Derbyshire Healthcare NHS
NHS Foundation Trust

# Meeting of the Board of Directors

# 1 February 2017

Trust Headquarters, Ashbourne Centre, Kingsway Site, Derby, DE22 3LZ
Tel: (01332) 623700
Acting Chief Executive: Ifti Majid  Acting Trust Chair: Caroline Maley

Better together

Derbyshire Healthcare NHS
NHS Foundation Trust

**NOTICE OF BOARD MEETING - WEDNESDAY 1 FEBRUARY 2017**
**TO COMMENCE AT 1.00 PM IN CONFERENCE ROOMS A&B, FIRST FLOOR, RESEARCH & DEVELOPMENT CENTRE, KINGSWAY, DERBY DE22 3LZ**

| | TIME | AGENDA | ENC | LED BY |
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| **1.** | 1:00 | Chair's welcome, opening remarks and apologies for absence | **-** | Caroline Maley |
| **2.** | 1:05 | Service Receiver Story 'The Voice of a Family' | **-** | Carolyn Green |
| **3.** | 1:30 | Declarations of Interest | **A** | Caroline Maley |
| **4.** | 1:30 | Minutes of Board of Directors meeting held on 11 January 2017 | **B** | Caroline Maley |
| **5.** | 1:35 | Matters arising – Actions Matrix | **C** | Caroline Maley |
| **6.** | 1:40 | Chair's Update | **-** | Caroline Maley |
| **7.** | 1:50 | Acting Chief Executive's Update | **D** | Ifti Majid |
| **OPERATIONAL PERFORMANCE, QUALITY AND STRATEGY** | | | | |
| **8.** | 2:00 | Integrated Performance and Activity Report | **E** | Mark Powell<br>Claire Wright<br>Amanda Rawlings<br>Carolyn Green |
| **9.** | 2:15 | Position Statement on Quality | **F** | Carolyn Green |
| **10.** | 2:35 | Board Committee Assurance Summaries and Escalations: Audit & Risk Committee 17 January, Quality Committee 12 January, People & Culture Committee 18 January<br>Ratified Minutes: Quality Committee 15 December, Audit & Risk Committee 13 December, People & Culture Committee 17 November, Extraordinary Meeting of the People & Culture Committee held on 14 December 2016 | **G** | Committee Chairs |
| **11.** | 2:45 | Emergency Preparedness, Resilience & Response (EPRR) Strategy | **H** | Mark Powell |
| **3:00 B R E A K** | | | | |
| **12.** | 3:15 | Deep Dive – Older People | **I** | Mark Powell |
| **13.** | 3:35 | Suicide Prevention Brief | **J** | John Sykes |
| **GOVERNANCE** | | | | |
| **14.** | 3:45 | Governance Improvement Action Plan Update | **K** | Sam Harrison |
| **15.** | 3:55 | Board Assurance Framework Update Issue 4 | **L** | Sam Harrison |
| **16.** | 4:05 | Report from Council of Governors Meeting held on 19 January 2017 | **M** | Sam Harrison |
| **CLOSING MATTERS** | | | | |
| **17.** | 4:15 | Any Other Business | **-** | Caroline Maley |
| **18.** | 4:20 | 2016/17 Board Forward Plan | **N** | Caroline Maley |
| **19.** | 4:25 | - Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework<br>- Meeting effectiveness | **-** | Caroline Maley |

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

*The Trust Chair may, under the Foundation Trust's Constitution, request members of the public to withdraw for the Board to conduct its remaining business in confidence as special reasons apply or because of information which is likely to reveal the identities of an individual or commercial bodies.*

**The next meeting will be held at 1.00 pm on 1 March 2017**
**in Conference Rooms A & B, Centre for Research and Development, Kingsway, Derby DE22 3LZ**
*Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.*
***Participation in meetings is at the Chairman's discretion.***

## Declaration of Interests Register 2016-17

| NAME | INTEREST DISCLOSED | TYPE |
|---|---|---|
| **Margaret Gildea**<br>Non-Executive Director | Director, Organisation Change Solutions Limited<br>Non-Executive Director, Derwent Living | (a, b) |
| **Ifti Majid**<br>**Acting Chief Executive** | Board Member, North East Midlands Leadership Academy Board | (a) |
| **Caroline Maley**<br>Acting Trust Chair | Director – C D Maley Ltd<br>Trustee – Vocaleyes Ltd. | (a)<br>(a, d) |
| **Barry Mellor**<br>Non-Executive Director | Non-Executive Director, Rotherham NHS Foundation Trust<br>Trustee, Rotherham Hospital Charity<br>Mrs Mellor is a befriender with Age UK | (a, d) |
| **Amanda Rawlings**<br>Director of People and Organisational Effectiveness (DHcFT) | Director of People and Organisational Effectiveness, Derbyshire Community Healthcare Services (DCHS)<br>Co-optee Cross Keys Homes, Peterborough | (a, d) |
| **Dr John Sykes**<br>Medical Director | Independent Deprivation of Liberty mental Health Assessor undertaking assessments on patients at the request of Derbyshire County Council via Medical Director's secretary | (b) |
| **Dr Julia Tabreham**<br>Deputy Trust Chair and Non-Executive Director | Non-Executive Director, Parliamentary and Health Service Ombudsman<br>Director of Research and Ambassador Carers Federation<br>Board member, RESTORE (supporting older offenders in the criminal justice system)<br>Lay Member - National Institute for Health and Care Excellence, Guideline Development Group, National Collaborating Centre for Mental Health of Adults in the Criminal Justice System<br>Julia Tabreham is assisting NICE (National Institute for Health and Care Excellence) to write training programmes for people providing lay advice to its Guideline Development Groups<br>Julia Tabreham has also been asked by the Department of Health to lead on the Parliamentary and Health Service Ombudsman's contribution to establishing NHS complaints advocacy support in Ireland | (a, d) |
| **Lynn Wilmott-Shepherd**<br>Acting Director of Strategic Development | Director of Commissioning at Erewash CCG | (a) |
| **Richard Wright**<br>Non-Executive Director | Director, Sheffield Chamber of Commerce<br>Chair, The Sheffield College Multi Academy Trust<br>Chair Sheffield University Technical College<br>Member of Advisory Board of Sheffield National Centre for Sport and Exercise Medicine | (a) |

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

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

# DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

## MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

**Wednesday 11 January 2017**

**MEETING HELD IN PUBLIC**

Commenced: 1pm Closed: 4:05pm

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| **PRESENT:** | Caroline Maley | Acting Trust Chair |
| | Margaret Gildea | Senior Independent Director |
| For Items DHCFT/2016/207 to 216 | Maura Teager | Non-Executive Director |
| | Dr Anne Wright | Incoming Non-Executive Director |
| | Richard Wright | Non-Executive Director |
| | Ifti Majid | Acting Chief Executive |
| | Claire Wright | Executive Director of Finance |
| | Carolyn Green | Executive Director of Nursing & Patient Experience |
| | Dr John Sykes | Executive Medical Director |
| | Mark Powell | Acting Chief Operating Officer |
| | Amanda Rawlings | Director of People & Organisational Effectiveness |
| | Samantha Harrison | Director of Corporate Affairs & Trust Secretary |
| **IN ATTENDANCE:** | Richard Eaton | Communications Manager |
| | Sue Turner | Board Secretary (Minutes) |
| For Item DHCFT/2016/213 | Libby Runcie | Professional Lead, Commissioning Differently |
| For Item DHCFT/2016/218 | Dr Chinwe Obinwa | Kedleston Low Secure Unit |
| For Item DHCFT/2016/218 | Dr Alice Levee | Kedleston Low Secure Unit |
| For Item DHCFT/2016/218 | Lisa Stone | Kedleston Low Secure Unit |
| For Item DHCFT/2016/218 | Paul Willis | Kedleston Low Secure Unit |
| For Item DHCFT/2016/218 | Rebecca Mace | Kedleston Low Secure Unit |
| For Item DHCFT/2016/218 | Ruth Green | Kedleston Low Secure Unit |
| **APOLOGIES:** | Dr Julia Tabreham | Deputy Trust Chair and Non-Executive Director |
| | Lynn Wilmott-Shepherd | Interim Director of Strategic Development |
| **VISITORS:** | John Morrissey | Lead Governor, Public Governor, Amber Valley South |
| | Gillian Hough | Public Governor, Derby City East |
| | Mark McKeown | Derbyshire Mental Health Alliance |

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| **DHCFT 2016/207** | **ACTING CHAIR'S WELCOME, OPENING REMARKS AND APOLOGIES**<br><br>Caroline Maley, who was appointed to the role of Acting Trust Chair on 1 January, opened the meeting and welcomed everyone. She welcomed new Non-Executive Director, Dr Anne Wright to the Board and made the public aware that Anne Wright will replace Maura Teager when she completes her term at the end of March. In the meantime Anne Wright will work closely with Maura Teager during the handover period. Apologies were noted as above. |
| **DHCFT 2016/208** | **SERVICE RECEIVER STORY**<br><br>Carolyn Green offered apologies to the Board for the absence of a service receiver story, and assured the Board that plans were in place for stories to be brought to the February and March meetings. |

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| **DHCFT 2016/209** | **DECLARATIONS OF INTEREST**<br><br>The Declaration of Interests register was noted. |
| **DHCFT 2016/210** | **MINUTES OF THE MEETING DATED 7 DECEMBER 2016**<br><br>The minutes of the previous meeting, held on 7 December 2016, were reviewed. The following amendment was requested:<br><br>**DCHFT2016/192 Interim Chairman's Verbal Report – page 3 of the minutes:** Ifti Majid's confirmed position to be amended from Chief Operating Officer and corrected to Acting Chief Executive. |
| **DHCFT 2016/211** | **MATTERS ARISING AND ACTIONS MATRIX**<br><br>The Board agreed to close all completed actions. Updates were provided by members of the Board and were noted directly on the actions matrix. |
| **DHCFT 2016/212** | **ACTING CHAIR'S VERBAL REPORT**<br><br>Having only been in post for eleven days, Caroline Maley commented that she could not provide an extensive update at this stage. She had attended the meeting of the Derbyshire Health and Wellbeing Board with Ifti Majid in Matlock last week and gave a brief outline of discussions.<br><br>Discussions had focussed on the Sustainability Transformation Plan (STP) and it was clear there is a lot of anxiety around the challenging contracting round currently taking place and the need to establish what the STP means to essential services. This is a good opportunity for the Trust to be involved through its integration plans with DCHS and we will try and move this forward as much as we can. Much concern had been raised about the support needed for GPs who are under pressure. The support to be given to practices to allow them to thrive was also reported upon and the actions proposed now need to be made a reality. The Health and Wellbeing Board also talked about getting the best use out of public assets and looked at collaborative ways of utilising facilities. Caroline Maley was pleased to report that the Trust is engaged in this process.<br><br>**RESOLVED: The Board of Directors noted the Interim Chairman's verbal report.** |
| **DHCFT 2016/213** | **ACTING CHIEF EXECUTIVE'S REPORT**<br><br>Ifti Majid, Acting Chief Executive, provided the Board of Directors with feedback on changes within the national health and social care sector as well as providing an update on developments occurring within our local Derbyshire health and social care community. The report also updated the Board on feedback from external stakeholders such as our commissioners and feedback from the Trust's staff.<br><br>Ifti Majid reminded the Board that at the October meeting the Board had heard how the Trust had been 'commissioning differently'. He introduced Libby Runcie, the professional lead for Commissioning Differently, who gave a gratifying update on a young service user who had finally been discharged after spending eleven years in hospital. The Board heard how the team had reacted when plans for her discharge had collapsed over the Christmas period and how they had put into place safe contingency plans which resulted in this young lady flourishing. Her repatriation will now include living-in staff assisted housing and she is very much looking forward to her future. Members of the Board commended the lateral thinking of the team and recommended their action be a lesson learned for the future. This was also an example of a team feeling empowered to act in |

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| | the best interests of people within their care.<br><br>Turning again to a local context, Ifti Majid talked about how he has noticed when visiting the wards that the level of acuity is quite noticeable in our services. It is clear that staff are worried about clinical pressures and have to work extremely hard to provide a good level of care and he was pleased to hear ideas from staff as to how we can improve our services. Staff are also concerned about changes that will arise from the STP and Ifti Majid urged people to talk to him and other members of the Board about their anxieties.<br><br>Ifti Majid informed the Board that when he attended the East Midlands Leadership Academy Board he had spoken to the Chair of Nottinghamshire Healthcare Foundation Trust and was impressed with the fact that they included a staff innovation slot at the end of their board meetings. He wished to propose to the Board that that a staff story could be included in future agendas that could focus on what it is like to work in our Trust.<br><br>The Board broadly supported this proposal as it would give staff exposure to the Board but thought it important that staff felt confident and be able to articulate sensitive issues. Ifti Majid thought it would be good to carry this out in a non-scripted way and it should be more about having a discussion with the Board and the timing and context of stories needs to be 'right' as well as managing the Board's and staff expectations. Amanda Rawlings pointed out that the People & Culture Committee receives staff stories each month and is working towards making staff feel comfortable relaying their stories. The Board heard that the team from Audrey House were attending the January People & Culture Committee meeting to talk about their recent experience moving from Vernon Street to the Kingsway site.<br><br>Margaret Gildea agreed that staff stories should be about innovation but felt these discussions would be more appropriate if they were held with staff in a less formal setting during a Board Development Session. Carolyn Green was of the opinion that staff governors could play a part in thinking about how this could work.<br><br>**RESOLVED: The Board of Directors noted the Acting Chief Executive's update and agreed to further consider closing the Public Board sessions with a staff story.** |
| **DHCFT 2016/214** | **<u>INTEGRATED PERFORMANCE AND ACTIVITY REPORT (IPR)</u>**<br><br>Mark Powell, Acting Chief Operating Officer, led the presentation of the integrated overview of performance as at the end of November 2016. The focus of the report was on workforce, finance, operational delivery and quality performance, all of which had been discussed in detail at various Board Committees over the last few weeks and is evidenced in the Board Committee Assurance Summary reports which are to be reviewed later during the meeting.<br><br>The Board noted that the key theme for month 8, which also progressed into month 9, related to ongoing staffing pressures in many of the Trust services. Also noted was the continued lower level of occupancy on wards 1 and 2 which enabled both wards to support other areas of the Trust with staff, when it has been safe to do so and showed evidence of the continued work to relieve staffing pressures. The report also included developing plans to close either ward 1 or 2 to enable a more managed approach to redeploying staff into inpatient and community teams to alleviate staffing pressures.<br><br>The Trust continues to deliver a good overall performance against many of its key indicators across November although the graphs in the report did highlight a number of challenged areas. Mark Powell was pleased to point out that good progress has been made with various actions relating to the Care Quality Commission (CQC) warning notice and he is expecting to meet with the CQC later this month to discuss the progress made.<br><br>The Board noted that the forecast for agency expenditure has increased and the level for |

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| | the final quarter of the year will cross the threshold to an agency Use of Resources score of 4. This means the overall year-end rating would be restricted to 3. Claire Wright informed the Board that she anticipates that the Trust will end the year having reached its control total surplus. She further mentioned that NHSI are requesting organisations to consider whether they are able to improve their final control total. She wished to make the Board aware that because the Trust is on target to deliver its control total she has taken the decision to adjust financial risk 4a from extreme to high on the Board Assurance Framework. In response to Caroline Maley's question as to how far the gap has closed as at month 9, Claire Wright explained she is hoping that by next month's Board meeting she will be able to report that the gap will have, in effect, closed.<br><br>Amanda Rawlings outlined the work undertaken to fill vacancies and hopes to soon see the benefits of measures being taken to recruit to medical and clinical posts. Ifti Majid asked what safer staffing protocols are in place for moving staff from a stable workforce to help in other areas. Mark Powell responded that he and the operations team have given thought to the challenges of redeploying staff. Quality protocols are currently being developed to move Wards 1 and 2 to a single ward to enable them to become self-sufficient. Maura Teager asked if there is a willing cohort of staff prepared to work in different areas and it would seem that some staff view this as a positive route to develop their skills and experience.<br><br>Discussion took place regarding the vulnerability of staff and patients during night shifts and adjusting shifts to compensate for this. Carolyn Green informed the Board that she has tried to introduce twilight shifts but this has not been attractive to staff on the wards although it has worked well with the Crisis Team. Twilight shifts, flexible working, skill mixing and making rosters more attractive is being discussed by the Quality Committee which will be reported to the Board through the Assurance Summary reports and Quality Committee minutes.<br><br>Mark Powell drew attention to the targets from the NHS Improvement Single Oversight Framework, which was a new addition to the report this month and asked the Board to consider any further additions that it would like contained in the report in future or issues that need to be included in the staffing framework. He undertook to circulate the Single Oversight Framework model to the Board outside of the meeting. Claire Wright welcomed this addition to the report; she thought it would be good to cover explicit issues that need to be included in compliance returns to NHSI.<br><br>It was noted that the early warning system and DTOC (Delayed Transfer of Care) and target for DTOC has significantly reduced since the beginning of December down from 7.5% to less than 1%. Mark Powell informed the Board he intends to start mapping risks and mitigations relating to DTOC through some of the Board Committees and will endeavour to include this data in the report due to be received at the April meeting.<br><br>The Board considered the content and style of the report and discussed all aspects of the IPR metrics and process of reporting and agreed that this month's executive summary was particularly effective. Caroline Maley thought the quality section had too many indicators and delegated the Quality Committee to oversee quality priorities and CQUINS. Carolyn Green and Mark Powell agreed to look at this outside of the meeting and agreed to take on board the suggestions made. He will ensure future reports contain enhanced data that will allow Board members to see the results and be assured of the decisions taken on a day to day basis.<br><br>**ACTION: Mark Powell will circulate a draft of changes made to the IPR to Board members for comment in advance of April, this will include KPIs taken from the single oversight framework.**<br><br>**ACTION: Quality Committee delegated to oversee quality priorities and CQUINS.** |

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| | **RESOLVED: The Board of Directors**<br>**1) Considered the content of the paper and level of assurance on current performance across the areas presented.**<br>**2) Discussed amendments to the Integrated Performance Report to align it more clearly to the Single Oversight Framework and high risk areas contained in the Board Assurance Framework.** |
| **DHCFT 2016/215** | **<u>POSITION STATEMENT ON QUALITY</u>**<br><br>Carolyn Green presented the statement to provide the Board of Directors with an update on the organisation's continuing work to improve the quality of services provided in line with the Trust's Strategy, Quality Strategy and Framework and strategic objectives.<br><br>The report set out:<br><br>1. Care Quality Commission (CQC) report, family liaison, access to psychological therapies and suicide prevention. Influencing the system and monitoring<br>2. Quality leadership engagement<br>3. Quality visits and methodology<br>4. Quality leadership teams and CQUIN (Commissioning for Quality Innovation) developments and leadership and engagement strategy<br>5. Action planning<br><br>The report covered the principles of family liaison service and duty of candour Carolyn Green assured the Board that this is regularly worked on through the Quality Committee. It was disappointing to note that the Derbyshire completed public health suicide rate has risen and that this is a significant rise, it was noted that the area had a below average performance and this is now rising and is a strategic concern for the community. (see attached papers for full details of percentage and rate in detail) . Ifti Majid asked John Sykes if he was aware of any profiles that have caused any increase in suicide and it would appear that academic evidence shows this is associated with the economic climate and is linked to austerity. Work related stress in sub-groups was also considered to be a possible contributory factor and John Sykes suggested that a deep dive in could be scheduled in the near future. The Board felt this would help the Health and Wellbeing Boards and Public Health be re-briefed and the Trust has a role in supporting the community and championing suicide prevention and recommended that a suicide prevention brief be prepared for the Board in the February meeting.<br><br>Barry Mellor asked about the inspection by the CQC to the Kedleston Unit. Carolyn Green reported that teams were well prepared and the CQC thought they were making headway against requirements and evidence of this could be seen in the deep dive taking place later in the meeting. It was noted that until a report is received all feedback is high level feedback.<br><br>Transfer and transitions were highlighted specifically by Carolyn Green as a CQUIN which may be a difficult aspect to achieve, this was specifically from CAMHS to adult mental health services and transition in Children's service is an area that needs to be improved. The Board noted that brainstorming sessions are taking place which will be progressed through the Quality Leadership Teams in their CQUIN improvement plan led by Deputy Director of Nursing and Quality Governance Darryl Thompson.<br><br>**ACTION: Suicide Prevention Brief to be submitted to the February Board meeting.**<br><br>**RESOLVED: The Board of Directors**<br>**1. Received and noted the Quality Position Statement**<br>**2. Gained assurance and information on the content of the statement.** |

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| **DHCFT 2016/216** | **BOARD ASSURANCE SUMMARIES & ESCALATIONS**<br><br>Assurance summaries were received from the Audit & Risk Committee held on 13 December and the Quality Committee on 15 December 2016. The following points were noted:<br><br>**Audit & Risk Committee**<br><br>Caroline Maley chaired the meeting on 13 December and had raised concern that internal audit findings were not –prioritised and actioned appropriately and asked that internal auditors give priority to this in future reports to the Committee. The Section 132 Patient Rights audit focussed on issues raised by the CQC and was referred to the Mental Health Act Committee to ensure compliance is followed through and the Executive Leadership Team will monitor the actions put in place.<br><br>**Quality Committee**<br><br>It was noted that no escalations were made to the Board or other Board Committees. Sustained headway is being made on the CQC action plan which the Quality Committee leading and was a very positive result from the meeting.<br><br>Ratified minutes of the meetings of Quality Committee held on 10 November and the Audit & Risk Committee on 11 October 2016 were included for information.<br><br>Maura Teager left the meeting at this point (2.45pm).<br><br>**RESOLVED: The Board of Directors received the Board Committee Assurance Summaries and Escalations.** |
| **DHCFT 2016/217** | **GOVERNANCE IMPROVEMENT ACTION PLAN (GIAP)**<br><br>Sam Harrison presented the GIAP report which provided Board members with an update on progress on the delivery of the GIAP.<br><br>The report reaffirmed the oversight committee for core areas of the GIAP and highlighted the lead director for each.<br><br>Sam Harrison pointed out that at their meeting on 19 December ELT had reviewed a report which highlighted the pipeline of planned completion of blue action forms for all GIAP recommendations. This resulted in eleven blue forms being presented to the Board for completion. Two recommendations were noted to be 'Off Track' and mitigations and further information provided was discussed and noted. Three items remain with some issues and detail of actions being taken to work towards completion were noted. This was seen as a significant step towards completion of the GIAP and Sam Harrison proposed to bring the report to the Board next month to show the completion timeline.<br><br>The blue completion forms were reviewed in turn and presented by their relevant Lead Director. Details of action taken, evidence supporting the action and plans to ensure that work was embedded in the organisation as business as usual was noted. Board members noted these details and received assurance that these forms had been scrutinised and challenged by their respective oversight Board Committees. Sam Harrison raised that in order for effective monitoring of recommendations to take place, relevant items would be added to the forward plan and where relevant the Terms of Reference of the People & Culture Committee.<br><br>Attention as drawn to the amber rated WOD7 and the Board was pleased to note that a paper will be brought to the January meeting of the People & Culture Committee that will close off this recommendation. |

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| | The Board reviewed the blue completion forms and was pleased to close off a significant amount of actions and was satisfied that this process is improving the way the Trust operates.<br><br>**ACTION: Monitoring and reporting to form part of forward planning for the People and Culture Committee and will be incorporated into the Committee's annual work plan for 2017/18**<br><br>**RESOLVED: The Board of Directors:**<br><br>**1) Noted the progress made against addressing GIAP recommendations**<br>**2) Discussed the areas rated as 'off track' and 'some issues', and obtained assurance on the mitigation provided**<br>**3) Formally approved the 11 blue forms as presented and confirmed that these are now complete namely:**<br>• **HR1**<br>• **HR2**<br>• **HR5**<br>• **PC1**<br>• **PC6**<br>• **CorpG2**<br>• **CorpG9**<br>• **CorpG10**<br>• **CorpG12**<br>• **CorpG13**<br>• **CQC1**<br>**4) Agreed at the end of the Public Board meeting whether any further changes are required to the GIAP following presentation of papers, outcomes of item specific discussions and/or other assurances provided throughout the meeting.** |
| **DHCFT 2016/218** | **<u>DEEP DIVE – KEDLESTON UNIT</u>**<br><br>Dr Chinwe Obinwa, Dr Alice Levee, Lisa Stone, Paul Willis, Rebecca Mace and Ruth Green joined the meeting to present a deep dive into the Kedleston Low Secure Unit.<br><br>The service is based on the Kingsway site and cares for males over the age of 18 and provides assessment, treatment and rehabilitation of patients with severe mental illness who have committed an offence or present a risk of aggression or violence to others. The Board heard how the Kedleston Unit embraces a recovery-focussed approach with patients providing a high standard of treatment and care and aims to provide a therapeutic but homely environment where patients thrive and take greater ownership of their journey towards recovery.<br><br>A key challenge for the team was receiving the disappointing CQC Rating of ''Inadequate' in June 2016 when the CQC raised concern with areas including capacity to consent, individualised care planning, HCR-20 risk assessment document completion as well as the physical environment of the unit. The Board heard how the unit was re-inspected in December by the CQC and received positive feedback when staff were praised with the improvements that had been put in place around person-centred care planning and saw that capacity assessments were now present. Extensive refurbishment of the unit is now of a good quality and plans are in place for further improvement. Improved communication is now taking place with NHS England.<br><br>The CQC also criticised the unit for not fully complying with the Mental Capacity Act. The Board heard how the service constantly assesses patients' capacity and this is now captured in the Electronic Patient Record system. The team wished to point out to the |

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| | Board that the CQC inspection in June took place at a time when the unit was transitioning from paper records to the EPR system. The system was new to them and meant they were perceived not to have been capturing this detail as well as they could have been. The team has also had to face the challenge of not having a stable management team in place and issues have been felt around staffing and the service has suffered from limited resources in occupational therapy and psychology and there is no team social worker.<br><br>Since the CQC visit took place in June person-centred planning has improved. This takes place through quality discussions with patients and documents the priorities of each individual. The team pride themselves on keeping patients safe throughout their rehabilitation so they can move on with their lives.<br><br>The Board was told how HCR-20 assessments are taking place to look at the health aspects of individuals. This is now a priority that is embedded into the ethos of the team and the process follows the person through their rehabilitation progress.<br><br>The team described the associated difficulties experienced as a stand-alone unit. The team has to transfer to the community some patients who have committed quite serious offences and explained how it is difficult to bring in staff to work in this low secure unit. Trained staff need to be on hand at all times due to the unstable nature of some of the patients who sometimes may need to be restrained.<br><br>Ifti Majid asked the team how the Board could support them more. The team responded that they constantly face challenges within the local government structure and local forensic services and Board support in this area would be helpful.<br><br>Amanda Rawlings offered support with recruitment and heard that lack of staffing was no longer an issue but the unit would benefit from a dedicated social worker. Having a dedicated social worker who is familiar with each case would help patients to be discharged quicker.<br><br>Carolyn Green invited the team to go with her to see how the Quality Leadership Teams (QLT) are working as some of the things the team described are being progressed through the QLTs and it would help to be able to share intelligence.<br><br>The Board appreciated hearing about the improvements the team have made as well as areas they want to improve and acknowledged the clinical challenges they are facing. Caroline Maley congratulated the team on their achievements and thanked them for sharing with the Board the great work they are carrying out.<br><br>**RESOLVED: The Board of Directors received and noted the deep dive into the Kedleston Low Secure Unit** |
| **DHCFT 2016/219** | **<u>REPORT FROM COUNCIL OF GOVERNORS MEETING HELD ON 14 DECEMBER 2016</u>**<br><br>Sam Harrison presented the report which provided a summary of issues discussed for noting by the Board.<br><br>At the Council of Governors held in private session on 14 December, governors discussed arrangements and recommendations from the Nominations & Remuneration Committee regarding the appointment of the Acting Trust Chair.<br><br>The Council of Governors also convened in public session on 14 December. Items addressed included the outcome of the ballot to appoint Caroline Maley as Acting Trust Chair. Lead governor and deputy governor arrangements were also discussed which involved extended terms of office for two public governors as well as the current Lead |

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| | Governor's role.<br><br>**RESOLVED: The Board of Directors noted the summary report from the Council of Governors** |
| **DHCFT 2016/220** | **ANY OTHER BUSINESS**<br><br>No items were discussed. |
| **DHCFT 2016/221** | **2016/17 BOARD FORWARD PLAN**<br><br>The forward plan will be carried forward to next year. Board Effectiveness survey is due to be carried out in February.<br><br>**RESOLVED: The Board of Directors noted the forward plan for 2016/17.** |
| **DHCFT 2016/222** | **IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK OR GIAP**<br><br>Financial risk 4a from extreme to high on the Board Assurance Framework and is noted in item DHCFT 2016/214 above.<br><br>**RESOLVED: The Board of Directors agreed to the adjustment of Financial Risk 4a.** |
| **DHCFT 2016/223** | **MEETING EFFECTIVENESS**<br><br>The Board agreed the meeting had been effective. Mark Powell proposed to work with teams so they understand the assurances the Board is seeking during deep dive items. |

The next meeting of the Board held in Public Session will take place at 1pm on Wednesday, 11January 2017.

