# AGENDA FOR

## Council of Governors Meeting

**Date:** Thursday 12 January 2017  
**Time:** 4.15 p.m. – 6.00 p.m.  
**Venue:** Paddock Lodge, Aintree Racecourse, Ormskirk Road, Liverpool L9 5AS

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<tr>
<th>No.</th>
<th>Item</th>
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<td><strong>PART 1</strong></td>
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<td>A</td>
<td>Council Business</td>
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<tr>
<td>A1</td>
<td>Welcome</td>
<td>B Fraenkel</td>
<td>Verbal</td>
<td>4.15 p.m.</td>
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<tr>
<td>A2</td>
<td>Apologies – Governors: Apologies – Attendees: M Birch</td>
<td>B Fraenkel</td>
<td>Verbal to note</td>
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<tr>
<td>A3</td>
<td>Declarations of Interest</td>
<td>B Fraenkel</td>
<td>Verbal to note</td>
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<tr>
<td>A4</td>
<td>Minutes of the Previous Meeting held on: 28 September 2016</td>
<td>B Fraenkel</td>
<td>Paper for decision [ref COG16/17/027]</td>
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<td>A5</td>
<td>Update from the Chief Executive</td>
<td>J Rafferty</td>
<td>Verbal to note</td>
<td>4.20 p.m.</td>
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<td>A6</td>
<td>Update from the Chairman</td>
<td>B Fraenkel</td>
<td>Verbal to note</td>
<td>4.25 p.m.</td>
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<td>A7</td>
<td>Update from the Lead Governor</td>
<td>H Tetlow</td>
<td>Verbal to note</td>
<td>4.30 p.m.</td>
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<td><strong>B Our Services</strong></td>
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<td>B3</td>
<td>Care Quality Commission Inspection – March 2017</td>
<td>R Walker / S O’Hear</td>
<td>Presentation</td>
<td>5.05 p.m.</td>
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<td><strong>C Our Future</strong></td>
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<td>C1</td>
<td>Review of the Trust’s Strategy and Operational Plan</td>
<td>L Edwards / G O’Keeffe</td>
<td>Paper for discussion [ref COG16/17/030] &amp; Presentation</td>
<td>5.15 p.m.</td>
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<td><strong>D Governance</strong></td>
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<td>D1</td>
<td>Membership and Engagement</td>
<td>A Meadows / S Jennings</td>
<td>Paper for decision [ref COG16/17/031]</td>
<td>5.25 p.m.</td>
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<td>D2</td>
<td>Appraisal of the Chairman and Non-Executive Directors</td>
<td>S Jennings</td>
<td>Paper for decision [ref COG16/17/032]</td>
<td>5.30 p.m.</td>
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<td><strong>PART 2 – TO BE HELD IN PRIVATE</strong></td>
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<td>D3</td>
<td>Appointment of External Auditor</td>
<td>H Tetlow/ P Williams/ S Jennings</td>
<td>Paper for decision [ref COG16/17/033]</td>
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<td><strong>D4</strong></td>
<td>Appointment and Re-appointment of Non-Executive Directors [In the absence of Non-Executive Directors]</td>
<td>A Meadows</td>
<td>Paper for decision [ref COG16/17/034]</td>
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<td><strong>D5</strong></td>
<td>Re-appointment of the Chairman [In the absence of the Chairman]</td>
<td>A Meadows</td>
<td>Paper for decision [ref COG16/17/035]</td>
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<td><strong>E</strong></td>
<td>Any Other Business</td>
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<td><strong>E1</strong></td>
<td>Any Other Business</td>
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Please note that Council of Governor meetings are meetings held in public. Any member of the public can attend these meetings, although they do not have the right to participate.
MINUTES OF THE MEETING OF THE
Council of Governors

Date: Wednesday 28 September 2016
Time: 3:15pm-5pm
Venue: Aintree Racecourse, Papillon Suite, Ormskirk Road, Aintree, Liverpool L9 5AS

Name
Present:
Beatrice Fraenkel
George Allen
Johanna Birrell
Debra Doherty
Mike Jones
David Kitchen
Hetalkumar Mehta
Jayne Moore
John Mousley
Martin Murphy
Brian Murphy
Scott Parker
Hilary Tetlow
Maria Tyson
Sandra Wright-Perkins
Veronica Webster

Job Title (Division/ Organisation*) *if not Mersey Care
Chairman (agenda items A1-C2 and E1)
Carer, Local (Liverpool, Sefton & Knowsley);
Service User, Local (Liverpool, Sefton & Knowsley);
Service user, Local (Liverpool, Sefton & Knowsley);
Staff, Non Clinical Staff;
Appointed, NHS England;
Staff, Medical;
Public, Liverpool;
Public, Sefton;
Service user, Local (Liverpool, Sefton & Knowsley);
Carer, Local (Liverpool, Sefton & Knowsley);
Staff, Nursing Staff;
Carer, Local (Liverpool, Sefton & Knowsley);
Staff, Nursing Staff;
Public, Liverpool;
Appointed, Sefton, Local Authority;

In Attendance:
Joe Rafferty
Andy Meadows
Sarah Jennings
Paula Murphy
Pam Williams
Matt Birch
Amanda Oates
Elaine Darbyshire
Wendy Copeland-Blair

Chief Executive (items A5-C1)
Trust Secretary
Deputy Trust Secretary
Corporate Governance Officer (minute secretary)
Non Executive Director
Non Executive Director
Executive Director of Workforce
Executive Director of Corporate Governance & Communications
Head of Performance Improvement

Apologies Received:
Clare Austin
Jess Chittenden
Sara Finlayson
Neil Frackelton
Mark Tattersall

Appointed, Academic;
Public, Liverpool;
Staff – Other Clinical, Scientific, Technical & Therapeutic Staff;
Appointed, Voluntary Sector;
Public, Knowsley;
A1 WELCOME AND INTRODUCTIONS

1. Mrs Fraenkel welcomed the Governors, Executives and Non-Executives to the meeting and thanked the public gallery for their attendance.

A2 APOLOGIES

2. The apologies for absence received for this meeting are detailed on page one of the minutes.

A3 DECLARATIONS OF INTEREST

3. No declarations of interest were made.

A4 MINUTES OF THE MEETING HELD ON 16 JUNE 2016

4. The minutes of the previous meeting held on 16 June 2016 were accepted as an accurate record. No amendments were required.

A5 CHAIRMAN’S UPDATE

5. Mrs Fraenkel confirmed that following the support and agreement of the Council of Governors at the previous meeting held on 16 June 2016, Mersey Care had been successful in acquiring Calderstones Partnership NHS Foundation Trust, with approval being granted by NHS Improvement with effect from 1 July 2016. The former Calderstones had now become the Specialist Learning Disability Division within the Trust.

6. Mrs Fraenkel informed Governors of two additional appointments to Mersey Care’s Board of Directors in order to strengthen the skill set of the officers on the Board, namely; Mark Hindle, Executive Director of Operations and Trish Bennett, Director of Integration. Mr Hindle introduced himself to the Governors and provided a brief outline of his previous and current roles.

7. Mrs Fraenkel advised Governors that she had recently chaired the Care Quality Commission (CQC) inspection of a mental health community adult trust in Staffordshire as the first Non-Executive to chair such an inspection. Mrs Fraenkel stated that the inspection had been very informative and provided an opportunity for sharing knowledge across the NHS.

8. Mr Meadows advised Governors that as outlined in the report, Mersey Care had submitted 2 bids to provide some of the community services currently provided by Liverpool Community Health NHS Trust, namely: (a) community and children’s physical health service for Liverpool and (b) community physical health services for
Sefton. It was expected that Mersey Care would be notified if it had been successful in achieving Preferred Bidder status in the first week on October 2016, with the intention that it would assume responsibility for the LCH service bundles from 1 April 2017.

9. Mrs Tetlow noted that the Trust did not currently offer children’s services and queried whether this posed a risk in terms of provision of new areas of business. In response, Mr Rafferty confirmed that the trust was bidding in partnership with 5 Boroughs Partnership NHS Trust (5 Boroughs) for these two bundles so as to provide a better service to local people, and therefore if successful, Mersey Care would be the lead contractor and would sub-contract a range of services to 5 Boroughs based on their existing experience of providing these services. Mr Rafferty added that 5 Boroughs had been subject to the Care Quality Commission (CQC) inspection for which a rating of ‘good’ was provided for the provision of effective, caring and responsive care.

