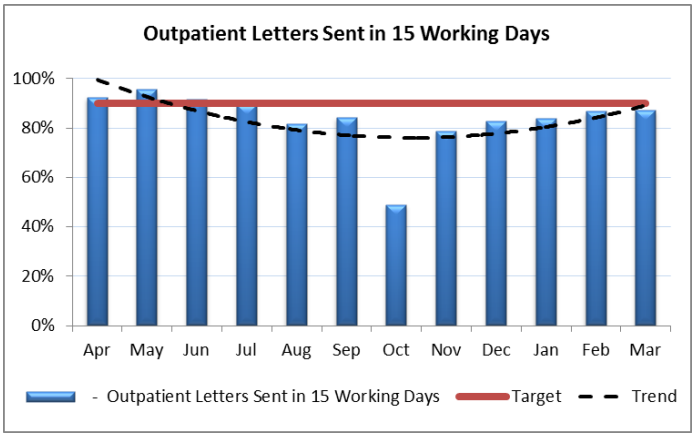
Research: http://ps.psychiatryonline.org/article.aspx?articleID=433008

Both suggest that text message reminders are effective in reducing non-attendance.

Action planned: Information Management and Technology have set up text message reminder functionality on Paris. We now need to ensure that mobile numbers held are valid and that service users are willing to receive text reminders. A form has been proposed for this purpose. Once approved this will be sent out over the coming months with all patient letters and, where staffing allows, completed with service users while they wait for their appointments

1.1.8 Schedule 4 –Outpatient Letters (Exceptions)





- Urgent and Planned Care Typing at the time of this report is 100%
- Some technical issues remain in relation to uploading dictations from Digital Voice Recorders in areas where a conflict between Dictate and Windows Software following Greater East Midlands upgrades. New client should resolve this Julie currently awaiting update from Anthony re testing following modification to the Microsoft Installer to accommodate Olympus software changes.
- Formal Review of Medical Secretary/Support Medical Secretary workforce in line with Neighbourhood plans has commenced.

Action planned

- Meeting held with Information Management and Technology on 26th March to begin process of Business as usual. Further meeting arranged for Connect processes and e-learning programmed development set for Monday 20th April.
- Concerns remain in relation to Greater East Midlands /Dictate support teams lack of ownership of some calls. Information Management and Technology have agreed to be internal link for Business as usual and arrangements for formal handover will begin following Meetings of 20th and successful installation of New Client.

2 Health Visitor Dashboard

2.1 Key Performance Indicators

14-15 Health Visitor Dashboard	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Health Visitors (FTE) in Post ESR	60.91	60.37	60.44	62.23	59.92	62.76	64.33	64.33	66.55	67.75	67.71	69.51
Health Visitors in Post (Headcount)	74	73	73	75	72	75	77	77	79	81	81	83
Number of Student Placements (Headcount)	27	27	26	26	26	23	23	22	21	16	11	9
Number of Student Placements (FTE)	27	27	26	26	26	23	23	22	21	16	11	9
Number of mothers receiving antenatal check	77	102	130	155	151	116	204	231	157	185	200	238
% Births that receive NBV within 10-14 days	76.61%	70.03%	85.76%	86.27%	87.34%	91.13%	90.61%	91.95%	87.25%	90.42%	92.19%	83.27%
% NBVs undertaken after 15 days	22.80%	29.10%	12.70%	13.70%	13.00%	7.30%	8.20%	5.30%	9.60%	8.00%	5.90%	2.80%
% Children to received a 12 month review	92.70%	93.50%	95.70%	95.00%	93.20%	97.40%	96.70%	96.20%	98.00%	96.20%	95.60%	94.00%
% Children who received a 12 month review at 15 months	87.00%	86.00%	90.10%	92.70%	93.50%	95.70%	95.00%	93.20%	97.00%	95.30%	95.50%	96.90%
% Children who received a 2 to 2.5 year review	74.70%	74.10%	90.10%	91.80%	90.40%	92.20%	91.40%	94.60%	97.10%	97.70%	97.00%	92.90%
% Staff who have received child protection training	79.70%	80.80%	80.80%	80.00%	80.60%	76.00%	76.60%	75.30%	72.20%	70.40%	70.40%	67.50%
% 10-14 Day Breastfeeding coverage	98.10%	98.90%	99.10%	98.10%	99.40%	98.80%	97.70%	99.10%	98.90%	96.90%	97.50%	98.60%
% 6-8 Week Breastfeeding coverage	97.40%	98.50%	99.70%	98.80%	100.00%	99.60%	99.10%	99.70%	99.70%	99.40%	99.60%	98.10%
% Still Breastfeeding at 6-8 Weeks	71.80%	74.20%	73.50%	73.00%	75.70%	73.10%	67.10%	74.70%	77.30%	75.00%	74.30%	70.80%

2.1.1 Exception Comments

No exceptions.

3 IAPT Services Dashboard

3.1 Dashboard

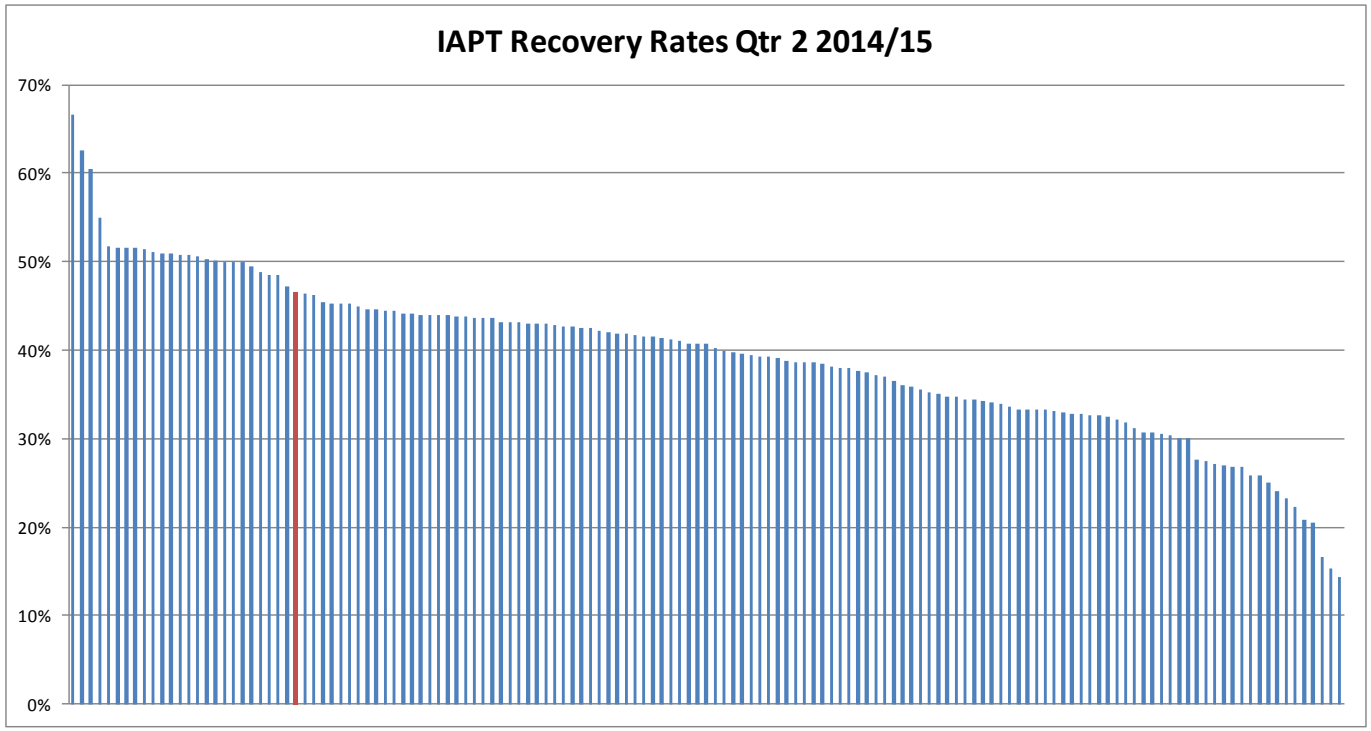
Indicator no.	Indicator name	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
3a	The number of people who have been referred for Psychological Therapies (during the reporting quarter)	809	813	927	931	840	1021	1138	1067	814	1091	1015	1117	11583
3b	The number of active referrals who have waited more than 28 days for treatment	1816	1539	1655	1629	1536	1560	1559	1623	1828	1900	1825	1912	
4	The number of people who have entered Psychological Therapies	551	558	529	604	514	566	633	518	311	613	505	446	6348
5	The number of people who have completed treatment (for any reason)	529	541	567	607	566	565	595	602	504	519	503	597	6695
6	The number of people who are "moving to recovery"	232	265	267	287	272	241	269	277	247	237	234	274	3102
6b	The number of people completing treatment who did not achieve caseness at the commencement of treatment	32	22	40	47	48	51	51	50	47	49	40	47	524
7	The number of people moving off sick pay and benefits	43	29	40	44	35	45	46	50	24	38	24	43	461

	Recovery Rates KPI 6 / (KPI 5 - KPI 6b)	**46.68%**	**51.06%**	**50.66%**	**51.25%**	**52.51%**	**46.89%**	**49.45%**	**50.18%**	**54.05%**	**50.43%**	**50.54%**	**49.82%**	**50.27%**

3.1.1 Exception Comments

Although the March recovery rate dropped slightly below 50%, both full year and quarter 4 performance was above 50%. Over many years our rate has fluctuated however our quarterly and yearly performance consistently remains on or above target. This year we have been above target for 8 out of 12 months and our quarterly performance has remained at or above target.

The latest published national data indicates that we have the 26th highest recovery rate out of 143 service providers, placing us in the top 18% performers with a recovery rate 6% above the national average



Actions planned to drive up improvement are focused on:

- improving the step 2 recovery rate
- introduction of a severity cut off at step 2,
- varying the care pathway in some of our new areas where we are attracting a higher proportion of more complex cases,
- reducing the numbers of completed cases signposted out of the service by offering one rather than two sessions,
- increasing the level of individual performance management of step 2 staff,
- re-launching silver cloud (a guided self-help computerised Cognitive Behavioural Therapy package)

4 Ward Safer Staffing

This section of the board performance report contains the information submitted to NHS England to demonstrate our compliance with the Safer Staffing initiative. The information is also displayed on the internet as requested by NHS England. Comments are provided by each Ward when the percentage fill rate is either over 125% or below 90%.