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

| | | | | BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - FEBRUARY 2017 | | | Enc C |
|---|---|---|---|---|---|---|---|
| **Date** | **Minute Ref** | **Item** | **Lead** | **Action** | **Completion Date** | **Current Position** | |
| **25.5.2016** | **DHCFT 2016/080** | Deep Dive - Neighbourhoods | Claire Wright | Building requirements of Neighbourhood teams in STP developments and as part of the Estates strategy to be considered by Claire Wright. | 2.11.2016 | The next 6 monthly progress update of the Estates Strategy will be received by the Finance and Performance Committee on 23 January and will cover neighbourhood estate requirements and will also include a section summarising progress with the Derbyshire STP estates workstream. ACTION COMPLETE | Green |
| **07.12.16** | **DHCFT 2016/202** | Deep Dive – Eating Disorders Service | Ifti Majid | Ifti Majid to include information on the Eating Disorders Service in a scheduled presentation to the Health & Wellbeing Board in January. | 11.01.2016 | Information on the Eating Disorders service presented to the Derby City Health & Wellbeing Board on 19 January ACTION COMPLETE | Green |
| **11.1.17** | **DHCFT 2016/214** | Integrated Performance Report | Mark Powell | Mark Powell will circulate a draft of changes made to the IPR to Board members for comment in advance of April, this will include KPIs taken from the single oversight framework. | 26.4.2016 | IPR to be submitted to April Board meeting to include KPIs taken from the single oversight framework. | Yellow |
| **11.1.17** | **DHCFT 2016/214** | Integrated Performance Report | Carolyn Green | Quality Committee delegated to oversee quality priorities and CQUINS | 1.2.2017 | Quality priorities and CQUIN are already delgated to the Quality Committee and are contained in the Committee's Terms of Reference ACTION COMPLETE | Green |
| **11.1.17** | **DHCFT 2016/215** | Position Statement on Quality | John Sykes | Suicide Prevention Brief to be submitted to the February Board meeting | 1.2.2017 | Suicide Prevention Brief received for February meeting ACTION COMPLETE | Green |
| **11.1.17** | **DHCFT 2016/217** | GIAP Update | Amanda Rawlings Sam Harrison | Monitoring and reporting to form part of forward planning for the People and Culture Committee and will be incorporated into the Committee's annual work plan for 2017/18 | 1.3.2017 | Amanda Rawlings to work with Sue Turner to incorporate agreed monitoring and reporting of GIAP into People & Culture Committee's forward plan and terms of reference where relevant. | Amber |

| | | | |
|---|---|---|---|
| **Resolved** | **GREEN** | 4 | 66% |
| **Action Ongoing/Update Required** | **AMBER** | 1 | 17% |
| **Action Overdue** | **RED** | 0 | |
| **Agenda item for future meeting** | **YELLOW** | 1 | 17% |
| | | 6 | 100% |

**Derbyshire Healthcare NHS Foundation Trust**
Report to Public Board of Directors 1 February 2017

## Acting Chief Executives Report to the Public Board of Directors

**Purpose of Report:**

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

**National Context**

1. The Department of Health has released its third progress report of the cross-government outcomes strategy to save lives following the publication of the National Suicide Prevention Strategy in 2012. This report gives case examples to support best practice development focussing on high risk groups including men under 50, young people and new mothers. The document makes clear recommendations associated with those people in specialist mental health services and importantly talks about wider social and economic influencers. The health Select Committee has made the following recommendations that are also included in the report:

    - Better and more consistent local planning and action by ensuring that every local area has a multi-agency suicide prevention plan in 2017, with agreed priorities and actions.

    - Better targeting of suicide prevention and help seeking in high risk groups such as middle-aged men, those in places of custody/detention or in contact with the criminal justice system and with mental health services.

    - Improving data at national and local level and how this data is used to help take action and target efforts more accurately.

    - Improving responses to bereavement by suicide and support services

    - Expanding the scope of the National Strategy to include self-harm prevention in its own right.

    This document will be reviewed by the Derbyshire Suicide Prevention Strategy Group.

2. The Government have now formalised their response to the Five Year Forward View for Mental Health. The report sets out the Governments response to the work of the mental health task force clearly accepting all recommendations. This report should be read in conjunction with NHS England's document Implementing the Five Year Forward View for Mental Health. In addition it should be noted that the Government have made the following commitments:
3.

- Publish a Green Paper on children and young people's mental health later this year, to contain new proposals for both improving services across the wider system and increasing focus on preventative activity across all delivery partners

- Supporting schools, colleges and local NHS services to work more closely together to provide dedicated children and young people's mental health services, by evaluating emerging models and approaches, to explore the impact closer working can have. This will be supported by funding the provision of mental health first aid training for teachers in secondary schools

- Launch a programme of pilot activity on peer support for young people with their mental wellbeing. The pilots will test the provision of well-trained mentors within a comprehensive support structure in schools, colleges and community settings, as well as online support and resources, to help identify issues and prevent them from escalating

- A programme of randomised control trials of promising preventative programmes, to test three different approaches to mental health promotion and the prevention of mental health illness. The results of these trials will help to give schools the information they need in deciding which programmes are most effective for their pupils

- Request that the Care Quality Commission undertakes an in depth thematic review of children and young people's mental health services in 2017/18

- NHS England will expand its delivery of digitally enabled mental health services

- Examining the best way for employers to register their commitment to the mental health of staff, and undertake a review of how people with mental ill-health in the workplace might suffer discrimination

- The Government will, with the organisation Money and Mental Health, undertake a review of the process through which people in debt inform creditors about their mental health

- The Government will also extend the current improving places of safety programme, with a further investment of up to £15m, to improve access to health based places of safety and provide and promote new models of community based care for people in mental health crisis.

As we move through the clarification process associated with our contract for 2017 to 2019 we will ensure commissioners are aware of the above direction of travel.

4. Public Health England has produced a report detailing the impact of alcohol on public health and how effective alcohol control policies have been. This report is essential as in recent years, many indicators of alcohol-related harm have increased. There are now over 1 million hospital admissions relating to alcohol each year, half of which occur in the lowest three socioeconomic deciles. Alcohol-related mortality has also increased, particularly for liver disease which has seen a 400% increase since 1970, and this trend is in stark contrast to much of Western Europe. In England, the average age at death of those dying from an alcohol-specific cause is 54.3 years. The average

age of death from all causes is 77.6 years. That said some positive trends have emerged over this period, particularly indicators which relate to alcohol consumption among those aged less than 18 years, and there have been steady reductions in alcohol-related road traffic crashes.

It is noted that there are three key influencers of alcohol consumption – price (affordability), ease of purchase (availability) and the social norms around its consumption (acceptability) – many policies have been developed with the primary aim of reducing the public health burden of alcohol. This review evaluates the effectiveness and cost-effectiveness of each of these policy approaches. As the provider of integrated drug and alcohol services for Derby City and the County of Derbyshire the themes contained in this report are key to our local service delivery strategy.

**Local Context**

5. On 19 January I made a presentation to the Derby City Health and Wellbeing Board (HWB) detailing the current challenges, opportunities and innovations within local mental health services, including the issues discussed at Board relating to using low BMI as only entry criteria for eating disorder services and how that corresponds to the Derbyshire Sustainability and Transformation Plan. Key messages form me included historical underfunding in mental health services and the parity agenda, significant capacity risks due to demand growth and the importance of mental health interventions in supporting people live physically healthier lives as well as the mortality gap between people with and without a major mental illness. The presentation was well received and supported strongly by the Chair of the HWB and the Police and Crime Commissioner. The Chair of the HWB has offered to form a formal mental health sub group to support campaigning for investment into the sector.

6. Derbyshire Chief Executives/officers have now agreed the terms of reference for the financial stocktake review of our Sustainability and Transformation Plan. In addition this review will seek to understand using the original principles for collaboration developed by the system, each Organisations commitment to ongoing system leadership and development.

**Within our Trust**

7. On 13 January I met our Junior Doctors at their regular academic meeting. Meeting regularly with trainee doctors is a great way of getting a dip test of how it feels to work in the Trust. We discussed some of the national drivers and what it means locally, parity of esteem and issues with rising suicide rates in Derbyshire. I received some key feedback about how important it is to trainee doctors to work in well-coordinated teams and to feel a part of services, having their voice heard.

8. Board members may be aware that on 9 December I commenced a weekly email to all staff in our Organisation called *The Weekend Note*. The purpose of the email is create an alternative route for staff to get information about the Trust and the Health Community, hear what I am doing and what decisions are being made or discussions being had at senior forums in the Organisation. I purposely have aimed for a more informal approach to communication to augment the more formal weekly connect and all staff emails we also use. Primarily I wanted to generate dialogue and conversation through the Organisation. To date (mid-January) I have received in the region of 120 responses form staff. These responses are sometimes simply saying they like the

emails saying have a good weekend but also include people sharing best practice, asking for clarity around topics I have mentioned, requesting team visits and even sharing concerns. Feedback from staff has been overwhelmingly positive, liking the informal style and in a number of cases describing it helping them to feel connected to the Trust. Two or three people have wondered about the length of the emails and two people questioned the content and not liking the informal nature of the emails. Early days but from feedback this seems to be an engagement approach that resonates in the Trust.

9. During January we had re-visits from the Care Quality Commission to our Older Adults In-Patient services and our Children's Universal and Specialist Services. The Board is already aware of the visit to the Kedleston Unit. We have not had formal feedback at the point of writing this report but the CQC inspectors did comment on how caring our staff were and how professional they were during the inspection process. My thanks to all our staff involved in these regulatory processes.

10. When I see some innovative practice I do like to share it with the Board and through the 'weekend note' I became aware of how some of our teams, thank you Kelly Woodward, were using local connect as a dynamic local web portal that contained all the information needed by the team to ensure efficient running of the service, so for example agency rules, Q&A around technology use, PADR completion rates, annual leave planning and so on. I was struck with both the simplicity and comprehensiveness of the approach and can see how it directly links to our Trust strategic priorities around improving quality and involving/engaging staff.

11. Ahead of the processes we have in place to declare our compliance with the EDS2 standard for 2017/18 we have a specific focus session at the Board Development on 8th March. As a way of increasing challenge and discussion at the Board associated with all 'Regards' (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual Orientation) groups I would like to propose we consider the identification of Board level 'Regards Champions'. These champions would learn more about a specific focus group relating to our Regards communities both people who interact with our services and our staff. I would ask Board members to consider this approach ahead of discussing at the Board Development session in March.

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

**(Board) Assurances**

- Our strategic thinking includes national issues that are not immediately in the health or care sector but that could be of high impact.
- The Board can take assurance that Trust level of engagement and influence is high in the health and social care community
- Feedback from staff is being reported into the Board

**Consultation**

- The report has not been to any other group or committee

**Governance or Legal Issues**

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

**Equality Delivery System**

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

**Recommendations**

The Board of Directors is requested to:

1) Note the contents of the update
2) Consider the request for 'Regards Champions' from the Board to be discussed further at the next development session

**Report presented by:**

**Ifti Majid**
**Acting Chief Executive**

**Report prepared by:**

**Ifti Majid**
**Acting Chief Executive**

**Derbyshire Healthcare NHS Foundation Trust**
Report to Board of Directors – 1 February 2017

# Integrated Performance Report Month 9

## Purpose of Report

This paper provides Trust Board with an integrated overview of performance as at the end of December 2016. The focus of the report is on workforce, finance, operational delivery and quality performance.

## Recommendations

The Board of Directors is requested to consider the content of the paper and consider their level of assurance on current performance across the areas presented.

## Executive Summary

The Trust continued to perform well against many of its key indicators during December. This Executive Summary provides an overview of the some of the key issues during the month, assurance in a number of challenged areas and a forward view of some future risks and/or issues Board members need to be aware of.

The key theme for month 9 continues to be one of ongoing staffing and activity pressure in many of the Trust's services. This is highlighted by the difficulty in achieving 100% Registered Nurse fill rates for night shifts on our inpatient wards. Although mitigated by extra Nursing Assistant cover this continues to be a concern which is being closely monitored.

Activity pressures on both Radbourne and Hartington Units are highlighted by very high bed occupancy across all wards. During December there continued to be patients placed Out of Area (OOA) because the Trust had no beds available. This also resulted in Royal Derby Hospital (RDH) reporting 1 x 12 hour trolley breach for a patient who required an acute adult inpatient bed which took significant time to source due to very limited availability nationally. This pressure has continued into January where there have been further breaches against the 12 hour trolley indicator. These include both adults (waiting OOA beds) and children (access to CAMHS Tier 4 beds). Board members can be assured that the Trust is involved in, and supports, acute Providers sourcing beds for these patients. In addition, COO is working with NHSI and RDH to seek support in engaging NHSE about the issue of access to Tier 4 beds as they are the commissioner of this service.

The exception to this context has been the continued under occupancy on wards 1 and 2 which has enabled a temporary amalgamation of these wards as discussed as last month's Board meeting, thus releasing staff to be placed in other services across the Trust on a temporary basis.

Set against this context though is small incremental improvements in some of the Trust's key performance areas; including safeguarding and Think Family training, a small reduction in

vacancies and lower in month agency spend. This is also underpinned by continued stability in many of the Trust's key indicators.

Quality Performance

During the month quality performance focus has remained on addressing the issues arising from the Trust's recent Care Quality Commission (CQC) inspection report. Clinical and operational teams, led by the Director of Nursing and Patient Experience have been working on the existing plan and the data requests for additional service visits to the Kedleston unit. We do envisage further unannounced visits throughout January 2017.

A number of the Trust's Committees received assurance on CQC plans.

Some of the key areas of sustained focus have been on:

- Maintaining Fire warden training compliance, with Campus teams improving back to over 75% following the change in the eligible group has been sustained this month.
- Safeguarding children's training at Level 3 which has increased and is now over 70 percent+ with Childrens services exceeding their target at over 90% compliance. There is a trajectory which will see compliance reaching over 85% in January 2016. There is improved performance required for medical staffing and an exception report has been provided to the Medical Director and his medical management support team and this data has been reviewed, cleansed and a requirement for staff to complete training has been issued.
- Ensuring that supervision and appraisals are recorded. This continues to improve in Neighbourhoods and Childrens services and in some areas is still challenging which impacts upon our Trust wide overall position with the Deputy Director of Operations taking oversight of the mitigation plan. Significant improvement has been made in management supervision and further improvement in clinical supervision is required to meet our own required standards. Month on month movements are very sensitive to working periods and the available days for supervision may have been impacted upon by the seasonal leave period.
- Reports on the capacity of teams such as Care co-ordination in mental health community teams has been reviewed and pressure on the teams remains significant and plans to mitigate this have not currently been established with our commissioners.

The use of CQC portals 1 and 2 action tracker has enabled an integrated approach to managing competing priorities and there continues to be extensive activity across all service lines to focus on environmental, clinical, policy and organisational governance priorities.

The quality committee has received up-dates on the Positive and safe training review and further information on the new training programme will be provided in Q4.

The number of concerns has increased, at this time; we are viewing this as a positive indicator and the ability to resolve complaints at a lower level of intervention.

This month sees the inclusion of complaints response time performance data and although the immediate acknowledgement letters have significantly improved from last year's response times there are performance improvement requirements with regards to completing complaints investigations and finalising the full complaint. This performance has slipped and has been

identified by the Executive Leadership team as an area that requires investment in a small team of investigators both for serious incidents and complaints to improve this performance. The job descriptions and service model to mitigate this risk have been designed and are in process of finalisation. This model will be prioritised for recruitment and we plan to have this service operational prior to the end of the financial year.

Operational Performance

Overall performance remains relatively stable, with all of the new activity based Single Oversight Framework indicators being achieved except for Early Intervention in Psychosis referral to treatment.

The early intervention in psychosis referral to treatment incomplete target was not met. This was a result of recording error linked to referral reasons. The records have since been corrected and the Board can be assured that future performance will not be affected by this, with January back on track and above target.

There are a number of areas where performance remains variable, with further detail provided in the main body of the report.

Key areas of note are as follows;

The Trust's new Delayed Transfer of Care (DTOC) target has been set very low by NHS England at 0.8% which is below the rate currently being achieved and much lower than the former national target for mental health trusts of 7.5%. The Trust is going to find it very difficult to meet this new target and therefore is seeking to discuss the rationale and methodology with NHSE. Board members should note that the main reasons for delays are public funding, housing and awaiting residential home placements, all issues that are largely beyond our control.

Performance is calculated using occupied bed days in the given month as the denominator. The smaller the denominator becomes, the higher is the apparent rate of delayed transfers. In calculating our target, NHSE have estimated that we will have 8384 occupied beds in March 2017 and 8113 occupied beds in September 2017. In reality we have seen a year on year decrease in bed occupancy. If the current pattern continues we would expect to see 8.5% fewer occupied bed days and 32.5% more delayed days than is estimated by NHSE.

Performance for outpatient letters targets is a cause for concern. Whilst current under performance is due to sickness and annual leave having a significant impact on capacity, further assurance has been sought from the General Manager that agreed actions are robust enough to deliver improvement to target and can be sustained This will be reviewed at Trust Management Team and reported back through this report in March.

The number of outpatient appointments cancelled by the Trust continues to be high. The main reasons were sickness absence /no consultant, both of which relate to short episodes of sickness from a small number of Doctors.

Financial Performance

The year to date, and forecast score, from the Use of Resources (UoR) metrics is unchanged

from last month: our overall UoR is a 3. Four of the five metrics are strong at 2, 1, 1 and 1, but the fifth metric, agency spend against ceiling, remains at 4, and that triggers an override that restricts the overall rating to a 3.

When considering the impact of agency on the Trust overall Use of Resources rating: to avoid triggering the override, the Trust would need to spend £360k less than forecast (i.e. to spend less than 50% above ceiling by the end of March). If that were the case, the overall use of resource rating of the Trust would be 2 not 3.

In surplus terms, the Trust remains ahead of plan cumulatively for the year to date, with a trajectory to return to planned control total by year end due to the aggregate impact of changes in the run rates of costs and income at year end.

Since last month there has been a favourable development that means the previously unmet CIP gap has been ameliorated. Aside from that however, in forecasting the achievement of the control total surplus, the Board are aware that it still assumes the mitigation of some significant risks, the risk of income clawback by commissioners, the potential for backdated pay which is not yet fully quantified, ongoing pressures in agency costs and out of area Psychiatric Intensive Care Unit costs.

Early planning continues for cost improvement action required to reach 17/18 control total financial plan. Whilst early plans exist for some of the Trust CIP of £3.85m (at our risk) the Commissioner-driven QIPP disinvestment of £3.05m (at commissioner risk) is not yet defined.

<u>People Performance</u>

In December we saw a slight movement in a number of our people metrics. Compulsory training decreased to 86.94% and remains below our 90% target but is above our CQUIN target of 85%. There has been a slight improvement in appraisal completions to 74.28% but this is still below the target of 90%. Staff attendance remains a significant challenge to the trust at 6.55% against a target of 5.04% which is very high against comparable trusts. The People and Culture Committee in February will be receiving an action plan of how we plan improve our attendance rate.

During the month our agency usage has reduced slightly due to the close monitoring and recent actions we have taken as a trust but there is still a long way to go. Our vacancy rate has reduced slightly in the month due to increased recruitment of qualified nurses and there is an ongoing focus on all clinical vacancies which is supported by a detailed action plan which was discussed at the People and Culture Committee. The action plan covers how we plan to tackle each vacancy and includes campaigns and open days across the UK, incentives where necessary and introducing overseas recruitment for hard to fill posts.

Our recruitment process is improving with changes to the approval process and the introduction in March 2017, E-Recruitment, using TRAC system, will enable managers and potential employees to utilise a streamlined, interactive and responsive process, which would reduce or eliminate paperwork and unnecessary delays.

**Strategic considerations**
This paper relates directly to the delivery of the Trust's strategy by summarising performance across the four key performance measurement areas.

**Board Assurances**
This report should be considered in relation to the relevant risks in the Board Assurance Framework.

As an integrated performance report the content of provides assurance across several BAF risks related to workforce, operational performance, quality performance, financial performance and regulatory compliance.

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

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

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

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

**Report presented by:** **Mark Powell, Acting Chief Operating Officer**
**Claire Wright, Director of Finance**
**Amanda Rawlings, Director of People and Organisational Effectiveness**
**Carolyn Green, Director of Nursing and Patient Experience**

**Report prepared by:** **Peter Charlton, General Manager, Information Management**
**Rachel Leyland, Deputy Director of Finance**
**Liam Carrier, Workforce Systems & Information Manager**
**Rachel Kempster, Risk and Assurance Manager**
**Peter Henson, Performance Manager**


Highlights

- Surplus better than plan YTD. Forecast to achieve plan at year end
- Cash better than plan at the end of December

Challenges

- CIP forecast not to deliver to full target
- Containment of agency expenditure which is currently triggering an override on the new Use of Resources Rating
- Mitigations of Financial risks during 16/17

Highlights

- 6-8 week coverage has improved

Challenges

- Compliance with Early Interventions in Psychosis – Incomplete waits is a challenge. Actions are in place to address.
- Clustering of patients
- Outpatient letters targets
- Outpatient Cancellations
- A new 0.8% DTOC target has been imposed which the Trust will find difficult to meet.

Highlights

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

Challenges

- Monthly and annual sickness absence rates remain high.
- Budgeted Fte vacancies remain high but are decreasing.
- Appraisal compliance rates remain low but compliance is increasing.

Highlights

- Despite number of episodes and incidents of seclusion increasing, the number of prone restraints has reduced.
- No of falls on inpatient wards has decreased
- % of staff compliant with Level 3 Safeguarding and Think Family training has increased
- No of complaints and concerns have fallen, no of compliments has increased
- Update of flu jabs has increased
- No of outstanding SI and CQC actions has reduced
- Board Assurance Risks in relation to equality (1b), enforcement action (3a) and finance (4a) have reduced

Challenges

- % of staff recorded as compliant with clinical and management supervision has fallen
- Timely response rates to complaints remains low

# FINANCIAL OVERVIEW – DECEMBER 2016

| Category | Sub-set | Metric | Period | Actual | Rating | Trend | Key Points |
|---|---|---|---|---|---|---|---|
| Governance | Use of Resources (UoR) Metric | Overall Use of Resources Metric | YTD | 3 | A | ⇨ | As at the end of December the Use of Resources Rating is 3 and is now also forecast to be a 3 at the end of the year, due to triggering an override on the agency. |
| | | | Forecast | 3 | A | ⇨ | |
| | | Capital Service Cover | YTD | 2 | Y | ⇨ | |
| | | | Forecast | 2 | Y | ⇨ | |
| | | Liquidity | YTD | 1 | G | ⇨ | |
| | | | Forecast | 1 | G | ⇨ | |
| | | Income and Expenditure Margin | YTD | 1 | G | ⇨ | |
| | | | Forecast | 1 | G | ⇨ | |
| | | Income and Expenditure variance to plan | YTD | 1 | G | ⇨ | |
| | | | Forecast | 1 | G | ⇨ | |
| | | Agency variance to ceiling | YTD | 4 | R | ⇨ | We have been segmented in segment 3. |
| | | | Forecast | 4 | R | ⇨ | |
| | Single Oversight Framework | NHS I Segment | YTD | 3 | n/a | n/a | |

| Category | Sub-set | Metric | Period | Plan | Actual | Variance | Trend | Key Points |
|---|---|---|---|---|---|---|---|---|
| I&E and profitability | Income and Expenditure | Control Total position £'000 | In-Month | 197 | 578 | G | ⇧ | The Control Total shows the position including the Sustainability Transformation Fund (STF) and the Underlying Income and Expenditure position excludes the STF. Surplus is better than plan in the month and due to changes in the run rate is forecast to achieve plan at the end of the financial year.<br><br>The Normalised Income and Expenditure shows the financial performance adjusting for any non-recurrent costs or benefits that will not continue. |
| | | | YTD | 1,758 | 2,811 | G | ⇧ | |
| | | | Forecast | 2,531 | 2,531 | G | ⇨ | |
| | | Underlying Income and Expenditure position £'000 | In-Month | 127 | 509 | G | ⇧ | |
| | | | YTD | 1,136 | 2,188 | G | ⇧ | |
| | | | Forecast | 1,701 | 1,701 | G | ⇨ | |
| | | Normalised Income and Expenditure position £'000 | In-Month | 127 | 560 | G | ⇧ | |
| | | | YTD | 1,136 | 2,132 | G | ⇧ | |
| | | | Forecast | 1,701 | 2,122 | G | ⇧ | |
| | Profitability | Profitability - EBITDA £'000 | In-Month | 800 | 1,172 | G | ⇧ | |
| | | | YTD | 7,224 | 8,073 | G | ⇧ | |
| | | | Forecast | 9,806 | 9,698 | R | ⇨ | |
| | | Profitability - EBITDA % | In-Month | 7.0% | 10.4% | G | ⇧ | |
| | | | YTD | 7.0% | 8.0% | G | ↗ | |
| | | | Forecast | 7.1% | 7.2% | G | ⇨ | |
| Liquidity | Cash | Cash £m | YTD | 11.949 | 15.390 | G | ⇧ | Cash is currently above plan but is forecast to be below plan at year end due to the forecast release of some provisions.<br>Capital is slightly behind plan YTD but is forecast to fully spend by the end of the financial year. |
| | | | Forecast | 13.153 | 12.711 | R | ⇨ | |
| | Net Current Assets | Net Current Assets £m | YTD | 6.298 | 8.650 | G | ⇧ | |
| | | | Forecast | 7.570 | 6.505 | R | ⇨ | |
| | Capex | Capital expenditure £m | YTD | 2.469 | 1.724 | R | ⇧ | |
| | | | Forecast | 3.450 | 3.450 | G | ⇨ | |
| Efficiency | CIP | CIP achievement £m | In-Month | 0.358 | 0.194 | R | ⇩ | CIP is currently behind plan and is forecast not to deliver the full plan at the end of the financial year. This is compensated for by other cost avoidance and underspends in the overall position. |
| | | | YTD | 3.225 | 1.714 | R | ⇩ | |
| | | | Forecast | 4.300 | 2.299 | R | ⇩ | |
| | | | Recurrent | 4.300 | 1.645 | R | ⇨ | |

Key:

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

**Plan** In-month or Year end Trust plan

Achieving plan
Not achieving plan

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

# OPERATIONAL OVERVIEW – DECEMBER 2016

| Category | Sub-set | Metric | Period | Plan | Actual | Variance | Trend | Key Points |
|---|---|---|---|---|---|---|---|---|
| Performance Dashboard | NHSI | CPA 7 Day Follow-up (M) | Month | 95.00% | 95.38% | G | ↓ | All NHSi metrics are compliant except Early Intervention in Psychosis. This is due to team members choosing a specific referral reason used to signify early onset Psychosis. Records are being amended and IM&T are implementing a change to PARIS to prevent this from occurring.<br>For each metric we have indicated if it is monitored by NHSi Quarterly (Q) or Monthly (M). |
| | | | Quarter | 95.00% | 96.70% | G | → | |
| | | Data completeness - Identifiers (M) | Month | 95.00% | 99.51% | G | → | |
| | | | Quarter | 95.00% | 99.51% | G | → | |
| | | Data completeness - Priority Metrics (M) | Month | N/A | 70.68% | | → | |
| | | | Quarter | N/A | 68.83% | | ↓ | |
| | | Crisis Gatekeeping (Q) | Month | 95.00% | 98.53% | G | → | |
| | | | Quarter | 95.00% | 97.72% | G | ↓ | |
| | | IAPT RTT within 18 weeks (Q) | Month | 95.00% | 99.83% | G | → | |
| | | | Quarter | 95.00% | 99.66% | G | → | |
| | | IAPT RTT within 6 weeks (Q) | Month | 75.00% | 86.97% | G | ↓ | |
| | | | Quarter | 75.00% | 87.39% | G | ↓ | |
| | | Early Intervention in Psychosis RTT Within 14 Days - Complete (Q) | Month | 50.00% | 90.91% | G | ↑ | |
| | | | Quarter | 50.00% | 74.19% | G | ↑ | |
| | | Early Intervention in Psychosis RTT Within 14 Days - Incomplete (Q) | Month | 50.00% | 16.07% | R | ↓ | |
| | | | Quarter | 50.00% | 36.62% | R | ↓ | |
| | | Patients Open to Trust In Employment (M) | Month | N/A | 8.87% | | → | |
| | | | Quarter | N/A | 8.62% | | → | |
| | | Patients Open to Trust In Settled Accommodation (M) | Month | N/A | 59.61% | | → | |
| | | | Quarter | N/A | 56.98% | | ↓ | |
| | | Under 16 Admissions To Adult Inpatient Facilities (M) | Month | 0 | 0 | G | → | |
| | | | Quarter | 0 | 0 | G | → | |
| | | IAPT People Completing Treatment Who Move To Recovery (Q) | Month | 50.00% | 53.67% | G | → | |
| | | | Quarter | 50.00% | 53.31% | G | → | |
| | | Physical Health - Cardio-Metabolic - Inpatient (Q) | Month | N/A | | | | |
| | | | Quarter | N/A | | | | |
| | | Physical Health - Cardio-Metabolic - EI (Q) | Month | N/A | | | | |
| | | | Quarter | N/A | | | | |
| | | Physical Health - Cardio-Metabolic - on CPA (Community) (Q) | Month | N/A | | | | |
| | | | Quarter | N/A | | | | |

Key:

**Period**

Month — Current Month

Quarter — Current Quarter

Achieving target

Not achieving target

↑ → ↓ Trend compared to previous month/quarter

# OPERATIONAL OVERVIEW – DECEMBER 2016

| Category | Sub-set | Metric | Period | Plan | Actual | Variance | Trend | Key Points |
|---|---|---|---|---|---|---|---|---|
| Performance Dashboard | Locally Agreed | CPA Settled Accommodation | Month | 90.00% | 96.80% | G | → | An improvement plan has been defined to address Clustering. |
| | | | Quarter | 90.00% | 96.80% | G | → | |
| | | CPA Employment Status | Month | 90.00% | 97.33% | G | → | |
| | | | Quarter | 90.00% | 97.33% | G | → | |
| | | Data completeness - Identifiers | Month | 99.00% | 99.51% | G | → | |
| | | | Quarter | 99.00% | 99.51% | G | → | |
| | | Data completeness - Outcomes | Month | 90.00% | 93.96% | G | → | |
| | | | Quarter | 90.00% | 93.96% | G | → | |
| | | Patients Clustered not Breaching Today | Month | 80.00% | 76.65% | R | → | |
| | | | Quarter | 80.00% | 77.38% | R | ↓ | |
| | | Patients Clustered regardless of review dates | Month | 96.00% | 94.12% | R | → | |
| | | | Quarter | 96.00% | 94.58% | R | → | |
| | | 7 Day Follow-up - all inpatients | Month | 95.00% | 96.00% | G | → | |
| | | | Quarter | 95.00% | 95.98% | G | → | |
| | | Ethnicity coding | Month | 90.00% | 90.81% | G | ↓ | |
| | | | Quarter | 90.00% | 90.81% | G | ↓ | |
| | | NHS Number | Month | 99.00% | 99.99% | G | → | |
| | | | Quarter | 99.00% | 99.99% | G | → | |
| | | CPA Review in last 12 Months (on CPA > 12 Months) | Month | 95.00% | 95.44% | G | → | |
| | | | Quarter | 95.00% | 95.44% | G | → | |
| | | Community Care Data - Activity Information Completeness | Month | 50.00% | 93.56% | G | → | |
| | | | Quarter | 50.00% | 93.96% | G | → | |
| | | Community Care Data - RTT Information Completeness | Month | 50.00% | 92.31% | G | → | |
| | | | Quarter | 50.00% | 92.31% | G | → | |
| | | Community Care Data - Referral Information Completeness | Month | 50.00% | 73.05% | G | ↓ | |
| | | | Quarter | 50.00% | 75.10% | G | ↓ | |
| | | Early Interventions New Caseloads | Month | 95.00% | 146.60% | G | ↓ | |
| | | | Quarter | 95.00% | 146.60% | G | ↓ | |
| | | Clostridium Difficile Incidents | Month | 7 | 0 | G | → | |
| | | | Quarter | 7 | 0 | G | → | |
| | | 18 Week RTT Greater Than 52 weeks | Month | 0 | 0 | G | → | |
| | | | Quarter | 0 | 0 | G | → | |