10. Mr Rafferty noted the current fragmented provision of health care and informed Governors that the acquisition would allow for provision of truly integrated care for those individuals presenting with physical and mental health concerns. In addition, evidence indicated that integrated care (though a bio-psycho-social model) resulted in improved outcomes for patients and a reduction in costs.

11. In response to a question asked by Mr Kitchen regarding the benefits of the trusts provision of physical health services, Mr Rafferty confirmed that individuals would be treated in a much more holistic way through a single point of access and social issues would be addressed including isolation and housing through partnership working.

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<tr>
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<td>• Note the contents of the report</td>
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B1 REPORT ON FINANCIAL AND ACTIVITY PERFORMANCE

12. Mr Birch (Non Executive Director and Chair of the Performance, Investment and Finance Committee), presented the performance report, explaining that the report provided an update on key performance information and actions to address adverse performance. The report also contained information in relation to safe staffing.

13. Mr Birch confirmed that the Trust continued to perform well in respect of external assessments and financial performance and was compliant with CQC registration requirements achieving ‘Good’ in the Chief Inspector of Hospitals inspection.

14. Mr Birch stated that phase one of the new reporting system (Quality Dashboard) had been implemented and a demonstration delivered to the Quality Assurance Committee in September 2016 and the new indicators would be reported from Q2, 2016/17. The
report provided assurance against a number of strategically significant risks and these were detailed within the relevant sections.

15. Mr Birch referred to the Data Quality Indicators Kite-Mark on page 5 of the report and advised that this provided assurance of the data trustworthiness and external assurance through the Audit Committee ensured confidence in the data.

16. The report focused on 4 sections of performance monitoring: quality, external environment/regulators, workforce indicators and financial indicators. Mr Birch summarised by stating that the Trust was meeting its statutory obligations.

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<td>• Note the assessment of performance contained within this report and the performance improvement actions detailed in the performance escalation sections.</td>
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B2 MERSEY CARE ANNUAL REPORT 2015/16

17. Mrs Williams (Non Executive Director/Chair of the Audit Committee), presented the Trust's Annual Report 2015/16 and advised that production of the report was a statutory requirement and provided a review of the Trust’s services and financial performance in the previous year. Mrs Williams confirmed that a draft of the report had been considered by the Audit Committee (Aug-16) and had been recommended to the Board of Directors for formal approval. At it’s meeting earlier in the day (28 Sep-16), the Board had approved the Annual Report subject to minor amendments and was presented to the Council of Governors for information in line with good governance.

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<td>Recommendations approved by the Council of Governors, namely:</td>
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<td>• Consider and note the 2015/16 Annual Report</td>
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C1 PROCESS FOR APPRAISAL OF THE CHAIRMAN AND NON-EXECUTIVE DIRECTORS

18. Miss Jennings advised the Council of Governors that the NHS Foundation Trust Code of Governance recommended that the Board of Directors should undertake a formal, rigorous annual evaluation of its own performance and of its committees and individual Directors.

19. In line with the Code, the Council of Governors were responsible for leading on agreement of the process for the evaluation and appraisal of the Chair and the Non-Executives. In light of this, a proposed process for appraisal of the Chairman and Non-Executive Directors had been provided for consideration and approval.

20. Miss Jennings advised Governors that the proposal had been devised following review of existing appraisal processes across other Foundation Trusts and had been considered by the Nomination and Remuneration Committee who had recommended this for approval by the Council of Governors. The Committee had suggested however, that the 2017/18 appraisal process for the Chairman incorporated the request for feedback from external stakeholders. The appraisal process would be reviewed on an annual basis and presented to the Council of Governors for approval.

21. Miss Jennings confirmed that the proposed process would assist the Council of Governors in performing its statutory duties, specifically when considering the potential re-appointment or removal of the chair.

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<td>• Approve the proposed process for the appraisal of the Chairman including the proposed timescales for 2016/17 appraisals;</td>
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<td>• Approve the proposed process for the appraisal of the Non-Executive Directors including the proposed timescales for 2016/17 appraisals;</td>
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<td>• Note the arrangements for the appraisal of Executive Directors;</td>
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<td>• Note that future appraisals of the Chairman and Non-Executive Directors will take place annually between April and June.</td>
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<td><strong>Further actions required:</strong></td>
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C2 PROCESS FOR THE APPOINTMENT OF AN EXTERNAL AUDITOR

22. Miss Jennings advised that the appointment of the External Auditor was set out in the Trust’s Constitution and was the statutory responsibility of the Council of Governors. In order to support the Council of Governors in making this appointment, it was proposed that a working group would be established (Audit Appointment Working Group) to lead the process and to make a recommendation to the Council of Governors.
Agenda Item No: A4

Governors regarding appointment of the auditor. Miss Jennings confirmed that the Audit Committee, chaired by Pam Williams (Non-Executive Director), had considered the proposed process and had recommended this to the Council of Governors for approval.

23. Miss Jennings stated that subject to approval of the process, Governors would be provided with an outline of the duties and associated indicative time commitments for the working group and representation on the group would be sought. It was expected that the working group would meet on approximately 3 occasions to ensure an External Auditor was in place from 1 April 2016.

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<tr>
<td>• Consider and approve the proposed process for the appointment of the External Auditor from 1 April 2016 including the establishment of an Audit Appointment Working Group and associated timescales.</td>
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<td>Further actions required:</td>
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<td>• Confirmation of time commitments and duties for the time limited Audit Appointment Working Group to be circulated via email to Governors to seek members.</td>
<td>S Jennings</td>
<td>Sep-16</td>
<td>Completed.</td>
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C3 APPOINTMENT OF THE LEAD GOVERNOR

24. Mr Meadows received confirmation from Governors that all those present had submitted a ballot paper to vote for the Lead Governor. The votes had been collected and counted by the Corporate Governance Team, and the ballot results were as follows:
   • Debra Doherty – 4 votes
   • Sara Finlayson – 0 votes
   • Dave Kitchen – 5 votes
   • Mark McCarthy – 0 votes
   • Hetal Mehta – 1 vote
   • Hilary Tetlow – 5 votes

25. Mr Meadows confirmed that as there was a tie, a further ballot would be held and all Governors present would be asked to vote for one of the two governors with the most votes, namely; Dave Kitchen and Hilary Tetlow.

*Governors submitted a second vote.*

26. Following the second ballot, Mr Meadows confirmed the outcome as follows:
   • Dave Kitchen – 7 votes
   • Hilary Tetlow – 8 votes

27. Hilary Tetlow was officially announced as the elected Lead Governor for the Council of Governors and in light of this, Mrs Tetlow was asked to chair the meeting for the
following item (in which the Chairman and all Non Executive Directors were excluded due to conflict of interest).

28. Governors raised concerns regarding late receipt of hard copies of the Council of Governors papers and although emailed papers had been received, the majority of Governors preferred printed copies for ease of reading. Mr Meadows acknowledged this concern and confirmed that whilst these were posted to all Governors on 22 September 2016 there had been a delay in delivery. Mr Meadows apologised for this issue and advised that where possible, these would be circulated 10 days prior to meetings going forward with the exception of those reports which relied on data which may not be available.

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| Further actions required:  
• Timely circulation of meeting papers to be arranged going forward. | A Meadows | Jan-17 and onwards | On-going |

E1  ANY OTHER BUSINESS

29. Mr Meadows referred to the service visits arranged for Governors and proposed that Governors were to contact the Corporate Governance team if they had any further requirements or questions (paula.murphy@merseycare.nhs.uk or sarah.jennings@merseycare.nhs.uk)

30. Mrs Tetlow (Lead Governor) gave permission for the Corporate Governance Team to circulate her contact details to Governors. Mr Meadows agreed to contact Mrs Tetlow to discuss any support required to fulfil her new role as Lead Governor.