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	100.0%	97.9%	100.0%	100.0%	No	None required
Child Bearing / Perinatal Inpatient	121.5%	169.1%	110.7%	171.0%	Yes	Perinatal Inpatient went over the average fill rate for care staff day and night due to the level of activity on the ward, observation levels and supporting the mothers to carry out baby care.
CTC Residential Rehabilitation	93.7%	101.6%	100.0%	100.0%	No	None required
Enhanced Care Ward	80.6%	106.3%	76.4%	126.9%	Yes	Staffing remains largely unchanged. Still showing RMN vacancies (3.8) and after discussions with finance appears that establishment was under numbers by a further 3.6 WTE. We have 1 RMN going through pre employment checks, and I have been allocated another RMN from March recruitment who will start in September. I continue to attempt to cover each shift with 1 ECW RMN as a minimum including nights. There has been an exception to this in March where another RMN from the Radbourne covered short term sickness. All NIC shifts covered by ILS trained staff and no incidents of bank or agency nurses acting as NIC. We have filled RMN slots with our own unqualified staff where possible to ensure continuity of care and correct competencies are met where possible i.e PMOVA. We have had extremely high levels of clinical activity in March and have often required extra staff numbers. This has been largely covered by the nurse bank and my own staff doing bank shifts.
Hartington Unit Morton Ward Adult	105.9%	101.6%	108.0%	92.0%	No	None required

Ward name	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
Hartington Unit Pleasley Ward Adult	99.4%	88.0%	107.0%	95.2%	Yes	The ward has had high levels of nursing observations throughout the month which has impacted on our ability to maintain increased levels of Nursing Assistants often at short notice due to increasing levels. This despite prompt action by bleep holders and senior nursing staff to put out requests to nurse bank and contact all regular staff.
Hartington Unit Tansley Ward Adult	106.3%	73.9%	73.0%	118.8%	Yes	Tansley has had high levels of nursing observations throughout much of March. They have also carried some short term sickness. On occasion this has led to qualified shifts being covered with nursing assistants which accounts for the difference between planned and actual staffing.
Kedleston Unit - Curzon Ward	85.5%	113.7%	103.1%	106.5%	Yes	The figures appear to be a true representation of the current situation involving the qualified staffing deficit.
Kedleston Unit - Scarsdale Ward	88.2%	112.0%	103.2%	101.6%	Yes	The figures appear to be a true representation of the current situation involving the qualified staffing deficit.
KW Cubley Court Female	100.0%	89.0%	71.0%	106.9%	Yes	All our nights planned Registered nurses should be 2 not 1 as some were recorded as 1. We had increased level of sickness and other leaves like carers leave in March. We still have one registered nurse still on long time sickness. We recruited 3 staff last month 1 qualified and 1 unqualified. All started now. We have 2 vacancies and we are going to recruit into the 2 posts shortly. Nurse Bank is not covering most of our shifts and sometimes some bank staff cancel shifts at last minute making it very difficult to cover shifts.
KW Cubley Court Male	98.7%	90.8%	88.6%	99.2%	Yes	The reasons for low % qualified fill rate are : 4 night shifts ~ due to sickness. The remaining are due to current vacancies (registered nurses) which equal 3.8 whole time equivalents. We currently have a Registered Nurse advert out on NHS Jobs which has a closing date of 08/04/15. Mid month we also seconded a Lead Nurse to Tissington.
KW Melbourne House	97.6%	97.8%	95.1%	97.9%	No	None required

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 (%)		
KW Tissington Unit Older People	98.7%	93.6%	96.8%	100.0%	No	None required
LRCH Ward 1 OP	99.3%	93.5%	79.6%	108.3%	Yes	The night fill rate has been dictated by long tern sickness levels and covered by Bank Staff (regular care staff are booked familiar with the ward). Efforts are made to rotate staff over a 24 hour period. Registered Nurses flex to cover deficits, current shortfalls of 0.6 and 1 x w/t vacancy and 2x 37.5 long term sick. also 1x 0.6 redeployed to Radbourne Unit as an emergency measure There are periods when where patient numbers are reduced and staff are utilised in other areas. There is the need for short term emergency measures where staff are needed to provide escorts to patients in other hospitals. The Temporary Staffing department cannot always backfill requests made
LRCH Ward 2 OP	100.8%	95.0%	100.0%	91.3%	No	None required
RDH Ward 33 Adult Acute Inpatient	95.1%	101.5%	94.4%	103.3%	No	None required
RDH Ward 34 Adult Acute Inpatient	82.4%	129.7%	54.8%	271.4%	Yes	We have 10.5 RN vacancies on the ward and are unable to fulfil safer staffing requirements.
RDH Ward 35 Adult Acute Inpatient	87.0%	107.1%	105.3%	110.9%	Yes	We currently have two vacancies for qualified nurse and a further nurse who is not currently working on the ward but another clinical area.
RDH Ward 36 Adult Acute Inpatient	103.6%	92.0%	108.8%	126.5%	Yes	ward 36 is consistently over usual staffing on night duty as we have a patient who is still being nursed on level 2 engagement at night, this is regularly reviewed but thus far we have been unsuccessful in finding an alternative placement or reducing the risk

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 29th April 2015

Finance Director's Report Month 12

Purpose of Report

This paper provides the Trust Board with an update on the end of year financial performance against our operational financial plan and is consistent with the information submitted in the quarter 4 Monitor return.

Also contained in the report for information is a summary of capital expenditure for the financial year.

Recommendations

The Board of Directors is requested to:

1) Consider the content of the paper and receive a good level of assurance on the outturn financial performance against the operational financial plan for 2014/15.

Executive Summary

- End of year underlying surplus achieved of £1.8m which is better than plan by £0.3m this is an adverse change of £0.9m. The change in outturn position mainly relates to the update of year end provisions.
- Actual net deficit achieved at end of year of £(0.2)m which was worse than plan by £0.5m which is due to higher impairments than in the plan.
- We ended the year with a risk rating of three as per the operational plan.
- The Cost Improvement Programme has been fully achieved this financial year, with a small amount £86k of savings being found non-recurrently. There are no revenue generation schemes, all schemes relate to cost reductions.
- Capital expenditure has exceeded the 2014/15 plan following additional revenue funding being received from the Nurse Technology Fund.
- Cash is ahead of plan by £3.6m which is mainly related to outstanding payments to other organisations.

Strategic considerations

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

Board Assurances

This report should be considered in relation to the financial risks contained in the Board Assurance Framework, namely:

- 3b: "*Risk to financial performance as a result of under delivery of savings from the efficiency programme or other inability to contain costs to budgeted levels*" and

- 3c: "*Risk that there is a material variance against planned income levels for services that are not funded through block income targets. This may lead to an adverse effect on Trust COSRR risk rating and could also increase the value of savings required from the CIP programme*"

Consultation

- Finance and Performance Committee challenges key strategic aspects of financial performance and financial risks.

- Performance and Contracts Overview Group regularly discuss many aspects of financial performance

- Asset Planning and Agile Working Board oversee the capital expenditure plan which is operationally managed by the Capital Action Team on a monthly basis.

- Financial information presented to all of these meetings is entirely consistent with financial information presented to Trust Board.

Governance or Legal issues

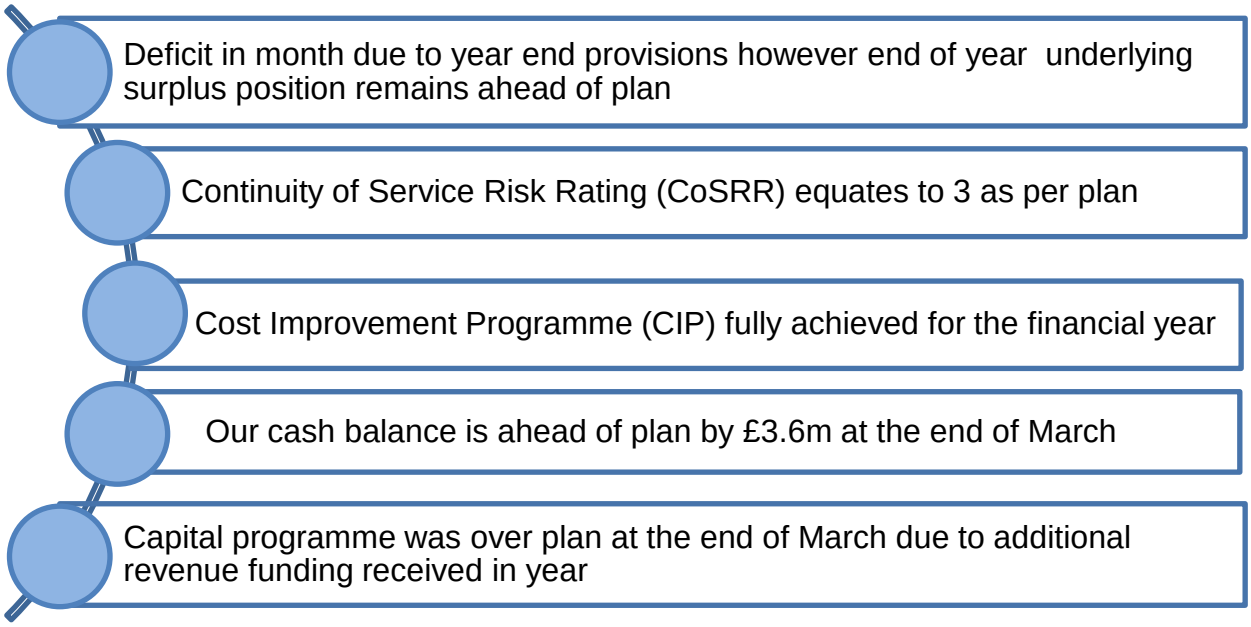
There are no governance or legal exceptions. Delivery of the operational plan is reported to Monitor the Regulator in our in-year submissions.