# OPERATIONAL OVERVIEW – DECEMBER 2016

| Category | Sub-set | Metric | Period | Plan | Actual | Variance | Trend | Key Points |
|---|---|---|---|---|---|---|---|---|
| Performance Dashboard | Schedule 6 | Consultant Outpatient Trust Cancellations | Month | 5.00% | 7.34% | R | ↓ | Information is now available to identify the specific reason cancelations occur. |
| | | | Quarter | 5.00% | 6.22% | R | → | |
| | | Consultant Outpatient DNAs | Month | 15.00% | 14.94% | G | → | |
| | | | Quarter | 15.00% | 15.01% | R | ↑ | |
| | | Under 18 admissions to Adult inpatients | Month | 0 | 0 | G | → | |
| | | | Quarter | 0 | 0 | G | → | |
| | | Outpatient letters sent in 10 working days | Month | 90.00% | 78.49% | R | ↓ | Typing targets have been missed due to sickness and annual leave. Plans are in place to recover the situation in January. |
| | | | Quarter | 90.00% | 84.13% | R | ↓ | |
| | | Outpatient letters sent in 15 working days | Month | 95.00% | 91.54% | R | ↓ | |
| | | | Quarter | 95.00% | 92.96% | R | ↓ | |
| | | Inpatient 28 day readmissions | Month | 10.00% | 6.14% | G | ↑ | |
| | | | Quarter | 10.00% | 9.42% | G | ↓ | |
| | | MRSA - Blood stream infection | Month | 0 | 0 | G | → | |
| | | | Quarter | 0 | 0 | G | → | |
| | | Mixed Sex accommodation breaches | Month | 0 | 0 | G | → | |
| | | | Quarter | 0 | 0 | G | → | |
| | | Discharge Fax sent in 2 working days | Month | 98.00% | 99.06% | G | → | |
| | | | Quarter | 98.00% | 98.82% | G | → | |
| | | Delayed Transfers of Care | Month | 0.80% | 1.01% | R | → | Trust Target has been set by the NHS at 0.8% which is below the rate currently being achieved. |
| | | | Quarter | 0.80% | 1.74% | R | → | |
| | | 18 Week RTT Less Than 18 Weeks - Incomplete | Month | 92.00% | 93.24% | G | → | |
| | | | Quarter | 92.00% | 92.94% | G | ↓ | |

# OPERATIONAL OVERVIEW – DECEMBER 2016

| Category | Sub-set | Metric | Period | Plan | Actual | Variance | Trend | Key Points |
|---|---|---|---|---|---|---|---|---|
| Performance Dashboard | Fixed Submitted Returns | 18 weeks RTT greater than 52 weeks | Month | 0 | 0 | G | → | Compliant with Fixed Targets |
| | | | Quarter | 0 | 0 | G | → | |
| | | 18 Week RTT incomplete | Month | 92.00% | 93.40% | G | ↓ | |
| | | | Quarter | 92.00% | 94.55% | G | ↑ | |
| | | Mixed Sex accommodation breaches | Month | 0 | 0 | G | → | |
| | | | Quarter | 0 | 0 | G | → | |
| | | Completion of IAPT Data Outcomes | Month | 90.00% | 97.47% | G | ↑ | |
| | | | Quarter | 90.00% | 96.29% | G | → | |
| | | Ethnicity coding | Month | 90.00% | 90.70% | G | ↓ | |
| | | | Quarter | 90.00% | 91.25% | G | → | |
| | | NHS Number | Month | 99.00% | 99.99% | G | → | |
| | | | Quarter | 99.00% | 99.99% | G | → | |
| Other Dashboards | Health Visiting | % 10-14 Day Breastfeeding coverage | Month | 98.00% | 98.52% | G | ↓ | Vacancies have impacted on compliance |
| | | | Quarter | 98.00% | 98.84% | G | → | |
| | | % 6-8 Week Breastfeeding coverage | Month | 98.00% | 98.80% | G | → | |
| | | | Quarter | 98.00% | 98.14% | G | → | |
| | IAPT | Recovery Rates | Month | 50.00% | 53.57% | G | → | Compliant with IAPT Targets |
| | | | Quarter | 50.00% | 53.28% | G | → | |
| | | Reliable & Recovery Rates | Month | 65.00% | 68.93% | G | → | |
| | | | Quarter | 65.00% | 69.43% | G | ↓ | |
| | Safer Staffing | Inpatient Safer Staffing Fill Rates | Month | 90.00% | 101.1% | G | → | Detailed ward level information shows specific variances |
| | | | Quarter | 90.00% | 101.1% | G | ↑ | |

# WORKFORCE OVERVIEW – DECEMBER 2016

| Category | Sub-set | Metric | Period | Plan | Actual | Variance | | Trend | Key Points |
|---|---|---|---|---|---|---|---|---|---|
| Workforce Dashboard | NHSI Key Performance Indicator (KPI) | **Turnover** (annual) | **Dec-16** | 10% | **11.28%** | ↘ | G | ↑ | Annual turnover remains within the Trust target parameters and is below the regional Mental Health & Learning Disability average of 12.65% (as at June 2016 latest available data). The monthly sickness absence rate is 0.10% lower compared to the previous month, however it is 0.27% higher than in the same period last year (December 2015). The annual sickness absence rate is running at 5.60% (as at 30th November 2016 latest available data). The regional average annual sickness absence rate for Mental Health & Learning Disability Trusts is 5.09% (as at July 2016 latest available data). Anxiety/stress/depression/other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 24.35% of all sickness absence, followed Surgery at 15.85% and cold, cough, flu - influenza at 9.54%. Budgeted Fte vacancy rates have decreased by 0.77% compared to the previous month. The number of employees who have received an appraisal within the last 12 months has increased by 2.04% to 74.28%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £1.392m of which £820k related to Medical staff. Compulsory training compliance has decreased this month by 0.73% but still remains above the 85% main contract non CQUIN. |
| | | | Nov-16 | | 11.71% | | G | | |
| | | **Sickness Absence** (monthly) | **Dec-16** | 5.04% | **6.55%** | ↘ | R | ↓ | |
| | | | Nov-16 | | 6.65% | | R | | |
| | | **Vacancies** (including 10% funded fte flexibility / cover) | **Dec-16** | 10% | **15.63%** | ↘ | A | ↓ | |
| | | | Nov-16 | | 16.40% | | A | | |
| | | **Vacancies** (actual against target) | **Dec-16** | 0% | **5.63%** | ↘ | A | ↓ | |
| | | | Nov-16 | | 6.40% | | A | | |
| | | **Appraisals** (all staff - number of employees who have received an appraisal in the previous 12 months) | **Dec-16** | 90% | **74.28%** | ↗ | R | ↑ | |
| | | | Nov-16 | | 72.24% | | R | | |
| | | **Appraisals** (medical staff only - number of employees who have received an appraisal in the previous 12 months) | **Dec-16** | 90% | **80.19%** | ↘ | R | ↓ | |
| | | | Nov-16 | | 85.59% | | R | | |
| | | **Qualified Nurses** (to total nurses, midwives, health visitors and healthcare assistants) | **Dec-16** | 65% | **69.05%** | ↗ | G | ↑ | |
| | | | Nov-16 | | 68.09% | | G | | |
| | | **Agency Usage** (£ year to date level of agency expenditure exceeding the ceiling set by NHSI) | **Dec-16** | £0 | **£1.392m** | ↗ | R | ↑ | |
| | | | Nov-16 | | £1.332m | | R | | |
| | | **Agency Usage** (% year to date level of agency expenditure exceeding the ceiling set by NHSI) | **Dec-16** | 0% | **61.20%** | ↘ | R | ↑ | |
| | | | Nov-16 | | 65.89% | | R | | |
| | Other KPI | **Compulsory Training** (staff in-date) | **Dec-16** | 90% | **86.21%** | ↘ | G | ↓ | |
| | | | Nov-16 | | 86.94% | | G | | |

Key:

**Period** Current month and previous month

**Plan** Trust target

↗ Variance to previous month

Achieving target/within target parameters

Approaching target/approaching target parameters

Not achieving target/outside target parameters

Trend based on previous 4 months

Turnover parameters (8% to 12%)

Vacancy parameters (10% to 20%)

# QUALITY OVERVIEW – DECEMBER 2016

| Category | Sub-set | Metric | Period | Plan | Actua | Varianc | Trend | Key Points |
|---|---|---|---|---|---|---|---|---|
| Quality | Safe | No of incidents of moderate to catastrophic actual harm | Month | 24 | 28 | | | Plan: average last fin yr (month) |
| | | | Quarter | 73 | 83 | | NA | Plan: average last fin yr (Qtr). Actual: Q2. Inclusion of trend data to commence Q3 |
| | | No of episodes of patients held in seclusion | Month | 6 | 12 | | | Plan: previous month. Actual: Current month. |
| | | | Quarter | 35 | 59 | | | Plan: Q1 data. Actual: Q2 data |
| | | No of incidents involving patients held in seclusion | Month | 20 | 16 | | | |
| | | | Quarter | 61 | 60 | | | Q2 data |
| | | No of incidents involving physical restraint | Month | 55 | 44 | | | |
| | | | Quarter | 165 | 211 | | | Q2 data |
| | | No of incidents involving prone restraint | Month | 5 | 8 | | | Plan: Mth/Qtr, average from 1/4/16 when prone restraint collected on Datix as defined field. |
| | | | Quarter | 15 | 30 | | | Q2 data |
| | | No of incidents of physical assault - patient on patient | Month | 15 | 13 | | | |
| | | | Quarter | 44 | 42 | | NA | Q2 data. Inclusion of trend data to commence Q3 |
| | | No of incidents of physical assault - patient on staff | Month | 20 | 10 | | | |
| | | | Quarter | 61 | 81 | | NA | Q2 data. Inclusion of trend data to commence Q3 |
| | | No of falls on in-patient wards | Month | 38 | 19 | | | |
| | | | Quarter | 113 | 84 | | NA | Q2 data. Inclusion of trend data to commence Q3 |
| | | No of incidents of absconsion | Month | 43 | 24 | | | |
| | | | Quarter | 130 | 85 | | NA | Q2 data. Inclusion of trend data to commence Q3 |
| | | No of patients with a clinical risk plan (FACE or Safety Plan) | Month | 100% | 79.68% | | | |
| | | | Quarter | 100% | 79.51% | | | |
| | | Of above, no of patients with a Safety Plan | Month | 90% | 1.69% | | | Early stage of implementation. Go live from 1/11/16. |
| | | | Quarter | 90% | 1.61% | | | |
| | | % of staff compliant with Level 3 Safeguarding Children training | Month | 95% | 76.46% | | | |
| | | | Quarter | 95% | NA | | | Qtr comparison not available |
| | | % of staff compliant with Think Family training | Month | 95% | 79.06% | | | |
| | | | Quarter | 95% | NA | | | Qtr comparison not available |
| | | % of staff compliant with Clinical Safety Planning eLearning | Month | 95% | 92.89% | | | |
| | | | Quarter | 95% | NA | | | Qtr comparison not available |
| | | % of staff compliant with Fire Warden training | Month | 90% | 75.7% | | | Figures for Nov 2016 shown as Dec 2016 figures not yet available. |
| | | | Quarter | 90% | NA | | | Qtr comparison not available |
| | | No of people with LD or Autism admitted without a CTR (Care & Treatment Review) | Month | 0 | 3 | | | |
| | | | Quarter | 0 | 7 | | | |

# QUALITY OVERVIEW – DECEMBER 2016

| Category | Sub-set | Metric | Period | Plan | Actua | Varianc | Trend | Key Points |
|---|---|---|---|---|---|---|---|---|
| Quality | Caring | No of complaints received | Month | 9 | 8 | | | |
| | | | Quarter | 26 | 39 | | | Q2 data. Inclusion of trend data to commence Q3 |
| | | No of concerns received | Month | 18 | 30 | | | |
| | | | Quarter | 53 | 121 | | | |
| | | No of compliments received | Month | 72 | 117 | | | |
| | | | Quarter | 217 | 292 | | | |
| | | No of incidents requiring Duty of Candour | Month | 2 | 0 | | | These figures will fluctuate based on the outcome of investigations. |
| | | | Quarter | 8 | 1 | | NA | |
| | | % of responded to (orange) complaint investigations completed within 40 working days | Year | 100% | 37% | | | From 1/4/16 to 31/12/16. 45 of the 101 'orange rated complaints were not responded to within 40 working days. 30 complaints are still ongoing |
| | | % of responded to (red) complaints investigations completed within 60 working days | Year | 100% | 0% | | | From 1/4/16 to 31/12/16. 3 of the 5'red' rated complaints were not responded to within 60 working days. 2 complaints are still ongoing. |
| | | No of incidents requiring Duty of Candour | Month | 2 | 0 | | | These figures will fluctuate based on the outcome of investigations. |
| | | | Quarter | 8 | 1 | | NA | |
| | Effective | % of in-patients with a recorded capacity assessment | Month | 100% | 88.95% | | | |
| | | | Quarter | 100% | NA | NA | NA | Qtr comparison not available |
| | | % of patients who have had their care plan reviewed and have been on CPA > 12months | Month | 90% | 95.41% | | | |
| | | | Quarter | 90% | 95.79% | | | |
| | | No of seclusion forms not received by MHA Office | Month | 0 | 1 | | | |
| | | | Quarter | 0 | 10 | | NA | Q2 data. Inclusion of trend data to commence Q3 |
| | | % of CTO rights forms received by MHA Office | Month | 100% | 92% | | | Relates to whole cohort of patients |
| | | | Quarter | NA | NA | NA | NA | |
| | | % of in patient older adults rights forms received by MHA Office | Month | 100% | 71% | | | 89% average compliance across 3 of the wards but 33% compliance on cubley female ward due to 3 new admisisons in Jan 17 |
| | | | Quarter | 100% | 100% | | NA | |
| | Responsive | % of staff uptake of Flu Jabs | Month | 45% | 38.4% | | | Data to end of 30/11/16 |
| | | | Year | 45% | 22.7% | | | Relates to 2015.16 compaign |
| | | % of policies in date | Month | 95% | 97.2% | | | |
| | | | Quarter | NA | NA | NA | NA | |
| | Well Led | % of staff who have received Clinical Supervision, within defined timescales | Month | 90% | 40.83% | | | Previous month 52.75% |
| | | | Quarter | 90% | NA | NA | NA | |
| | | % of staff who have received Management Supervision, within defined timescales | Month | 90% | 59.1% | | | Previous month 63.1% |
| | | | Quarter | 90% | NA | NA | NA | |
| | | No of outstanding actions following serious Incident investigations | Month | 0 | 30 | | | Figure as at 10/01/2017 |
| | | | Quarter | 0 | 7 | | NA | Average for Q2. Comparison to Q1 not analysed |
| | | No of outstanding actions following complaint investigations | Month | 0 | 54 | | | Figure as at 10/01/2017 |
| | | | Quarter | 0 | NA | NA | NA | |
| | | No of outstanding actions following CQC comprehensive review report | Month | 0 | 150 | | | As at 22/12/2016, 88% of all the actions are either complete or, in progress and on target. |

# Financial Section

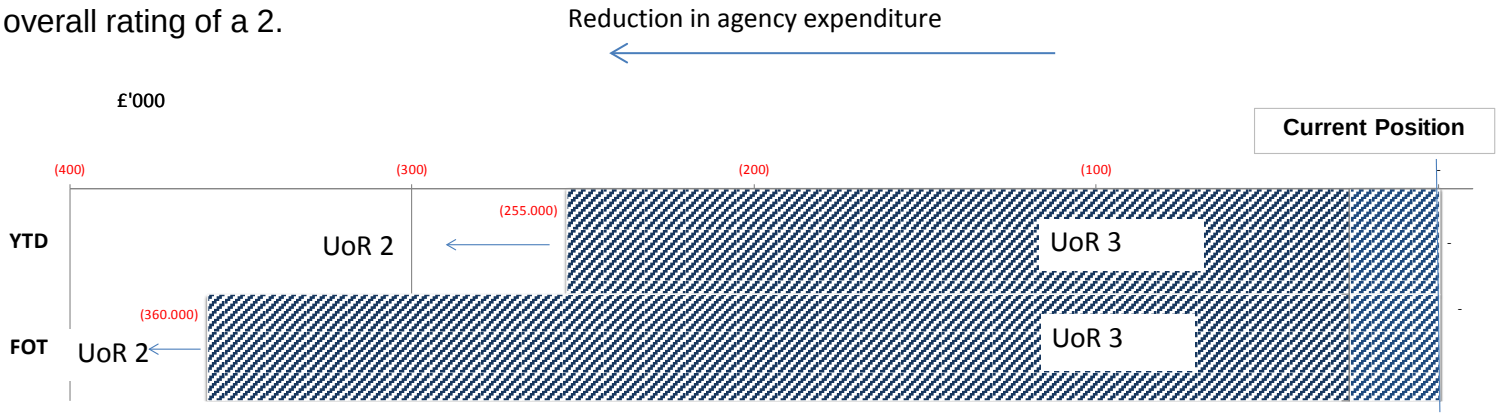
## Governance – Use of Resources (UoR) Rating

The Use of Resources rating at the end of December is a 3 which is due to triggering the override rule as the agency metric is a 4. The agency expenditure is forecast to continue to be in excess of 50% above the ceiling and therefore continuing to trigger a 4 generating a UoR rating of 3 at the end of the financial year.

| | YTD @ Quarter 1 | | YTD @ Quarter 2 | | YTD @Quarter 3 | | YTD @ Quarter 4 | |
|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Capital Service Capacity rating | 3 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Liquidity rating | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| I&E Margin rating | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Distance from Financial Plan | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Agency distance from Cap | 1 | 4 | 1 | 4 | 1 | 4 | 1 | 4 |
| **UoR** | 2 | 2 | 1 | 2 | 1 | 2 | 1 | 2 |
| **4 on any metric** | No Trigger | Trigger | No Trigger | Trigger | No Trigger | Trigger | No Trigger | Trigger |
| **UoR** | 2 | 3 | 1 | 3 | 1 | 3 | 1 | 3 |

To note some of the metrics including the overall rating does not have a plan set by NHS Improvement, so the plan figures are based on an internal calculation.

As four of the metrics are in a healthy position and it is the agency metric that is driving the lower rating and the trigger this is the area of focus from a headroom perspective, which is shown in the chart below. YTD if agency expenditure was £0.3m less we would have not triggered an override and remained at an overall rating of 2. From a forecast perspective we would need to reduce expenditure by £0.4m in order avoid triggering an override and achieve an overall rating of a 2.



# Income and Expenditure

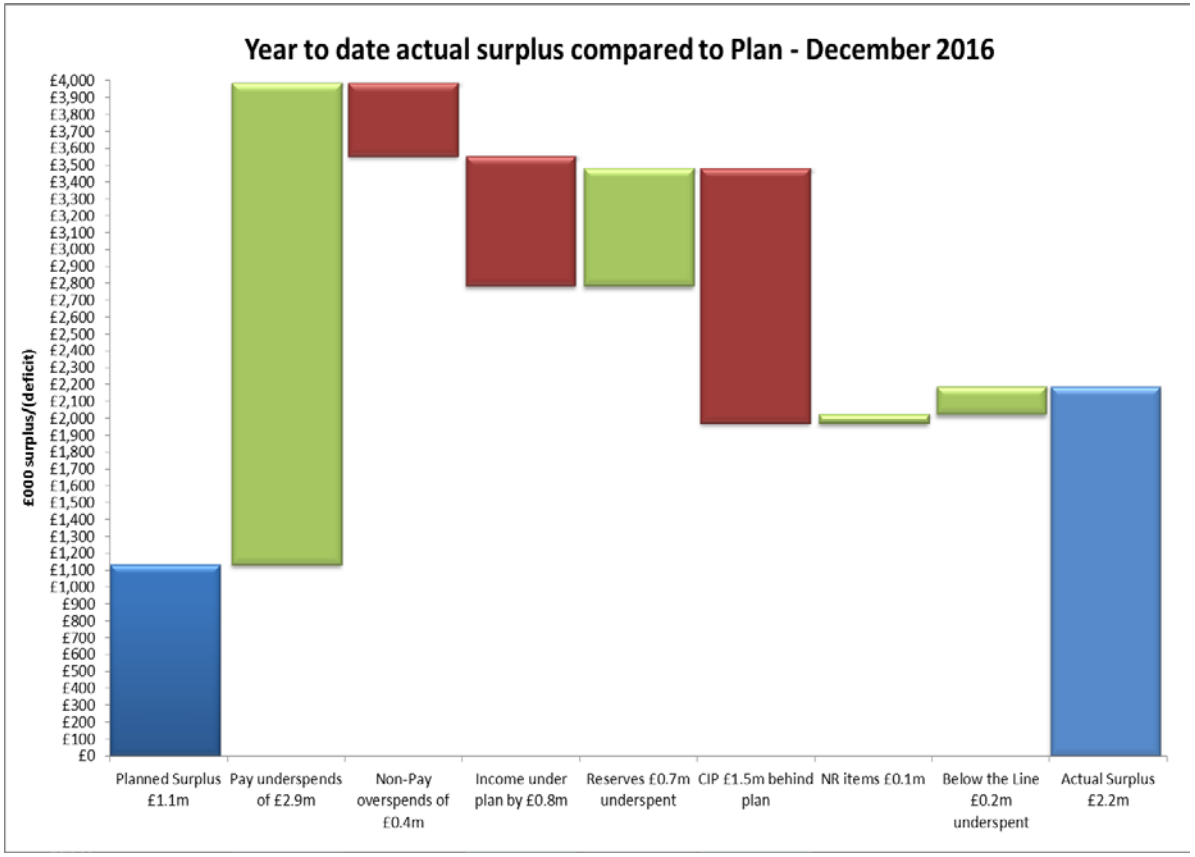
## Statement of Comprehensive Income — December 2016

| | Current Month | | | Year to Date | | | Forecast | | |
|---|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | Variance Fav (+) / Adv (-) | Plan | Actual | Variance Fav (+) / Adv (-) | Plan | Actual | Variance Fav (+) / Adv (-) |
| | £000 | 0 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Clinical Income | 10,594 | 10,472 | (122) | 95,460 | 93,429 | (2,031) | 127,406 | 124,871 | (2,535) |
| Non Clinical Income | 849 | 774 | (75) | 7,643 | 7,096 | (546) | 10,190 | 9,387 | (803) |
| Employee Expenses | (8,426) | (7,974) | 451 | (76,226) | (72,331) | 3,895 | (101,492) | (96,899) | 4,593 |
| Non Pay | (2,218) | (2,100) | 118 | (19,652) | (20,122) | (469) | (26,298) | (27,661) | (1,363) |
| **EBITDA** | **800** | **1,172** | **372** | **7,224** | **8,073** | **848** | **9,806** | **9,698** | **(108)** |
| Depreciation | (295) | (285) | 10 | (2,651) | (2,458) | 193 | (3,534) | (3,451) | 83 |
| Impairment | 0 | 0 | 0 | 0 | (36) | (36) | (300) | (300) | 0 |
| Profit (loss) on asset disposals | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Interest/Financing | (175) | (175) | (0) | (1,615) | (1,592) | 24 | (2,141) | (2,104) | 37 |
| Dividend | (133) | (133) | (0) | (1,200) | (1,213) | (13) | (1,600) | (1,613) | (13) |
| **Net Surplus / (Deficit)** | **197** | **578** | **382** | **1,758** | **2,775** | **1,016** | **2,231** | **2,231** | **0** |
| Technical adjustment - Impairment | 0 | 0 | 0 | 0 | (36) | (36) | (300) | (300) | 0 |
| **Control Total Surplus / (Deficit)** | **197** | **578** | **382** | **1,758** | **2,811** | **1,052** | **2,531** | **2,531** | **0** |
| Technical adjustment - STF Allocation | 69 | 69 | 0 | 622 | 622 | 0 | 830 | 830 | 0 |
| **Underlying Net Surplus / (Deficit)** | **127** | **509** | **382** | **1,136** | **2,188** | **1,052** | **1,701** | **1,701** | **0** |

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

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

Clinical Income is £0.1m less than plan in month and is forecast to be £2.5m less than plan by the end of the year of which a significant proportion is due to differences in planning assumptions with offsetting expenditure reductions. There is however forecast underperformances on activity related income.
Non Clinical income is less than plan in the month by £75k and has a forecast outturn of £0.8m behind plan. £0.4m relates to a miscellaneous income target with no income forecast against it.
Pay expenditure is £0.45m less than the plan in the month and the year end forecast position is £4.6m more favourable than plan which is due to planning assumptions (with offsetting income reductions) but also vacancies and recruitment.
Non Pay is underspent in the month by £118k and has a forecast outturn of £1.4m worse than plan which mainly relates to Drugs and PICU expenditure.




## Summary of key points

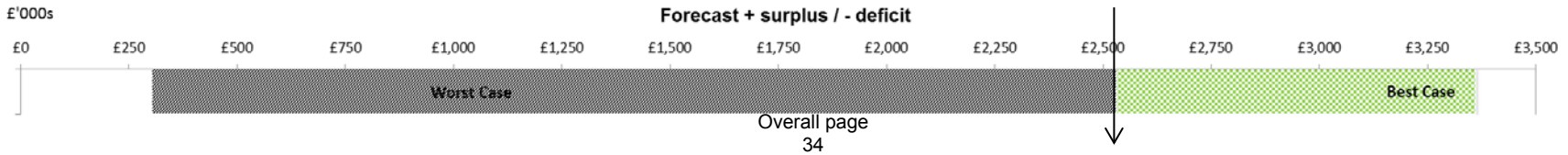
Overall favourable variance to plan year to date which is driven by the following:

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

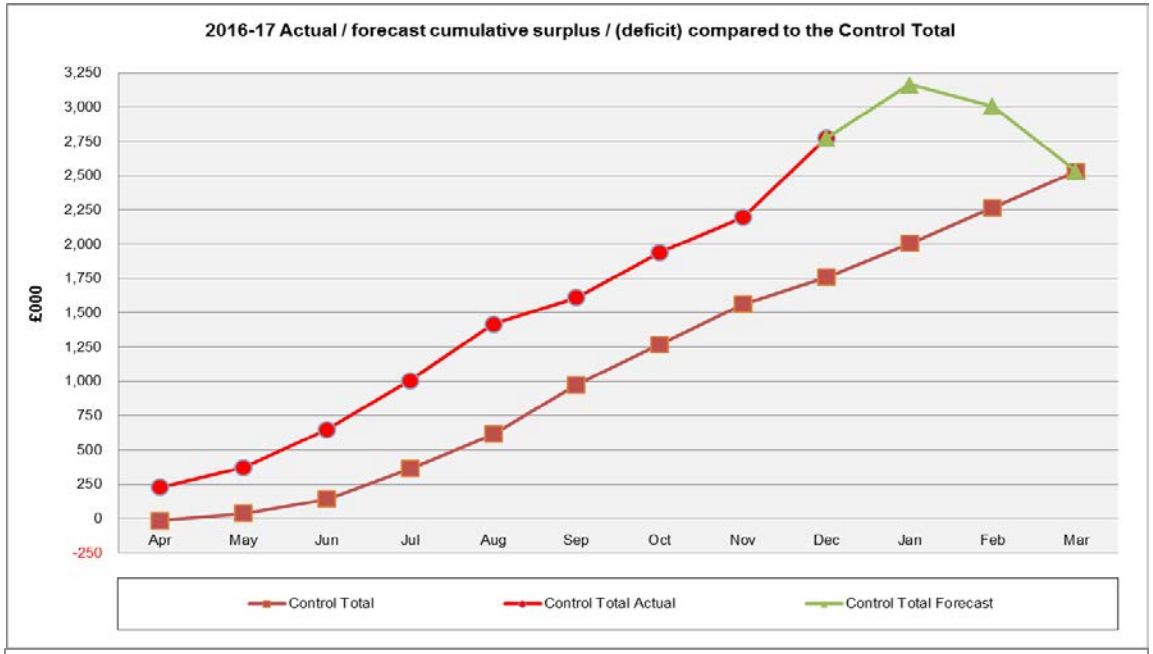
## Forecast Range

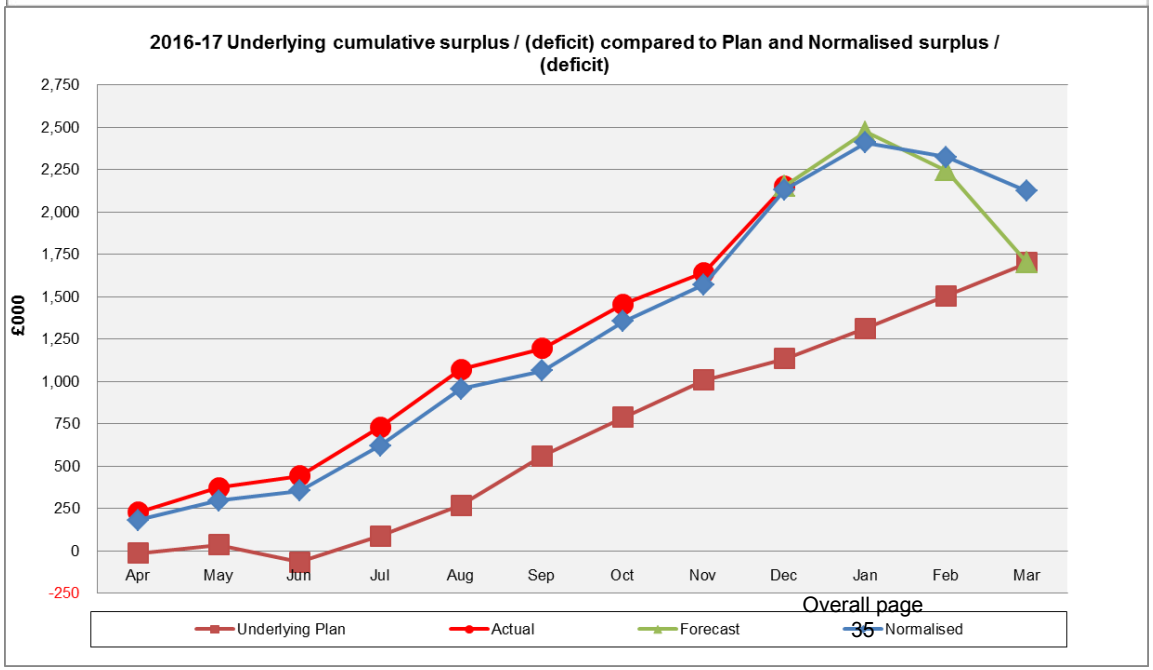
| Best Case | Likely Case | Worst Case |
|---|---|---|
| £3.4m surplus | £2.5m surplus | £0.3m surplus |

The main variables in the forecast range are: STF income, income claw back, agency expenditure, AfC backlog claims, PICU, IAPT, CPC income and other unexpected non-pay costs.