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| Further actions required:  
• Circulate contact details to the Council of Governors for the newly elected Lead Governor, Hilary Tetlow;  
• Mr Meadows and Mrs Tetlow to discuss any support requirements for the Lead Governor role. | P Murphy | Sep-16 | Completed |
| | A Meadows | Oct-16 | Oct-16 |

31. No other business was discussed.

32. The meeting closed.
COUNCIL OF GOVERNORS

REPORT ON FINANCIAL AND ACTIVITY PERFORMANCE

Report Author(s): Wendy Copeland-Blair, Head of Performance Improvement and Customer Relationship Management

Summary of Key Issues:
- The trust is performing well against the majority of the indicators.
- The Care Quality Commission are due to undertake an inspection of all core services and to complete a “Well-Led” review on 20 March 2017.
- The trust has been allocated by NHS Improvement to segment 2 in its new single oversight framework and has been allocated a finance and use of resources score of 3.
- Key areas for performance improvement include:
  - NHSi Single Oversight Framework
    - Agency spend
    - Data completeness: priority metrics
    - IAPT: Recovery
    - Staff sickness
    - Temporary staff (proportion of paybill)
    - Aggressive cost reduction plans
    - CPA 7 day follow up
  - STeIS incidents (Our Services)
  - Detention under MHA for BME service users (Our Services)
  - Patient Experience (Our Services)
  - Physical health – community service users annual health checks (Our services)
  - Bed Management - Unplanned out of area treatments (Our Services)
  - Statutory Training (Our People)
  - Vacancies v Budgeted Establishment (Our People)
  - Inpatient Ligature Incidents (Our Future)
  - Restrictive Practice Incidents (Our Future)
  - Contract Risks - Talk Liverpool (Our Future)

Recommendation: The Council of Governors are asked to:
1) Note the content of this report.

PURPOSE

1. To provide the Council of Governors with an overview of trust performance for the three months ending 30 November 2016.
BACKGROUND

2. The trust has established a new approach to reporting performance to the board and its' committees following a board development session in August 2016.

3. The new approach enables scrutiny of performance in the following areas:

   a) Regulatory – this includes information relating to the trust’s compliance with Care Quality Commission requirements and performance against indicator in the NHS Improvement Single Oversight Framework.

   b) Our services – this looks at whether services are safe, timely, effective, equitable, efficient and patient centred.

   c) Our people – this looks at whether we have supported managers and effective teams, a productive workforce with the right skills and the extent to which we working side by side with service users and carers.

   d) Our resources – this looks at our investment in technology to help us provide better care, buildings that work for us, how we can save time and money to ensure the most efficient use of the funding we get and our NHS Improvement finance and use of resources score.

   e) Our future – this includes measures that show the benefits of research and innovation, our progress in growing our services and how we work effectively with primary care and other organisations.

4. The new report also enables the three clinical divisions to highlight key operational performance issues.

5. This paper is organised into the areas above for consistency of approach.

ISSUES

Regulatory

Care Quality Commission (CQC)

6. The trust has been notified that the next CQC visit will take place on 20 March 2017. This will focus on core service areas and a trust wide well led review.

7. Preparation for the forthcoming visit in March has already commenced. Actions agreed from the previous visit will be closed off on SharePoint (end of December 2016) and responsibility for maintaining the improved standards of compliance and ensuring this can be evidenced during any future visits from CQC remains with the operational managers from each of the divisions. A project board has been established, divisional CQC meetings have been set up and CQC is a topic for discussion at the trust's weekly Stand-Up Meeting with Executive Directors.

8. The CQC inspector is attending the Trust Board development session on 14 December 2016 to explain the process of the well-led review and five engagement
meetings have been set up between CQC and the trust with good representation at senior management level from all divisions.

NHS Improvement – Single Oversight Framework

9. On 1 October 2016, NHS Improvement implemented a new approach to monitoring the performance of NHS trusts and NHS foundation trusts. This is called the Single Oversight Framework (SOF) and includes five themes:
   a) quality of care
   b) finance and use of resources
   c) operational performance
   d) strategic change
   e) leadership and improvement capability

10. Trusts have been segmented by NHS Improvement based upon their performance against the measures in use. The segments range from 1 to 4 with 1 confirming that trust can operate with maximum autonomy and segment 4 being aimed at providers who would be considered to be in special measures (where there has been an actual or suspected breach of the provider’s licence conditions).

11. The trust has been allocated to segment 2 based on the good CQC rating and our operational performance.

12. The trust is achieving the majority of metrics associated with the SOF.

13. The trust is currently 74% above national spending targets for agency staff and this has led to the trust receiving a finance and use of resources score of 3. Analysis of the reasons for this identified high levels of medical locums within the local division; the trust’s hosting of iMerseyside (which provides IT support to a number of other organisations); agency nursing costs in the specialist learning disability division to fill vacancies following the decision by NHS England to announce the closure of the Whalley site services; and short-term posts within the corporate division for people with specialist expertise to support the work on the acquisition and integration of Calderstones Partnerships NHS Foundation Trust and on the bid for community physical health services in Liverpool and Sefton.

14. Actions to address this include:
   a) An approach to NHS Improvement to ask for a review of the agency cap value to acknowledge the particular circumstances for the trust;
   b) Development of a plan by the associate medical director of the local division to address medical locum spend;
   c) The use of the centralised agency booking service has been strengthened and approval levels amended with only director level roles now able to approve;
   d) A review of all agency staff in post for more than six months with any future planned spend on these roles to be approved by the executive team;
e) Monthly reporting to the executive team on progress via the Agency Expenditure Ceilings Report;

15. Based on our internal analysis, we have a number of operational performance and quality indicators that are currently underperforming:
   a) Data completeness - priority metrics (ethnicity, settled accommodation status, employment status and diagnostic coding)
   b) Talk Liverpool (IAPT) – The percentage of people moving to recovery
   c) Sickness absence
   d) The percentage of temporary staff
   e) Aggressive cost improvement plans
   f) CPA 7 day follow up.

16. A detailed paper outlining the issues driving these areas of underperformance and the actions in train has been received by the performance, investment and finance committee.

Our services

17. Concerns were raised by the quality assurance committee that the trust was not achieving all of the standards associated with the duty of candour requirements. Immediate action was taken and the trust is now confident that all standards will be achieved in fully by 31 January 2017.

18. A pleasing reduction in the proportion of incidents resulting in harm has been observed.

19. The trust is achieving the trajectory for delayed discharges agreed with NHS Improvement, however there remain challenges in the local division in relation to out of area treatments associated with high levels of bed occupancy in acute wards. Concerns exist relating to the potential for further delays to discharge in the specialist learning disability division. The trust is working closely with commissioners to ensure early escalation of these issues.

Our people

20. A review is underway to determine the stability of leadership to clinical teams to ensure consistent support to teams as 31% of teams currently report that they do not have a substantive consultant, team manager and deputy who has been in post for more than three months.

21. A reduction in the percentage of staff up to date with statutory training has been observed this month following a change in reporting to require staff to have completed all eight subjects. Previously seven out of eight of the core subjects had to be completed to be deemed compliant. There have also been some technical issues relating to staff being access the system and a small number of anomalies in the e-
learning system and BiT reporting which has affected the accuracy of the data. Work to address the technical issues is in train and expected to be completed early 2017. A number of one day drop in sessions have been arranged to support staff to complete their training as well as a series of reminders to managers.

22. Sickness absence rates continue to be above target and have increased to 7.1% this month. This is higher than the rate reported in November 2015. A number of actions are in train including analysis of the reasons for sickness within each of the clinical divisions and identification of any themes within staff groups or teams.

23. The trust has seen vacancy rates rise to just over 10% in the last three months (latest data was for October 2016). As previously mentioned high levels of vacancies have been observed in the specialist learning disability division. The trust has also a number of medical vacancies at consultant level and we are also experiencing some recruitment difficulties with junior medics. This is directly linked to future supply and is being monitored accordingly.

24. Pleasing performance continues to be observed for the measure relating to working side by side with service users and carers with over 95% of people completing the trust’s patient experience questionnaires reporting that they have been involved in the development of their care plan.

Our resources

25. The trust is on plan to meet its key financial targets of:
   a) Breakeven £6.903m surplus
   b) Capital £21.853m
   c) Cash £12.018m
   d) BPPC 95%

26. Spend on information management and technology is currently on plan. Actions are currently being implemented to resolve overspends.

27. Gross capital expenditure is on plan. The plan is significantly higher at the latter end of the year due to the commencement of larger developments.

28. The trust has identified a risk to achieving all of its commissioning for quality and innovation targets (CQUIN) in relation to physical health. The financial consequence is a potential loss of income of £0.092m.