Equality Delivery System

This report has a neutral impact on REGARDS groups.

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

FINANCIAL OVERVIEW
MARCH 2015



1. Overall Financial Performance

Income & Expenditure – key statistics

In the month there was an underlying deficit of £(2.2)m which was worse than plan by £2.4m. EBITDA was worse than plan by £1.8m which equates to (9.8)% of income, against a plan of 6.8%. This has mainly been driven by various year end provisions, some of which were in the forecast previously. The approach to provisions has been discussed with auditors before being actioned.

At the end of the financial year the Trust achieved an underlying surplus of £1.8m which remained better than plan by £0.3m. EBITDA was £8.7m against a plan of £7.8m which equates to 6.6% of income compared to a plan of 6.1%.

STATEMENT OF COMPREHENSIVE INCOME						MARCH 2015
	Current Month			Year to Date		
	Plan	Actual	Variance Fav (+) / Adv (-)	Plan	Actual	Variance Fav (+) / Adv (-)
	£000	£000	£000	£000	£000	£000
Clinical Income	9,889	10,155	266	117,966	119,634	1,668
Non Clinical Income	742	1,237	495	9,028	11,191	2,163
Pay	(7,908)	(8,212)	(305)	(94,607)	(95,079)	(472)
Non Pay	(2,004)	(4,244)	(2,239)	(24,579)	(27,071)	(2,492)
EBITDA	**719**	**(1,064)**	**(1,783)**	**7,807**	**8,675**	**867**
Depreciation	(275)	(321)	(46)	(3,300)	(3,337)	(37)
Impairment	(1,200)	(1,372)	(172)	(1,200)	(1,984)	(784)
Profit (loss) on asset disposals	0	3	3	0	347	347
Interest/Financing	(157)	(323)	(166)	(1,945)	(2,499)	(555)
Dividend	(83)	(452)	(369)	(1,000)	(1,369)	(369)
Net Surplus / (Deficit)	**(996)**	**(3,529)**	**(2,533)**	**363**	**(166)**	**(529)**
Technical adj - Impairment	(1,200)	(1,372)	(172)	(1,200)	(1,984)	(784)
UnderlyingSurplus / (Deficit)	**204**	**(2,157)**	**(2,361)**	**1,563**	**1,817**	**254**

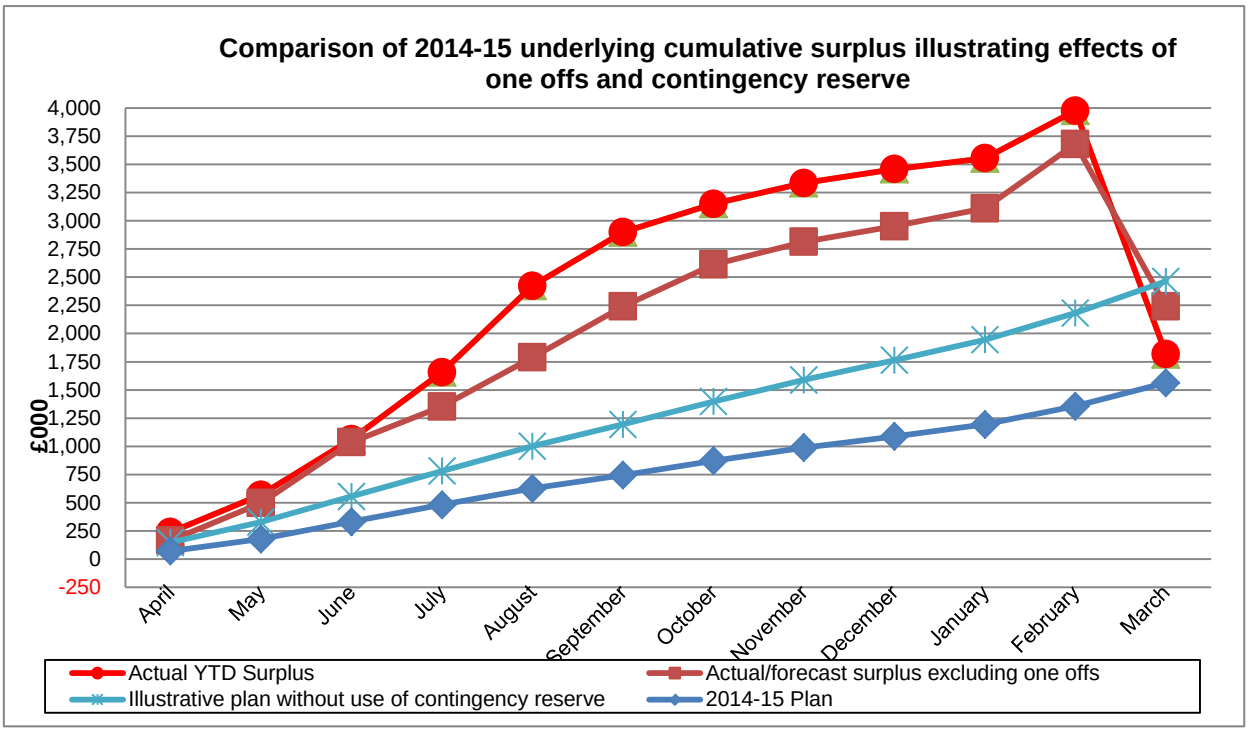
- At the end of the financial year clinical income is better than plan by £1.67m which is mainly driven by Service Developments that were not included in the original plan due to the timing of the plan submission and agreement of contracts, these have corresponding pay and non-pay expenditure.
  This was higher than previously forecast by £171k which has mainly been driven by some non-recurrent income in the last month of the year which has corresponding non-pay expenditure.

- Overall non-clinical income was better than plan by £2.2m which has been driven throughout the year by higher pharmacy recharges which has corresponding expenditure. There was also an increase in the last month due to additional income received from the Nurse Technology Fund which has been spent on capital items.
  This was £157k better than previously forecast last month difference being mainly due to the level of pharmacy recharges.

- Pay expenditure ended the financial year at £472k overspent which was slightly more than previously forecast by £31k. The overspend during the year mainly relates to Service Developments that were not included in the original plan as reported throughout the year.

- Non pay expenditure has overspent in the month by £2.2m increasing the previous small overspend to £2.5m, which has mainly been driven by year end provisions, some of which were already included in the forecast. In the previous month the forecast for the end of year position was an overspend of £1.4m, which has actually increased by £1.1m. The adverse movement relates to an increase in provisions along with smaller increases across the Trust on general non pay expenditure.

The graph below shows the cumulative underlying surplus for both actual and forecast compared to the plan. It also includes additional lines to illustrate what the underlying surplus would look like excluding the one-off costs and benefits this year, and what the financial plan surplus would be if expenditure related to the use of the general contingency had not been included in the plan.



The significant differences between the actual underlying surplus and adjusted underlying surplus relates to the release of an accrual in July and the profit on sale of a property August, as previously reported. The peak in February is mainly driven by higher income levels.
The significant drop in the last month of the year relates to the pensions discount factor, holiday pay ruling provision and other provisions along with the increase in Public Dividend Capital payment, some of these provisions have been one offs and have therefore been adjusted for in the 'actual/forecast surplus excluding one offs' line in the graph above.

2. Risk Rating

The Continuity of Services Risk Rating (CoSRR) is a 3 at the end of the financial year as per plan. Previously the Liquidity metric was forecast to end the year at a 4 however due to the changes in the operating expenditure the Liquidity metric out-turned at a 3.

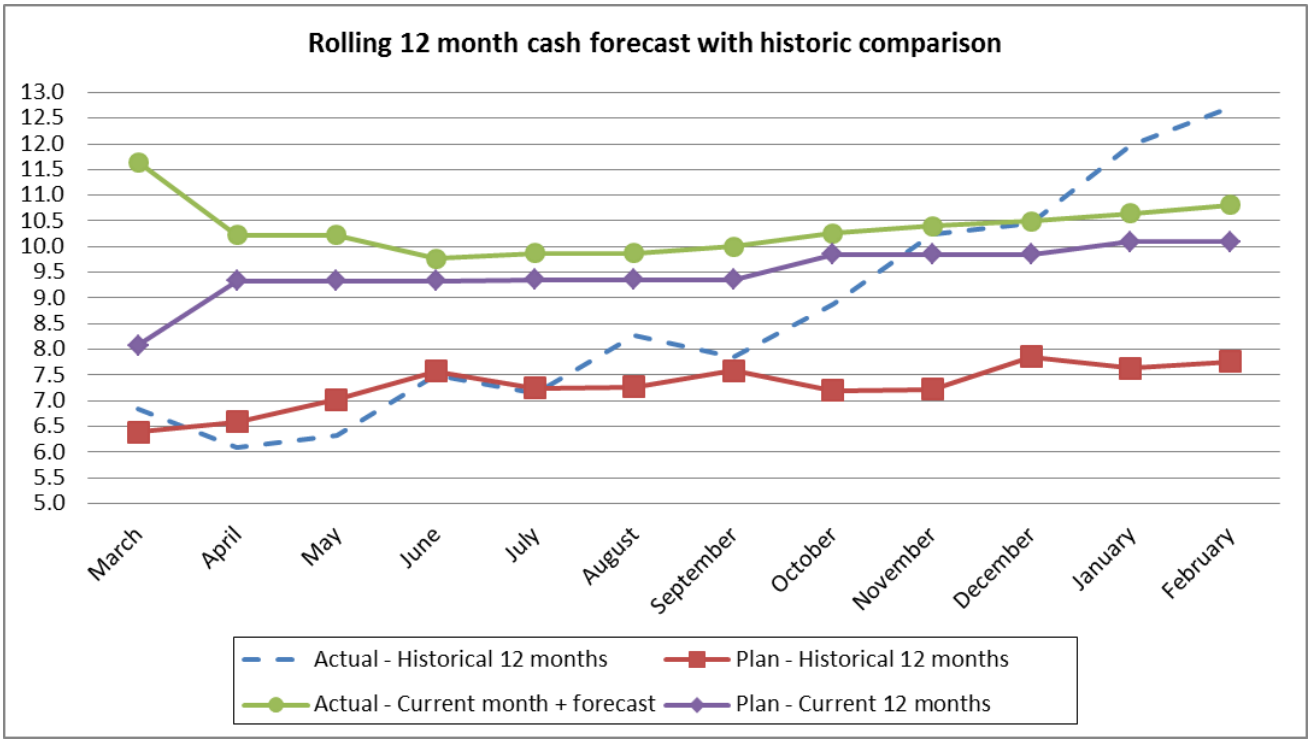
3. Efficiency / Cost Improvement Programme (CIP)

We have delivered all programmed savings in year and therefore delivered the full CIP programme of £4.3m. During the year £86k has been found non-recurrently and there have been no revenue generation schemes.