# Normalised Income and Expenditure position



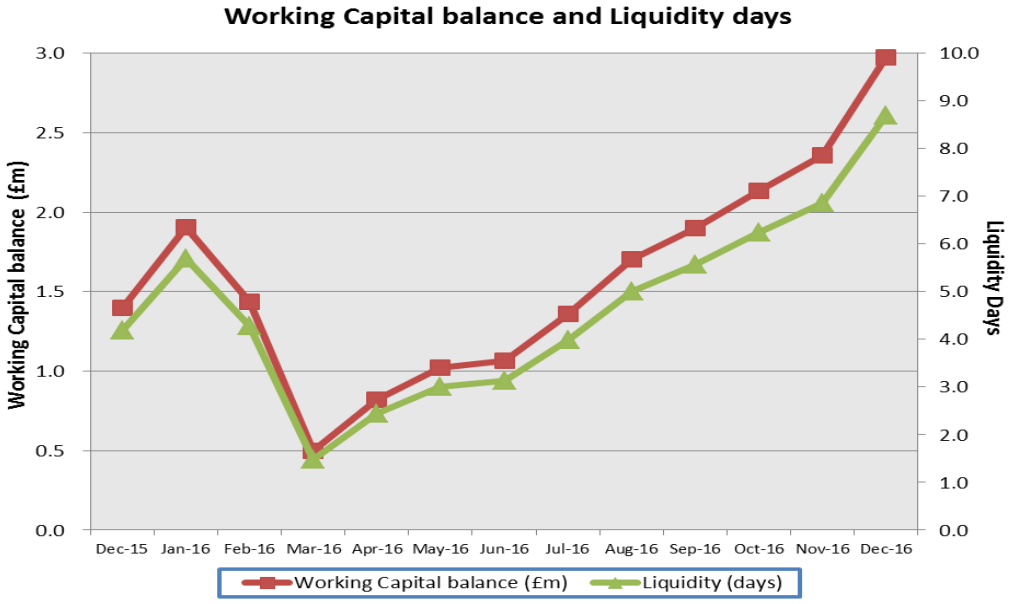

The first graph shows the actual and forecast cumulative surplus against the control total (including the Sustainability Transformation Fund (STF). The surplus is forecast to remain ahead of plan until the latter part of the financial year when it will reduce back down to the planned control total.

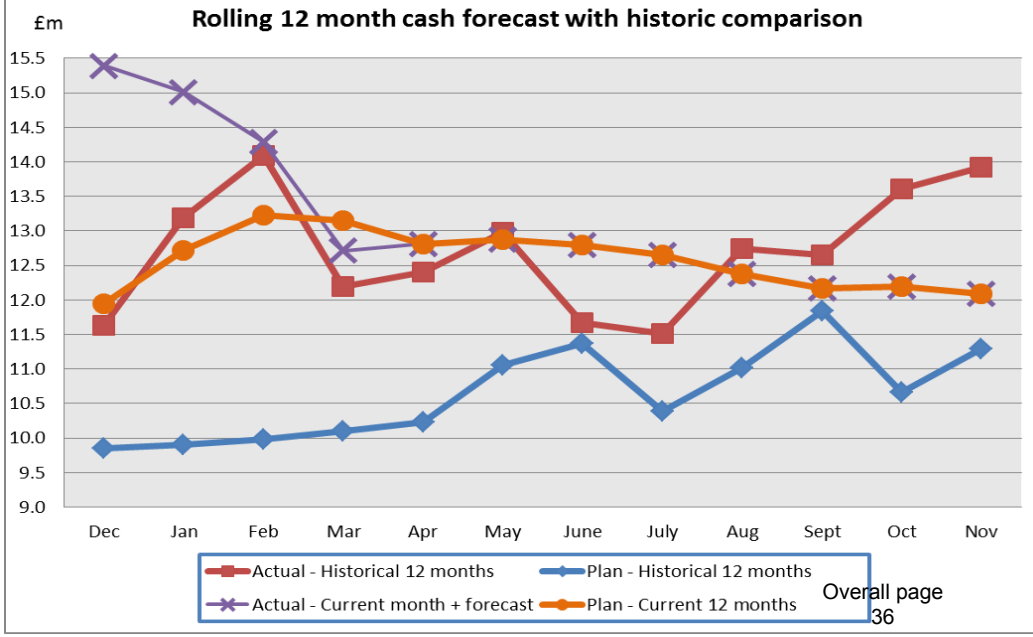
The second graph shows the underlying actual and forecast surplus against the underlying plan excluding the STF.

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

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

# Liquidity



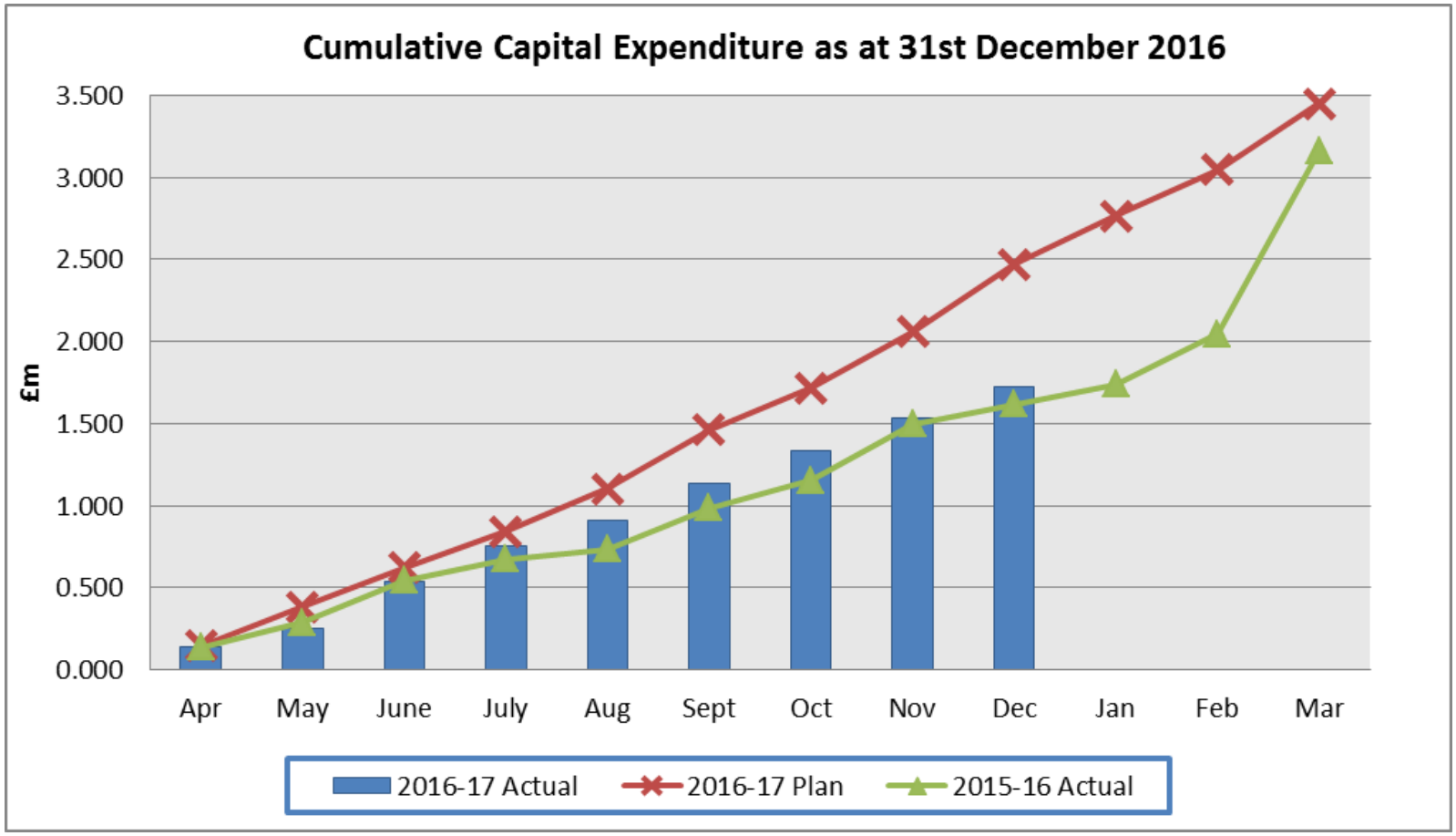

The first graph shows the working capital balance for the last 12 months (net current assets less net current liabilities adjusted for assets held for sale and inventories) and how many days of operating expenses that balance provides.

During last financial year working capital continued to improve due to improved cash levels. The downward trend at the end of last financial year is reflective of the reduction in cash due to year end transactions. November continues to show a further improvement up to 8.69 days which still gives a rating of 1 (the best) on that metric (-7days drops to a rating of 2).

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

Cash is currently at £15.4m which was £3.4m better than the plan at the end of December. This is mainly driven by the Income and Expenditure surplus and capital being slightly behind plan.

## Capital Expenditure

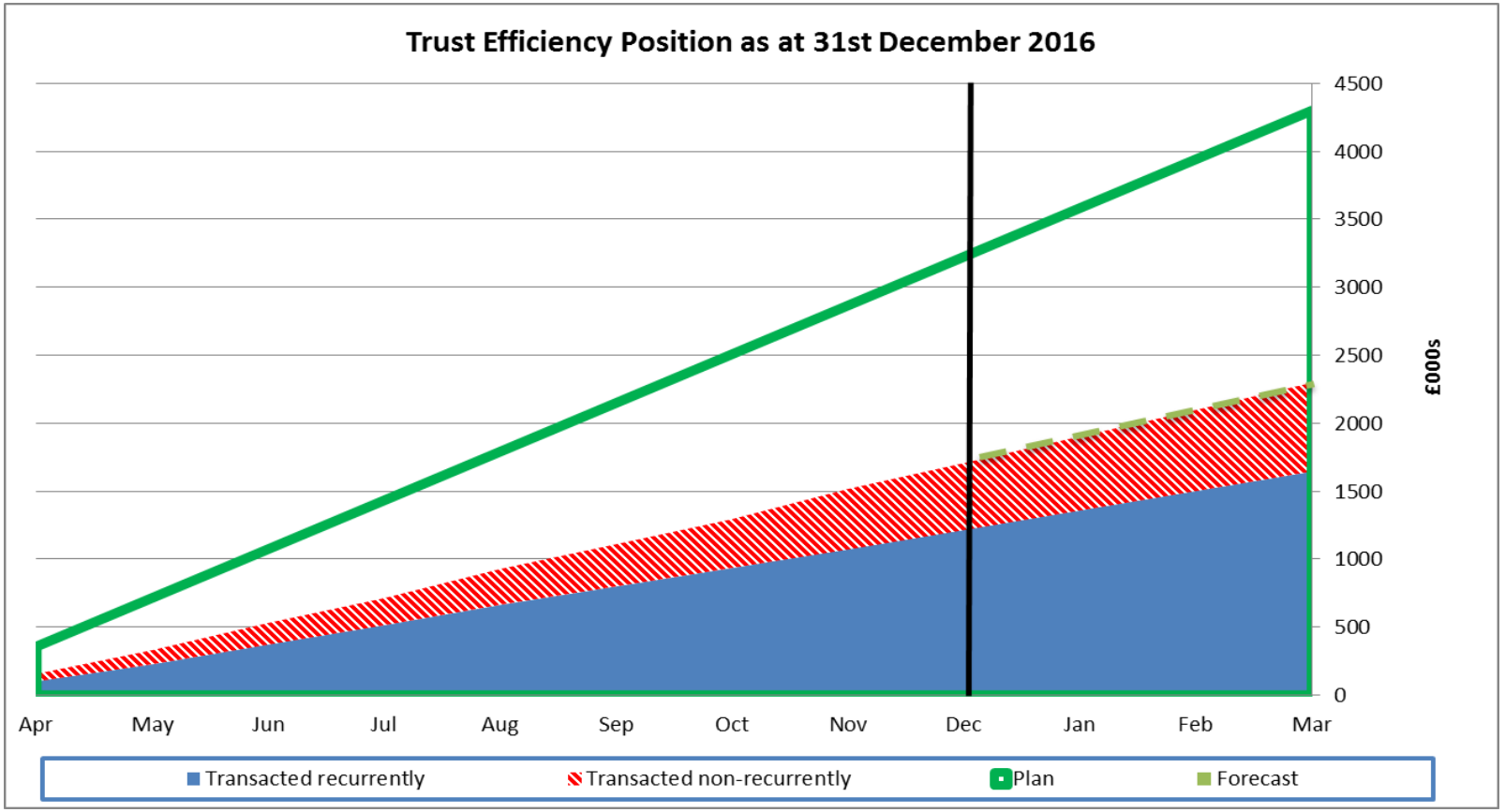



Capital Expenditure is £745k behind plan year to date but is forecast to spend to the plan of £3.45m by year end.

The 2016/17 schemes are regularly reviewed by Capital Action Team (CAT) including the reprioritisation to fund any new schemes. Some reprioritisation of schemes has already taken place to date this year in order to fund more urgent schemes. Capital Action Team members are overseeing the delivery of CQC-related capital requirements related to environment.

# Efficiency

## Cost Improvement Programme (CIP)



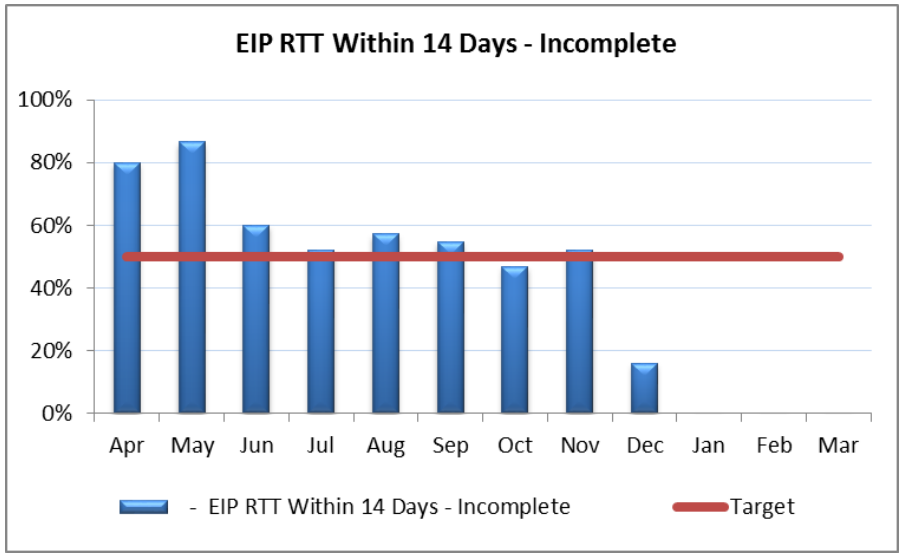

At the end of December there was a shortfall against the year to date plan of £1.511m. The full year amount of savings identified at the end of December reporting is £2.3m leaving a gap of £2.0m.

The forecast assumes no further CIP will be achieved by the end of the financial year leaving unfound CIP at £2.0m. This underachievement is compensated for by cost avoidance and other underspends in the overall position.

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

# Operational Section

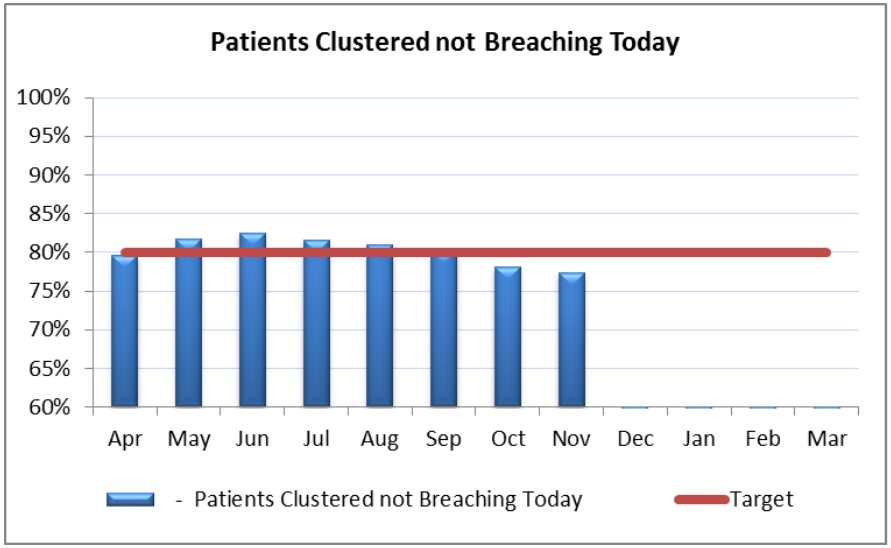
# EIP RTT Within 14 Days - Incomplete

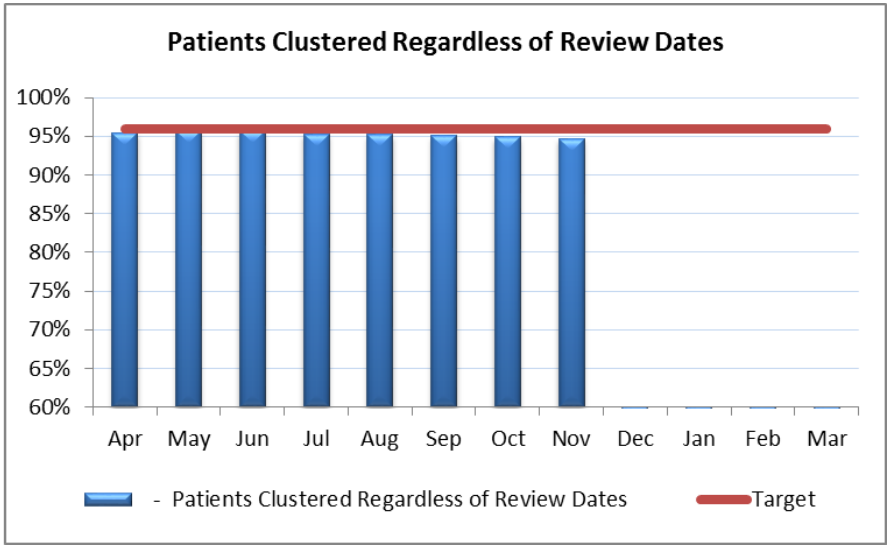



A national requirement was introduced in October for all trusts to record the primary reason for referral, for all referrals, selecting from a nationally defined list of options. Unfortunately this has resulted in some clinicians picking “at risk mental state” as a reason, which is also used to start the clock for the purposes of the Early Intervention waiting times target calculation. This is no fault of the clinicians – it fits perfectly as a reason for A&E liaison referrals, for example. However to resolve the problem this causes with EI, IM&T are going to make it invisible as a referral reason for any team but EI and the single points of access. Remedial work has been undertaken to correct the records and as it stands we have achieved 73% for December.

- Records have been corrected
- IM&T solution to be implemented

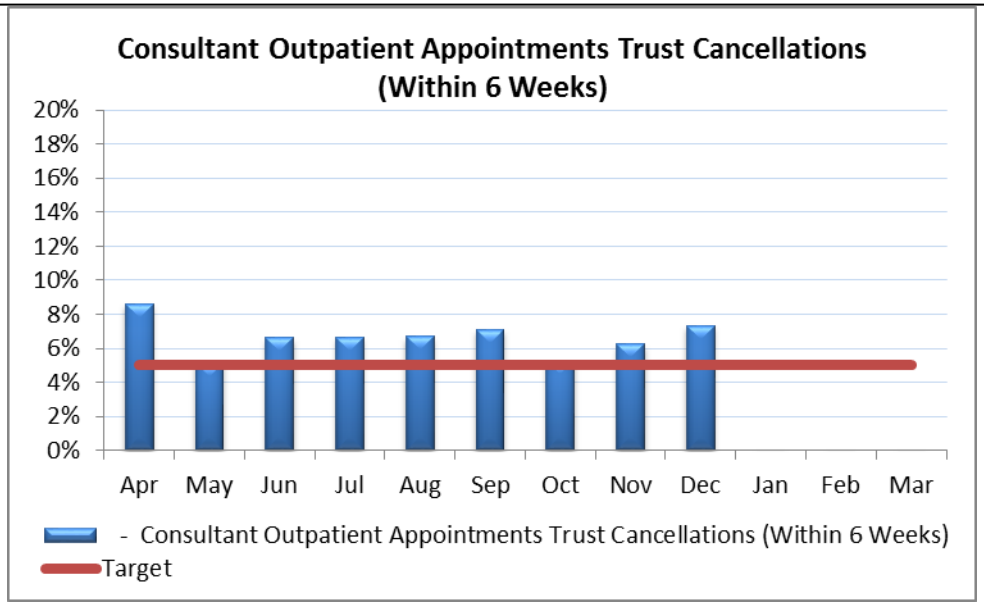
# Clustering




An action plan has been implemented. We will start to evaluate the impact of the actions as each is completed over the next few months.

# Consultant Outpatient Appointments Trust Cancellations (within 6 weeks)

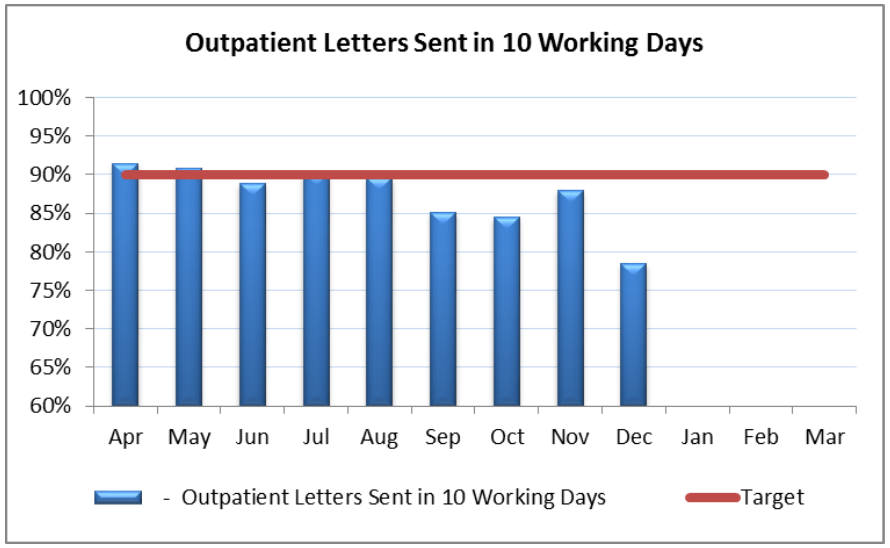


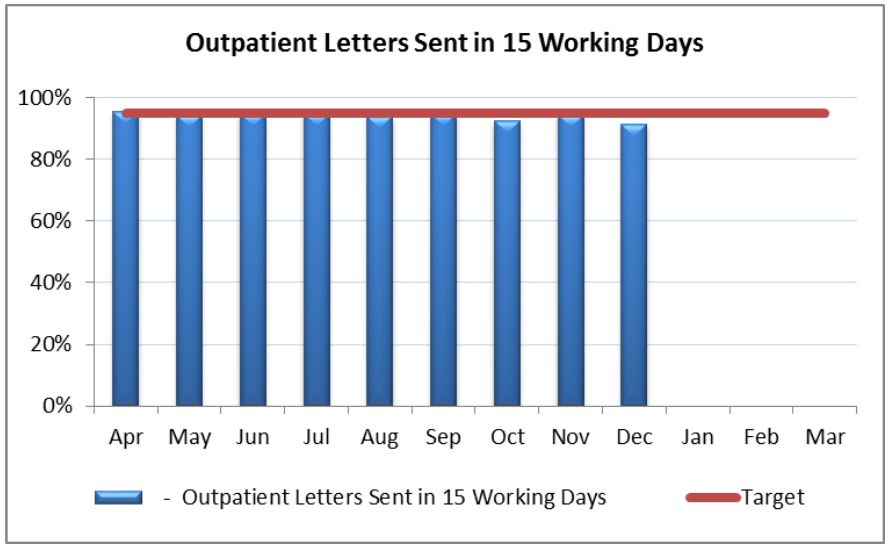

The main reason for cancellations continues to be consultant sickness absence:

- Associate Clinical Directors to review cancellation reasons monthly and discuss with consultant(s) concerned where reasons do not appear valid, if applicable.
- Medical Director to re-brief all medics by 31/1/2017 of the requirement to book annual leave giving at least 6 weeks' notice to ensure patients are not inconvenienced.

| Reason | n | % |
|---|---|---|
| Clinician Absent From Work | 111 | 39% |
| No Consultant | 98 | 34% |
| Clinician Must Attend Tribunal | 25 | 9% |
| Clinician On Annual Leave | 11 | 4% |
| Clinic Booked In Error | 11 | 4% |
| Moved to fit in more urgent appt (18 week RTT) | 10 | 3% |
| Moved - Location Issue | 7 | 2% |
| Moved - Staff Issue | 4 | 1% |
| Moved - Trust Rescheduled | 4 | 1% |
| Virtual Clinic | 2 | 1% |
| Moved - Clinic Cancelled | 2 | 1% |
| Clinician Must Attend Training | 1 | 0% |
| MHA Assessment Urgent Work | 1 | 0% |
| **Grand Total** | **287** | **100%** |

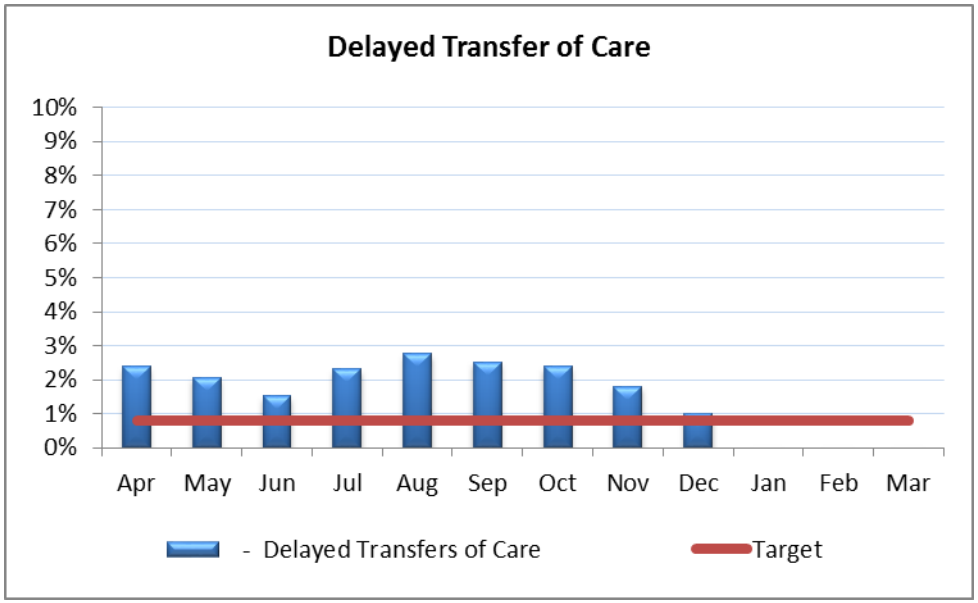
# Outpatient Letters Sent in 10 and 15 Working Days




As reported last month, as expected we fell below target in December owing to sickness and annual leave having a significant impact on capacity.

# Delayed Transfers of Care




The Trust's Target has been set unrealistically low by NHS England at 0.8% which is below the rate currently being achieved and much lower than the former national target for mental health trusts of 7.5%. Main reasons for delays are public funding, housing and awaiting residential home placements, all issues that are largely beyond our control.

Performance is calculated using occupied bed days in the given month as the denominator. The smaller the denominator becomes, the higher is the apparent rate of delayed transfers. In calculating our target, NHSE have estimated that we will have 8384 occupied beds in March 2017 and 8113 occupied beds in September 2017. In reality we have seen a year on year decrease in bed occupancy. If the current pattern continues we would expect to see 8.5% fewer occupied bed days and 32.5% more delayed days than is estimated by NHSE.

Nationally our DTOC rate is low when compared with other mental health trusts: latest published data on NHS Choices ranks us 12th lowest out of 43 Trusts at 2.06%.