29. As mentioned previously, the trust’s finance and use of resources score is 3 as a result of agency expenditure in excess of the value set by NHS Improvement.

Our future

30. Through the investment in research and innovation, the trust anticipates sustained reductions in the number of inpatient ligatures and restrictive practice:
   a) Inpatient ligatures: The trust monitors this data on an in quarter basis and has observed an increasing trend in the number of these incidents since Q3 2015/16.
95% of these incidents occur within the local division. A design thinking project is underway and is at the stage of identifying remedial actions. Research based information is used to support teams considering actions. Harrington ward continues to experience the highest number of self-harm incidents within the project group many of which are ligature related. This ward is actively being supported by the management team specifically in relation to monitoring the number of people with similar presentations.

b) Restrictive practice incidents: The trust monitors this data on a rolling twelve month basis and has observed a sustained reduction in the number of restrictive practice incidents since April 2016 (a small rise was observed in November 2016). Performance has remained broadly stable within local and secure divisions with the majority of the reductions being observed within the specialist learning division. The No Force First programme continues to be a key component of the trust’s perfect care aspirations and aims to eliminate physical restraint and medication led restraint within Mersey Care NHS Foundation Trust. Actions include:

- A reducing restrictive practice forum has been established at the Whalley site and resources allocated in relation to training and engagement.
- Trend data for all inpatient areas relating to restraint (physical and medication led) and incidents of aggression is being shared with ward managers to agree and develop plans.
- The No Force First Guide of Strategies has been expended to include a number of new approaches. Roll out commenced November 2016 on pilot wards.
- The restrictive practice policy is scheduled to be presented to the trust policy group in December 2016.

31. The trust was successful in recent bids for perinatal services and South Sefton community services but was not successful in its bid for Liverpool community services.

32. The trust has identified a small number of risks associated with contracts:
   a) Increased demand due to block contract
   b) Investment in liaison services
   c) Underperformance against the early intervention in psychosis referral to treatment target
   d) Talk Liverpool performance and delivery of the agreed recommendations following the NHS England Intensive Support Team review.

**Key operational issues for clinical divisions**

**Local division**

33. The three main performance issues are as listed below:
a) The IAPT service continues to underperform against targets. The trust has received notification from Liverpool CCG advising that they will impose contract penalties in 2016/17 for the underperformance. The penalties are capped at 2.5% of the quarterly contract value; therefore the penalty for Q1 was £0.03m. Despite this there has been a significant improvement in waiting times post implementation of the new clinical model.

b) Impact of commissioning decisions - relationships with the CCGs are currently challenging due to the funding issues concerning non recurrent investment. The initial contract offer is expected to be signed off 23 December 2016.

c) Use of adult acute out of area treatments - these are monitored on a daily basis. A review of bed management issues has been completed via an external contractor. A review of the acute care pathway has been commissioned and will report internally and externally via the transformation boards.

Secure Division

34. The secure division highlighted the following areas:

a) All serious incidents have been reviewed as per procedure.

b) Delayed discharges are actively being managed including working closely with Commissioners and the Local Authority.

c) Safe staffing levels have improved.

d) Patient experience scores continue to report well for the division, any dips in performance are considered at surveillance.

e) The division has achieved 2016/17 cost improvement plans and is forecasting a £300k underspend for year end.

f) All secure CQUIN schemes are on target to be achieved.

g) The 75% flu vaccine target was achieved mid November 2017.

h) Care Quality Commission preparations for 2017 have commenced.

i) There have been on-going system and data issues with the recording and reporting of statutory training, a plan is being developed with Learning & Development to resolve.

Specialist Learning Disabilities Division

35. The three main performance issues are as listed below:

a) Safe contraction of services - There is a weekly Strategic Implementation Group which has oversight of the contraction plan. The plan details people (service users/staff), buildings and finance. The plan was discussed at executive committee in November and an update received in December 2016.
b) Workforce retention and sickness levels – There is a weekly Staffing Analysis Meeting attended by the Chief Operating Officer. Sickness remains at 9 to 10%. Retention percentages have been stable for a number of weeks.

c) Use of agency staff – This relates to three main areas of covering vacancies, sickness and enhanced observations. The division has a comprehensive action plan in place for the reduction of enhanced observations which is a particular issue within low secure services.

RECOMMENDATION

36. The Council of Governors are asked to:

   a) Note the content of this report.

WENDY COPELAND-BLAIR
HEAD OF PERFORMANCE IMPROVEMENT

16 December 2016
COUNCIL OF GOVERNORS

Quality Review Visits

Report Author(s): Joanne Bull: Head of Nursing for Quality and Compliance

Summary of Key Issues:
- Requirement for monitoring as part CQC regulation
- Development of review framework and alignment with CQC key Line of Enquiries
- Ensuring a unified approach across all elements of regulation and audit
- Ensuring triangulation of information
- Current themes identified during current QRV visits

Recommendation:
The Council of Governors is asked to:
1) Note contents of report
2) Review scope of their roles for involvement in QRV process

PURPOSE

1. To provide an oversight of the Trust’s internal process to monitor quality, safety and compliance, known as Quality Review Visits.

BACKGROUND

2. The Health and Social Care Act 2008 (Regulated Activities) Regulation 2010 stipulates that any provider of regulated activities, including the NHS, must be registered with the Care Quality Commission (CQC) in order to legally provide services. NHS trusts must be able to demonstrate that they comply with the legally enforceable fundamental standards of quality and safety regulations as set out in the Act. This registration system places emphasis on ongoing compliance rather than snap-shot evaluation. It is designed to provide a rigorous method of monitoring and should help to ensure greater consistency and higher standards in the quality of care.

3. Between 2009 and 2012 significant failings in the delivery of health and social care in England led to numerous inquiries, investigations and reviews. Themes that emerged were that health and social care organisations’ systems and processes for monitoring and assessing the quality and safety of care were failing to identify that standards were not being met and that those failings were not being adequately addressed.

4. The Health and Social Care Act (Regulated Activities) Regulations 2014 implement the Fundamental Standards which identify the minimum standards of quality and safety for health and social care. Aspects of care that have always been good practice but were not defined in law have now been included.

5. The CQC’s strategy for 2013-2016 highlights key priority areas and following review and extensive consultation, introduced new methods of inspecting NHS hospitals and mental health trusts. The new inspection regime combines announced and unannounced
inspections, the aim of which is to get to the heart of patients’ experiences. CQC inspectors look at the quality and safety of the care provided based on the things that matter to people and using the Key Lines of Enquiry (KLOE) the five key questions asked of services are:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people’s needs?
- Are they well-led?

6. Through this approach, CQC hope to achieve a richer and broader understanding of the quality provided. It will also allow them to comment on new areas around leadership and governance.

7. In response to the new regulations and CQC approach the Nurse Executive team undertook a review and introduced a self-assessment process and inspection framework called Quality review Visit (QRV) based on the KLOEs and fundamental standards. A reporting system in SharePoint was developed, which included a team action tracker, and enabling more seamless reporting. This approach has greater transparency thereby providing increased internal assurance to the board that issues are being addressed by services. The trust’s governance arrangements for CQC compliance are of a high standard and systems and processes are well developed.

8. A key element of the QRV process is the unified approach to audit, monitoring and regulation that captures all required information, assessment and actions needed, with a multi-professional coordinated approach. These include:

- Infection control annual audit
- Environmental risk assessment
- Fire risk assessment
- Specialist Partnership Agreement audit
- 13 week audit (facilities cleaning)
- Mental Health Act and Mental Capacity Act Audit
- Medicines management audits
- Pharmacy quarterly audits

9. There are planned days throughout the year with teams identified to be able to respond to reactive requests for visits to services. Team managers are notified of the requirements of the visit to enable them to collate their evidence in advance to ensure efficient use of time on the day and smooth running of the inspection and to put in place measures to minimise disruption to service delivery.

10. The key stages in the QRV process are:
- Reviews are completed on line and held in SharePoint.
- SharePoint has the ability to track completion of actions automatically.
• Reviewers are now required to record the evidence used to inform the assessments of each standard.
• An approval stage has been introduced to help standardise and improve the quality of reports.
• Reports will in future classify teams using CQC categories e.g. Outstanding, Good, Requires improvement of Inadequate.