4. Cash Balances

The cash balance at the end of the financial year was £11.6m which is ahead of plan by £3.6m.
The cash being ahead of plan is driven by some outstanding payments to other providers which are on hold whilst contract issues are being resolved and capital creditors which were not fully paid at the end of the year.

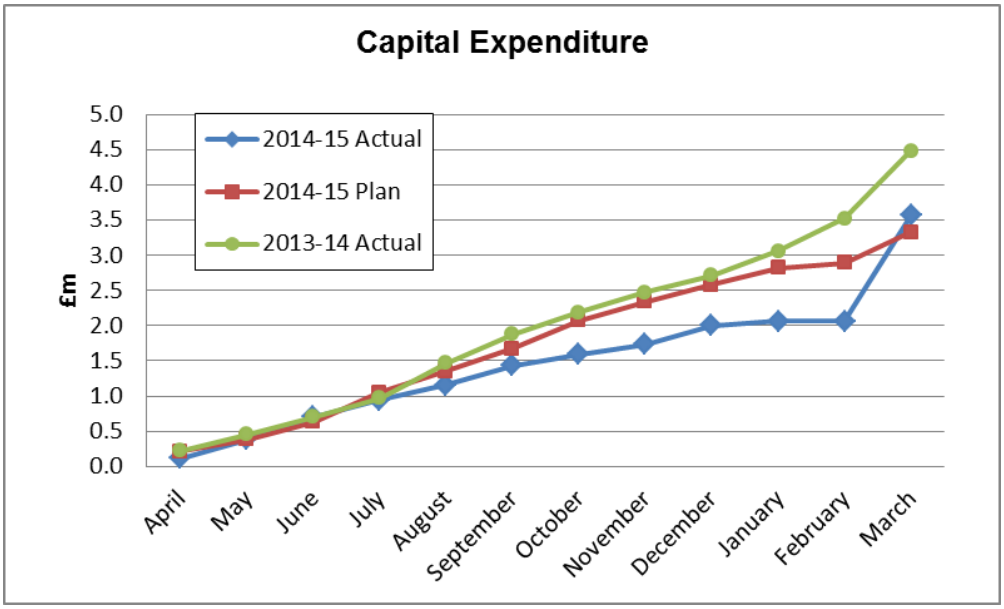
The forecast graph below assumes that the capital creditors will be paid in April along with some high invoices that have been paid in the month to date and that the other contract issue currently in discussion will be resolved by the end of June.



During quarter 2 of the financial year we improved into a net current asset position and maintained that throughout the year until the final month where we have reverted into net current liabilities; however this was still better than the plan. This change in the final month of the year has been driven by the increase in provisions.

5. Capital Expenditure

Capital Expenditure was £239k more than planned at the end of March. The reason for the expenditure being higher than plan was due to income (received as revenue) from the Nurse Technology Fund, which has been spent on mobile devices.



During the financial year each of the planned schemes are monitored on a monthly basis by the Capital Action Team (CAT). During this financial year CAT has reprioritised several schemes in order to fund urgent bids that have arisen in year. The table below contains a summary of the schemes including the original planned budgets and actual expenditure.

	Original Plan	Actual expenditure	Variance
	£'000	£'000	£'000
Estates			
Backlog Maintenance	400	393	7
Estates Staff	130	99	31
City Locality Refurbishment	250	256	(6)
Ripley Library Refurbishment	180	182	(2)
Recovery and Resilience Suite	-	124	(124)
Hartington Unit S136 Upgrade	36	36	0
Cubley Court Flooring	40	40	0
Kingsway Site Car Parking	55	127	(72)
Cherry Tree Bungalow	75	75	0
Refurbishment Day Hospital	-	90	(90)
OT Kitchen Cubley	-	39	(39)
Other Estate schemes	90	75	15
Sub-total Estates	**1,256**	**1,536**	**(280)**
IM&T			
Electronic Patient Records	1,348	1,119	229
PC and Server replacement	144	549	(405)
Other IT projects	309	283	26
Sub-total IM&T	**1,801**	**1,951**	**(150)**
Other			
Transformation	100	0	100
Environmental Works / Anti-Ligature	37	39	(2)
Infection Control	50	44	6
Other Miscellaneous	85	(2)	87
Sub-total Other	**272**	**81**	**191**
Total Capital Expenditure 2014-15	**3,329**	**3,568**	**(239)**

Derbyshire Healthcare NHS Foundation Trust
Report to Public Board 29th April 2015

COUNTY CHILD & ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

This report provides an in depth view of staffing, activity and performance relating to the County CAMHS services.

Executive summary

Context: In 2011 Derbyshire Healthcare NHS Foundation Trust CAMHS service was successful in its bid to be in the first phase of a unique opportunity to join the National Children and Young People's Improving Access to Psychological therapies (CYP-IAPT) 4 year Department of Health initiative.

The aim of C&YP IAPT is based on transforming services in response to the key findings of the National CAMHS Review and National Advisory Council, which highlighted; the need for CAMHS to improve accessibility; have clear evidence based pathways that will enhance the interventions provided; work in partnership with children and families in the decision making process about their care and have a full participation agenda which will enable the community / patients to shape future services; and provide a more comprehensive system for collating outcome performance data that is clinically relevant and can assist in targeting resources more effectively.

The C&YP IAPT project aims to build on the strengths of the existing services for children & young people, whilst working with our partner agencies to build more robust pathways of care and a sustainable CAMHS that is equipped to meet the needs of our young population over the coming years.

Year 4 progress to Date of the workforce development :
Over 50% of the Specialist CAMHS workforce is now trained in an Evidence based treatment modality (CBT, Parenting Therapy, Dialectical Behavioural Therapy, EMDR, Systemic Family Practice, Family Therapy) and or a specialist assessment (Sensory assessments, ADOS / DISCO ASD assessments etc.)

The service has developed and is continuing to roll out a Core CAMHS Competency Training Programme for all CAMHS clinicians/staff to develop a sound baseline of skills and knowledge both in service and also with Derby University. This is now being planned to be rolled out to Children's Services within DHCFT and our partner agencies.

Phase	Number	Type of Training	Agency
1 (2012)	4x 2x	Cognitive Behavioural Therapists (Anxiety, Trauma, Depression Pathway) Parenting Therapist (ASD, ADHD, CD and ODD Pathway)	CAMHS Tier 2 and 3
2 (2013)	2x 1x	Cognitive Behavioural Therapists Parenting Therapist	CAMHS Tier 2 and 3
3 (2014)	4x	Systemic Family Practitioners (Depression, Self-Harm and CD Pathway)	MATS x 2 Third Sector x 1 CAMHS Tier 3 x 1
4	1x	Cognitive Behavioural Psychotherapist	CAMHS x 5

(2015)	3x 4x	Eating Disorder Systemic Family Practitioners Systemic Family Practitioners	MATS x 2 YOS x 1
4 (2015)	20x	Enhanced Evidence Based Practice Depression and Anxiety care pathways	CAMHS x 2 School Health x 3 Third Sector x 3 MATS x 11 Social Care x 1

In addition to the above we have funded 6 CAMHS Tier 3 clinicians to undertake the Intensive DBT Training as part of our Tier 3+ pathway. This has now been completed (Borderline Personality Disorder, Self-Harm and Suicidal Behaviour Pathway) and the team continues to support in excess of 40 young people per year (reducing both A& E admissions and Tier 4 hospital admissions).

Workforce challenges for Phase 4 IAPT :

Phase 4 IAPT involves ongoing development of the workforce to access evidence based training and has involved as follows:

- I Nurse from Dale Bank being seconded to CBT training
- 3 Workers seconded to undergo advance training in eating disorders enabling the development of the Specialist Eating Disorder Service, improving care and treatment outcomes and reducing the need for Tier 4 admissions.

- I worker to train as a systemic family practitioner (depression, self-harm and CD pathway)
- 2 IAPT systemic supervisors- part time training
- The DH has offered Derbyshire Healthcare 19 places on the certificate programme for 2015 which can include Derby City / Southern Derbyshire – DHCFT CAMHS, Children's Services, Local Authorities, YOS, Voluntary Sector, and Non Statutory Sector. The aim is the development of CAMHS Core Competencies to include, Assessment in Behavioural and emotional difficulties/mental health, routine outcome monitoring – improving clinical effectiveness, depression – basic formulation and treatment interventions, anxiety – basic formulation and treatment intervention and sleep deprivation – basic formulation and treatment interventions- The certificate programme training is below the threshold for specialist CAMHS, and fits in well with the proposed Behavioural Pathways work and the emotional well-being model in targeted/ universal services Tiers 1 & 2 and is integrated with a recently funded joint commissioning programme.

Identified Challenges:

1. Backfill vacancy pressures to the current Rivermead service provision – delayed recruitment from January to April 2015.
2. Difficulty recruiting to the Consultant vacancies at Rivermead and Swadlincote – (related to the National shortage of Consultants)
3. Lack of robust day to day management & Leadership of the Rivermead Team – the model of 1 team manager to oversee the 3 County Teams was trialled from January 2015 and evaluated in March 2015 in acknowledgement to the difficulties fulfilling the role requirements).
4. Current CAMHS staffing levels at 60% below the National CAMHS staffing guidance (RCP & DH Tier 2 and 3 CAMHS Service Specification 2014).