# WARD STAFFING

| Ward name | | Day | | Night | | Comments Required | Analysis and Action Plan for 'Average fill rate' above 125% and below 90% |
|---|---|---|---|---|---|---|---|
| | Occupancy % Rate | 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 | 94.67% | 139.7% | 70.1% | 180.6% | 19.4% | Yes | The percentage for which our qualified staff is above 100percent on both days and nights is due to our skill mix change in which we have been given authorisation for 2 additional RN posts to replace 2 NA posts this is to where possible to have 2RN staff working night shifts and 2 in the day. We currently only have 4 full time NA and 1 Part time NA the rest are qualified staff. High number of sickness over the Christmas period so some shifts covered by RN staff to enable safety. |
| CHILD BEARING INPATIENT | 74.44% | 69.6% | 332.2% | 103.2% | 329.0% | Yes | Staffing levels were broken for days (registered and unqualified) and nights (unqualified) due to the high observation levels, infant care required, long term sickness absence and 2.8 WTE vacancy. |
| CTC RESIDENTIAL REHABILITATION | 86.52% | 112.8% | 85.0% | 100.0% | 100.0% | Yes | Cherry Tree Close has broken the current fill rate tolerances because of the reduction of staff due to patients going on home leave over the Christmas period .Staff were granted annual leave during this period to enable them to use up their annul leave for this current year .We also had few staff sickness |
| ENHANCED CARE WARD | 98.33% | 83.6% | 101.7% | 66.1% | 156.5% | Yes | ECW continues to carry both RN and NA Vacancies. We are interviewing to cover NA Vacancies on 24/01/17 and are confident of filling all vacancies. We have taken on 1.6 RNs this month with a further 0.4vacancy being filled on 31/01/17. |
| HARTINGTON UNIT - MORTON WARD ADULT | 96.81% | 123.4% | 137.7% | 53.2% | 232.3% | Yes | We are currently carrying Band 5 vacancies (on going recruitment process to fill these posts) and so cannot always have x2 qualified staff on night duty.<br>We have also been carrying x2 Band 3 vacancies which have now been recruited into and we are awaiting start dates for those staff. |

# WARD STAFFING

| Ward name | | Day | | Night | | Comments Required | Analysis and Action Plan for 'Average fill rate' above 125% and below 90% |
|---|---|---|---|---|---|---|---|
| | Occupancy % Rate | 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 | 94.50% | 117.0% | 75.3% | 40.5% | 145.2% | Yes | Following review of the eRoster the rationale for why there is a higher percentage of qualified on days is because Registered Nurses have picked up bank shifts to cover vacancies and sickness because these have not been covered by Healthcare Assistants or Nursebank when safer staffing levels of 5,5,3 need to be met.<br>The rationale for a lower percentage of qualified staff on nights is because of short term sickness and the need for the second qualified on Pleasley Ward to cover the bleep due to the supernumery bleep holder being off sick. The deficit in safer staffing requirements have been met be bank Healthcare Assistants to ensure 3 staff, where possible, have been on nights. |
| HARTINGTON UNIT - TANSLEY WARD ADULT | 98.06% | 81.8% | 121.7% | 53.3% | 183.9% | Yes | Mitigating circumstances for Registered Nurse deficits:<br>• There are currently 4.4 wte vacancies at Band 5 and 1 and an additional Band 5 on special leave with no provisional date for return.<br>• All posts are open to the rolling recruitment programme and we are actively looking for staff to fill the vacancies. One nurse was recruited at the recent recruitment fayre in Derby however she is still a student and will not qualify until September 2017 and as such unavailable until that time. We have made arrangements for her to complete her current placement on Tansley Ward and have keeping in touch arrangements planned until she qualifies.<br>• Of the staff currently in post 5 registered nurses are under preceptorship having recently commenced in post and are working predominantly day duty as part of their induction to the ward and role. From December onwards they have had periods of rotation onto night duty bringing some of the night shifts in December up to the required numbers.<br>• 1 x Band 5 and 1 x Band 6 Nurse commenced periods of long term sick in December and there was additional short term sickness of Band 5 nurses contributing to the reduction in numbers of registered nurses available for duty. HR and staff support services are fully involved where required and we look forward to supporting them back to work in February if all goes well.<br>• Although the skill mix did not meet the planned requirements registered nurse deficits were covered by Bank HCAs and |

# WARD STAFFING

| Ward name | | Day | | Night | | Comments Required | Analysis and Action Plan for 'Average fill rate' above 125% and below 90% |
|---|---|---|---|---|---|---|---|
| | Occupancy % Rate | Average fill rate - registered nurses / midwives (%) | Average fill rate - care staff (%) | Average fill rate - registered nurses / midwives (%) | Average fill rate - care staff (%) | | |
| KEDLESTON LOW SECURE UNIT | 82.33% | 99.4% | 97.8% | 101.6% | 99.2% | No | |
| KINGSWAY CUBLEY COURT - FEMALE | 65.93% | 67.5% | 83.4% | 62.9% | 102.2% | Yes | Ward has broken the current fill rate tolerances due to reduction in our staffing level in December due to the number of patients we have on the ward (Less than 10 patients all December). Also the ward had high sickness level in December 2016. |
| KINGSWAY CUBLEY COURT - MALE | 71.30% | 83.2% | 123.4% | 64.5% | 171.0% | Yes | increased levels of engagements 1-1 this caused the increase in the number of unregistered staff required<br>Shift request were put out to the bank not all of these shifts were filled<br>Have RN vacancy's out to advert have limited interest in these posts |
| LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP | 86.04% | 112.8% | 67.7% | 72.6% | 158.0% | Yes | Some factors re: staffing last month:<br>Band 5 seconded to CCM for 6 months.<br>Bleep off site for band 6's and 7 – 9 shifts.<br>Training commitments – 14 R/N days.<br>1 NA Long Term Sick and 8 short term sick days (4RN's and 4 NA's).<br>Bank unable to cover some shifts requested.<br>No agency shifts used.<br>Staff movement between wards, both registered and unregistered, to cover emergency shortages caused by sickness etc. – 10 ward 1 staff days went to other wards but 11 came to the ward from other wards. |
| LONDON ROAD COMMUNITY HOSPITAL - WARD 2 OP | 61.88% | 108.0% | 75.3% | 109.7% | 112.9% | Yes | The patient numbers on the ward were low at that time and staff had been used else where to support other areas,<br>The RN percentage was also a little higher than usual which also off sets the NA ratio. |
| RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT | 103.67% | 78.8% | 136.5% | 54.8% | 124.2% | Yes | Ward 33 have 7.8 Band 5 vacancies and the shifts are staffed with unqualified staff where we cannot achieve the current fill rate for Registered Staff. |
| RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT | 101.50% | 102.1% | 112.5% | 46.8% | 306.5% | Yes | Ward 34 continue to carry vacancies which is being addressed through recruitment, however ward 34 is not in a position to take any more preceptorship nurse due to currently having 5 and a lack of experience on the ward. Ward 34 continue with a high level of clinical activity. |
| RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT | 100.33% | 71.2% | 131.5% | 66.1% | 138.7% | Yes | We currently have qualified staff vacancies and a number on maternity leave |
| RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT | 100.50% | 74.4% | 101.0% | 50.0% | 124.2% | Yes | |

# Workforce Section

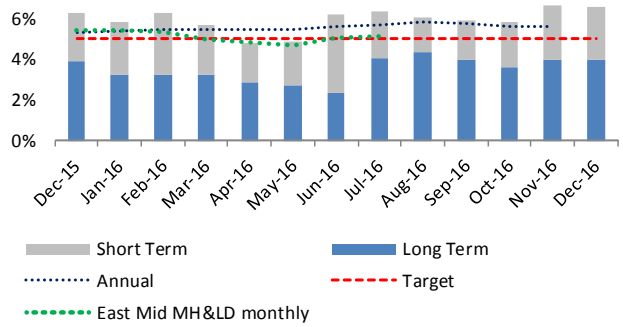
WORKFORCE DASHBOARD

Wellbeing

## Sickness Absence

| (Monthly) | Oct-16 | Nov-16 | Dec-16 |
|---|---|---|---|
| | 5.85% | 6.65% | **6.55%** |

Target 5.04%

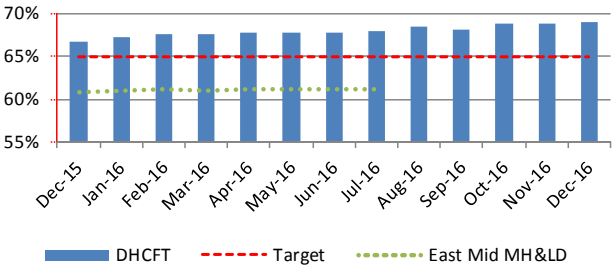



The monthly sickness absence rate is 0.10% lower compared to the previous month, however it is 0.27% higher than in the same period last year. The Trust annual sickness absence rate is running at 5.60% (as at Nov 2016 latest available data). In Nov 2016 long term sickness increased by 0.35%, notably surgery, and short term absence increased by 0.45%, notably cold-cough-flu. Cold-cough-flu continues at the same level this month and surgery has increased further. Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 24.35% of all sickness absence, followed by surgery at 15.85% and cold-cough-flu at 9.54%.

## Qualified Nurses

| (To total nurses, midwives, health visitors and healthcare assistants) | Oct-16 | Nov-16 | Dec-16 |
|---|---|---|---|
| | 68.75% | 68.86% | **69.05%** |

Target 65%

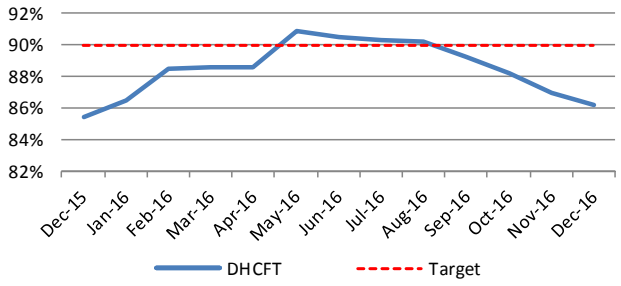



Contracted staff in post qualified nurses to total nurses, midwives, health visitors and healthcare assistants is running at 69.05%. Vacancy rates can impact on this measure. The average for East Midlands Mental Health & Learning Disability Trusts is 61.19%. Health Visitors represent 5.20% of the Trust total and are not included in the Qualified Nurses calculation. Healthcare Assistants and Nursing Support staff represent 25.75% of the total.

## Compulsory Training

| (Staff in-date) | Oct-16 | Nov-16 | Dec-16 |
|---|---|---|---|
| | 88.22% | 86.94% | **86.21%** |

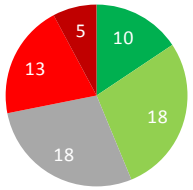
Target 90%

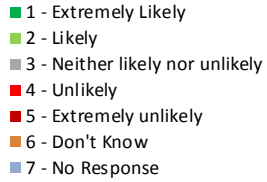



Compulsory training compliance continues to remain high running at 86.21%, although a decrease of 0.73% compared to the previous month. Compared to the same period last year compliance rates are 0.77% higher. Compulsory training compliance remains above the 85% main contract commissioning for quality and innovation (CQUIN) target.

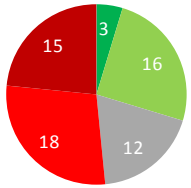
## Staff FFT Q2 2016/17 (In-Patient campus focus; 64 responses, 10.08% response rate) & Staff Survey 2015

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




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

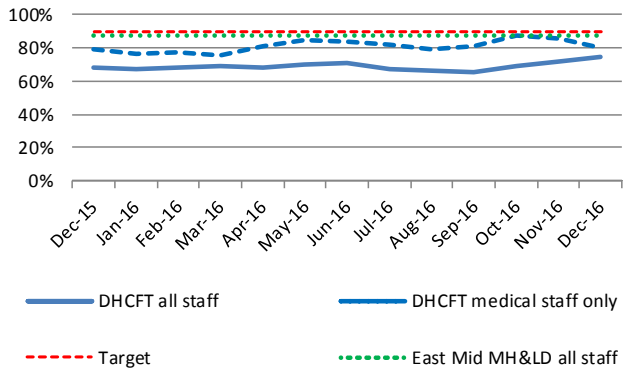



| | 2014 | **2015** | National Average |
|---|---|---|---|
| Overall staff engagement | 3.75 | **3.73** | 3.81 |

## Appraisals

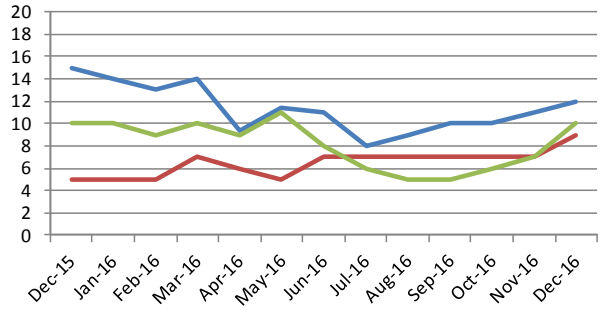
| | Oct-16 | Nov-16 | **Dec-16** |
|---|---|---|---|
| (All staff) | 68.66% | 72.24% | **74.28%** |

*Target 90%*

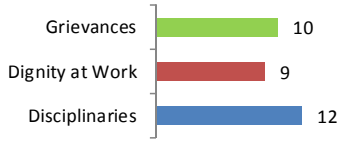



The number of employees who have received an appraisal within the last 12 months has increased by 2.04% during December 2016 to 74.28%. Compared to the same period last year, compliance rates are 6.33% higher. Medical staff appraisal compliance rates are running at 80.19%. According to the 2015 staff survey results, the national average for Mental Health & Learning Disability Trusts is 91%. Local benchmarking data for a range of Trusts in the East Midlands shows an average completion rate of 82.86%.

## Grievances/Dignity at Work/Disciplinaries as at 31/12/16



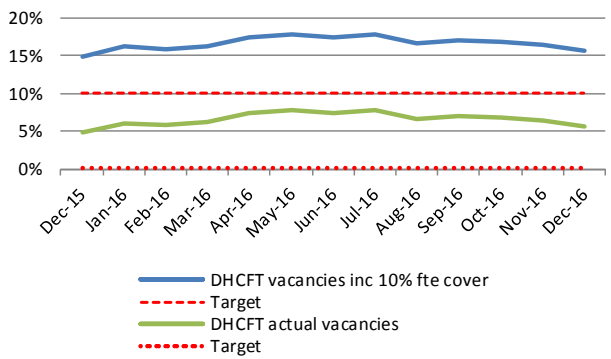

There are 10 grievances currently lodged at the formal stage, 3 new grievances have been lodged and efforts continue to resolve the issues. There are 9 dignity at work cases currently lodged, 2 of which are new cases. Efforts continue to bring existing cases to a conclusion. There are 12 disciplinaries in progress, 1 case has been resolved and 2 new cases have been received. It is anticipated that at least one case will be resolved in the near future.



WORKFORCE DASHBOARD

Attendance

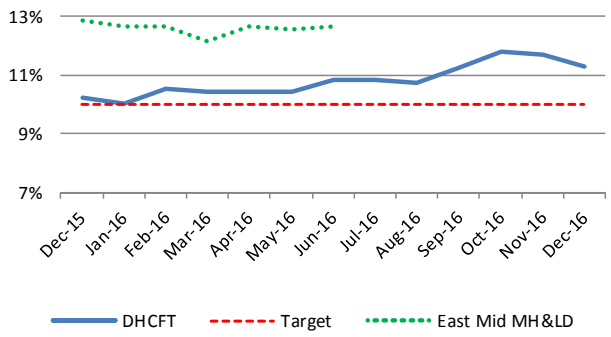
| Vacancy | | Oct-16 | Nov-16 | Dec-16 |
|---|---|---|---|---|
| (Budgeted full time equivalent) | Including 10% funded fte flexibility/cover | 16.82% | 16.40% | **15.63%** |
| | Actualagainst target | 6.82% | 6.40% | **5.63%** |




*Target 10%/0%*

The Trust target for contracted staff in post is 90% which allows 10% funded full time equivalent surplus for flexibility including sickness and annual leave cover in In-Patient areas. The budgeted fte vacancy rate has decreased by 0.77%. April 2016 included additional full time equivalent investment for 2016/17. New recruitment activity during December 2016 was for 92 posts. 49% were for qualified nursing, 18% medical, 19% admin, 7% allied health professionals, 4% prof-scientific-technical, 2% additional clinical services and 1% estates-ancillary.

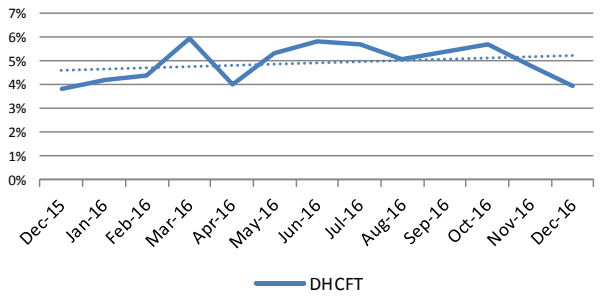
| Turnover | Oct-16 | Nov-16 | Dec-16 |
|---|---|---|---|
| (Annual) | 11.79% | 11.71% | **11.28%** |




*Target 10%*

Annual turnover remains within Trust target parameters at 11.28% and remains below the average for East Midlands Mental Health & Learning Disability Trusts. The average number of employees leaving over the last 12 months has decreased slightly to 22.75. During December 2016 16 employees left the Trust which included 3 retirements. A key factor still remains for the increase in recent turnover rates, which is a reduction in overall contracted staff in post caused by unfilled vacancies.

| Agency Usage | Oct-16 | Nov-16 | Dec-16 |
|---|---|---|---|
| (Spend) | 5.65% | 4.79% | **3.91%** |




Total agency spend in December was 3.91% (4.56% including medical locums). Of total agency and locum spend for all staff groups, Qualified Nursing represented 0.5%, Medical 2.8% and other agency usage 0.6%. Agency Qualified Nursing spend against total Qualified Nursing spend in December was 1.4%. Agency Medical spend against total Medical spend in December was 15.8%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £1.392m of which £820k related to Medical staff.

# Quality Section

## Strategic Risks (Board Assurance Framework)

| Risk Description | Risk rating | Trend |
|---|---|---|
| 1a) Failure to achieve clinical quality standards | HIGH | ⟷ |
| 1b) Risk of not operating inclusively to deliver equity of outcomes for staff and service users | MOD | ↓ |
| 1c) Risk to delivery of care due to being unable to source sufficient clinical staff | HIGH | ⟷ |
| 1d) Lack of compliance with MHA Code of Practice and MCA | HIGH | NEW |
| 1e) Lack of compliance with Civil Contingencies Act (identified through EPRR process) | HIGH | NEW |
| 2a) Risk to delivery of national and local system wide change. | HIGH | ⟷ |
| 3a) Loss of public confidence due to Monitor /CQC notices and adverse media attention | HIGH | ⟷ |
| 3b) Loss of confidence by staff in the leadership of the organisation at all levels | HIGH | ⟷ |
| 4a) Failure to deliver short term and long term financial plans | HIGH | ↓ |
| 4b) Failure to deliver the agreed transformational change at the required pace | HIGH | ⟷ |

3c) Risk associated with turnover of the Board has been closed.

## Clinical Risks (Significant). *The list below relates to themes from across a number of risk assessments recorded on Datix*

| Risk Description | Risk rating | Trend |
|---|---|---|
| Significant staffing level risks across a number of service areas remain: Radbourne Unit, pharmacy, paediatricians, psychology, neighbourhood teams. A number of risks associated remain with exceeding of the agency cap for reasons of patient safety | HIGH | ⟷ |
| Associated with the number of staff vacancies, risks related to work related stress and increased risks of violence and aggression on the Radbourne Wards remain | HIGH | ⟷ |
| Risks with respect to discharge from the DRH and transfer across neighbourhood boundaries remain | HIGH | ⟷ |
| New risks have been identified in relation to: patient transport, Section 136 suite and adherence to the waiting list policies | HIGH | |

**Derbyshire Healthcare NHS Foundation Trust**
Report to Board of Directors 1 February 2017

# Quality Position Statement

The purpose of this report is to provide the Trust Board of Directors with an update on our continuing work to improve the quality of services we provide in line with our Trust Strategy, Quality Strategy and Framework and our strategic objectives.

## Executive Summary

This position statement sets out:

1. Learning Candour and Accountability
2. Quality Leadership teams and commencement of the Trust management meeting
3. Quality visits and feedback from the January review forum
4. CQC action planning from the June comprehensive inspection visit and the Joint area local SEND inspection in Derbyshire

## Strategic considerations

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

## (Board) Assurances

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

## Consultation

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

## Governance or Legal issues

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

Children and Families Act 2014

**Equality Delivery System**

Any impacts or potential impacts on equality have been considered as part of all our quality work, the risks to older men of working age remains a focus of the suicide prevention strategy and work plan.

Children with disabilities have a number of protected characteristics and this group and specifically excluded children have special requirements and the Trust has duties to discharge their duties as effectively as they can to fully discharge their duties under the Children and Families Act 2014.

The report specifically notes under some specific feedback on the use of comprehensive, accurate data to inform health service provision is underdeveloped in Derbyshire. This is a risk to delivery of an effective service if the data set that services is not of the requisite standard.

There are wider concerns re the proportion of adults with learning disabilities in paid employment is too low and below the national average, the data set that is used may not be the Trust commissioned services. However further exploration of this issue to review the performance of the Trust services will be undertaken to learn from this wider systems review.

**Recommendations**

The Board of Directors is requested to:

1) Receive this quality position statement
2) Gain assurance, be advised on quality leadership strategy and engagement and information on its content and seek clarity or challenge on any aspect of the report

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

# QUALITY POSITION STATEMENT

## 1. SAFE SERVICES

### 1.1 The CQC published its review of learning, candour and accountability

The Trust is completing a review of this paper which will be led by the Quality Committee, the Medical Director and the Lead professional for Patient Safety and will also involve a review with Commissioners at the joint quality assurance meeting in January in addition the Quality committee received a detailed report against the recommendations.

In the spirit of public accountability the Trust is submitting its full assessment in to the public domain.

**CQC, Learning, candour and accountability report**

http://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

The above report was published in December 2016. The report has made seven recommendations, with the focus being that investigating deaths becomes a much greater priority for health and social care, with opportunities to improve patient care at local and national level. The report asks for Trust boards and CCG to support changing the way we learning from investigating deaths. Recommendations 1 - 6 are co-ordinated by HEE, DOH, NHSI, NHSE.

**Recommendation 7 –**

This recommendation asked for provider organisations and commissioners to review local approach and ensure national guidelines are implemented.

- Patients who have died under their care are properly identified – Trust SUI policy defines which deaths should be reported on the Trust incident reporting system Datix, these deaths are then reviewed at the SIG. All other deaths are notified through EPR (Paris and System one), these deaths will be reviewed at the Trust Mortality Group. The Trust has appointed a Mortality Technician, who will support with data collection and Analysis. The Mortality review group at the last meeting reviewed deaths within the Liaison Team, south, looking at themes and learning from trends, for example changing questions asked in assessments.

- Case records of all patients who have died are screened to identify concerns and possible areas for improvement and the outcome documented – The mortality technician, to the Mortality Group will support this role, as part of data gathering and learning. The group will review Mazars tools, and this will form part of the death data base which is being set up.

- Staff and families/carers are proactively supported to express concerns about the care given to patients who have died – The Trust has appointed a Family Liaison team, they contact all families (when contact details are known and there was consent) of all deaths reported through Datix. The Family Liasion team supports families through the investigation process, and ensures that they have input in to the Terms of Reference if they wish, and that that on completion on the investigation all the families questions have been answered. The team also feeds back the findings to families and is able when requested supports at an inquest. The FL team works alongside the PET (complaints team) and this has streamlined the

process when families express concerns with patient care and are able to provide a single point of contact.

- Appropriately trained staff are employed to conduct investigations – Staff completing Serious incident investigations have Trust Root Cause Analysis training, this has recently been reviewed and amended, it also starts to implement in more detail around human and system learning factors. We are planning to roll out half day refreshers in the new financial year April 2017. The Trust is also taking part in a pilot with East Midlands Academic Health Science Network, on service improvement and specifically at how human and system factors can be used in investigating serious incidents. From April 2017, funding is in place from Trust business planning to recruit 2 whole time investigation facilitators at band 7, Investigation Facilitators, who will support the completion of investigations.

- Where serious concerns about a death are expressed, a low threshold should be set for commissioning an external investigation – The Trust has supported all external investigations, and will continue to do so. Discussing external investigations with CCG and other partners. The patient safety lead, attends quarterly meetings with NHSE (midlands group) who share learning from all midlands Trusts external investigations.

- Investigations are conducted in a timely fashion, recognising that complex cases may require longer than 60 days – The Trust currently has 10 externally reportable investigations, overdue (though not all these are deaths). The Trust recognises this is an area for improvement, but not at the cost of the quality of investigation, the patient safety team meet monthly with the CCG, all overdue investigations are reported to the Director led Serious Incident Group weekly, and there is an exculpation process in place to raise with investigating officers line management. With in the job role of the Mortality Technician allocated time to support Serious Investigation administration has been identified and funding appointed to appoint two investigation facilitators, starting in April 17.

- Families and carers are involved in investigations to the extent that they wish – As previously mentioned the Family Liaison team fulfil this recommendation. We do have families that do refuse this support and involvement and we respect their wishes and understand that at times this may fluctuate, in line with the grieving process.

- Learning from reviews and investigations is effectively disseminated across the organisation, and with other organisations where appropriate – this is also a recognised area for improvement, with a revised practice matters coming out early this year. The patient safety lead is an active member in learning clinics and sharing forum across the Midlands. Learning from incidents and themes from this has been added to the Root Cause analysis training.

- Information on deaths, investigations and learning is regularly reviewed at board level, acted upon and reported in annual Quality Accounts – the trust Medical Director, is already in place as lead and chairs the Serious Incident Group. A monthly Serious Incident report is presented to Quality Committee, which reports on number of deaths, reported as Serious Incidents' and learning. The mortality group review all deaths (thematically). A review of data on the quality dashboard (EF and DT) is being undertaken in light of this recommendation.

- That particular attention is paid to patients with a learning disability or mental health condition – All deaths of patients with a Learning Disability are reported on Datix. All patients in receipt of Mental Health services ( at the time or 12 months prior to death) are reported on Datix if they meet Serious Incident /incident reporting criteria.

- We also recommend that provider Boards strongly consider nominating a non-executive director to lead on mortality and learning from deaths – the Quality Committee has considered this request and Anne Wright Clinical lead Non-Executive Director for Quality has been confirmed. There are no known duties for this role or role descriptor to reduce potential differences in how this role is undertaken in Trust. If this information is released nationally Anne will be supported in this endeavour, until then her role as an ex director of Public Health and her understanding of the role of Child death overview panels will be key to considering both quantitative and qualitative approaches to this work.

**Action: The Quality Committee to lead the review of this published paper on publication of the revised investigation framework in 2017. The Lead Professional for Patient Safety will adopt this into Trust practice.**

## 2. WELL LED

### 2.1 Quality Leadership

The Executive Director of Nursing and Patient Experience attended a Quality governance CPD event with the Quality Leads in the services. The events explored Quality Governance and models of how this has developed over the years. Also discussed, was the new Trust management group, streamlining of meeting structures to integrate the senior management team and QLT structures.

Further development and an education and improvement plan to really understand the needs of our clinical leadership group will be developed by the Medical Director and Nurse Director to understand the role of quality governance, visits to external service, review of board papers of other Trusts and a review of appraisal objectives for all staff with clinical leadership responsibilities that have key quality governance objectives.

In addition the Trust wide governance improvement action plan following the January well led inspection recommended a sub quality group to the quality committee to reduce the risk of the Quality committee being required to deep dive into operational matters rather than maintaining its assurance focus. A sub group to the Quality committee was designed and briefings to the Trusts Quality leadership team were put in place, this was revised by the Executive leadership team to develop a Trust management meeting to focus on integrated quality, operational and financial performance. This has commenced in January 2017 and one of the first key objectives was a unified and joint leadership response to reviewing complaints response times and a systems response to improvement and working on collective responsibility to embed governance improvements in ensuring best clinical practice is reviewed and put in practice.

**Action: Medical and Nurse Director to consult with key quality colleagues on required and developmental needs and submit a joint paper to the People and Culture committee on a developmental solution to support individuals on their scope of role. To develop an improvement plan to meet this need.**

## 2.2 Findings from Quality visits

The Trust held a quality visit review of the season visits with external and internal; quality visit members to reflect on the learning and improvements for the season. This was a passionate and positive event.

A technical guidance and new briefing on quality visits is in development following this meeting and will be issued prior to the commencement of the new season.

The Trust executive team would formally like to express thanks to our Governors and commissioners for their continued support in quality visits to all of our Corporate and clinical service.

The outcome was:

- A revised quality visit theme was agreed by the group. The decision was to maintain showcasing of any practice which was linked to the regulatory quality standards of the CQC key lines of enquiry with the addition of family inclusive practice and or / the Triangle of Care for Clinical services and for Corporate services to showcase inclusivity/ accessibility in line with our Equalities agenda to replace this year's Corporate theme of efficiency.
- 
- The design of addition information for a Quality visit technical guidance and a small adjustment to the model of practice to include some self-assessment of key compliance information.

**Action: The Deputy Director of Nursing and Quality governance will lead this work and improvements**

## 2.3 Care Quality Commission Comprehensive Inspection

The CQC full inspection report was published on 29 September 2016. We continue to work on our action plan. December has been a busy month with continued progress in all areas of the CQC portal and progress on actions in all areas.

In addition, in December 2016 we submitted additional evidence and the Trust also received an unannounced inspection of the Kedleston unit, the Older Adults service and Child Health under the Safety domain were all re-visited in December and January 2017. We look forward to receiving our re-inspection reports in January 2017 for factual accuracy checks and publication in January to February 2017.

This will be led by the joint Quality leads and overseen from an assurance level by the Quality Committee.

## 2.4 Joint area local SEND inspection Derbyshire

In May 2016, the two inspectorates, Ofsted and the Care Quality Commission (CQC), started a new type of joint inspection. The aim is to hold local areas to account and champion the rights of children and young people.

Under the Local area special educational needs and disabilities inspection framework, inspectors review how local areas meet their responsibilities to children and young people (from birth to age 25) who have special educational needs or disabilities (or both).

Children and young people with special educational needs or disabilities (or both) often receive a number of different services. These could be provided by nurseries, schools or colleges and specialist therapists, as well as professionals in education, health and social care.

Under the Children and Families Act 2014, the government placed new duties on the local health, social and education services that provide for these children and young people. The Special Educational Needs Code of Practice was updated to reflect these new duties.

In particular, the local area health, social and education services need to work together to:

- publish a 'local offer' setting out the support and provision in the area for children and young adults with special educational needs or disabilities (or both)

- provide accessible information to children and young people, as well as parents and carers, about the services and support available in the local area

- work with children and young people, their parents and carers, and service providers to make sure that any special needs or disabilities (or both) are identified as early as possible

- assess (in co-operation with children and young people and their parents and carers) the needs of children and young people with special educational needs or disabilities (or both) who may need an education, health and social care plan (EHCP)

- produce an EHCP for all children and young people who are assessed as needing one (all relevant agencies should cooperate to do this and involve the children and young people and their parents and carers)

- provide children and young people with the support agreed in their EHCP, and regularly review their plans

Inspectors will be looking for evidence of how children and young people with special educational needs or disabilities (or both) are identified, how their needs are assessed and met, and how they are supported to move on to their next stage of education, the world of work and wider preparation for adulthood.

Inspectors will not carry out inspections of individual education, social care or health services or providers and they will not make any judgements on the decision-making or the quality of support provided to individual children or young adults.

In November 2016, Derbyshire system undertook special educational needs or disabilities assessment and the findings have been reported and published. The local authority and the chief commissioning officers have been sent a letter to inform them of the findings of good practice and areas to improve.

The letter is published Ofsted website and on the CQC website along with all previous inspections of this nature. The Derbyshire letter will is attached.