ISSUES

11. In preparation for the CQC visit (w/c 20th March 2017) the visits have increased and we are encouraging external reviewers to become more involved, particularly volunteers, service user/carers and Governors. This helps to provide an independent view of the quality of services.

12. Themes emerging from the visits are as follows:
   • Handovers
   • Cleanliness and hygiene.
   • Recording of Assessment of Capacity to consent to treatment
   • Access to mandatory and statutory training

13. There is significant work at team level and corporate level to address these issues and form an integral part of the Trust Quality Surveillance process.

14. Appendix A outlines the preparation for the visit and Appendix B describes the review process.

RECOMMENDATION

15. The Council of Governors are asked to:
   a) Note contents of report
   b) Review scope of their roles for involvement in QRV process

JOANNE BULL
HEAD OF NURSING FOR QUALITY AND COMPLIANCE

December 2016
Appendix A: QRV Preparation Process

- **Identifying date for QRV**: For annual review, develop programme 3 months in advance. For ad hoc reviews, liaise with team and lead inspectors to agree best date.

- **Assembling Team for QRV**: Annual Review requires full team. Inadequate review requires only Lead and Manager. Others may be co-opted for Inadequate Review based upon identified issues.

- **Identifying Lead**: Liaise with Head of Nursing Quality and Compliance to agree their dates. Whatever cannot be completed by HoN request support from Exec Nurse Team. If no BNT extend out to bank after confirmation with HoN.

- **Identifying Manager**: Liaise with Divisional Leads and send dates. As Managers are Identified add them to the QRV Calendar.

- **Identifying H&S Rep**: Liaise with all members of H&S team send dates. Reps may not be identified until close to visit date - follow up if no name 3 days prior to visit. Add names to QRV calendar. Visit may not take place on the date but +/-3 days.

- **Identifying IPC Rep**: Liaise with all members of IPC team send dates. Reps may not be identified until close to visit date - follow up if no name 3 days prior to visit. Add names to QRV calendar. Visit may not take place on the date but +/-3 days.

- **Identifying MHAM**: Identify if MHAM needed for visit - inpatients with detained patient only. Send out dates to all MHAMs. Request that they visit any date in the 3 days prior to the visit. When date agreed notify ward so they ensure RN available. Send audit sheets via email out to MHAMs.

- **Identifying Governor**: Liaise with MerseyCareCoG. As Governors are Identified confirm dates with MerseyCareCoG. Add names to QRV calendar.

- **Identifying Volunteers**: Liaise with Volunteer Services for names. Contact volunteers individually and ask for expressions of interest. Confirm with volunteers and add to calendar.

- **Coordinating Team for Visit**: 5 days prior to visit email all confirmed team members. Liaise with Volunteer separately. Include Ward Team Manager of area being visited so they know who to expect.

- **Assembling Inspection Pack**: Assemble packs for QRV Leads. Notify them 2 days prior to visit where these can be collected.
COUNCIL OF GOVERNORS

REVIEW OF THE TRUST’S STRATEGY AND OPERATIONAL PLAN

Report Author(s): Louise Edwards, Director of Strategy

Summary of Key Issues:

- This purpose provides an update to the Council of Governors regarding the annual review of the Trust’s strategy and the planning process for 2017/18 and 2018/19.
- There are two components to Mersey Care’s plans for 2017/18 and 2018/19.
- 2017/2019 NHS Operational Planning and Contracting (September 2016) guidance sets out the national priorities and financial and business rules for the NHS for a two year period.
- Through the contracting negotiations with our commissioners, the Trust has made it clear that the standards and targets set out in the Five Year Forward View for Mental Health can only be delivered if the allocated additional funding is provided to the Trust.
- The Trust is included in Cheshire and Merseyside Sustainability and Transformation Plan which has identified priorities that would make our health and care system sustainable in the near medium and long term:
  - Alongside the development of the NHS England required operational plan, each year the Trust develops our internal business plan, outlining the priority areas to support delivery of our perfect care strategy.
  - Once finalised, the plan will be presented to the Trust Board in March 2016.
  - A number of priorities have emerged for consideration in the plan for 2017/18.
  - The Trust must prioritise the development of a consistent operating platform in order to be a stable, high performing organisation.

Recommendation:

The Council of Governors is asked to:
1) Note this update regarding the planning process for 2017/19.
2) Comment on the emerging priorities and the proposal to prioritise the development of ‘firm foundations, but doing the basics consistently well.’
PURPOSE

1. This purpose provides an update to the Council of Governors regarding the annual review of the Trust’s strategy and the planning process for 2017/18 and 2018/19.

2. There are two components to Mersey Care’s plans for 2017/18 and 2018/19;
   a) a two-year operational and activity plan (2017-2019) which must meet the requirements of the NHS Planning guidance published by NHS Improvement in September 2016
   b) an internal Mersey Care business plan, which sets out how we will continue to deliver our strategy for perfect care.

NHS IMPROVEMENT PLANNING GUIDANCE

3. 2017/2019 NHS Operational Planning and Contracting (September 2016) guidance sets out the national priorities and financial and business rules for the NHS for a two year period.

4. The guidance sets out the ‘must dos’ for 2017-19 (included in appendix 1), and outlines the expectations in relation to mental health transformation:
   a) Local areas must plan to deliver in full the implementation plan for the Five Year Forward View for Mental Health.
   b) Additional funding underpinning the delivery of the Five Year Forward View for Mental Health must not be used to supplant existing spend or balance reductions elsewhere.
   c) Ongoing requirement to increase baseline investment by at least the overall growth in allocations to deliver the Mental Health Investment Standard.
   d) Savings arising from new services (such as integrated Improving Access to Psychological Therapies/Long Term Conditions and Mental Health liaison in A&E) resulting from this new investment need to be reinvested to maintain services and ensure delivery of the commitment to treat an additional one million people with mental illness by 2020/21.
   e) CCGs should commit to sharing and assuring financial plans with local Healthwatch, mental health providers and local authorities.

5. Through the contracting negotiations with our commissioners, the Trust has made it clear that the standards and targets set out in the Five Year Forward View for Mental Health can only be delivered if the allocated additional funding is provided to the Trust.

SUSTAINABILITY AND TRANSFORMATION PLANS (STP)

6. In 2016/17, every health and care system has been required to work together to produce a Sustainability and Transformation Plan, covering the period October 2016 to

1 https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/
March 2021. As part of this, local leaders will be required to set out clear plans to pursue the ‘triple aim’ set out in the NHS Five Year Forward View – improved health and wellbeing, transformed quality of care delivery, and sustainable finances.

7. The sustainability and transformation plan footprint in which Mersey Care operates is that for Cheshire and Merseyside, covering a population of 2.4 million. Within this footprint, we are members of the North Mersey Local Delivery System and the mental health workstream.

8. Cheshire and Merseyside STP has identified priorities that would make our health and care system sustainable in the near medium and long term:

   a) Improve the health of the C&M population by:
      • Promoting physical and mental well being
      • Improving the provision of physical and mental care in the community (i.e. outside of hospital)

   b) Improve the quality of care in hospital settings by:
      • Reducing the variation of care across C&M;
      • Delivering the right level of care in the most appropriate setting
      • Enhancing delivery of mental health care

   c) Optimise direct patient care by:
      • Reducing the cost of administration
      • Creating more efficient clinical support services

9. Three priorities have been identified for early implementation by the mental health workstream:

   a) Eliminate out-of area-placements
   b) Develop integrated clinical pathways for those with a personality disorder
   c) Enhance Psychiatric Liaison provision across the footprint and establish Medically Unexplained Symptoms (MUS) service

MERSEY CARE BUSINESS PLAN 2017/18

10. Alongside the development of the NHS England required operational plan, each year the Trust develops our internal business plan, outlining the priority areas to support delivery of our perfect care strategy.

11. Review of the delivery of our plan in 2016/17, along with an assessment of our environment (including the STP) and its impact upon the organisation, has been undertaken to support the development of our plan for 2017/18.

12. Mersey Care is about to enter the fourth year of a five year plan to transform our services. The plan for 2017/18 will retain the strategic objectives set out in the strategy wheel, with the deliverables refined in order to ensure that the Trust responds to the strategic challenges its faces and continues to make progress in delivering perfect care.
13. Staff are engaged in the planning process through the Collaborative Leadership Forum and Managers’ Forum.