5. The development of a Specialist Eating Disorder Service by using existing resources and therefore impacting on other under resourced service areas - taking staff from one service area to another when all service areas are at critical staffing levels – Current staffing levels offer no economies of scale for flexibility or to absorb service changes.
6. Staff retention and appropriate replacement of experienced staff / AFC banding (for sustainability need to recognise additional qualifications and increase pay banding where appropriate.
7. Multiple roles that our experienced a staff have – e.g. Consultant / Senior staff also have evidence based training and have management responsibilities in addition to other job roles.
8. External pressures due to service cuts in other areas.

Action taken:

Service	Secondee	Current Interim plan	Long term Plan
Derby City	Adrian Pugh	Agency covering	Band 6 recruited
Rivermead	Sarah Gray Denise Sprout Rachel Mcillwrick (4 days wte)	I bank Nurse I CBT therapist band 5 part time I WTE fixed term contract due to start 1st March 2015	All back fill recruited to awaiting start dates
Dale Bank	Kerry Blaine	Bank newly qualified Nurse Covering	IAPT back fill recruited to

An action plan has been developed to address the leadership issues across the County. This includes strengthening the management at Rivermead by seconding a very experienced Manager, Alison Reynolds in to the service, creating a new deputy role and transferring the Clinical Director, Dr Lucia Whitney to provide leadership, support & direction to the staff who are feeling stressed and overwhelmed with demands and lack of sufficient resources to meet service needs.

Ann Cox is now full time in her role as Team manager at Dale bank View and Dave Watkinson is the full time manager at Century House.

Interviews for the Consultant position is due to take place in May. So far we have 3 applicants and 2 of these appear to be of high calibre.

As part of our IAPT process CAMHS is moving towards more specialist care pathways with the aim of achieving more effective evidence based interventions and outcomes for our young people .However all this transformation does reduce capacity in the teams resulting in the lack of support & critical mass to staff which we need to keep under review. On this basis it has also been decided to reduce the current 3 County Multidisciplinary Teams to 2 teams but to crucially maintain the satellite services at Century, Rivermead & Dale bank which ensures our services remain accessible in these areas. There are huge benefits to the proposed change as it will enable more support, resilience & cohesion to the teams .Other identified benefits include the opportunity to increase skills , build capacity with opportunity for more throughput including better access to specialist therapies . Dr Whitney, Ann Cox and the Service Line

Manager will be working closely with the County Team members to plan this change compassionately.

The strategic direction of CAMHS means we are moving towards a more integrated interagency collaborative care pathways which involves further transformation and more effective use our resources and the Consultants under New Ways of Working. A draft service model is being developed by the senior clinicians to address this and in preparation for potential future tendering to ensure alignment with best practice and commissioning intentions. This is being done also in consideration of the 1.25 billion identified for CAMHS services in the future.

The level of funding and subsequent poor staffing numbers in CAMHS has been recognised both at a National and Local level. CAMHS Management and the Exec team have raised this with the local commissioners and will continue to keep this on the CMDG and Transformational board agenda.

In summary **the** IAPT back fill delays, staff sickness, team culture, increase demand on service, limited resources and lack of robust day to day management & leadership has resulted in work related stress, increased sickness and a lack of containment specifically to the Rivermead Team . This has impacted negatively on service quality and performance resulting in increased in waiting time for service users and slippages in choice and partnership (CAPA) systems in the Rivermead service.

Strategic considerations

Staffing levels impact on the following strategic outcomes:
Outcome 1: People receive the best quality care
Outcome 3: The public have confidence in our healthcare and developments

(Board) assurances

- To assure the Board of action being taken to minimise risk and address the staffing level shortfalls
- To assure the Board that the services continue to perform well despite the staffing pressures

Consultation

- Consultation has taken place within the CAMHS Senior management Team

Governance or legal issues

- Health and Safety at Work etc. Act 1974
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (Regulation 22)

Equality Delivery System

- All efforts are taken to have staff working in areas who understand the communities there services serve. In times of pressure on staffing the priority has to be on staffing levels to maintain safe care and this may lead to staff being moved to cover other areas where they are less familiar with the local communities. With all service areas at critical staffing levels this needs to be managed sensitively and is something that will be monitored by senior clinicians and operational managers.

Recommendations

The Board of Directors is requested to:

1. Review the contents of this report.
2. Consider the risks facing the service through poor staff retention / CIP programmes and National Programmes against the opportunities of service development within a high growth potential service area which will be able to improve the quality of care to a wider population.
3. Support the ongoing Service Transformation programme with assurances that we are aiming

	to provide a fully NICE compliant service and improve the quality of care and improve treatment outcomes for children and families accessing services from not only ourselves but also our partner agencies.

Report presented by: **Ifti Majid Chief Operating Officer/Deputy Chief Executive**

Report prepared by: **Helen Mac Mahon**

County Child & Adolescent Mental Health Services (CAMHS)

Introduction

The Trust provides specialist CAMHS services in Southern Derbyshire via 3 teams who are based in Amber Valley, Erewash and South Derbyshire.

Amber Valley CAMHS
Rivermead, Belper

Erewash CAMHS
Century House, Long Eaton

South Derbyshire CAMHS
Dale Bank View, Swadlincote

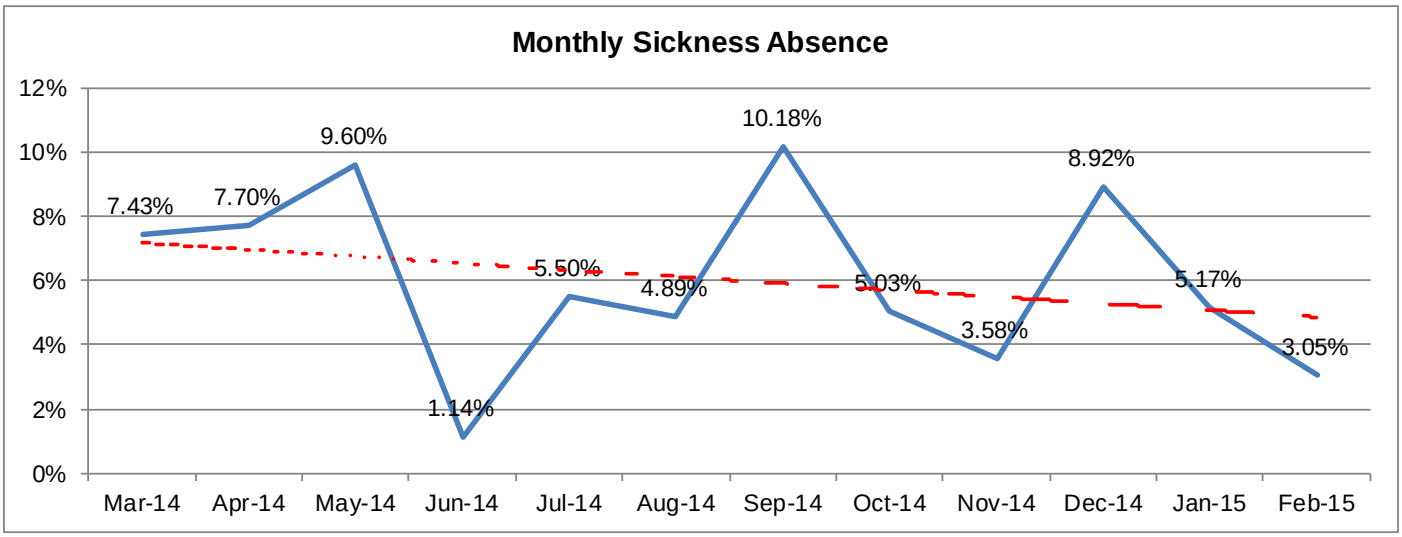
The teams are committed to providing comprehensive and targeted treatments, delivered in the heart of our communities, which positively impact upon the emotional and psychological wellbeing of children and young people. They deliver thorough assessments and a range of therapeutic interventions for children presenting with significant mental health issues.

1 Staffing (County only excluding YPSS services)

1.1 Vacancies

Vacant Post Job Title	WTE	Band	Team/Ward	Funded Establishment
I band 7 family therapist (no backfill)	7 wte	Consultant X1 Band 7 x3 Band 6 x3	Dale Band	7wte
I PMHW	5.4 WTE	Consultant X1 Band 7 x 2 Band 6 x 3	Century	5.4 wte
I Consultant vacancy (locum in post) Awaiting IAPT back fill band 5 but there is temporary back fill of band 5, band 6 x 2 via use of bank, fixed term contract and zero hours contact equating to additional 3 WTE. There is also additional band 7 x 2 to support risk management issues.	8.6 and additional Band 7 x2 Band 6 x 3 =13 wte temporary arrangement	Consultant x1 Band 7x1 Band 6 x 7	Rivermead	8.6

1.2 Sickness absence



Absence Reasons

Absence Reason	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Total Days Lost
Anxiety/stress/depression/ other psychiatric illnesses	23	22	34	1	0	0	9.75	0	1	17	22	11	140.75
Not assigned	0	0	0	0	23	21	22	23	13	16	2	0	120
Endocrine/glandular problems	21	22	22	0	0	0	0	0	0	0	0	0	65
Gastrointestinal problems	1	0	3	3	3	2	4	0	2	1.75	2	2	23.75
Care of a dependant	0	2	2	0	0	0	2	2	1	2	0	1	12
Ear, nose, throat (ENT)	0	0	0	0	0	0	3	0	0	6.75	0	0	9.75
Bereavement	1	3	0	0	0	0	4	0	0	0	0	0	8
Cold, cough, influenza	2.75	1	0	0	0	0	3	0	0	1	0	0	7.75
Headache / migraine	0	0	1	1	1	1	0	0	0	0	0	0	4
Other known causes – not elsewhere classified	0	0	1	0	0	0	0	0	0	0	0	0	1
Surgery	1	0	0	0	0	0	0	0	0	0	0	0	1

Commentary

- In the 12 month period covered above, overall there was 6% absence
- In total there were 393 days lost through absence
- The most common reason for absence was anxiety/stress/depression/other psychiatric illnesses, which accounted for 36% of all absence

3.3 Action being taken re staffing levels

1)By strengthening the management of the team by seconding a very experienced Manager , Alison Reynolds in to the service , creating a new deputy role and transferring the Clinical Director, Dr Lucia Whitney to provide leadership, support & direction to the staff who are feeling stressed and overwhelmed with demands and lack of sufficient resources to meet service needs.