**Action:**

1. The Safeguarding Committee will lead the receipt of the full letter and associated health and system actions plans and oversee the section of Derbyshire services that the Trust is a care provider for and implement all aspects that impact upon the Trust and its provision.

2. The Trust will use this learning from the Derbyshire inspections in preparation for a Derby City Local area special educational needs and disabilities inspection framework.

3. The Trust will use the learning from this letter to consider some specific feedback on the use of comprehensive, accurate data to inform health service provision is underdeveloped in Derbyshire. The letter also identifies a legacy of fragmented commissioning and the lack of equal access to 24/7 community children's nursing and the children's learning disability service. It was noted by commissioners that they recognised that there is more urgent action needed to improve transition arrangements for young people up to the age of 25 into adult services.

4. In wider learning, the proportion of adults with learning disabilities in paid employment is too low and below the national average. Plans to address this are underdeveloped and consequently are unlikely to result in significant improvements. The Learning Disability Clinical reference group will review this data submitted and compare the City and South services against this benchmark and review their own strategy, performance and development plans in this area of practice and report to the Quality committee on their findings. The Trust has a positive history in social recovery and enablement and Neighbourhood and Central service Lead professional for Occupational Therapy will draft a position

statement with the Learning disability services on the Trust performance, the evidence base and learning. This may be an area of collaboration with Derbyshire Community services to develop shared service improvements.

**Report prepared and presented by**
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21 November 2016

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Steve Allinson, Clinical Commissioning Group Chief Officer, North Derbyshire

Andy Gregory, Clinical Commissioning Group Chief Officer, Hardwick

Rakesh Marwaha, Clinical Commissioning Group Chief Officer, Erewash

Gary Thompson, Clinical Commissioning Group Chief Officer, South Derbyshire

Steve Pleasant, Clinical Commissioning Accountable Officer, Tameside and Glossop

Kathryn Boulton, Local Area Nominated Officer

Dear Ms Parfrement

**Joint local area SEND inspection in Derbyshire**

From 14 to 18 November 2016, Ofsted and the Care Quality Commission (CQC) conducted a joint inspection of the local area of Derbyshire to judge the effectiveness of the area in implementing the disability and special educational needs reforms as set out in the Children and Families Act 2014.

The inspection was led by one of Her Majesty's Inspectors from Ofsted, with team inspectors including an Ofsted Inspector and a Children's Services Inspector from the Care Quality Commission (CQC).

Inspectors spoke with children and young people who have special educational needs and/or disabilities, parents and carers, representatives of the local authority and National Health Service (NHS) officers. They visited a range of providers and spoke to leaders, staff and governors about how they were implementing the special educational needs reforms. Inspectors looked at a range of information about the performance of the local area, including the local area's self-evaluation. Inspectors also met with leaders from the local area for health, social care and education. Inspectors reviewed performance data and evidence about the local offer and joint commissioning.

This letter outlines the findings from the inspection, including some areas of strength and areas for further improvement.

## Main findings

- Leaders in the Derbyshire local area have taken effective account of the reforms. Professionals from education, health and social care agencies and other stakeholders are working together more closely than previously to support children and young people who have special educational needs and/or disabilities (SEND). However, the understanding of frontline staff of their roles and responsibilities in relation to the implementation of the reforms varies between agencies.
- There is clear commitment from strategic leaders to ensure that the legacy of fragmented commissioning does not affect children and young people's access to services in the future. Alongside investment in countywide pathways to services, there is a clear, well-understood strategic vision to support equitable provision of health services across Derbyshire.
- Leaders and managers have devised an effective hierarchy of strategic stakeholder task groups. Staff and stakeholders from across these groups regularly share information and jointly commission and implement the planned improvements. Overall, recent improvements have ensured that the needs of children and young people who have SEND are identified more quickly and are well supported. However, there are some inconsistencies and some children and young people are yet to benefit from the developments.
- The local area leaders have a very good understanding of how effectively the local area identifies and meets the needs of children and young people who have SEND. Leaders have evaluated their work to implement the SEND reforms effectively and rigorously. They have accurately identified the areas that they need to improve.
- Leaders understand the challenges involved in successfully implementing the reforms. They recognised at an early stage that to implement the changes fully, not only was a change in organisation and processes required but also a change in the culture and values of the local area. Consequently, leaders have sought to ensure that changes are based on, or reflect, a shared set of principles and values.
- Stakeholders from across the local area, including children, young people and parents and carers, are well represented and their voices are listened to. Their views are taken into account at a strategic level and to a lesser extent at an operational level. However, the further away children, young people, parents, carers and local area staff are located from key partners, the less informed and engaged they are.

- Leaders have trialled key changes that they have made before implementing them more widely. This has enabled leaders to evaluate the impact of the proposed changes before they are made and make good use of resources. Derbyshire Parent and Carer Voice and Derbyshire Information, Advice and Support Service (DIASS), with partners such as the Independent Parental Special Education Advice (IPSEA) and the Education Psychology Service, provide effective support to parents and carers. They also provide local area leaders with valuable feedback representing the views of parents and carers, which helps to shape future arrangements.
- There has been no consistent approach to training health professionals to empower them to deliver the SEND reforms. Consequently, any developments rely on individual teams. Similarly, the use of comprehensive, accurate data to inform health service provision is underdeveloped in Derbyshire.
- Leaders have acted decisively to address the increased caseload of health visitors and ensure that the needs of individual children are identified, by recruiting additional trained health visitors.

## The effectiveness of the local area in identification of children and young people who have special educational needs and/or disabilities

### Strengths

- The introduction of GRIP (graduated response for individual pupils) has improved the accuracy of SEND needs identification and the provision of support. GRIP also supports effective decision-making in the education, health and care assessment process.
- The appointment of 14 SEND officers has established an approach that places children and young people, parents and carers at the centre of the education, health and care planning process. In cases where a facilitator or SEND officer led and supported the process, parents and children and young people reported greater satisfaction with the process and the outcome. In addition, the resulting plans have more effectively identified the needs of the child or young person and have set out the support they should receive clearly and unambiguously.
- Identification of need through universal services is effective and enables health visitors and school nurses to make prompt and supportive interventions. For example, the screening pathways within 0–19 universal services utilise multi-agency relationships to embed sound processes in delivering the healthy child programme. Appropriate GP and health visitor pathways also facilitate timely support to families. An increased number of health visitors helps to ensure that appropriately qualified practitioners continue to identify needs effectively. In addition, schools support the return of school health screening questionnaires, and there are good return rates from health screening of all children on entry to school and again at Year 6.

- A successful section 75 agreement ensures a joined-up approach to the commissioning of services for those children who meet the local criteria of 'high complex needs'. Local area leaders are making good progress in their development of a single approach to the provision of personal health budgets across the Derbyshire local area. This joined-up approach is leading to improvements in the provision of community-based equipment for children and young people with SEND.

**Areas for development**

- Some children and young people have not had education, health and care plan (EHCP) or SEND statement reviews supported or led by an EHCP facilitator or SEND officer. They, and their parents and carers, are reliant on school staff to secure the participation of all relevant stakeholders to identify the needs of the child or young person. Consequently, the contribution of staff from other agencies has been inconsistent and has resulted in some needs not being accurately identified and addressed.
- Despite employing a range of appropriate strategies, local area leaders and managers have not yet enabled most parents to develop a secure understanding of the process for identifying children and young people's SEND. Some parents and carers continue to believe that their children cannot be considered for EHCP assessment until they have a diagnosis or assessment from a professional, for example a paediatrician or an educational psychologist.
- Providers and commissioners do not have effective oversight of the numbers of children and young people with SEND on their caseload. Insufficient use is made of data to identify the needs of children and young people across health caseloads.
- A legacy of fragmented commissioning arrangements and lack of consistent data are hampering the work of health partners to implement the SEND reforms. Families across Derbyshire do not have equal access to services, including continence services, 24/7 community children's nursing and the children's learning disability nursing team. Commissioners recognise that there is more urgent action needed to improve transition arrangements for young people up to the age of 25 years into adult services.
- Some health services and managers do not maintain an effective oversight of the numbers of children with SEND (with or without an EHCP). This limits managers' understanding of practitioner caseload complexity and their capacity to ensure equitable service delivery and accurately plan for future service delivery. Some processes are in place in areas to start to collect the data. For example, at Chesterfield Royal Hospital there is a single point of access for requests for input into EHCPs.
- Resources allocated to the role of the designated medical officer (DMO) are insufficient to implement the SEND reforms in full across health services in

Derbyshire. The DMO is not able to maintain oversight of how effectively children and young people are having their health needs met through EHC planning.

## The effectiveness of the local area in assessing and meeting the needs of children and young people who have special educational needs and/or disabilities

### Strengths

- In those cases where co-production of plans has been strong, either led or facilitated by special educational needs coordinators (SENCos), EHCP facilitators or SEND officers, needs have been met and parents and children and young people believe that they receive good support.
- Similarly, where schools have a good understanding of the reforms, they meet the needs of the children and young people well. For example, a further education college worked very effectively with public health to raise awareness of social, emotional and mental health needs in a college setting.
- Increasingly, the local area is working effectively with local education leaders to improve the range and quality of SEND provision. An example of this is reducing out-of-area placements for children and young people with autism spectrum disorder by increasing provision within the local area.
- A 'tell-it-once' approach ensures that some parents, children and young people do not have to repeat their story when they meet with a new professional. The approaches, including one-page profiles and direct referrals to community paediatricians from universal services, were co-produced by staff, parents and young people and support effective communication between services. 'Tell-it-once' approaches are increasingly embedded within school SEND practice, therapies and universal health services across Derbyshire.
- Children looked after by Derbyshire who are placed outside of the local area benefit from having their health assessments and reviews carefully checked by the children in care health team. This process helps to ensure that the children's health needs are consistently met. It also provides the corporate parenting board with assurance that there is oversight of this vulnerable group of children.

### Areas for development

- The local offer is not always straightforward for users to access. For example, the 'key word search' function does not enable users to find the information they are looking for very easily. Some parents and health professionals are not well informed about the local offer despite the range of strategies the local area has employed to inform them.
- Waiting times for community paediatricians are too long, and sometimes are up to 18 months. Long waiting times can have a negative effect on timely completion of education, health and care assessments because medical information may be

missing. As a result, the needs of a minority of children and young people are not fully understood or met. This leaves them, and their parents and carers, feeling frustrated and dissatisfied. Leaders have recognised this issue and a management plan, supported by additional investment, has been implemented, as part of an initiative to reduce waiting times.

- The local area has developed and trialled an effective model to ensure that stakeholders and partners work together to construct EHCPs. However, the impact to date has been limited to those cases within the trial or those more recently initiated.
- Managers in the local area have a positive record of making payments, including payments of personal budgets and direct payments to families. However, too few are focused on meeting the learning needs of children and young people with SEND. Some parents remain ill informed about how to access personal budgets. Few parents who do understand the arrangements choose to apply for personal budgets, because they remain anxious that managing the budget will be too complex.
- Frontline health professionals across the local area have a variable understanding of the SEND reforms and the implications for their statutory roles and responsibilities. For example, poor awareness of the local offer has meant that health practitioners are not consistently signposting families or supporting them to access it. There has also been an inconsistent approach in the local area to contributions towards the health element of EHC plans.

## The effectiveness of the local area in improving outcomes for children and young people who have special educational needs and/or disabilities

### Strengths

- Children and young people with SEND in Derbyshire who attend early years provision or primary schools typically do as well as or better than their peers in other areas of the country. For example, the proportion of children achieving the national standard in phonics in Year 1 has improved and is now broadly in line with the national average. Key stage 2 children have made at least the same progress as their peers nationally in reading, writing and mathematics and in some cases have made better progress and attained higher outcomes than their peers nationally by the end of Year 6.
- Similarly, those young people who attend secondary schools and further education settings make good progress and remain in education, employment or training. For example, SEND pupils make better progress in reading, writing and mathematics from key stage 2 to key stage 4 than their peers nationally. In addition, the vast majority of young people were in employment, education or training in the first two terms following the completion of A levels.
- Leaders and managers have taken effective action to reduce the level of exclusions for pupils with SEND. Consequently, levels of fixed-term exclusions

have decreased and are close to the national figure for this group. Permanent exclusions have also decreased and are now in line with national averages. Leaders have taken robust action to challenge those few schools where exclusions of SEND pupils are too high.

- Establishing education, health and care planning facilitators and appointing SEND officers has improved the timeliness with which EHCPs are completed. It has also improved the rate of conversion from statements of special educational needs to EHCPs. As a result, the local area is on track to meet statutory deadlines. Similarly, when pupils and parents or carers have been well supported, by SEND officers, EHCP facilitators or effective school SENCos, children and young people have a good understanding of their targets and how the support they receive helps them to learn well and achieve their outcomes.

**Areas for development**

- The proportion of adults with learning disabilities in paid employment is too low and is below the national average. Plans to address this are underdeveloped and consequently are unlikely to result in significant improvements.
- Too few parents or carers are taking up personal budgets. As a result, they are not accessing the services and support that they need to help their children to learn more effectively. This is a missed opportunity for the local area, parents and carers and most significantly for children and young people.
- In health services across Derbyshire, 'preparation for adulthood' pathways are inconsistent in their effectiveness. Transition arrangements for young people from the 'continuing health care team' into adult primary care services are weak. In some cases, practitioners are unable to identify an appropriate service or practitioner for young people with complex needs. Consequently, young people and families in Derbyshire may find it difficult to identify services that address health needs when preparing for adulthood – a time when they are at their most vulnerable.

Please accept my thanks for the time and cooperation that all representatives from the local area gave to the inspection team. I hope you find the content of this letter useful in helping you to tackle the areas identified for further development.

Yours sincerely

Derek Myers
**Her Majesty's Inspector**

| Ofsted | Care Quality Commission |
|---|---|
| Christopher Russell<br>Regional Director | Ursula Gallagher<br>Deputy Chief Inspector, Primary Medical Services Children, Health and Justice |
| Derek Myers HMI<br>Lead Inspector | Lucy Harte<br>CQC Inspector |
| Jackie Lown<br>Ofsted Inspector | |

CC: Clinical Commissioning Group
Director, Public Health for the Local Area
Department for Education
Department of Health
NHS England

# Board Committee Summary Report to Trust Board
# Audit & Risk Committee – 17 January 2017

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other Committee) |
|---|---|---|---|---|---|
| **Draft Minutes of the Audit & Risk Committee meeting 13 December 2016** | The minutes were presented and reviewed for accuracy. | Full assurance was received that these were an accurate record of the meeting. | **-** | Agreed as an accurate record of the meeting. Ratified December minutes to be included in February Public Trust Board papers. | **None.** |
| **Actions Matrix**<br>**Matters Arising** | All actions were reviewed and updates noted. | Significant assurance received on progress and completed actions agreed. | **-** | Updates to actions matrix agreed. | **None.** |
| **RISK** | | | | | |
| **Review of Board Assurance Framework:** | Sam Harrison presented the Quarter 3 BAF report noting good engagement with Executive Directors in updating and review.<br><br>Rachel Kempster provided detail on the risk and updates provides during the last quarter. | Significant assurance of engagement with Executive Leads in ongoing BAF review was noted.<br><br>Partial Assurance was received regarding progress with the Emergency Planning risk in that good progress had been made in developing the strategy and that this had been reviewed by the January Quality Committee. | Risks as outlined as part of BAF. | Agreed to be presented to Trust Board subject to amendments and updates as outlined – and to incorporate recommendations arising from Deep Dive discussions (as outlined below).<br><br>Rachel Kempster is to seek update on Emergency Planning risk prior to finalising Board report. | None. |
| **Deep Dive BAF Risk 3a Regulatory Compliance** | Ifti Majid presented an update on actions/controls being taken by the Trust to mitigate BAF risk 3a. Current controls were outlined and update on | Significant assurance was received relating to oversight and grip on this risk as outlined.<br><br>Assurance was received on | Risks as outlined in the presentation arising from gaps in control and gaps in assurance. | The proposed reduction in risk from 15 (5x3) to score of 12 (3x4) was agreed and this will be incorporated into the February BAF Board | None. |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other Committee) |
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| | assurance outlined. Details of media coverage were noted and this detail was welcomed. Positive assurance (opportunities) were noted. | media coverage analysis as presented. It was agreed that a report be prepared for the Trust Board on media coverage (Sam Harrison).<br>It was agreed that the GIAP process should be reaffirmed at Board Committee Chairs meeting in February (Sam Harrison).<br>External Assurance on this risk is to be sought through CQC review visits and Deloitte GIAP/Well Led review (currently being scheduled) and NHSI review of licence conditions. | | report. | |
| **Deep Dive BAF Risk 3b Loss of Confidence in Leadership** | Amanda Rawlings presented an update on BAF risk 3b, including details of key controls, gaps in control, assurances on controls and positive assurances. The current risk rating of 15 (5x3) was discussed and wording of the risk was debated. | Significant assurance was received in terms of oversight and grip of this risk.<br>Gaps in assurance and positive assurances were noted as outlined.<br>Further assurance will be received on closing down of relevant GIAP recommendations. Further assurance will be sought from the staff survey. Assurance was received that all actions from PwC audit are now closed. | Key areas of risk were identified to include the restructuring of the HR function, recruitment/ vacancy issues and staff engagement.<br>Julia Tabreham noted the issue of potential false assurance and it was confirmed that regular 'pulse checks' help to ensure real time feedback. | The Committee agreed to reword the risk to remove the word 'fundamental'.<br>It was agreed that the Trust was in a much improved position. A recommendation would be put to Board to consider that this risk should be reduced to 4x3(12). | None. |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other Committee) |
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| | | Staff survey results and associated action plan noted to be on the forward plan for the Trust Board (Amanda Rawlings). | | | |
| **FINANCE** | | | | | |
| **Annual Reporting and Planning Timetable** | Rachel Leyland outlined the annual reporting and planning timetable as per NHSI reporting timetable published on 15 November. | Significant assurance was received regarding the planning timetable which outlined key dates for submission of element of annual reporting.<br>Sam Harrison confirmed that a task and finish group was to be convened to coordinate the production of the annual report, accounts and quality account. | None identified. | The planning timetable was agreed. Further detail from NHSI as part of the Annual Reporting Manual is awaited. | None. |
| **Review of Accounting Policies for 2016/17 Annual Accounts** | Rachel Leyland outlined the review of the accounting policies including noting proposed changes as per national guidance. | Significant assurance was received that the Trust's accounting manual has been updated as appropriate. | None identified. | The updated accounting policies were agreed. | None. |
| **GOVERNANCE** | | | | | |
| **Governance Improvement Action Plan Update Report** | Sam Harrison presented the updated progress on actions within the GIAP for which the Committee has oversight. | Significant assurance was received that there is a clear programme for progress of actions and receipt of completion of forms relating to recommendations for which the Committee has | No specific risks identified. Lack of evidence to be able to present completion forms to March Committee is a risk for all outstanding actions. | The Committee agreed to the timescales as outlined and also agreed the completion of recommendation of ClinG2 which is a joint recommendation between | None. |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other Committee) |
|---|---|---|---|---|---|
| | | oversight. | | the Audit & Risk Committee and the Quality Committee. | |
| **Implementation of Internal and External Audit Progress Report** | Rachel Kempster presented an update on progress with completion of internal and external audit recommendations.<br>The more frequent reporting and changes to the format of the report were welcomed.<br>KPMG offered to share best practice regarding off payroll procedures. | Significant assurance was received that there is a clear grip on managing actions and recommendations. | Risks that non-completion of actions in a timely way will lead to ongoing lack of compliance and best practice recommendations not implemented. | Internal Audit Reports are to be taken to Executive Leadership Team meetings on receipt of draft – to agree recommendations and ensure oversight of completion of required actions arising.<br>The Committee agreed to continue with quarterly reports on this issue (previously 6 monthly)<br>Rob Chidlow to contact Claire Wright, Amanda Rawlings and Rachel Leyland regarding off-payroll procedures and recommendation to be updated as appropriate. | None. |
| **EXTERNAL AUDIT – Grant Thornton** | | | | | |
| **Verbal update on external audit progress** | Joan Barnett outlined plans for preparations for the final accounts. The Trust has been identified for a National Audit Office review which will entail additional external audit resource of two days alongside final accounts work.<br>Trust staff were invited to | Significant assurance was received from the verbal report given that year end planning processes were underway in liaison with the Trust. | None identified. | **-** | **None.** |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other Committee) |
|---|---|---|---|---|---|
| | attend the Grant Thornton seminar on annual accounts in Birmingham. Joan Barnett confirmed that she was meeting with Sam Harrison to discuss year end requirements relating to the GIAP (17 January 2016). | | | | |
| **INTERNAL AUDIT AND COUNTER FRAUD – KPMG** | | | | | |
| **Internal Audit Progress Report** | Robert Chidlow presented the update on the internal audit plan for the remainder of 2016/17. | Significant assurance was received that the programme is on track and that an effective handover process from PwC has been made. | None identified. | Relevant sector updates were noted for information. | None. |
| **Draft Local Counter Fraud Specialist Strategic Plan** | Robert Chidlow presented the Counter Fraud Strategic Plan 2016/17 to 2018/19. A fraud risk assessment self-review will be carried out by the 1 April deadline and will be brought to the March Audit & Risk Committee. This is in line with NHS Protect Standards.<br>Future work is to include gifts, hospitality and declaration of interests and also e-rostering. | Significant assurance was received on effective handover of the counter fraud work, and that the required risk assessment would be undertaken to give assurance on current position.<br>Significant assurance was received that the new KMPG team had been promoted within the Trust as two referrals had already been received. | Potential risk of fraud arising from the merger/acquisition work was raised and feedback will be explored by KMPG. | It was agreed that promotion of counter fraud contacts would continue within the Trust. | **None.** |
| **MEETING CLOSE** | | | | | |
| **Any Other** | No items raised. | **-** | **-** | **-** | **-** |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other Committee) |
|---|---|---|---|---|---|
| **Business** | | | | | |
| **Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework** | No items raised other than those raised as part of previously itemised agenda items. | - | - | - | - |
| **2016/17 Forward Plan** | The forward plan was noted. | - | - | Sam Harrison to update and work with Committee Chair to develop 2017/18 forward plan. | - |
| **Meeting Effectiveness** | Committee members and attendees welcomed the focus on assurance by the Committee.<br>It was noted that there was not full attendance from NED members and that this affected Committee discussion and challenge. Full attendance was noted to be important for effective Committee discussion. | Assurance was noted by Julia Tabreham regarding Executive Director grip on key functions and actions. | Risk to full debate on agenda items by reduced member attendance | Barry Mellor and Julia Tabreham to discuss NED membership outside of the meeting.. Barry Mellor is to consider the nature of pre-meeting and who may be most appropriate to attend. | None. |

# Board Committee Summary Report to Trust Board

## People & Culture Committee - meeting held on 18 January 2017

***Identification of key risks, successes, decisions made/escalated from the meeting***

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other committee) |
|---|---|---|---|---|---|
| **Minutes of People & Culture Committee held 17 November 2016** | Approved | N/A | N/A | N/A | N/A |
| **Minutes of Extraordinary Meeting of People & Culture Committee held 14 December 2016** | Approved | N/A | N/A | N/A | N/A |
| **Matters Arising** | Workforce plan development | To be developed across the trust with involvement of key professions | Links to the workforce supply issue in the BAF | To bring a draft back to March 2017 meeting for discussion | Plan will then need Board approval for any investments |
| **Staff Story** | Audrey House move to Kingsway and lessons that can be learnt about how to engage with staff and service users to achieve a positive outcome for all involved | The What, When, Where, How ward operation guide – how to promote as best practice across the trust | Mandatory route is not the preferred option but to promote as best practice | N/A | N/A |
| **Strategic Workforce Report** | The committee were appraised of progress on the leadership training roll out, the pending changes to the redundancy terms and the national announcements of proposed workforce developments:<br>Skills escalator - entry level | The committee noted the report | E rostering compliance | The committee would like to receive a next steps leadership development strategy, date TBD | The Board will need assurance during 2017 regarding e-rostering compliance |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other committee) |
|---|---|---|---|---|---|
| | apprenticeship to nursing degree apprenticeships<br>By the end of 2017 all Trust to meet best practice on e rostering<br>Programme to encourage more clinicians into senior leadership posts | | | | |
| **Governance Improvement Action Plan Update Report** | All actions reviewed and closure dates planned<br>2 close now<br>7 actions for February<br>5 Actions for March | Workforce and OD team to work to close off the actions for the People & Culture Committee and Board to approve | N/A | Timings for closure of each outstanding actions agreed | All blue forms will come to the Board for approval |
| **Staff Survey Results – Early Findings** | Initial staff survey results were presented. Full census. Trends emerging for further discussion | Action plan to be developed for the February meeting. To focus on 3 or 4 big actions, communicate to staff the action plan and monthly updates | The gap to achieve our corporate goal to a top 20% employer for staff survey results in the NHS | Develop action plan for February and communicate to staff. Focus on 3 or 4 key areas | Board to receive the results in confidential January Board meeting |
| **People Plan 2017** | Seven key themes for the 2017 plan | Plan approved | N/A | Plan approved, KPI to be added | N/A |
| **Recruitment Review and Action Plan** | Progress on the improvements in the recruitment process was noted.<br>Strategy to attract staff to a range of hard to fill posts was supported | Monthly updates to PCC on the progress being made with recruitment | The Committee noted the challenge in filling the vacant medical posts and impact this is having agency spend and the trusts finances | To seek ongoing updates on recruitment progress | N/A |
| **Employee Relations Update** | The committee received a deep dive reports employment cases and how these are being managed. This relates to WOD 1 and | The report received positive assurance and the committee agreed that WOD1 and WOD 7 can be closed | The Committee noted the progress made to improve oversight of employment cases and gave the report | To move to blue forms for WOD1 and WOD7 | N/A |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other committee) |
|---|---|---|---|---|---|
| | WOD 7 in the GIAP | | positive assurance | | |
| **People Performance Report** | Report noted, mandatory training dipped for December | Monthly ongoing review of people metrics | Achieving year end people KPI's | N/A | N/A |
| **Operational Update** | None noted | N/A | N/A | N/A | N/A |
| **Equalities Update** | Comprehensive update provided and EDS2 assessment plan shared | Positive assurance received on the progress being made | N/A | N/A | N/A |
| **Any Other Business** | N/A | N/A | N/A | N/A | N/A |
| **Notes from Equality Forum meeting held 30 November 2016 for information** | Received positive assurance | N/A | N/A | N/A | N/A |
| **Forward Plan** | Amanda Rawlings and Sue Turner to work together to shape the forward agenda | N/A | N/A | N/A | N/A |

# Board Committee Summary Report to Trust Board
# Quality Committee - meeting held on 12 January 2017

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other committee) |
|---|---|---|---|---|---|
| **Minutes and Actions Matrix** | Agreed and ratified | Good assurance | See minutes for full actions<br>Risks with some overdue actions that need further information (John Sykes) | | |
| **Service Recipient and Carer Feedback** | The lived experience and the impact of errors in appointment letters | Family and care experience | Confirmation of individual investigation<br>Systems learning of human factor incident<br>Exploration of adjustment to EPR to reduce the future likelihood of re-occurrence | Information Governance meeting to lead following SIRI investigation and put in place risk mitigation plan | |
| **CQC**<br>**Action Plan** | Significant improvement and good assurance on progress.<br>Reviewed with analysis and challenge. | Good assurance partial assurance due to being a work in progress<br>Internal Auditors undertaking checks on the system and evidence, to gain independent assessment of the model with recommendations | None currently identified.<br>Developing a pipeline of expected actions against delivery dates<br>CQC action issues external to the organisation control. | Evidence presented and agreed.<br>Exploration and discussion with commissioners on the risks to patient care. | |
| **Policy Governance** | GIAP recommendation ClinG2. Policy compliance is now at 96%, | This improvement has been maintained and embedded into practice.<br>Scrutiny of policy governance and recommendation for sign | None | Signed off GIAP recommendation ClinG2. | |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other committee) |
|---|---|---|---|---|---|
| | | off agreed | | | |
| **Quality Dashboard** | Significant improvement<br>Detailed discussion on the information included and actions already in place, demonstrating progress. | Good assurance on planning<br>Further work on a summary that distinguishes- quality committee and Board level information and discussion | Clinical and management performance of supervision<br>Complaints completion and performance | Additional weekly monitoring by COO remains in place.<br>New investment in complaints response time improvement model in process of recruitment | None |
| **Safer taffing review – in-patient and community mental health model** | Carolyn Green presented the biannual report, reviewing the skill mix and proposing recommendations to enable the Trust to support front line staff in delivering safe, high quality clinical care across inpatient wards, both mental health and community.<br>Discussion on model and findings. | The report sets out the Trust's current position and makes recommendations from a professional standards requirement perspective with regards to staffing establishment. | In next version to use more clinical information from bed occupancy and acuity in addition to the incident and wider data set used to develop this report.<br>Mark Powell to feedback to Quality Committee on 9 March after ELT discussion on 16 February regarding mitigations for current waits for mental health care coordination in neighbourhood services | Further discussion at trust management team on the operational implementation of this and the financial impact.<br>Plans for future iterations Child health<br>Psychology, Learning disability and substance misuse.<br>Agreed revisions for next skill mix review in 6 months | |
| **Serious incident monthly report** | Paper presented and discussed New CQC paper and the trust response and improvement plan<br>Detailed review of incidents and themes<br>No immediate cluster or concerns | Good assurance | Close monitoring of serious incidents and death rate<br>The committee reviewed the possibility of a predictive pipeline for actions about to go out of date, but concluded that this would exceed the potential added value.<br>On the suggestion of Anne | Additional actions agreed to include detailed CQC paper in the February QPS for the public. | |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other committee) |
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| | | | Wright, Emma Flanders agreed to provide assurance/ review checks against 3-monthly moving averages in order to identify any trends. | | |
| **Positive and Safe** | Full written report on progress<br>Up-date on the action plan<br>Peer review of education | Partial and increasing assurance | Reducing risks overall<br>Risks escalated to committee on police information sharing agreement and | John Sykes work to minimise the risks the information sharing agreement and advisory flowcharts to staff to support them when they have concerns and police are resistant to share information<br>Move to 6 monthly reports as a quality priority | |
| **Seclusion plans project up-date** | The building programme began on site on 21 November and is on schedule to complete by 7 April 2017. | Good assurance on the plan in place to meet required regulatory standards. | None noted at this time overall<br>No current key risks to delivery | None | |
| **Quality Visits and revised quality visit guidance** | Carolyn Green presented the proposal for Season 8<br>Further discussion at panel members reflection event | Assurance | No current key risks to delivery | Agreed in principle subject for Quality visit event and amendments. | |
| **Quality assurance summary** | The group holds the Trust to account against quality contractual performance but is also a link for the Trust to escalate and highlight risks. Carolyn | Assurance | A significant disinvestment removal of service could cause significant patient safety concerns<br>New BAF risks is in development due to this | None | |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other committee) |
|---|---|---|---|---|---|
| | Green had raised the risks regarding gaps in community service staffing, concerns with the eating disorders service as discussed at Trust Board in a deep dive, lack of investment in staff in 136 areas with serious concerns, as well as the lack of progress with contract negotiations. | | significant concern | | |
| **Consideration of BAF risks** | Clinical risks for mental capacity will be a stand-alone risk for the BAF.<br>Mental Health Act Committee will focus on that risk and this will assist committees in not having repetition or inappropriate levels of cross over | Assurance received on the identified risk areas and plans | As discussed risks are being added around disinvestment from commissioners and the potential for increased risk to patient safety as a result of the contract settlement round. | Revisions to the BAF. | |
| **Emergency preparedness Resilience and response** | Gap in assurance<br>Reduced performance, due to capacity issues<br>Additional technical advice and support requested from partners | Limited assurance<br>Increasing assurance on improvement plan<br>Significant work in development and in delivery phase | Continues as a risk to service delivery<br>Challenge on delivery times | Monthly reporting<br>Strategy approved | |
| **Governance Improvement Action plan** | Reviewed the content of the update and received assurance. | Increasing assurance.<br>Improved performance | None at this time. | Reviewed the 'blue form' for ClinG2 and agreed to sign off as complete.<br>Agreed that the Committee's actions matrix | |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other committee) |
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| | | | | meets requirements and a 'blue form' will be produced for sign off of the action in the February meeting. | |
| **Neighbourhood and Campus QLT** | Part 1 No attendance from chair | Limited assurance | Mark Powell and Carolyn Green to raise at Trust Management Team meeting on 15 January regarding responsibilities and lines of accountabilities, with feedback requested at the February Quality Committee. | Further development work with the QLT | |
| **Childrens and Central services** | Richard Morrow confirmed the QLT has met as planned. The SMT and QLT for Children's have combined into one meeting structure effective 31 January. QLT Terms of Reference have been incorporated. Feedback will be given in due course with a specific report to Quality Committee. Meeting this time. | Increasing assurance | No issues to escalate from the QLT | | |
| **Information Governance** | Sam Harrison presented the quarterly report from the Information Governance (IG) Committee on behalf of John Sykes, to update the Committee on performance | Assurance | Risks to delivery Acknowledged the IG toolkit baseline and the work to achieve compliance. | Report received risks noted and mitigation plans led by IG team | |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other committee) |
|---|---|---|---|---|---|
| | in Q3 towards the requirements of the IG Toolkit, as well as the work of the IG Committee and information on IG breach monitoring. | | | | |
| **Neighbourhood and Campus QLT** | Part 2 Chair - Simon Thacker joined the meeting at 4.30 pm.<br>Verbal report<br>Concerns raised re identity and role | Continues to require additional development and role clarity | Risks to delivery<br>The Chair considered it fundamental to the Governance Improvement Action Plan that the infrastructure of QLTs is addressed. | Post meeting note<br>Action<br>A revised model to be developed by Simon Thacker based upon his proposal and recommendations for CRG's, with revisions submitted to the Quality committee for sign off | |
| **Service recipient feedback** | Some very useful information to take back to Mental Health Alliance, particularly around the involvement in the Kedleston Unit décor, 4Es meetings and lack of uptake for advocacy | Communication with stakeholder groups | None | | |
| **Any other business and effectiveness** | None<br>Meeting over ran but large agenda was confirmed | | | | |

**DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST**

**MINUTES OF A MEETING OF QUALITY COMMITTEE**

**HELD ON THURSDAY 15 DECEMBER 2016**
**AT 2.00 PM IN MEETING ROOM 7,**
**RESEARCH & DEVELOPMENT CENTRE, KINGSWAY**

| | | |
|---|---|---|
| **MEMBERS PRESENT (M)** | Julia Tabreham | Committee Chair & Non-Executive Director |
| | Carolyn Green | Executive Director of Nursing & Patient Services |
| Item 2016/216 onwards | Maura Teager | Non-Executive Director |
| Items2016/ 209 - 216 | Margaret Gildea | Non-Executive Director (by phone) |
| Item 213 onwards | Mark Powell | Acting Chief Operating Officer |
| **ATTENDEES (A)** | Rachel Kempster | Risk & Assurance Manager |
| | Sandra Austin | Derby City & South Derbyshire MH Carers Forum |
| | Sam Harrison | Director of Corporate Affairs & Trust Secretary |
| | Deepak Sirur | Associate Clinical Director – Governance (Deputising for Medical Director) |
| | Petrina Brown | Lead Psychologist |
| | Richard Morrow | Children's Services QLT Chair |
| | Emma Flanders | Lead Professional for Patient Safety |
| | Rubina Reza | Research & Clinical Audit Manager |
| | Darryl Thompson | Deputy Director of Nursing |
| Item 2016/216 | Claire Biernacki | Acting General Manager, Neighbourhood Services |
| Item 2016/217 | Mark Ridge | Head of Clinical & Operational Care Currencies & Outcomes |
| Item 2016/230 | Owen Fulton | Principal Employee Relations Manager |
| Item 2016/230 | Harinder Dhaliwal | Assistant Director for Engagement and Inclusion |
| | Donna Cameron | Corporate Services Officer & Note Taker |
| Items 2016/218 & 219 | Sam Kelly | Consultant Nurse, Crisis Resolution Home Treatment Team |
| **BY INVITATION** | Samragi Madden | Quality Assurance & Compliance Officer, Healthwatch Derby |
| **APOLOGIES** | John Sykes (M) | Executive Medical Director |
| | Simon Thacker (A) | Neighbourhood & Campus QLT Chair |
| | Sarah Butt (A) | Assistant Director - Clinical Practice and Nursing |

| | |
|---|---|
| **QC/2016/209** | **WELCOME & APOLOGIES FOR ABSENCE**<br><br>The Chair welcomed Samragi Madden from Healthwatch Derby to the meeting and extended an invitation to her to remain for the meeting.<br><br>Apologies were noted as above. |
| **QC/2016/210** | **MINUTES OF THE PREVIOUS MEETING**<br><br>Minutes of the previous meeting, held on 10 November 2016, were accepted as a correct record. |
| **QC/2016/211** | **CARER REPRESENTATIVE FEEDBACK**<br><br>Sandra Austin reported no contact had been received regarding IG Group |

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| | attendance at the 4E Carer Group to discuss recent IG concerns.<br><br>Sandra Austin had recently attended a clinic with her spouse for an appointment only to find it had been changed and notification had not been sent. This is now being processed as a complaint.<br><br>**ACTION:**<br>**1. Carolyn Green to remind the Executive Medical Director regarding representation at the 4E Carer Group.** |
| **QC/2016/212** | **MATTERS ARISING AND ACTIONS MATRIX**<br><br>The Committee reviewed the actions matrix and agreed updates and amendments which were added directly to the matrix. |
| **QC/2016/213** | **HEALTHWATCH REPORT**<br><br>The Chair welcomed Samragi Madden, Quality Assurance & Compliance Officer, Healthwatch Derby to the meeting.<br><br>In 2014 Healthwatch Derby conducted a comprehensive consultation 'Think Healthy' into the services of the Trust. 'Think healthy' was completed in February 2015. The full consultation report identified the Trust's Complaints Process as an area that requires improvement. Healthwatch worked with the Trust following the outcomes of the 'Think Healthy' consultation, and also worked closely with service commissioners Hardwick CCG.<br><br>In late 2015, Hardwick CCG commissioned Healthwatch to undertake a complaints audit of the Trust, which was completed in 2016. The complaints audit survey was sent to a random sample of individuals who went through the complaints process. Healthwatch received 34 responses, and further engaged with patients and conducted a closed Complaints Forum, and also completed three safeguarding referrals. The audit shows significant negatives recorded from patient experiences around the themes of timeliness and effectiveness of response to complaints. Lack of empathy, and allegations of neglect were also reported. Healthwatch will continue to monitor feedback and work closely with the service, commissioners, inspectors, patients and carers to help improve services.<br><br>Samragi Madden gave additional information from her personal experience not written in the formal submission to the committee. This included:<br><br>• level of responsiveness to complaints in the services.<br>• specific complaints re the crisis team<br>• unconfirmed information that a trust manager had feedback that there was no support in complaints handling from the central support team<br>• an example of a complaints / safeguarding resolution and completing an information action taken over 3months to fully resolve<br>• concerns re how and the culture of learning and responsiveness<br>• concerns re the complaints handling of another provider<br><br>The Chair thanked Samragi Madden for her report and emphasised the Trust's commitment to address concerns early on and its improved |

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| | approach to complaints. Carolyn Green highlighted the improvements made in responding to complaints and concerns. As reported to Audit & Risk Committee on 13 December 2016, the Trust has achieved 100% acknowledgement of complaints, 100% increase on performance to the year before, however the full investigation response rates require improvement. It has been proposed for a new model and additional funding has been requested to resource complaint investigators as an 'invest to save'. The Committee is asked to be mindful of the difficult contractual negotiations; the Trust is experiencing a substantial disinvestment from the CCG. A substantial decommissioning has been requested by the CCG. If funding is to be removed, front line services must be protected and the result may be that the Trust cannot invest in new investigators. Carolyn Green is raising this as a risk to delivery.<br><br>Carolyn Green responded that she was unable to fully respond to all of the issues, without further information and she would be able to act further on these concerns and respond, but she was not able to in this assurance forum.<br><br>**ACTIONS:**<br>**1. The Chair and Carolyn Green will meet with Healthwatch to discuss recommendations.**<br>**2. Quality Dashboard will be reviewed relating to the content feedback historical, current and emergent complaints. This is being added to the Board and Quality committee performance dashboard**<br>**3. Specifics regarding responsiveness will be picked up by Carolyn Green following confirmation of the specific case.**<br><br>**RESOLVED: The Quality Committee noted the report from Healthwatch Derby.** |
| **QC/2016/214** | **<u>CQC ACTION PLAN</u>**<br><br>Carolyn Green presented the report to brief the Committee on the CQC regulations and comprehensive inspection of key aspects of regulation breaches.<br><br>The Trust continues to make good improvements and Carolyn Green is confident of progress. CQC continues to be updated on current plans. Areas to improve on are quality assessments, particularly the decision making detail.<br><br>The CQC made an unannounced visit to the Kedleston Unit on Wednesday 14 December. Good feedback was received, but also areas identified for improvement. There is good understanding on what those improvements are required to be. Improved clinical record keeping of clinical work was seen in areas of Mental Capacity Act and advice given on further enhancements to ensure more detailed documentations of the clinical formulations. The Trust will continue to move forward and embed action plans. In January the Committee can expect a report on a substantial number of actions at the next meeting.<br><br>Carolyn Green suggested that the CQC portal was reviewed to see the model and undertake any random checks if required. |

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| | **RESOLVED: Quality Committee**<br>**1. Received the update on current plans and information on planning and engagement with staff.**<br>**2. Received partial assurance on progress but not full assurance on delivery.** |
| **QC/2016/215** | **QUALITY DASHBOARD**<br><br>Carolyn Green presented the quality dashboard to provide a summary of highlights and challenges through the use of high level quality indicators identified in line with the quality elements of the trust Strategy and the Trust's Quality Priorities.<br><br>The dashboard is becoming well embedded and moving forward. Consideration is being given to adding an indicator on complaints completions compliance.<br><br>The Committee was asked to note the financial risks associated with not achieving the flu vaccination CQUIN. However, this is the domain of People & Culture and the Committee and is monitored by the lead committee.<br><br>**RESOLVED: The Quality Committee**<br>**1. Noted the progress made on the CQC actions and recommendations.**<br>**2. Received assurance from the detailed reviews undertaken by the service area leads and the Director of Nursing.** |
| **QC/2016/216** | **CURRENT WAITS FOR MENTAL HEALTH CARE COORDINATORS IN THE COMMUNITY**<br><br>The Committee welcomed Claire Biernacki, Acting General Manager, Neighbourhood Services to the meeting to address a request from the Committee to be updated on waits for mental health care coordinators in the community.<br><br>In summarising her report, Claire Biernacki advised that the service had had experienced 40 leavers in year. 18 of the posts vacated were Care Coordinator posts. More leavers are expected over the next five years due to an ageing population of nurses and mental health practitioners and the on-going challenges in recruitment. Any leavers or retirees are automatically invited back on part time hours and this has delivered some success.<br><br>A datix risk was raised on 14 December 2016 as the team is under pressure and struggling to meet the waiting list policy standards due to the increase in referrals over the past 12 months, combined with staff shortages due to a more difficult recruitment picture. The policy will be reviewed to see if there is any change that can be made to improve the situation. This is a known clinical and workforce risk that was partly mitigated this year with a partial settlement with the Commissioners. In the meantime, feedback will be given to the Commissioners that the Trust is still under significant pressure and has reviewed the gap and the gap continues to widen with significant growth in activity. The gap is now 60 |

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| | care coordinators to meet the care co-ordinators recommended caseload of 35. In addition, referrals and the caseloads continue to grow.<br><br>Maura Teager asked if there were any early warning triggers on client, patient or staff groups. Claire Biernacki considered that managers are aware of caseloads, but there is variation across the piece on how they are managed most appropriately within each area/team. Staff are stressed and risk assessments are completed when required. Staff and vacancies can be moved around to better manage some workloads, but the same cannot be done with medical staff; nine consultants have left Neighbourhoods in the past year and no replacements have been secured. Carolyn Green assured the Committee that she is monitoring this situation closely but highlighted the current patient experience and the very real and imminent potential for safety issues to occur. CQC has said that waiting list management is strong and done well but there is a fundamental structural deficit that without contractual investment is worrying. Concerns were declared to the CQC at the last inter-agency meeting.<br><br>The Committee thanked Claire Biernacki for her report and asked for an update in two months' time. The following actions were agreed.<br><br>**ACTIONS:**<br>**1. Agreed to escalate this to Trust Board as a rising risk.**<br>**2. Waiting list management information to be added to the integrated dashboard for oversight.**<br>**3. Carolyn Green will take this full report to the Quality Assurance Group meeting with Commissioners so that the Commissioners'' Accountable Officers can be briefed and held to account.**<br>**4. Further update requested in two months' time.**<br><br>**RESOLVED: The Quality Committee**<br>**1. Received significant assurance of understanding of the problem.**<br>**2. Noted the capacity gap is increasing and suspected to increase further.** |
| **QC/2016/217** | **<u>QUALITY INDICATORS AND OUTCOMES</u>**<br><br>The Committee welcomed Mark Ridge, Head of Clinical & Operational Care Currencies & Outcomes to the meeting.<br><br>From April 2017 the Trust and Commissioners will be monitoring a set of quality indicators and outcome measures as part of contract monitoring. Over the last year the Trust has led a group to identify a how a range of indicators might be applied to contracts with a view of providing evidence that care is delivered to a good standard. The work has completed and initial quality indicators have been agreed and are in the process of implementation. Additional quality indicators are under review.<br><br>A decision is needed to be made as to which patient reported outcome measure is the default Trust choice ether the Short Warwick and Edinburgh Mental Wellbeing Scale (SWEMWBS) or Recovering Quality of Life (ReQoL). After the report to Quality Committee the Trust was able to confirm ReQol can be integrated and added to nd PARIS so on balance, the Quality Committee is asked to approve ReQoL as the preferred solution. |

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| | **RESOLVED: The Quality Committee approved the request to select and implement ReQol as the default patient reported outcome measure.** |
| **QC/2016/218** | **HEALTHWATCH CRISIS REPORT AND ACTION PLAN**<br><br>Sam Kelly, Consultant Nurse, Crisis Resolution Home Treatment Services, joined the meeting to provide assurance to the committee in relation to presenting the report and her lead role in the implementation of the actions within the Trust's response to Healthwatch Derbyshire's Mental Health Crisis Report, received in October 2016.<br><br>An action plan to respond to the experiences shared in the Healthwatch Derbyshire report, based on 40 responses, had been prepared. Many of the themes in the report are recognised, ie pathways, complexities in and out of services. As one of the service providers the Trust needs to take a partnership approach with other providers to improve the services. Additional services have been requested many times for crisis services and there will be further opportunities to try and influence commissioning in the STP work. In the meantime there is a diversion service, the mental health advice and assessment hub pilot and nurse are street triaging with police to respond to people who may be in crisis.<br><br>Carolyn Green raised some potential themes to listen to, the spirit of the feedback both in this case and some of the concerns raised in Samragi Madden's patient experience examples and wider complaints. The expectations and needs are not always a commissioned NHS level of service, further work is needed to signpost individuals to help to gain support.<br><br>Samragi Madden welcomed the report and action plan and committed to continue to work complaints and crisis services in the new year. She added that unannounced visits are being considered – part of the statutory powers awarded to Healthwatch.<br><br>**RESOLVED: The Quality Committee noted the report and received assurance that recommendations that can be effected by the Trust are being implemented.** |
| **QC/2016/219** | **SUICIDE AND SELF HARM SAFETY PLAN AND TRAINING STRATEGY**<br><br>Apologies were offered on behalf of the Executive Medical Director. He had not been able to attend the meeting due to an accident.<br><br>In in his absence, the Chair reported she had attended a suicide reduction and prevention forum recently where she noted that a lot of data to populate the plan is collected by Public Health and the Health observatory although it is widely recognised there are problems with category data in<br><br>There is a concern that suicides are rising in our community. Carolyn Green added that Derbyshire figures are raising substantially but cautioned that the figures had been historically very low compared to population for a number of years. Figures are being tracked very carefully, as there is a significant rise in the community suicide rate. The majority of national |

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| | suicides (around 75%), of those who do complete suicide, are unknown to mental health services. The Quality Committee is expecting its benchmarked data form the National enquiry in January 2017.<br><br>The Trust is rolling out its training programme and contributing to the Public health led suicide reduction/prevention collaborative.<br><br>Challenge was made whether the suicide prevention training is effective and cost effective In response to Maura Teager, Sam Kelly confirmed the Suicide Prevention Strategy Group is confident about the training trajectory and prioritising next steps. There is however potential to use a non-accredited training and provide the training internally which may be a cost effective solution.<br><br>**ACTION:**<br>**1. John Sykes to review the financial efficiency and best value of training against an internally led provision.**<br><br>**RESOLVED: The Quality Committee:**<br>**1. Noted the level of training already taken place and the future trajectory**<br>**2. Noted the progress made in the Suicide Prevention Strategy Group**<br>**3. Supported the actions of the group, particularly in encouraging staff to attend training.** |
| **QC/2016/220** | **<u>POSITIVE AND SAFE</u>**<br><br>Carolyn Green delivered the verbal update in the absence of Sarah Butt.<br><br>The Trust is nearing completion of revisions to Positive and and Safe Therapeutic holding Training. This is a large component of the Positive & Safe Strategy a key quality priority in reducing violence, the use of seclusion wherever possible and distress both to our patients and staff.<br><br>We continue to see effective use of the new seclusion clinical pathways around restraint and elements of violence. This will continue to be monitored on the integrated dashboard for trends and actions to mitigate.<br><br>A full written report will be delivered to Quality Committee in January, to update on significant moves in assurance in the Positive & Safe Plan. |
| **QC/2016/221** | **<u>PERSON CENTRED CARE – CARE PLANNING TASK GROUP</u>**<br><br>Richard Morrow, Head of Nursing, presented the update on person centred care. A booklet approach has been taken to reflect the components of care required to be built into each individual's needs and care requirements. The plan to produce this by the end of the financial year is on target.<br><br>**ACTION:**<br>**For the January meeting an implementation plan, including how training will be delivered, was requested. POST MEETING NOTE – this was delayed to February due to timescales/turnound.**<br><br>**Radbourne Unit Assurance Compliance & Assurance Report**<br>Simon Thacker presented the above report to provide assurance to the |

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| | Committee that there is a robust action plan and governance to achieve and maintain compliance with regulatory standards within the Radbourne Unit. Significant improvements have been made in all areas identified in the CQC's inspection but work is still on-going. Partial assurance is given until activities are further embedded.<br><br>**RESOLVED: Quality Committee**<br>**1. Noted the update on person centred care.**<br>**2. Received partial assurance from the Head of Nursing and Radbourne Unit report.** |
| **QC/2016/222** | **SERIOUS INCIDENT REPORT**<br><br>Emma Flanders, Lead Professional for Patient Safety presented the Serious Incident Report to update the committee on serious incidents (SIs) during November 2016. The report was taken as read.<br><br>Maura Teager requested information regarding Incident W29491 and the risk related to this incident. Emma Flanders will follow up with Sandra Mir, Patient Safety Lead at the Royal Derby flag this and share with the Royal.<br><br>An increase in incidents and deaths overall in the Trust was noted but is not substantial, there is no pattern and cluster and a monitoring brief for all learning over and above the immediate actions is in place.<br><br>**RESOLVED: THE Quality Committee**<br>**1. Noted the report and received assurance.**<br>**2. Is aware of the emergent and current issues under a monitoring brief by the SI Group.** |
| **QC/2016/223** | **CLINICAL AUDIT UPDATE**<br><br>Rubina Reza presented the update of the Clinical Audit Programme for 2016/17.<br><br>There had been significant focus on improving completion rates of clinical audit projects over the last year and success in maintaining completion rates this year. However, as a consequence there are now many more improvement action plans to implement. The volume of actions have increased by 42% and so have a lot of overdue actions. There is a clear capacity issue in managing this workload. Mark Powell added that in trying positively progress clinical audit, the Trust needs to recognise the challenges associated with it. Mark Powell agreed that the Research & Development Board need to develop a solution for further discussion at Quality Committee with recommended actions and solutions. It was agreed therefore that the next update on Clinical Audit will take place in February, rather than March as per the forward plan.<br><br>**ACTION: Next Clinical Audit Update scheduled for February 2017 to receive proposals to the resource challenge in Clinical Audit.**<br><br>**RESOLVED: The Quality Committee**<br>**1. Noted the progress made on delivery of the 2016/17 Clinical Audit Programme.**<br>**2. Noted the current issue around over-due clinical audit actions** |

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| | **under the monitoring brief of the R&D Governance Committee.** |
| **QC/2016/224** | **EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE – MONTHLY PROGRESS REPORT ON COMPLIANCE AND ACTION PLAN**<br><br>Mark Powell presented the report on non-compliance with our self-assessment and regional assessment for emergency preparedness, resilience and response (EPRR). The report provides a monthly update of progress against the EPRR action plan to Quality Committee. This was due to a change in the rating criteria this year and the reality of not prioritising this area of need and investing in a dedicated resource.<br><br>The support of colleagues in DCHS, NHS England and the Trust lead was acknowledged in the preparation of this report.<br><br>Progress against the core standards dashboard was noted. A further 'confirm and challenge meeting' is scheduled with the CCG where they will take stock against progress made. Southern Derbyshire CCG has expressed concerns regarding the Trust's compliance. Hardwick CCG is preparing a joint response to advise that assessors are happy with the progress being made and we will take stock again in February.<br><br>Overall, the Trust is moving in the right direction. Resource is a concern but it is hoped that DCHS can provide some support. If that does not emerge it may materialise as a risk that will require escalation to the Executive Leadership team for investments and briefing to the Board with a full mitigation plan. This is already on the BAF as a key risk. A further report will be presented to Quality Committee in January.<br><br>**RESOLVED: The Quality Committee**<br>**1. Noted the content of the report.**<br>**2. Confirmed assurance was received via the report and that progress was being made.** |
| **QC/2016/225** | **REVIEW OF COMMITTEE TERMS OF REFERENCE**<br><br>Julia Tabreham presented proposed revisions to the Terms of Reference for the Committee.<br><br>The Committee noted the changes regarding membership and attendees, including the addition of a Governor observer. Expanding upon the induction that will be offered to Service User/Group and Carer Representatives, Carolyn Green confirmed that support will be provided for these attendees and the Governor Observer should they require support in attending the Committee. It was noted that as a clinical assurance committee, detailed information with regard to difficult and distressing events in Childrens and Mental Health services are often presented and reviewed at the Committee.<br><br>The Committee thanked Samragi Madden of Healthwatch for the suggestion to invite Healthwatch to present reports or have a presence in the meeting until the resolution of the CQC action plan and to raise any issues directly with commissioners due to her attendance at the Hardwick quality committee, |

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| | Carolyn Green shared that commissioners had requested to attend the Quality Committee and discussion regarding Commissioner attendance will take place in confidential session. The Chair will raise the item with Board Committee Chairs. Carolyn Green confirmed that meeting papers are routinely provided to Commissioners are part of the contractual agreement and all of today's papers are shared.<br><br>Sam Harrison suggested that item 1.3 regarding oversight of the GIAP may be removed for the 2017/18 round, but this will be confirmed.<br><br>**ACTIONS:**<br>**1. Julia Tabreham to discuss Commissioner attendance at Quality Committee in Board Committee Chair Meeting.**<br><br>**RESOLVED: The Quality Committee approved the proposed revisions to the Terms of Reference of the Committee. These will be forwarded for review as part of the annual review by Trust Board.** |
| **QC/2016/226** | **<u>RISK ESCALATION REPORT</u>**<br><br>Rachel Kempster, Risk and Assurance Manager, presented the risk escalation report to provide Quality Committee with a summary of current top (high/extreme) risks to ensure the Committee is aware of the Trust's most significant risks both strategically and operationally.<br><br>Rachel Kempster highlighted the intelligence on exceeding the agency cap. A Risk Management Strategy had been agreed at Audit & Risk Committee on 13 December 2016, which will have a direct impact on reporting.<br><br>**RESOLVED: The Quality Committee approved the report and agreed to continue to receive a bi-monthly report.** |
| **QC/2016/227** | **<u>GOVERNANCE IMPROVEMENT ACTION PLAN</u>**<br><br>Carolyn Green presented the Committee with an update against Core 3 recommendations within the Governance Improvement Action Plan (GIAP).<br><br>**ClinG1 – Refresh the role of the Quality Leadership Teams**<br>At the last Quality Committee review of this item it was agreed that when the Committee had received QLT reports consistently on a monthly basis for four months the task can be signed off. Evidence continues to be collected.<br><br>**ClinG2 – Robust and thorough policy review programme**<br>This is a joint responsibility of Audit & Risk Committee and Quality Committee. Audit & Risk Committee, at its meeting on 13 December, agreed this had been achieved. Quality Committee concurred. A 'blue completion form' will be prepared to present the evidence in order for the Committee to sign off this action.<br><br>**ClinG3 – Increase the effectiveness of the Quality Committee**<br>The Committee was asked to consider how this could be evidenced. It had indicated that improvements in the Actions Matrix by the end of December would be an indicator. It was agreed that a blue completion would be |

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| | prepared to present the evidence in order for the Committee to sign off the action.<br><br>Sam Harrison advised that the next meeting of Quality Committee will be observed, as part of the GIAP process, by Mel Curd, Deputy Trust Secretary from Derbyshire Community Healthcare NHS Foundation Trust.<br><br>**RESOLVED: The Quality Committee**<br>**1. Reviewed the paper and received assurance.**<br>**2. Agreed there was sufficient evidence that ClinG2 had been completed and a blue form can be prepared for submission to the next meeting.**<br>**3. Agreed there was sufficient evidence that ClinG3 had been completed and a blue form can be prepared for submission to the February meeting.** |
| **QC/2016/228** | **CHILDREN'S AND CENTRAL SERVICES QLT MINUTES**<br><br>The minutes of the Quality Leadership Team (QLT) meetings held on 6 October 2016 and 3 November 2016 were noted, as was the assurance summary from the meeting held on 3 November 2016. The Chair was assured by the documentation.<br><br>**RESOLVED: The Quality Committee received and noted the minutes of the QLT Meetings.** |
| **QC/2016/229** | **NEIGHBOURHOOD AND CAMPUS QLT MINUTES**<br><br>The minutes of the Quality Leadership Team meetings held on 3 October 2016 and 7 November 2016 were noted.<br><br>The Drug & Alcohol Advisory Group (DAAG) had identified discharge issues from hospital which potentially put patients at risk. An action plan has been put in place with links to the Royal Derby Hospital.<br><br>The following escalations were raised.<br><br>**ACTIONS:**<br>**1. Quality Committee was asked for support in establishing an interface between each clinical reference group CAMHS/ Childrens and Adult mental health. Mark Powell and Carolyn Green agreed to set up a meeting to unblock this situation.**<br>**2. Richard Morrow requested assistant in resolving a SI regarding a child detained at Royal Derby pending transfer to a Tier 4 provider. Mark Powell offered to meet with Richard Morrow to discuss.**<br><br>**RESOLVED: The Quality Committee received and noted the minutes of the QLT Meetings.** |
| **QC/2016/230** | **REVISED EQUALITY IMPACT RISK ASSESSMENT POLICY AND PROCEDURE**<br><br>Owen Fulton, Principal Employee Relations Manager and Harinder Dhaliwal, Assistant Director for Engagement & Inclusion joined the meeting |

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| | to present to Quality Committee a revised policy regarding the use of the REGARDS Equality Impact Risk Analysis (EIRA) Policy and Procedure.<br><br>The revised policy provides an enhanced screening process for EIRA to ensure that evidence based decisions are made regarding the impact on people of policies. The governance of this has been strengthened following CQC feedback.<br><br>The role of scrutiny and assurance in screening Equality Impact Risk Analysis for each policy was raised and guidance on who is best placed to support this function<br><br>Carolyn Green suggested that the Committee and group responsible for the policy have a duty in signing of the policy to review the EIRA. Carolyn Green suggested that the policy on policy is revised and each ratifying group, terms of reference is reviewed to reflect that duty. Furthermore it was recommended and confirmed that to enable the quality committee to be assured the Committee that whenever a policy is reviewed for approval an EIRA must be included; ensuring this forms part of the committee's effectiveness review which is formally placed in the accountability framework. It was agreed to amend the EIRA and Policy on Policies to reflect that. Rachel Kempster added that, as the officer responsible for publishing policies, no policy would be published without a completed EIRA. In addition it would be the duty of the Equalities forum to spot check and review the quality of the EIRAs of each committee and group to ensure a good standard of this key equality assessment.<br><br>In addition the Equalities leads would provide a training workshop to all chairs of ratifying committees and groups on the expected standard of practice of EIRA's.<br><br>**ACTION:**<br>**1. Carolyn Green would like to see all chairs or officers of policy ratifying committees briefed/ trained on the new guidance.**<br>**2. Responsibility be reflected in Terms of Reference as a duty and included in an effectiveness review of the groups.**<br><br>**RESOLVED: The Quality Committee**<br>**1. Agreed the policy with the amendment agreed above.** |
| **QC/2016/231** | **GOVERNORS GOVERNANCE COMMITTEE**<br><br>Carolyn Green advised the Committee that she will shortly be commencing the work on the Quality Account, with Darryl Thompson. Both will be attending the Governors' Governance Committee in January to ask them governors to choose the indicators as outlined in the NHS I ARM guidance, Guidance for NHS foundation trusts on producing their 2015/16 annual reports and accounts. to be audited by the external audit team which is then subsequently reviewed by the Audit & Risk Committee. Findings will be brought back to Quality Committee. |
| **QC/2016/232** | **CONSIDERATION OF BAF RISKS RELATING TO QUALITY COMMITTEE** |