14. Service Users and Carers are engaged in the planning process through the Service User and Carer Assembly. The emerging priorities for the annual plan were discussed with the Assembly at its meeting in early December. Assembly members stressed the importance of ensuring that basics of care, such as customer care and communication are addressed within the Trust plan. Ensuring that all services users and carers receive standardised information and a named point of contact within 24 hours (for service users) or 72 hours (for carers) for first coming into contact with Trust services was discussed as a goal for the Trust in 2017/18 as, currently, this does not happen consistently, particularly for carers.

Emerging Priorities

15. Through environmental scanning and engagement discussions to date a significant number of priorities have emerged for consideration in the plan for 2017/18. These are outlined below at thematic level and aligned to the quadrants of our strategy, namely:

a) Our services - continuous improvements to quality;

b) Our people - supporting our people to work in better teams, to work more productively and side by side with service users and carers;

c) Our resources - creating more value from use of our IM&T (information management and technology), buildings and finances; and

d) Our future - working more effectively with other organisations, delivering tangible benefits from research and development and growing our service.
16. In order to focus efforts and resources for greatest impact in delivering our strategy, these emerging priorities will be reviewed. As shown below, the Trust must prioritise the development of a consistent operating platform in order to be a stable, high performing organisation. Furthermore, his prioritisation must also align with the prioritisation of cost pressures undertaken through the annual financial planning process.
17. Once finalised, the Trust annual plan will be presented to the Trust Board in March 2016 for approval. It will be made available in a public-facing version for service users, carers and other stakeholders.

RECOMMENDATION

18. The Council of Governors is asked to:

   a) Note this update regarding the planning process for 2017/19.

   b) Comment on the emerging priorities and the proposal to prioritise the development of ‘firm foundations, but doing the basics consistently well.’

LOUISE EDWARDS
DIRECTOR OF STRATEGY

December 2016
Sustainability and Transformation Plans

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

Finance

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

Primary care

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

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

Referral to treatment times and elective care

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

Cancer

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

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

People with learning disabilities

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

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

Membership & Engagement

Report Author(s): Sarah Jennings  
Deputy Trust Secretary

Summary of Key Issues:
- All Governors were invited to attend an informal meeting to commence discussions regarding how they wished to communicate and engage with the wider membership going forward and as such, a number of Governors attended on 28 November 2017 at Quaker Meeting House, Liverpool.
- The outcomes of these discussions are reflected in this report including a series of recommendations for consideration and approval by the Council of Governors.

Recommendation:
The Council of Governors is asked to:
1) Consider and agree the implementation the proposed mechanisms for communication and engagement outlined in paragraphs 8-15 above.
2) Approve the proposed establishment of the Membership and Engagement Committee
3) Approve the Membership and Engagement Committee Terms of Reference outlined in Appendix A;
4) Note that the Membership Strategy will be reviewed by the Membership and Engagement Committee in spring 2017 and presented to the Council of Governors for approval.

PURPOSE
1. To outline to the Council of Governors for consideration and approval, a series of proposed mechanisms in respect of membership communication and engagement recommended by Governors following a meeting on 28 November 2016.

BACKGROUND
2. In accordance with the FT Code of Governance, the Council of Governors must represent the interests of the trust members and the public and should both seek the views of and feedback to members regarding the trust, its vision, performance and material strategic proposals made by the Board of Directors.

3. Effective engagement is an essential element of Foundation Trust status and members who feel involved and listened to are likely to contribute more. The engagement of the membership is critical because it provides members with a voice, helps us to improve our services, gives the public confidence in the Trust and what we provide and creates a sense of ‘ownership’ of the Trust.
4. All Governors were invited to attend an informal meeting to commence discussions regarding how they wished to communicate and engage with the wider membership going forward and as such, a number of Governors attended on 28 November 2017 at Quaker Meeting House, Liverpool. Corporate Governance, Communications and People Participation were also represented at the meeting to participate in discussion.

5. It was agreed that the outcomes of the discussions would be reported to the Council of Governors on 12 January 2017.

PROPOSED MECHANISMS OF COMMUNICATION AND ENGAGEMENT

6. A discussion paper was circulated to those attending in advance of the meeting to provide a basis for this session.

7. The proposals in this paper reflect proposals from the Governors present regarding mechanisms of communication and engagement to the full Council of Governors.

8. **Membership and Engagement Committee**

9. All Governors present at the meeting on 28 November 2016 supported the need to establish a Membership and Engagement Committee of the Council of Governors in order to:

   a) support the Trust in developing and engaging the membership;
   b) review and oversee implementation of the Membership Strategy;
   c) develop mechanism to facilitate the communication between Governors, members and the local community.

10. There was consensus that membership of this proposed committee should not be limited to allow all interested Governors to participate.

11. Terms of Reference for a Membership and Engagement Committee have been prepared, reflecting these discussions, and are attached as **Appendix A** for approval.

12. **Governor engagement**

   a) Governors to be asked to voluntarily commit to a number of Quality Review Visits per year to gain an understanding of services provided, experience of staff and service users and to ensure Governor visibility. Information and training should be provided for Governors on the purpose and process of Quality Review Visits to ensure Governors understand what to expect and understand their individual role in these visits;

   b) A diary of events to be prepared, regularly updated and circulated to Governors to ensure sufficient notice of events;
c) Governors to voluntarily commit to attending a small number of events per year to ensure representation at all events providing opportunity to communication with constituents and awareness raising of the role of the Council of Governor;

d) Exit interviews to be undertaken for any Governors who resign as Governors to ensure the Trust understands the rationale for resignation and can learn from this;

e) A report to be prepared for the Council of Governors outlining proposed sub-Committee’s to be established such as a Quality Committee (including equality and diversity within its remit) and seek interest from Governors in terms of participation;

f) Feedback from Council of Governors Sub-Committee’s to be provided to each Council of Governors meeting by the relevant Chair;

13. Membership Monitoring and Recruitment

a) Focus to be given to communication and engagement with existing membership and not to the active recruitment of additional members;

b) Information leaflets and posters providing the following information to be developed and displayed in GP surgeries and other appropriate locations within local communities:
   - Overview of Mersey Care
   - The services we provide
   - How to become a member
   - Benefits of being a member (including NHS discounts where applicable)

14. Communication

a) People Participation Team to ensure wider and more frequent communication of the Service User and Carer Assembly and other opportunities for engagement;

b) Information on the role of the Council of Governor and details of Governors (including contact information) via a generic email to be circulated to raise awareness;

c) Mersey Care Magazine to include regular updates on individual Governors and the work of the Council of Governors;

d) Governors to be provided with key topics on a quarterly basis (i.e. internal developments / issues) to ensure Governors can cascade this in communication with constituents;

15. Membership Engagement

a) Mersey Care email addresses to be set up for each constituency to be monitored by the Corporate Governance Team and fielded to the relevant Governors (i.e.
generic staff constituency email address, generic public constituency email address, generic service user/ carer email address);

b) The Membership and Engagement Committee to consider and develop mechanisms and opportunities for membership engagement including membership events;

c) A diary of events to be prepared, regularly updated and circulated to the membership to provide opportunities for engagement;

NEXT STEPS

16. Subject to the Council of Governors approval of the recommendations outlined in the report the following steps will be taken:

a) All Governors will asked to consider whether they wish to sit on the Membership and Engagement Committee and the Terms of Reference will be finalised accordingly;

b) The proposed mechanisms for membership communication and engagement outlined in paragraphs 8-15 will be reflected in an action plan with timescales and leads, implementation of which will be overseen by the Membership and Engagement Committee.

RECOMMENDATIONS

17. The Council of Governors is asked to:

a) Consider and agree the implementation the proposed mechanisms for communication and engagement outlined in paragraphs 8-15 above.

b) Approve the proposed establishment of the Membership and Engagement Committee

c) Approve the Membership and Engagement Committee Terms of Reference outlined in Appendix A;

d) Note that the Membership Strategy will be reviewed by the Membership and Engagement Committee in spring 2017 and presented to the Council of Governors for approval.
MEMBERSHIP AND ENGAGEMENT COMMITTEE
TERMS OF REFERENCE

1 CONSTITUTION

1.1 The Council of Governors hereby resolves to establish a Membership and Engagement Committee to be known as the (referred to as the “Committee” below). The Committee is authorised by the Council of Governors to act within its terms of reference.