2) Robust management of caseloads to support clinically appropriate through put.

3) More consistent administration to review PTL to ensure all C & YP who are at risk have breaching waiting time are proactively managed

2 Workforce Dashboard

	Target	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Headcount	N/A	23	23	23	23	24	23	23	23	23	24	23	24
FTE	N/A	21.16	21.16	21.16	20.51	21.51	20.91	20.91	20.91	20.91	21.91	20.57	21.77
Outstanding RTW	N/A	0	0	0	0	0	0	0	0	0	0	0	0
Annual Turnover	10%	10%	11%	12%	12%	11%	15%	12%	12%	8%	4%	7%	N/A
IPR Completion	90%	43%	43%	48%	52%	83%	91%	96%	91%	96%	88%	83%	83%
RTW Interview Completion	95%	50%	100%	67%	75%	100%	71%	N/A	100%	0%	50%	N/A	N/A
Sickness Absence	4.7%	7%	9%	1%	6%	5%	9%	5%	3%	9%	5%	3%	0%
Bank Usage	4.98%	12%	3%	3%	2%	0%	0%	N/A	2%	3%	3%	7%	N/A
Agency Usage	1.9%	4%	5%	1%	-10%	-1%	6%	N/A	-4%	-6%	-4%	0%	N/A
Compulsory Training	95%	78%	81%	78%	78%	78%	79%	74%	80%	76%	75%	75%	75%
Trust Induction	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100.00%	N/A
Workplace Induction	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.00%	N/A

5 Performance Dashboard

	Target	Apr-14		May-14		Jun-14		Jul-14		Aug-14		Sep-14		Oct-14		Nov-14		Dec-14		Jan-15		Feb-15		Mar-15	
Monitor Targets																									
CPA Review in last 12 Months	95%	3	100%	3	100%	2	100%	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Data Completeness: Identifiers	97%	373	99%	501	99%	610	99%	703	99%	760	99%	825	99%	890	99%	917	99%	955	99%	977	99%	1,011	99%	1,043	99%
Data Completeness: Outcomes	50%	3	60%	3	60%	2	50%	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Locally Agreed																									
CPA HoNOS Assessment in last 12 Months	90%	3	0%	3	0%	2	0%	1	N/A	1	N/A	1	N/A	1	N/A	1	N/A	1	N/A	1	N/A	1	N/A	1	N/A
CPA Settled Accommodation	90%	3	67%	3	67%	2	50%	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
CPA Employment Status	90%	3	100%	3	100%	2	100%	1	N/A	1	N/A	1	N/A	1	N/A	1	N/A	1	N/A	1	N/A	1	N/A	1	N/A
Data Completeness: Identifiers	99%	373	99%	501	99%	610	99%	703	99%	760	99%	825	99%	890	99%	917	99%	955	99%	977	99%	1,011	99%	1,043	99%
Data Completeness: Outcomes	90%	3	60%	3	60%	2	50%	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Schedule 4 Contract																									
Outpatient Letters Sent in 10 Working Days	90%	49	88%	49	92%	59	88%	57	91%	27	96%	54	98%	50	86%	63	71%	38	61%	38	50%	57	70%	48	79%
Outpatient Letters Sent in 15 Working Days	100%	49	98%	49	98%	59	95%	57	98%	27	100%	54	100%	50	96%	63	81%	38	66%	38	61%	57	81%	48	93%
Average Community Team Waiting Times (Weeks)	N/A	121	8.28	121	7.40	121	6.03	112	6.13	88	5.33	104	4.50	95	3.95	70	4.34	59	4.22	65	4.44	68	5.07	37	5.83
CPA Review in last 12 Months	90%	3	100%	3	100%	2	100%	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%

6 Activity

6.1 Referrals

Erewash CCG:

Apr, 2014	May, 2014	Jun, 2014	Jul, 2014	Aug, 2014	Sep, 2014	Oct, 2014	Nov, 2014	Dec, 2014	Jan, 2015	Feb, 2015	Mar, 2015	Total
19	32	38	28	21	15	16	27	38	25	39	45	343

Display Team	Referral Source	NHS EREWASH CCG
County South CAMHS	Community Paediatrics	3
	Education Service	4
	Gp	58
	Internal Comm. Adult Mh Team	1
	Internal Comm. Camhs Mh Team	2
	La/social Services	2
	Other Secondary Care Specialty	1
	Other Service Or Agency	5
	School Nurse	2
County YPSS	Drug Action / Misuse Agency	1
	Gp	15
	Internal Comm. Camhs Mh Team	1
	Nhsdirect	1
	Other Service Or Agency	2
	School Nurse	2
Derbys CAMHS Liaison	A&e	8
Derbyshire LD CAMHS	Other Service Or Agency	1
Total		109

Hardwick CCG:

Apr, 2014	May, 2014	Jun, 2014	Jul, 2014	Aug, 2014	Sep, 2014	Oct, 2014	Nov, 2014	Dec, 2014	Jan, 2015	Feb, 2015	Mar, 2015	Total
30	33	34	33	21	40	48	84	111	96	106	102	738

Display Team	Referral Source	NHS Hardwick CCG
County South CAMHS	A&e	1
	Education Service	2
	Gp	49
	Other Service Or Agency	10
	Out Of Area Agency	3
	School Nurse	3
County YPSS	Education Service	1
	Gp	51
	Internal Comm. Camhs Mh Team	2
	Other Primary Health Care	1
	Other Service Or Agency	4
	School Nurse	5
	Self Referral	11
Derby City CAMHS	Community Paediatrics	3
	Education Service	2
	Gp	17
	Internal Comm. Camhs Mh Team	1
	Other Primary Health Care	1
	Other Service Or Agency	2
	School Nurse	8
	Voluntary Sector	1
Derby City YPSS	Community Paediatrics	3
	Education Service	1
	Gp	26
	Nhsdirect	2
	Other Service Or Agency	4
	School Nurse	2
	Self Referral	6
Derbys CAMHS Liaison	A&e	59
Derbyshire LD CAMHS	Carer	2
	Education Service	4
	Gp	4
	La/social Services	2
	Other Primary Health Care	1
	Other Service Or Agency	6
	School Nurse	1
Youth Offending Service	Court	1
Total		**302**

North Derbyshire CCG:

May, 2014	Jun, 2014	Jul, 2014	Aug, 2014	Nov, 2014	Total
1	1	1	1	1	5

Southern Derbyshire CCG:

Apr, 2014	May, 2014	Jun, 2014	Jul, 2014	Aug, 2014	Sep, 2014	Oct, 2014	Nov, 2014	Dec, 2014	Jan, 2015	Feb, 2015	Mar, 2015	Total
110	127	115	100	81	125	131	130	117	154	131	173	1494

Display Team	Referral Source	NHS SOUTHERN
County South CAMHS	Community Paediatrics	10
	Education Service	1
	Gp	114
	Internal Comm. Camhs Mh Team	5
	Other Primary Health Care	2
	Other Service Or Agency	19
	Out Of Area Agency	2
	School Nurse	4
	Self Referral	4
County YPSS	Gp	41
	Internal Comm. Camhs Mh Team	11
	Other Independent Sector Mh Sr	1
	Other Primary Health Care	1
	Self Referral	10
Derby City CAMHS	Community Paediatrics	2
	Education Service	2
	Gp	26
	Internal Comm. Camhs Mh Team	3
	La/social Services	3
	Other Primary Health Care	2
	Other Service Or Agency	1
	School Nurse	10
Derby City YPSS	Education Service	1
	Gp	16
	Internal Comm. Camhs Mh Team	9
	Other Primary Health Care	1
	Other Service Or Agency	3
	School Nurse	2
	Self Referral	4
Derbys CAMHS Liaison	A&e	103
	Carer	1
	Internal Comm. Camhs Mh Team	18
	School Nurse	2
	Self Referral	3
Derbyshire LD CAMHS	Education Service	2
	Gp	6
	Internal Comm. Camhs Mh Team	5
	Other Service Or Agency	3
Youth Offending Service	Internal Comm. Camhs Mh Team	1
	Self Referral	1
Total		**455**

6.2 Waiting Times

(a) Referral to Assessment

Erewash CCG:

Waiting Range	Apr, 2014	May, 2014	Jun, 2014	Jul, 2014	Aug, 2014	Sep, 2014	Oct, 2014	Nov, 2014	Dec, 2014	Jan, 2015	Feb, 2015	Mar, 2015
0-12 Weeks	15	21	20	22	18	23	12	14	15	16	17	18
12-18 Weeks	0	0	2	0	0	0	0	0	1	1	0	1
18+ Weeks	3	2	1	0	0	1	0	0	0	0	0	0
Total	**18**	**23**	**23**	**22**	**18**	**24**	**12**	**14**	**16**	**17**	**17**	**19**
Average Weeks Waiting	**6.99**	**3.61**	**4.68**	**4.11**	**5.15**	**5.95**	**4.87**	**3.01**	**4.29**	**6.09**	**4.18**	**3.91**
Maximum Weeks Waiting	**23.86**	**22.00**	**21.43**	**11.57**	**12.00**	**35.14**	**10.29**	**8.57**	**14.14**	**15.00**	**11.00**	**12.29**

Hardwick CCG:

Waiting Range	Apr, 2014	May, 2014	Jun, 2014	Jul, 2014	Oct, 2014	Nov, 2014	Dec, 2014	Jan, 2015	Feb, 2015	Mar, 2015
0-12 Weeks	0	2	1	4	4	3	4	1	3	1
12-18 Weeks	1	0	0	0	0	0	0	0	1	0
18+ Weeks	0	1	1	0	0	1	0	0	0	0
Total	**1**	**3**	**2**	**4**	**4**	**4**	**4**	**1**	**4**	**1**
Average Weeks Waiting	**13.14**	**8.29**	**9.93**	**2.72**	**2.86**	**9.11**	**3.14**	**4.14**	**6.47**	**11.00**
Maximum Weeks Waiting	**13.14**	**21.00**	**19.86**	**5.00**	**4.86**	**18.29**	**6.43**	**4.14**	**12.29**	**11.00**