2 ACCOUNTABILITY

2.1 The Committee is accountable to the Council of Governors and the Council of Governors must approve any changes to these terms of reference.

3 AUTHORITY

3.1 The Committee is authorised by the Council of Governors to:

(a) investigate any activity within its terms of reference;
(b) make recommendations to the Council of Governors;
(c) act in accordance with the trust’s Constitution;
(d) subject to funding approval by the Board of Directors, request the advice of professionals or other individuals or authorities from outside of the trust with relevant experience or expertise if it considers this necessary for, or expedient to, the exercise of its functions;
(e) request such information as is necessary and expedient to fulfil its functions.

4 MEMBERSHIP

4.1 The Committee shall consist of:

(a) [the following] Governors appointed by the Council of Governors:

(i) [Drafting Note –

• it is for the Council to decide the number of Governors to be appointed to this Committee. No guidance exists which states that a certain number / proportion of Governors need to be neither members, nor that governors need to be representative of all the constituencies, although the second may be an advantageous. In considering the number to appoint the Council will also need to be mindful of the requirements to be quorate]

• as to how this membership is reflected in these terms of reference, the Council has some options]
4.2 The membership of the Committee will be disclosed in the annual report.

4.3 Only members of the Committee have the right to attend meetings, there is no provision for deputies to attend.

5 **ATTENDANCE**

5.1 The following non-voting attendees will attend meetings of the Committee:

(a) the Trust Secretary;
(b) the Deputy Trust Secretary;
(c) Membership Manager;
(d) Communications Officer;
(e) People Participation Team Representative,
(f) Minute Secretary.

5.2 The chair of the Committee may also extend invitations to other personnel with relevant skills, experience or expertise as necessary to enable it to deal with matters before the Committee, subject to paragraph 3.1(d) above.

6 **QUORUM**

6.1 A quorum shall be [insert number] members, at least [insert number] of whom must be [insert type] governors.

6.2 Non-voting attendees nor invited attendees shall not be considered when considering if the meeting is quorate.

7 **FREQUENCY**

7.1 Meetings shall be held as required, but at least a minimum of twice a year.

8 **DUTIES**

8.1 The Committee will carry out the duties below:

(a) Advise on the review and implementation of the Trust’s Membership Strategy;
(b) Evaluate progress towards achieving the objectives of the Membership Strategy and make recommendations to the Council of Governors as appropriate;
(c) Regularly review membership data;

(d) Advise on the development of effective membership recruitment mechanisms that recognise particular issues of recruiting from ‘hard to reach’ groups and will facilitate a fully representative membership;

(e) Advise on the development of mechanisms to ensure two way communications between Governors and members;

(f) Receive a report on the process for and outcome of the periodic election of Governors and make recommendations to the Council of Governors as appropriate;

(g) Advise on the process to be in place for Governors to be involved in agreeing the relevant content for the Mersey Care Magazine to ensure work of the Governors is effectively communicated to the Trust’s members and the wider public;

(h) Agree an annual report of the Committee’s activities, including progress in implementation of the membership strategy, for submission to the Council of Governors for approval;

(i) Agree an annual cycle of business for the activities of the Committee in line with these terms of reference during each financial year for submission to the Council of Governors for approval.

9 REPORTING

9.1 The Committee will have the following reporting requirements:

(a) to ensure that the minutes of its meetings are recorded and submitted to the Council of Governors, supported by a chair’s report

(b) to ensure that any issues that require disclosure to the Council of Governors are brought to the attention of the Council of Governors.

9.2 The Committee will outline its work to the Council of Governors through an annual work plan and will provide assurance to the Council of Governors of compliance with the requirements of these terms of reference through the development and presentation of an annual report, presented at the end of the financial year.

10 RESPONSIBILITY OF GOVERNORS AND ATTENDEES

10.1 Governors of the Committee have a responsibility to:

(a) attend a minimum of 50% of meetings a year, having read all papers beforehand;

(b) agree an annual business cycle for the Committee;
(c) act as ‘champions’, disseminating information and good practice as appropriate,

11 ADMINISTRATIVE ARRANGEMENTS

11.1 The Trust Secretary will ensure:

(a) that the Committee receives sufficient resources to undertake its duties;

(b) correct minutes of meetings are taken and once agreed by the chair that they are distributed to the members (unless a conflict of interest or matter of confidentiality exists);

(c) the minutes of the meeting are distributed within 10 working days of the meeting taking place;

(d) a record of matters arising is produced with issues to be carried forward;

(e) an action list is produced following each meeting and any outstanding action is carried forward on the action list until complete;

(f) conflicts of interest are recorded along with the arrangements for managing those conflicts;

(g) appropriate support to the chair and Committee members to enable them to fulfil their role;

(h) that advice is provided to the Committee on pertinent areas;

(i) the agenda is agreed with the chair prior to sending papers to members no later than five working days before the meeting;

(j) management of the Committee’s annual business cycle;

(k) the papers of the Committee are filed in accordance with the trust’s policies and procedures.

11.2 The Trust Secretary will collate the Committee’s annual report and agree the ways of working to enable the Committee to meet the wide range of responsibilities set out in these terms of reference.

12 REVIEW

12.1 Terms of reference will be reviewed at least annually by the Committee for the approval of the Council of Governors.

Version: Draft No. 1 (December 2016)
COUNCIL OF GOVERNORS

Report provided (check necessary boxes):

To Note: ☐ For Decision ☐

Paper No: COG16/17/032

Meeting Date: 14 January 2017

Chairman and Non Executive Director Appraisals

Report Author(s): Sarah Jennings
Deputy Trust Secretary

Summary of Key Issues:

• The appraisal of the Chairman and Non-Executive Directors was conducted in line with the process agreed at the previous Council of Governors meeting in September 2016.
• This report outlines the process undertaken, alongside a summary of the key outcomes.
• No significant performance issues have been identified through this process.

Recommendation:
The Council of Governors is asked to:
1) Note the outcomes of the process for the appraisal of the Chairman;
2) Note the outcomes of the process for the appraisal of the Non-Executive Directors;
3) Note the completion of the annual Fit and Proper Persons Test self-Declaration by all Non-Executive Directors;
4) Note that the appraisal process will be reviewed for 2017/18 by the Nomination and Remuneration Committee.

PURPOSE

1. The purpose of this report is to summarise the outcomes of the Chairman Non-Executive Directors’ annual appraisals and to confirm areas for their further development.

CONTEXT

2. Every Foundation Trust should be headed by an effective Board of Directors. Collectively, the Board is responsible for the performance of the NHS Foundation Trust. The NHS Foundation Trust Code of Governance states that the Board of Directors should undertake a formal, rigorous annual evaluation of its own performance and of its committees and of its individual Directors.

3. In line with Your statutory Duties: a Reference Guidance for NHS Foundation Trust Governors’, conducting performance appraisals and then reviewing the results will significantly assist the Council of Governors in performing its statutory duties, specifically when considering the potential re-appointment or removal of the Non-Executive Directors or Chairman.
4. The Council of Governors, which is responsible for the appointment and re-appointment of Non-Executive Directors, agreed the process for the evaluation and appraisal of the Chair and the Non-Executives in September 2016 following recommendation by the Nomination and Remuneration Committee.

CHAIRMAN’S APPRAISAL

5. In line with the NHS Foundation Trust Code of Governance, the focus of the Chairman’s appraisal should be their performance as leader of the Board of Directors and the Council of Governors. As such, the Chairman’s appraisal covered the following criteria:
   a) Chairing meetings of the Board of Directors and the Council of Governors;
   b) Leadership;
   c) Corporate Understanding and strategic awareness
   d) Commitment;
   e) Holding to account;
   f) Personal style;
   g) Independence and objectivity;
   h) Self-development;
   i) Impact;

6. The Senior Independent Director in December 2016 undertook the appraisal of the Chairman with the involvement of the Lead Governor, taking soundings from the Chief Executive, Executive Directors and members of the Council of Governors collated through the Lead Governor by way of 360 degree review. The appraisal of the Chairman consisted of:
   a) A self assessment form completed by the Chairman;
   b) Completion of peer assessments, on an anonymous basis, by all voting and non-voting Board members;
   c) Complete of peer assessments, on an anonymous basis, by Governors (4);
   d) Discussion of the Chairman’s performance by Non Executive Directors in the absence of the Chairman;
   e) Joint discussion between the SID, Lead Governor and Chairman regarding performance, professional and personal development based on a summary of the peer assessments and development of objectives and a personal development plan for the forthcoming year;

7. In summary, the Chairman’s performance has been confirmed as very good during a significant year when the Trust was approved as a Foundation Trust and completed the acquisition of Calderstones Foundation Trust under her leadership.