North Derbyshire CCG:

Waiting Range	Jun, 2014	Jul, 2014	Dec, 2014
0-12 Weeks	1	1	0
12-18 Weeks	0	0	1
Total	**1**	**1**	**1**
Average Weeks Waiting	**0.29**	**0.71**	**16.57**
Maximum Weeks Waiting	**0.29**	**0.71**	**16.57**

Southern Derbyshire CCG:

Waiting Range	Apr, 2014	May, 2014	Jun, 2014	Jul, 2014	Aug, 2014	Sep, 2014	Oct, 2014	Nov, 2014	Dec, 2014	Jan, 2015	Feb, 2015	Mar, 2015
0-12 Weeks	91	82	102	95	67	92	115	102	69	79	67	82
12-18 Weeks	5	13	3	6	1	3	0	0	0	0	5	2
18+ Weeks	4	4	1	6	1	0	1	0	0	0	0	0
Total	**100**	**99**	**106**	**107**	**69**	**95**	**116**	**102**	**69**	**79**	**72**	**84**
Average Weeks Waiting	**4.88**	**5.92**	**3.81**	**5.48**	**3.67**	**3.19**	**2.67**	**3.13**	**2.73**	**2.69**	**3.57**	**3.27**
Maximum Weeks Waiting	**21.29**	**24.71**	**21.71**	**21.00**	**33.00**	**15.71**	**18.57**	**10.14**	**11.00**	**10.14**	**17.14**	**14.86**

(b) Referral to Treatment

Erewash CCG:

Waiting Range	Apr, 2014	May, 2014	Jun, 2014	Jul, 2014	Aug, 2014	Sep, 2014	Oct, 2014	Nov, 2014	Dec, 2014	Jan, 2015	Feb, 2015	Mar, 2015
0-12 Weeks	12	8	18	12	11	18	5	8	4	6	11	11
12-18 Weeks	3	2	1	0	0	3	5	0	3	2	3	4
18+ Weeks	3	3	3	2	0	1	1	1	0	2	2	1
Total	**18**	**13**	**22**	**14**	**11**	**22**	**11**	**9**	**8**	**10**	**16**	**16**
Average Waiting Weeks	**10.37**	**11.84**	**7.92**	**7.93**	**6.44**	**7.60**	**11.22**	**6.06**	**9.12**	**15.07**	**9.87**	**9.50**
Maximum Waiting Weeks	**44.29**	**28.86**	**30.86**	**20.14**	**12.00**	**27.29**	**19.29**	**23.43**	**15.29**	**51.00**	**18.43**	**39.00**

Hardwick CCG:

Waiting Range	Apr, 2014	May, 2014	Jun, 2014	Jul, 2014	Oct, 2014	Nov, 2014	Dec, 2014	Jan, 2015	Feb, 2015	Mar, 2015
0-12 Weeks	2	1	1	1	3	1	0	0	1	1
12-18 Weeks	0	0	0	0	0	0	1	1	0	3
18+ Weeks	0	1	2	0	0	0	0	0	0	0
Total	**2**	**2**	**3**	**1**	**3**	**1**	**1**	**1**	**1**	**4**
Average Waiting Weeks	**6.36**	**10.36**	**17.43**	**3.86**	**3.57**	**6.00**	**13.86**	**12.29**	**1.71**	**11.71**
Maximum Waiting Weeks	**7.14**	**19.14**	**24.00**	**3.86**	**6.14**	**6.00**	**13.86**	**12.29**	**1.71**	**14.29**

North Derbyshire CCG:

Waiting Range	Dec, 2014
12-18 Weeks	1
Total	**1**
Average Waiting Weeks	**16.57**
Maximum Waiting Weeks	**16.57**

Southern Derbyshire CCG:

Waiting Range	Apr, 2014	May, 2014	Jun, 2014	Jul, 2014	Aug, 2014	Sep, 2014	Oct, 2014	Nov, 2014	Dec, 2014	Jan, 2015	Feb, 2015	Mar, 2015
0-12 Weeks	54	54	58	59	47	58	76	50	47	40	51	44
12-18 Weeks	9	7	6	10	9	9	6	3	7	6	5	10
18+ Weeks	11	7	13	17	11	6	7	6	4	8	4	5
Total	**75**	**68**	**77**	**86**	**67**	**73**	**89**	**59**	**58**	**54**	**60**	**59**
Average Waiting Weeks	**9.58**	**9.32**	**10.71**	**12.38**	**11.25**	**7.56**	**5.97**	**9.71**	**7.71**	**10.24**	**7.49**	**8.82**
Maximum Waiting Weeks	**49.29**	**77.43**	**64.86**	**57.86**	**70.00**	**60.29**	**40.43**	**65.86**	**45.29**	**55.57**	**46.71**	**67.00**

6.3 Contacts

Erewash CCG:

Apr, 2014	May, 2014	Jun, 2014	Jul, 2014	Aug, 2014	Sep, 2014	Oct, 2014	Nov, 2014	Dec, 2014	Jan, 2015	Feb, 2015	Mar, 2015
252	**243**	**255**	**276**	**192**	**257**	**247**	**195**	**210**	**212**	**240**	**257**

Hardwick CCG:

Apr, 2014	May, 2014	Jun, 2014	Jul, 2014	Aug, 2014	Sep, 2014	Oct, 2014	Nov, 2014	Dec, 2014	Jan, 2015	Feb, 2015	Mar, 2015
20	19	38	45	28	26	44	24	21	19	16	29

North Derbyshire CCG:

May, 2014	Jun, 2014	Jul, 2014	Aug, 2014	Sep, 2014	Oct, 2014	Nov, 2014	Dec, 2014	Jan, 2015	Feb, 2015	Mar, 2015
2	3	1	3	2	6	1	3	1	2	4

Southern Derbyshire CCG:

Apr, 2014	May, 2014	Jun, 2014	Jul, 2014	Aug, 2014	Sep, 2014	Oct, 2014	Nov, 2014	Dec, 2014	Jan, 2015	Feb, 2015	Mar, 2015
1485	1453	1656	1858	1198	1628	1672	1325	1000	1115	1243	1286

6.4 Appointment Outcomes

Erewash CCG:

Attendance Status	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Total
Not Known					1			1					2
Attended	252	243	255	276	192	257	247	195	210	212	240	257	2836
Cancelled by Client	31	31	37	31	27	23	29	27	20	32	13	32	333
Cancelled by Trust	5	4	7	5	5	3	6	6	3	4	2		50
DNA	23	26	31	44	30	34	15	18	20	25	28	27	321
To Be Attended				1	7	1	6	44	40	7	6		112
Total	**311**	**304**	**330**	**357**	**262**	**318**	**303**	**291**	**293**	**280**	**289**	**316**	**3654**

Hardwick CCG:

Attendance Status	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Total
Attended	20	19	38	45	28	26	44	24	21	19	16	29	329
Cancelled by Client	2	1	9	5	3	1	1	1		1	3	2	29
Cancelled by Trust						2	2				1		5
DNA	1	4	2	9	1	5	2	2		6	3	3	38
To Be Attended								3					3
Total	**23**	**24**	**49**	**59**	**32**	**34**	**49**	**30**	**21**	**26**	**23**	**34**	**404**

North Derbyshire CCG:

Attendance Status	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Total
Not Known								1					1
Attended		2	3	1	3	2	6	1	3	1	2	4	28
Cancelled by Client	1					1				1			3
Cancelled by Trust							1						1
DNA							1	1	1			1	4
Total	**1**	**2**	**3**	**1**	**3**	**3**	**8**	**3**	**4**	**2**	**2**	**5**	**37**

Southern Derbyshire CCG:

Attendance Status	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Total
Not Known					1	1	1	1					4
Attended	1485	1453	1656	1858	1198	1628	1672	1325	1000	1115	1243	1286	16919
Cancelled by Client	125	206	196	197	129	154	143	104	90	76	98	110	1628
Cancelled by Trust	25	31	24	23	13	34	19	24	27	16	18	20	274
DNA	172	160	157	199	153	139	146	94	112	106	90	118	1646
To Be Attended	7	11	14	14	12	18	21	201	134	31	23	11	497
Total	**1814**	**1861**	**2047**	**2291**	**1506**	**1974**	**2002**	**1749**	**1363**	**1344**	**1472**	**1545**	**20968**

6.5 Discharges and Length of Stay

Erewash CCG:

Length Of Stay In Service	Apr, 2014	May, 2014	Jun, 2014	Jul, 2014	Aug, 2014	Sep, 2014	Oct, 2014	Nov, 2014	Dec, 2014	Jan, 2015	Feb, 2015	Mar, 2015
Greater Than 12 Months		1		1	2		2	1	2	5	9	15
Less Than 12 Months	7	10	7	18	5	3	6	10	38	39	36	44

Hardwick CCG:

Length Of Stay In Service	Apr, 2014	May, 2014	Jun, 2014	Jul, 2014	Aug, 2014	Sep, 2014	Oct, 2014	Nov, 2014	Dec, 2014	Feb, 2015	Mar, 2015
Greater Than 12 Months	44	31	37	45	37	37	35	21	1		1
Less Than 12 Months	114	100	88	152	104	88	92	72	8	6	5

North Derbyshire CCG:

Length Of Stay In Service	Oct, 2014	Dec, 2014	Feb, 2015
Greater Than 12 Months		1	
Less Than 12 Months	1		1

Southern Derbyshire CCG:

Length Of Stay In Service	Apr, 2014	May, 2014	Jun, 2014	Jul, 2014	Aug, 2014	Sep, 2014	Oct, 2014	Nov, 2014	Dec, 2014	Jan, 2015	Feb, 2015	Mar, 2015
Greater Than 12 Months	12	6	13	14	8	5	5	16	29	26	10	28
Less Than 12 Months	47	38	49	48	32	32	46	63	144	136	151	157