NON EXECUTIVE DIRECTOR APPRAISALS

8. Consistent with the arrangements agreed by the Council of Governors in September 2016, the trusts’ Chairman has conducted an appraisal of the Non Executive Directors in post as follows:
a) Gerry O’Keeffe (Vice Chairman and Senior Independent Director)
b) Matt Birch (Chair of the Performance, Investment and Finance Committee)
c) Pam Williams (Chair of the Audit Committee)
d) Nick Williams
e) Rob Beardall

9. Brenda Roe, Non Executive Director and Chair of the Quality Assurance Committee, was excluded from the appraisal process given her resignation as a Non-Executive Director expected to be effective from May 2017.

10. The appraisal process comprised of:

a) a competency based self assessment completed by each non-executive director which covered the following areas:
   • performance against individual objectives;
   • strategic direction;
   • holding to account;
   • influencing and communication;
   • team working;
   • intellectual flexibility;
   • patient and community focus;
   • values;
   • fulfilment of the role of Senior Independent Director (where applicable)

b) a discussion in respect of the self assessment between the Chairman and the individual Non-Executive Director;

c) Agreement of objectives with individual Non-Executive Directors and their personal development plan for the coming year;

11. All Non-Executive Directors were assessed as performing at a good level.

12. Whilst no significant development needs have been identified through the appraisal process, the common areas for development identified, and which will be incorporated into personal development plans and where appropriate, the overarching Board Development Plan are:

a) participation in visits to clinical services;

b) completion of statutory and mandatory training.

FIT AND PROPER PERSONS TEST

13. In direct response to failing at the Winterbourne View Hospital and the Francis Inquiry into Mid Staffordshire NHS Hospital Trust Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (referred to as the 2014 Regulations) was been introduced.
14. In January 2015 that Board of Directors agreed a process which has been adopted by the Trust to ensure that ‘directors’ are subject to the fit and proper persons test. This included a robust process to be undertaken on the appointment of a director (including non-executive directors) and annual review process.

15. The regulations state that ‘the fitness of directors is regularly reviewed by the provider to ensure that they remain fit for the role they are in; the provider should determine how often fitness must be reviewed based on the assessed risk to business delivery and/or the service users posed by the individual and/or role.’

16. The process for the on-going (annual) review of directors in respect of the Fit and Proper Persons Test of Directors includes a completion of a self-declaration form.

17. In November/ December 2016 all Non-Executive Directors were required to complete the annual Fit and Proper Persons Test self-declarations all of which were completed satisfactorily. A copy of this declaration is attached at Appendix A.

SUMMARY AND FUTURE APPRAISALS

18. The annual appraisal of the Chairman and Non-Executive Directors is essential to ensuring strong effective independent leadership of the trust.

19. It should be noted that feedback from Non Executive Directors during the appraisal process has identified the need to streamline the self-assessment form they are required to complete. The form was significantly more detailed than previous years and a number of Non Executive Directors have asked that this be reviewed. As such, and as agreed by the Council of Governors in September 2016, the appraisal process for the Chairman and Non Executive Directors will be further reviewed by the Nomination and Remuneration Committee and revised documentation will be presented to the Council of Governors for approval in advance of the 2017/18 appraisals.

RECOMMENDATION

20. The Council of Governors are asked to:

   a) Note the outcomes of the process for the appraisal of the Chairman;
   b) Note the outcomes of the process for the appraisal of the Non-Executive Directors;
   c) Note the completion of the annual Fit and Proper Persons Test self-Declaration by all Non-Executive Directors;
   d) Note that the appraisal process will be reviewed for 2017/18 by the Nomination and Remuneration Committee.

ANDY MEADOWS
TRUST SECRETARY
December 2016.

APPENDIX A

Fit and Proper Person Declaration

In line with the Fit and Proper Persons Regulations for Directors and Non Exec Directors, I hereby declare

<table>
<thead>
<tr>
<th>Declaration</th>
<th>Confirmed (yes/no)</th>
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<tbody>
<tr>
<td>I am of good character by virtue of the following:</td>
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<tr>
<td>• I have not been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence or charged with an offence that has not yet been disposed of?</td>
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</tr>
<tr>
<td>• I have not been erased, removed or struck-off a register of professionals maintained by a regulator of health or social care.</td>
<td></td>
</tr>
<tr>
<td>• I have not been sentenced to imprisonment for three months or more within the last five years</td>
<td></td>
</tr>
<tr>
<td>• I am not an undischarged bankrupt</td>
<td></td>
</tr>
<tr>
<td>• I am not the subject of a bankruptcy order or an interim bankruptcy order</td>
<td></td>
</tr>
<tr>
<td>• I do not have an undischarged arrangement with creditors</td>
<td></td>
</tr>
<tr>
<td>• I am not included on any barring list preventing me from working with children or vulnerable adults</td>
<td></td>
</tr>
<tr>
<td>• I do not know of any current NHS Counter Fraud and Security Management Service investigation following allegations made against me?</td>
<td></td>
</tr>
<tr>
<td>• I have not been investigated by the Police, or any other investigatory body resulting in my dismissal from employment?</td>
<td></td>
</tr>
<tr>
<td>• I am not currently the subject of any investigation or fitness to practice proceedings by any licensing or regulatory body in the UK or any other country?</td>
<td></td>
</tr>
<tr>
<td>I Have the qualifications, skills and experience necessary for the position I hold on the Board</td>
<td></td>
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<td></td>
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<tr>
<td>I am capable of undertaking the relevant position, after any reasonable adjustments under the Equality Act 2010</td>
<td></td>
</tr>
<tr>
<td>I have not been responsible for any misconduct or mismanagement in the course of any employment with a CQC registered provider</td>
<td></td>
</tr>
<tr>
<td>I am not prohibited from holding the relevant position under any other law. e.g. under the Companies Act or the Charities Act.</td>
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</tbody>
</table>

Signed: 

Name: 

Position: 

Date: 
24. **Board of Directors – disqualification**

The following may not become or continue as a member of the Board of Directors:

24.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

24.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

24.3 a person who within the preceding five years has been convicted in the British Isles of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him;

24.4 a person who is a member of the Council of Governors;

24.5 a person who is the spouse, partner, parent or child of a member of the Board of Directors (including the Chairman) of the trust

24.6 a person who is a member of a local authority’s Overview and Scrutiny Committee covering health matters;

24.7 a person who is the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

24.8 a person whose tenure of office as a chairman or as an officer or director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for nondisclosure of a pecuniary interest;

24.9 a person who has within the preceding five (5) years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

24.10 in the case of a non-executive director, a person who has

24.10.1 refused without reasonable cause to fulfil any training requirement established by the Board of Directors; or

24.10.2 refused to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for directors.

24.11 on the basis of disclosures obtained through an application to the Disclosure and Barring Service (DBS), they are not considered suitable by the trust’s director responsible for Human Resources;

24.12 they are a person who has had his name removed or been suspended from any list (including any performers list maintained by a primary care trust) prepared under the 2006 Act or under any related subordinate legislation or who has otherwise been suspended or disqualified from any healthcare profession, and has not subsequently had his name included in such a list or had his suspension lifted or qualification reinstated.

24.13 they have within the preceding five (5) years been:

24.13.1 made subject to a Hospital Order under section 37 of the MHA whether or not subject to restrictions under section 41:

24.13.2 made subject to an interim Hospital Order under section 38 of the MHA;

24.13.3 made subject to a transfer direction under section 48 of the MHA whether or not subject to restrictions under section 49; and/or

24.13.4 made subject to an order under the Criminal Procedure (Insanity) Act 1964 as amended

24.14 they have previously been or are currently subject to a sex offender order and/or required to register under the Sexual Offences Act 2003 or have committed a sexual offence prior to the requirement to register under current legislation.