6.6 Diagnoses

CCG Name	No ICD10 Code	F00-F09	F10-F19	F20-F29	F30-F39	F40-F49	F50-F59	F60-F69	F70-F79	F80-F89	F90-F98	F99	Other	Total	% With ICD10 Code
NHS Erewash CCG	179	0	0	0	16	11	0	0	5	11	0	0	47	269	33.46%
NHS Hardwick CCG	30	0	0	0	2	0	0	0	0	2	0	0	5	39	23.08%
NHS North Derbyshire CCG	3	0	0	0	0	0	0	0	0	3	0	0	1	7	57.14%
NHS Southern Derbyshire CCG	1025	0	1	1	69	39	0	1	8	126	0	0	294	1564	34.46%
Total	1237	0	1	1	87	50	0	1	13	142	0	0	347	1879	34.17%

ICD10 Code Groups

- F00-F09 – Organic, including symptomatic mental disorders
- F10-F19 – Mental and behavioural disorders due to psychoactive substance use
- F20-F29 – Schizophrenia, schizotypal and delusional disorders
- F30-F39 – Mood affective disorder
- F40-F49 – Neurotic, stress-related and somatoform disorders
- F50-F59 – Behavioural syndromes associated with physiological disturbances and physical factors
- F60-F69 – Disorders of adult personality and behaviour
- F70-F79 – Mental retardation
- F80-F89 – Disorders of psychological development
- F90-F98 – Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
- F99 – Unspecified mental disorder
- Others – Any other ICD10

7 Incidents (reported between 1/3/2014 and 28/2/2015)

7.1 Serious Incidents

Incident category	Amber Valley	Erewash	South Derbyshire
Suspected overdose	1	0	0
Admission of an under 18 year old to adult ward	1	0	0

7.2 All incidents

Category	Amber Valley	Erewash	South Derbyshire
Abuse or aggression - patient to staff	0	0	1
Risk of abuse or neglect	0	1	0
Bed Crisis	1	0	0
Death	1	0	0
Disruptive behaviour/aggressive - other	0	1	0
Information security & missing records	0	0	2
Referral, intervention, transfer and discharge	0	0	1
Grand Total	**2**	**2**	**4**

7.3 Incident outcome

Outcome	Amber Valley	Erewash	South Derbyshire	Total

Catastrophic	1	0	0	1
Major	1	0	0	1
Moderate	0	1	1	2
Minor	0	1	2	3
Insignificant	0	0	1	1
Total	2	2	4	8

8 Feedback

Team	Complaints	Compliments	Concerns
Amber Valley	2	0	2
Erewash	1	0	0
South Derbyshire	4	2	3

8.1 Complaint Themes

The themes running through the complaints received included:

- lack of continuity of care
- significant gaps and delays with the service
- unprofessional behaviour
- communication
- staff attitude
- lack of support

8.2 Compliments

"Thank you for everything you have done for me this past year it means a lot. KW you are an amazing person :)"

“Thank you for all your support. Don’t know where we would be without you.”

9 Performance summary

CAMHS is challenged by capacity and demand of CAMHS based upon National guidance, which includes timely access to the evidence based interventions. The catastrophic incident involving a young person under Rivermead is currently subject to a Learning review. The Major incident also related to a young person open to Rivermead and relates to the lack of a Tier 4 bed and involved the young person being admitted to an adult bed for one night.

There is noted increased complexity among service users (National theme) and some significant gaps in local commissioning of tier 1 and 2 services and the lack of dedicated home treatment or local tier 4 services. Due to the caring nature of the staff and the service culture of keeping children out of hospital this has put tremendous stress on the workforce.

However a strong robust clinical management Team has been put in place and temporary backfills recruited to enabling assurances which will be closely supported and monitored. Also In time the overall service will benefit from the new evolving targeted specialist eating disorder service and other evidence based treatment pathways which is part of IAPT phase 4 transformations.

Actions

- Robust management & leadership to service
- All vacancies recruited to

- Address the lack of support & critical mass within the county by reducing 3 teams to 2 Teams enabling more support, shared resilience, increased leadership visibility, consistency by standardising systems & cohesion to the workforce.

2015-2016 Board Annual Forward Plan

Enc O

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	Apr-15	May-15	Jun-15	Jul-15	Sep-15	Oct-15	Nov-15	Jan-16	Feb-16	Mar-16	Apr-16
		PAPERS DUE	**17-Apr**	**15-May**	**12-Jun**	**17-Jul**	**18-Sep**	**16-Oct**	**13-Nov**	**14-Jan**	**12-Feb**	**18-Mar**	**15-Apr**
GFG	Apologies given		X	X	X	X	X	X	X	X	X	X	X
GFG	Declaration of Interests	FT Constitution	X	X	X	X	X	X	X	X	X	X	X
MT	Minutes/Matters arising/Action Matrix	FT Constitution	X	X	X	X	X	X	X	X	X	X	X
MT	Board Forward Plan	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X	X
X	Comments from observers during meeting	Statutory Outcome 3	X	X	X	X	X	X	X	X	X	X	X
MT	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													
MT	Chairman's report	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X	X
ST	Chief Executive's report	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X	X
MP	APR Monitor Annual Plan submissions and governance statements, including financial planning (subject to change for Monitor deadlines each year) *Confidential*	FT Constitution/Monitor Risk Assurance Framework (RAF)	APR Progress update/ approval	APR Progress update/ approval						Self-assessm't if not covered in Bd Devpmt	APR Progress update	Approve start budgets. APR progress update/approval	APR Progress update/ approval
CW	Monitor Compliance Return *Confidential*	Monitor Risk Assurance Framework (RAF)	X			X		X		X			X
ST	Monitor Feedback	Monitor Risk Assurance Framework (RAF)		X					X				
MP	Commercial Strategy updates *Confidential*	Licence Condition FT4			X		X				X		
CW	Estates Design and Agile Working Strategy update *Confidential*	Monitor Risk Assurance Framework (RAF)	X					X					X
CW	5 Year Capital Programme (required by Monitor)	Monitor Risk Assurance Framework (RAF)							X				
CW/CG	Annual Accounts and Annual Report and Quality Report & Annual Governance Statement (sign-off of final versions is delegated to Audit Committee annually)	FT Constitution	*Drafts* to be issued to Board for comment			Annual audit letter			Board to consider deleg'n of sign off to Audit Comm				*Drafts* to be issued to Board for comment
ST	Strategic review/quarterly progress to include Transformation Board update	Strategic Outcomes (all)		X					X			X	
IM	IM&T Strategy Updates that will include update on optimisation of EPR	Strategic Outcome 1 Strategic Outcome 2		X		Progress Report							X

2015-2016 Board Annual Forward Plan

Enc O

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	Apr-15	May-15	Jun-15	Jul-15	Sep-15	Oct-15	Nov-15	Jan-16	Feb-16	Mar-16	Apr-16
IM	Information Governance Updates	Strategic Outcome 1 Strategic Outcome 3 Information Gov toolkit	X					X				X	
AS	Communications Strategy - Yearly Report	Strategic Outcome 3					X						Next one Sept 2016
JSt	Workforce Strategy / Updates	Strategic Outcome 4 Licence Condition FT4	X			X		X		X			
JSy	Research & Development Strategy	Strategic Outcome 1 and 3			X					X Progress Report			
JSt	Staff Survey Results & Follow up activity	Strategic Outcome 3 and 4		Progress Report			Progress Report				X Results		
GFG	Review S.O.'s, SFI's, SoD	FT Constitution Standing Orders				X							
GFG	Trust Sealings	FT Constitution Standing Orders	X										
GFG	Annual Review of Register of Interests	FT Constitution Annual Reporting Manual	X										
CG	Board Assurance Framework Update	Licence Condition FT4		X				X				X	
GFG	Raising Concerns (whistleblowing)	Strategic Outcome 1 Public Interest Disclosure Act			X			X				X	
GFG	Whistleblowing Policy - annual nomination of NED role (one year rotation)	Francis Report						X					
GFG	Committee Annual Report - Audit - F & P - Mental Health Act - Quality	Licence Condition FT4			X								Next due Jun 2016
GFG	Committee Reports (following every meeting) - Audit - Finance & Performance - Mental Health Act - Quality Committee	Strategic Outcome 3	X	X	X	X	X	X	X	X	X	X	X
MT	Annual Members' Meeting - arrangements	FT Constitution			X								
OPERATIONAL PERFORMANCE													
IM	Integrated performance and activity report to include pre agreed deep dive based on risk	Licence Condition FT 4 Strategic outcome 1 Strategic Outcome 3	X	X	X	X	X	X	X	X	X	X	X
CW	Financial Performance Report	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X	X
CW	Reference cost sign off	Best practice		X									
QUALITY GOVERNANCE													
CG	Quality Dashboard	CQC and Monitor			X							X	

2015-2016 Board Annual Forward Plan

Enc O

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	Apr-15	May-15	Jun-15	Jul-15	Sep-15	Oct-15	Nov-15	Jan-16	Feb-16	Mar-16	Apr-16
CG	Position Statement on Quality (Incorporates Integrated Governance, Patient Experience and Patient Safety Reports)	Strategic Outcome 1		X	X	X	X	X	X	X	X	X	X
CG	Safeguarding Children	Children Act Mental Health Standard Contract			X					X			
CG	Safeguarding Adult	CQC Mental Health Standard Contract			X					X			
CG	Control of Infection Report	Health Act Hygiene Code		X									
CG	Integrated Clinical Governance Annual Report (inc MHA/Governance/Complaints and Compliments/SIRI's/Patient Safety/NHS Protect (LSMS) and Emergency Preparedness	CQC			X			X					
CG	Integrated H & S Governance Annual Report (including H&S and Fire Compliance and Associated Training)	CQC and H&S Act			X			X					
CG	Annual Patient Survey	Clinical Practice CQC					X						
Jsy	Clinical Incidents Update *Confidential*	Monitor Risk Assurance Framework (RAF)	X	X	X	X	X	X	X	X	X	X	X
CG	CQC Update - Verbal unless report required *Confidential*	Monitor Risk Assurance Framework (RAF)					X	X	X	X	X	X	X
JSy	Re-validation of Doctors	Strategic Outcome 3			X								
CG	Health and Safety (Carrina Gaunt)	Health & Safety At Work Act					X						