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| | Rachel Kempster clarified new risks to be identified from the EPRR. A new standalone risk will be created around Mental Health Act and Compliance which will replace the legislative section of BAF1a where it is currently placed.. |
| **QC/2016/233** | **ANY OTHER BUSINESS**<br><br>Samragi Madden sought clarification on the actions the Committee would be taking regarding the Healthwatch Audit. The Chair and Carolyn Green offered to meet with Healthwatch to discuss specifics regarding their recommendations. The Quality Dashboard will also be reviewed to see how material relating to emergent complaints can be included. The specifics regarding responsiveness will be picked up by Carolyn Green in the meeting. |
| **QC/2016/234** | **FORWARD PLAN**<br><br>The Committee was asked to note the addition items added to the forward plan, as highlighted in yellow. Any future changes will be reported in a similar fashion. |
| **QC/2016/235** | **MINUTES OF THE DRUGS AND THERAPEUTICS COMMITTEE**<br><br>The ratified minutes of the above meeting held on 22 September 2016 were noted, for information. |
| **QC/2016/236** | **DATE AND TIME OF NEXT MEETING**<br><br>The next meeting will be held on Thursday 12 January 2017 at 2.00 – 4.30 pm in Meeting Room 1, Albany House, Kingsway.<br><br>The meeting closed at 5.00 pm |

# MINUTES OF THE AUDIT AND RISK COMMITTEE

## HELD ON TUESDAY 13 DECEMBER 2016 FROM 2.00 – 4.30 IN MEETING ROOM 1, ALBANY HOUSE, KINGSWAY, DERBY, DE22 3LZ

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| **MEMBERS PRESENT** | Caroline Maley | Committee Chair & Senior Independent Director |
| | Julia Tabreham | Non-Executive Director |
| | Barry Mellor | Non-Executive Director |
| **IN ATTENDANCE** | Rachel Kempster | Risk & Assurance Manager |
| | Carolyn Green | Executive Director of Nursing & Patient Experience |
| | Sam Harrison | Director of Corporate Affairs & Trust Secretary |
| | Donna Cameron | Corporate Services Officer & Note Taker |
| | Mark Stocks | Partner, Grant Thornton |
| | Laura Weaver | Local Counter Fraud Specialist, KPMG LLP |
| | Sophie Jenkins | Director and Head of Internal Audit, KPMG LLP |
| | Rod Chidlow | Senior Manager, KPMG LLP |
| | Ali Breadon | Partner, PricewaterhouseCoopers |
| | Penny Gee | Counter Fraud Services |
| 2016/106 only | Susan Spray | Principal Workforce & OD Manager |
| 2016/106 onwards | Claire Wright | Executive Director of Finance |
| 2016/107 - 108 | Mark Powell | Acting Chief Operating Officer |
| | Melanie Curd | Observer – Deputy Trust Secretary, DCHS |

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| **AUD 2016/100** | **WELCOME & APOLOGIES**<br><br>Caroline Maley opened the meeting and introduced the attendees from KPMG as the Trust's new Internal Auditors. Apologies were noted from Amanda Rawlings, Rachel Leyland and Joan Barnett of Grant Thornton. |
| **AUD 2016/101** | **MINUTES OF THE PREVIOUS MEETINGS**<br><br>The minutes of the previous meeting, held on 11 October 2016 were accepted as a correct record with the correction of one item:<br><br>**AUD 2016/088 Quarterly Review of the BAF** - Page 2 of the minutes in the Action – reference to risk 3b to be corrected to risk 3c.<br><br>The minutes of the meeting held in confidential session on 11 October 2016 were also accepted as a correct record. |
| **AUD 2016/102** | **ACTIONS MATRIX**<br><br>All updates provided by the members of the Committee were noted directly to the matrix. |
| **AUD 2016/103** | **PATIENT EXPERIENCE REPORT: COMPLAINTS, CONCERNS AND COMPLIMENTS AND THE SERVICE PERFORMANCE**<br><br>Carolyn Green presented the report to the Audit & Risk Committee to present an overview of complaints systems and processes.<br><br>The Trust has a very small and 'Carter efficient' Patient Experience Team. Following an extension of the team to include a Family Liaison Service the performance of the team has shown a reduction in formal complaints. |

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| | In 2015 a concern had been raised by Healthwatch who had considered the Trust's response times too long and not responsive, which triggered the 2015 Complaints Survey. The Trust now benchmarks well in terms of its responses to complaints and will continue to build on the improvements made. At the time of its inspection, the CQC had no concerns regarding the service; minor suggestions were made which were acted upon.<br><br>Barry Mellor commented that response targets are being considerably missed. Carolyn Green advised that response times are internal and set in line with other organisations in mental health. Contact with complainants is kept and maintained throughout the process. The complexity of some complaints are so great that it has led to the request for increased resource to look at the more complex complaints and also to deliver additional training to support pressurised areas. Julia Tabreham assured the Committee that the Quality Committee keeps a close oversight on the area. In addition to this Carolyn Green suggested a visit could be arranged for NEDs to meeting with the patient experience team to look at the complexity and range of cases.<br><br>**RESOLVED: The Audit & Risk Committee:**<br>**Noted and scrutinised the report. The improved position since the last report was noted. The recommendation for capacity improvement work was noted. Partial assurance was received regarding systems working**. |
| **AUD 2016/104** | **<u>UPDATE ON RAISING CONCERNS (WHISTLEBLOWING)</u>**<br><br>Sam Harrison presented the report to update the Committee on the arrangements within the Trust by which staff may raise concerns and presented a review of activity since April 2016. It was noted that oversight of themes raised and cultural context rests with People & Culture Committee. The Audit & Risk Committee role was reaffirmed to review the robustness of processes and procedures in place.<br><br>In response to a query raised at the last meeting regarding what happens with calls to the NHS Whistleblowing Helpline, Sam Harrison advised that the Trust is not immediately notified unless a matter requires rapid action. The Trust is however notified within 90 days of all contacts through the helpline. Should the CQC be contacted the lead contact for the Trust, Carolyn Green, is advised via email or intelligence from the CQC helpline. The CQC does not necessarily investigate but all concerns are logged and a response is required within ten working days.<br><br>Sam Harrison confirmed that under the Trust's processes, all concerns raised are logged as a matter of course, but may not be classified as whistleblowing when initially investigated. The report for the last six months identifies just one whistleblowing incident since April. The reflection of Carinna Gaunt as Freedom to Speak Up Guardian is that they are almost all misdirected HR queries. Sam Harrison will work with the new Guardian, linking to the Engagement Forum, to raise awareness and link into other processes in the Trust. This will include education for staff on what is whistleblowing and greater awareness of HR policies and procedures. The Chair sought assurance that all issues are dealt with appropriately within timescales. Sam Harrison confirmed that a tracker records this level of detail and committed to including that information in the next iteration of the report.<br><br>Carolyn Green requested that feedback is given when issues/complaints are not upheld and support given to staff when complaints have not been upheld. |

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| | Sam Harrison reported that Carina Gaunt will no longer be fulfilling the role of Freedom to Speak Up Guardian as she is taking up a joint role with DCHS. A new Guardian will be identified. The Committee expressed its appreciation to Carina Gaunt for her work.<br><br>**ACTION: Tracker to be updated to reflect timeline and progress with cases.**<br><br>**RESOLVED: The Audit & Risk Committee**<br>**1. Received assurance on the arrangements for whistleblowing, noting the concerns raised since April 2016.**<br>**2. Noted that the Trust now has a new NED for Freedom to Speak up in Margaret Gildea, who took up the role on 1 November 2016.** |
| **AUD 2016/105** | **RISK MANAGEMENT STRATEGY**<br><br>Sam Harrison presented the report which proposed a new Risk Management Strategy for the Trust. The version provided to the Committee is based on amendments incorporated following discussion at Audit and Risk Committee on 11 October 2016 and meetings held with the Audit and Risk Committee Chair, Director of Corporate Affairs and Risk and Assurance Manager.<br><br>Julia Tabreham thanked Rachel Kempster for the document and suggested that additional narrative be added (to section 5.1) to expand upon the difference between minor and catastrophic issues related to individual's own perception on risk and harm. This was agreed. Rachel Kempster assured the Committee that the Trust does cover this as part of risk management training.<br><br>**ACTION: Risk Management Strategy to be highlighted to staff through a concise summary**<br><br>**RESOLVED: The Audit & Risk Committee ratified the Strategy subject to the one amendment requested above.** |
| **AUD 2016/106** | **DEEP DIVE INTO BAF RISK 1A – CLINICAL QUALITY STANDARDS**<br><br>Carolyn Green presented the 'deep dive' into the high level BAF Risk 1a – Failure to achieve clinical quality standards required by our regulators which may lead to harm to service users and/or staff.<br><br>The CQC inspection did not find harm but suggested that harm may occur unless the Trust improved some processes and standards. The Trust does have regulatory performance issues, reputational damage and significant gaps in mental health governance but strong mitigations, action plans and clinical controls are in place to prevent potential harms. The Committee was asked to note that the Trust is exposed to risk due to underfunding and increased patient activity. Models to address gaps in controls are being adopted from good/outstanding organisations. To address staff morale, which impacts on quality, workforce planning is being developed and a programme of talent management. The Quality Committee has improved oversight of the risk via the Quality Dashboard, which is reported monthly. Overall, the position has improved but the Committee was asked to note that expected outcomes are higher and a good contracting round is vital to continuing improvement.<br><br>Caroline Maley requested that as Health & Wellbeing is a quality indicator, it should be included within the BAF, despite not being an outlier or having a gap in assurance. In addition, there was nothing reported to change the risk score |

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| | for this item. The Committee was assured that the deep dive was evidenced and gaps in control are being monitored and improved upon.<br><br>Mark Stocks asked members how aware the Board is of this matter. The Chair confirmed the full BAF report goes to the Board four times a year. The item also appears on the Integrated Performance Report, which goes to each monthly Board meeting. Investment is an ongoing issue for debate. The Trust is in the bottom 25% of national mental health funding which impacts on outcomes. As a result, Carolyn Green confirmed that the CCG accept that the Trust is under-funded substantially leading to this risk rating and this is on the shared risk register with the CCG.<br><br>**RESOLVED: The Audit & Risk Committee**<br>**1. Noted the report and limited assurance.**<br>**2. Agreed the risk score will not change.**<br>**3. Requested to add Health & Wellbeing to the BAF.** |
| **AUD 2016/107** | **<u>GOVERNANCE IMPROVEMENT ACTION PLAN</u>**<br><br>Sam Harrison presented the report to provide assurance to the Committee and evidence of progress against each of the actions within the GIAP for which the Committee has oversight. A key area to address following the Phase 1 Deloitte's report was the request for Board Committees to reflect on the recommendations in the GIAP and their original context. This has been concluded and, as recommended by NHSI, 'blue completion forms' have been produced to identify evidence and close completed actions. For the purpose of Audit & Risk Committee (only), lilac forms have been produced to show progress towards completion.<br><br>The Committee was asked to review the blue forms, challenge the narrative for reflection of work done and evidence of completion to assure that the recommendation has been met.<br><br>The Chair reported she had reviewed all the blue and lilac forms with Sam Harrison and was content with the recommendations made. The Chair was also content that the GIAP is being well scrutinised and challenged. Julia Tabreham referred to 'robust attendance of all Executive Directors at committee meetings' as per CorpG4, which Sam Harrison agreed to take as an action.<br><br>Susan Spray, Principal Workforce & OD Manager, joined the Committee to update on progress against ClinG2 with Rachel Kempster. Susan Spray referred to a dispute with Staff Side which had previously resulted in suspension of meetings and, as a result 40-50 policies had become out of date. However, the Policy Review Group had now reformed with effective representation across the staff and operational sides. Policies are now up to date with best practice and a comprehensive management development programme has been developed to ensure managers understand and can deliver key HR policies.<br><br>The Committee was assured that systems and processes are in place to maintain policies and procedures and that there is scrutiny and challenge. In terms of failing to reduce the overall number of policies and procedures as recommended by Deloitte, the Committee was assured that the outcome of a higher number of polices was in response to ensuring the Trust had the policy structure it required. The Committee agreed that the recommendation had been fully addressed and that a blue completion form should be prepared for sign off. This will be considered by the Quality Committee who have overall |

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| | oversight for Clinical Governance Core recommendations on the GIAP.<br><br>**ACTION: Sam Harrison to develop process to monitor attendance of committee members and attendees.**<br><br>**RESOLVED: The Audit & Risk Committee:**<br>**1. Agreed to close recommendations CorpG2, CorpG10, CorpG12 and CorpG13**<br>**2. Noted the progress with the remaining Core 4 recommendations and that these all require further actions to either embed or provide assurance and to note the timescales proposed**<br>**3. Noted the review of all recommendations against the original Deloitte report that has been undertaken**<br>**4. Agreed that Corp G9 is no longer applicable.**<br>**5. Agreed ClinG2 had been completed and a blue form will be recommended to the January Quality Committee for sign off.** |
| **AUD 2016/108** | **INDICATIVE AUDIT PLAN**<br><br>Mark Stocks presented the Indicative Audit Plan and highlighted the key challenges faced by the Trust as achievement of financial targets and CIP, agency cap, governance (GIAP and CQC), STP and the potential merger with DCHS. Materiality for audit purposes remains unchanged from previous years.<br><br>In clarifying the business plan arrangements for the potential merger for Julia Tabreham, Claire Wright confirmed that the terms of reference for the Joint Programme Board that will report to both Trust Boards have been approved. There will be no impact in 2016/17 on the accounts regarding the potential merger. Value for Money work will cover the response to the GIAP and CQC actions.<br><br>Key dates for audit through to June 2017 were noted; Grant Thornton will be onsite in February for interim audit visits. There will be substantive testing on the financial statements and any findings brought back to the Committee.<br>The Committee reviewed Grant Thornton's assessment of its value added to the Trust. This included an assessment of performance against KPIs, additional services and information provided. Mark Stocks confirmed the usual scrutiny by peers had shown no concerns.<br><br>**RESOLVED: Audit & Risk Committee**<br>**1. Noted the Indicative Audit Plan.**<br>**2. Noted the Progress Report.**<br>**3. Noted the Performance Report.**<br>**4. Considered that the value of the services provided by Grant Thornton was good and could be considered effective.** |
| **AUD 2016/109** | **INTERNAL AUDIT**<br><br>**Update on Previous Audit Actions**<br>Ali Breadon presented the update on previous audit recommendations. Compliance issues were found in a number of areas. This was found to be where recommendations that had not been addressed or the trajectory had slowed. Overall seven issues are outstanding, all medium. Six had been completed that needed further work. Last year only two remained outstanding so there had been deterioration in performance across the period. A review of feedback on audit recommendations during the course of the year had found that some of the evidence provided was not robust and provided inaccurate |

assurance. The Chair expressed disappointment at this status. Claire Wright confirmed that this is not an ongoing trend but it is unacceptable. The responsibility for the action is the person who owns it, not the person receiving it. The Executive Leadership Team is to discuss and take a view regarding adding in an extra layer of oversight.

**Consultant Job Planning Internal Audit Report – High Risk**
There was a mixture of compliance and process issues in this area and as expected the audit came out as high risk. Mark Powell advised that he had discussed and provided a job planning framework to John Sykes.

**Patient Section 132 Rights Internal Audit Report – Medium Risk**
Medium risk was noted as a result of lack of evidence, documentation and compliance with policy and timeliness of documentation. Carolyn Green highlighted that the last compliance and performance check was 87%. Reports should be run through the Associate Clinical Directors and monitored through the Executive Lead of Mental Health Act Committee (Dr John Sykes). This outcome has been added to the dashboard to ensure systems and processes are effectively implemented in those areas and it was recommended that this be monitored by the Mental Health Act Committee with assurance reported to the Audit & Risk Committee.

**Data Security & Handling Internal Audit Report – Medium Risk**
The medium risk outcome was noted. Sam Harrison confirmed to the Chair she had been involved in this audit as SIRO and that the recommendations will be managed through the Information Governance Committee, via the Executive Lead, John Sykes. The audit was noted.

**Agency Controls Internal Audit Report – High Risk**
The high risk outcome was noted. The Chair referred to the action plan to address agency controls. Mark Powell reminded the Committee of the weekly agency meetings chaired by himself to oversee the actions. The plan is in hand to ensure all recommendations are delivered. The Chair was assured that action is being taken and the Acting Chief Operating Officer has a control on this huge challenge. (Mark Powell left the meeting at this time).

**Key Financial Systems (Data) Internal Audit Report – Low Risk**
The low risk report classification was noted. Claire Wright shared that she had followed up on the overtime observed in Catering, which was a result of outside events that had been built into charges, which is a positive outcome.

(Barry Mellor offered his apologies and left the meeting at this time.)

**Head of Internal Audit Opinion (to date)**
The Audit & Risk Committee noted the report and the drop in opinion category from the previous year which is related to the deterioration in the progress made in implementing recommendations made in prior years to improve or eradicate control weaknesses and the higher number of high and medium actions. The Chair thanked Ali Breadon for the Audit Opinion and said she was not surprised in the drop in rating but commented that the audit work requested had been focussed upon areas of known challenge.

The Committee discussed ownership of the Consultant Job Planning Internal Audit and concluded that it is correctly assigned to the Executive Medical Director and his five Associate Clinical Directors. The Chair asked the Executive Directors present to consider how the Medical Director may be supported to achieve completion of the recommendation to provide consultant

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| | job plans by the end of the financial year.<br><br>**ACTION: Executive Directors to consider how the Medical Director may be supported to achieve completion of the recommendation to provide consultant job plans by the end of the financial year**<br><br>**RESOLVED: The Audit & Risk Committee**<br>**1. Noted the audit reports.**<br>**2. Noted the Head of Internal Audit Opinion.**<br><br>The Committee thanked Ali Breadon and PWC for their contribution over the period of their contract. Ali Breadon left the meeting at this time. |
| **AUD 2016/110** | **INTERIM COUNTER FRAUD REPORT TO END OF CONTRACT**<br><br>Penny Gee introduced the report, which covers the period April to November 2016, and effectively serves as the handover of the contract to KPMG who have taken over Counter Fraud work for the Trust from 1 December 2016. Penny Gee confirmed that she had met with the KPMG Local Counter Fraud Specialist, Laura Weaver, and completed the handover process.<br><br>In reference to the Case Tables, one alleged fraud remains open which has been closed since the issue of this report; therefore no live cases have been handed over to KPMG. One closed case (EMRT/09/00033) still has a live arrest warrant outstanding, of which KPMG is aware.<br><br>The year-end process is referred to in the report from KPMG. 360 Assurance has fed into the standard self-assessment for the year end and is happy to provide any further help.<br><br>**RESOLVED: The Audit & Risk Committee**<br>**1. Noted the conclusion that during the period 1 April to 30 November 2016 the Trust had been compliant with NHS Protect Standards for Providers.**<br>**2. Noted the assurance that the Trust's counter fraud, bribery and corruption arrangements are embedded.**<br><br>The Chair thanked Penny Gee for her contribution on behalf of 360 Assurance. |
| **AUD 2016/111** | **INTERNAL AUDITORS – KPMG INTRODUCTIONS**<br><br>**Progress Report and draft plan for remainder of 2016/17**<br>Sophie Jenkins and Rob Chidlow presented the report. Activities to date were summarised. The Committee noted the draft plan and technical updates. The draft plan includes a review of the BAF, the CQC action plan and data quality. Sam Harrison asked that the GIAP also remain an option for consideration subject to alternative external review which is as yet to be finalised.<br><br>**Counter Fraud – verbal and technical update**<br>The Committee noted the report. Laura Weaver confirmed that she had met with colleagues from 360 Assurance and will now undertake a full fraud risk assessment in January. The Chair thanked KPMG for their work and welcomed them on Board.<br><br>**RESOLVED: The Audit & Risk Committee**<br>**1. Noted the draft plan**<br>**2. Noted the Counter Fraud update.** |

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| **AUD 2016/112** | **IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK**<br><br>Sam Harrison reported that the BAF had been presented to NHS Improvement (NHSI) on 12 December as part of the Trust's routine Performance Review Meeting. Feedback has been given to Rachel Kempster for potential development of the BAF in the 2017/18 round. NHSI noted that they were keen to make sure the actions the Trust is taking are making an impact which is reflected in the movement in BAF risk scores.<br><br>The Chair expressed her increasing concern regarding compliance issues in particular relating to the Mental Health Act Compliance. Sam Harrison confirmed that she has taken an action to raise this at ELT to follow up on the actions from the Audit. It will also be a verbal update at the next Board meeting as part of the escalation of Committee business. |
| **AUD 2016/113** | **MEETING EFFECTIVENESS**<br><br>The Chair noted that timings had not gone according to plan but had taken the time for further review of items as required.<br><br>**ACTION: The Chair will talk to Internal Audit regarding carrying out the annual effectiveness review for the Audit & Risk Committee.** |
| **AUD 2016/114** | **2016/17 FORWARD PLAN**<br><br>On the advice of Rachel Kempster, the Governance Item on the Implementation of Internal and External Audit Progress Reports will become a quarterly report going forwards (rather than bi-annually). The next report will come to the January Audit and Risk Committee.<br><br>**ACTION: Forward Plan to capture Implementation of Internal and External Audit Progress Reports on a quarterly basis** |
| **AUD 2016/115** | **DATE AND TIME OF NEXT MEETING**<br><br>The next meeting of Audit & Risk Committee will take place on Tuesday 17 January 2017 at 10.30 am in Meeting Room 1, Albany House, Kingsway, Derby, DE22 3LZ |

**DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST**

**MINUTES OF A MEETING OF PEOPLE & CULTURE COMMITTEE**

**HELD ON WEDNESDAY 17 NOVEMBER 2016 AT 1.00 PM**
**MEETING ROOM 1, ALBANY HOUSE, KINGSWAY**

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| **COMMITTEE MEMBERS PRESENT** | Margaret Gildea | Chair of Committee & Non-Executive Director |
| | Jim Dixon | Non-Executive Director |
| | Barry Mellor | Non-Executive Director |
| | Richard Wright | Non-Executive Director |
| | Mark Powell | Acting Chief Operating Officer |
| | Amanda Rawlings | Director of People and Organisational Effectiveness |
| **IN ATTENDANCE** | Kim Broadhurst | Workforce & Organisational Development Advisor |
| | Liam Carrier | Workforce Systems & Information Manager |
| | Lee Fretwell | Chair, Staff Side |
| | Owen Fulton | Principal Employee Relations Manager |
| | Marian Ogunkoya | Workforce & Organisational Development Advisor |
| | Brenda Rhule | BME Representative |
| | Faith Sango | Head of Education |
| | April Saunders | Staff Governor for Nursing and Allied Professions |
| | Anna Shaw | Deputy Director of Communications & Involvement |
| | Kelly Sims | Staff Governor Administration and Allied Support Staff |
| | Garry Southall | Principal Workforce & Organisational Development Manager |
| | Sue Turner | Board Secretary |
| **APOLOGIES** | John Sykes | Executive Medical Director |

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| P&C/2016/ 117 | **WELCOME AND APOLOGIES**<br><br>Margaret Gildea opened the meeting, welcomed attendees and led introductions. |
| P&C/2016/ 118 | **MINUTES OF THE MEETING HELD ON 19 OCTOBER 2016**<br><br>The minutes of the meeting held on 19 October 2016 were accepted as a correct record of the meeting. |
| P&C/2016/ 119 | **ACTIONS MATRIX**<br><br>Updates were provided and noted directly on the actions matrix. |
| P&C/2016/ 120 | **STAFF STORY**<br><br>This item was opened by Owen Fulton who gave a brief overview of the recent work carried out to attract the attention of patients and staff to celebrate Black History Month. Kelly Sims was introduced as the project lead for staff and |

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| | patient engagement and presented her report on Staff and Patient Engagement Through Food. The Committee heard how a themed event took place in the restaurant to celebrate the diversity of food enjoyed by Afro Caribbean and African staff. This had been a very successful event which had resulted in different groups of staff coming together to celebrate the Trust's cultural diversity.<br><br>The Committee was pleased to hear that the breakdown of diversity of the Trust's staff is being used to plan different events on a monthly basis through food served in the restaurant and future events will also focus on different religious festivals.<br><br>**RESOLVED: The People and Culture Committee noted the report on staff and patient engagement through food** |
| P&C/2016/ 121 | **STRATEGIC WORKFORCE REPORT**<br><br>Amanda Rawlings' report provided the People & Culture Committee with a monthly update on key national and local workforce projects.<br><br>Key points were noted as follows:<br><br>• NHS organisations continue to face workforce supply issues in relation to some of the health professional staff groups. The current shortage is essentially a supply issue and is not related to pay levels<br>• Tier 2 immigration route changes have been announced and it is hoped that the true percentage levels will be available at the end of November.<br>• Flu vaccinations are one of the key activities the Trust can carry out to protect staff. In comparison to last year figures show an increase of uptake and work is taking place to reach the Trust's target of 45%.<br>• Staff survey remains open until 2 December. A good sample of data from the survey will be obtained and participation rate is running at 30%<br><br>The report also highlighted the work being carried out by the OD team (Organisational Development) in implementing people policies through a series of workshops designed to help leaders address the typical challenges they face.<br><br>Amanda Rawlings was pleased to report that the appraisal process is being redesigned so it is simplified and guidelines are being prepared that will provide practical help to support managers on how to complete the documentation and conduct appraisals and to help them to participate effectively. Training will be provided to all staff who conduct performance appraisals which will be designed so that staff can understand how they can be held to account by their managers.<br><br>In reviewing the equalities and diversity update section Jim Dixon pointed out that he had noted when taking part in quality visits that there is an inclusive approach to work and asked how the organisation could return to the position of being one of the best performing trust's within the country. Amanda Rawlings informed the Committee she will be meeting with the CQC (Care Quality Commission) next week and will demonstrate how the Trust has achieved an exemplary performance. The Equalities Forum will be key to placing momentum behind this initiative and she was working with Harinder |

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| | Dhaliwal and Owen Fulton to drive this forward.<br><br>**RESOLVED: The People and Culture Committee noted the Strategic Workforce Report** |
| P&C/2016/ 122 | **GOVERNANCE IMPROVEMENT ACTION PLAN RECONCILIATION REPORTING**<br><br>Due to the high number of reports currently being produced for the GIAP that the Committee has oversight for it was decided that these reports would be circulated after the meeting.<br><br>Mark Powell informed the Committee that Kelly Sims has now undertaken the Governance Improvement Action Plan (GIAP) reconciliation reporting on behalf of the Committee. He and Amanda Rawlings, Sam Harrison, Kelly Sims and Lee Fretwell had met to discuss the recommendations the Committee has oversight for and tracked each action back to the original documentation. He was pleased to report that a significant number of these actions have now moved towards completion although there are still some key areas to close by April 2017.<br><br>It was noted that the GIAP actions the Committee has oversight for are now more manageable and can be delivered. The following two agenda items covering GIAP action WOD7 provide evidence that work is progressing in the right direction to close the Committee's GIAP actions.<br><br>**ACTION: GIAP reports to be circulated to the members of the Committee.**<br><br>**RESOLVED: The People & Culture Committee noted the verbal update on GIAP reconciliation reporting** |
| P&C/2016/ 123 | **GIAP WOD7 – MONITORING OF ADHERENCE TO THE FRIEVANCE, DISCIPINARY AND WHISTLEBLOWING POLICIES**<br><br>This report updated the People & Culture Committee on the actions taken and progress made since the PwC Audit recommendations were received around the Discipline and Grievance Procedures.<br><br>The report contained an overview of the actions taken following the audit of the five current and five historic Discipline and Grievance cases each selected by PwC at random. Garry Southall was pleased to report that the action taken is an indicator that progress is being made to ensure that Discipline and Grievance Procedures are adhered to and audit trails are maintained. Barry Mellor asked how the Committee could ensure the system was embedded in the organisation and be certain these new documentation templates are being used correctly. Garry Southall responded that the internal audit being carried out for the HR department will ensure this takes place. Lee Fretwell added that he was satisfied that the action plan to ensure correct use of the documentation templates and IT processes are now in place.<br><br>The Committee was pleased to note that the report identified the intended progress against the audit which will continue into the future for all cases and was satisfied this was now under control. |

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| | **RESOLVED: The People & Culture Committee**<br>**1) Considered the report**<br>**2) Scrutinise the contents**<br>**3) Obtained assurance that action has been taken against the recommendations made by PWC following the audit report of Discipline & Grievance Procedures submitted August 2016** |
| P&C/2016/ 124 | **GIAP WOD7 – TRACKER FOR BACKLOG OF CASES FOR DISCIPLINE GRIEVANCES AND DIGNITY AT WORK**<br><br>Garry Southall provided the Committee with a verbal update on progress relating to the investigation tracker for discipline grievances and dignity at work. He was pleased to report that colleagues from Staffside are helping to develop this initiative and that the trajectory for resolving discipline and grievances is reducing. It was noted that the tracker is also reviewed by the Executive Leadership Team (ELT) on a monthly basis.<br><br>Lee Fretwell commented that Staffside welcomed the opportunity to meet with HR to go through the case reviews and it was considered that input from Staffside will speed up the process.<br><br>**ACTION: Representatives from Staffside to work with the HR team to progress case reviews of discipline, grievances and dignity at work.**<br><br>**RESOLVED: The People & Culture Committee noted the verbal update on the investigation tracker for discipline grievances and dignity at work.** |
| P&C/2016/ 125 | **RECRUITMENT REVIEW AND ACTION PLAN**<br><br>Liam Carrier presented his report which provided the People & Culture Committee with an update on the latest vacancy data at Trust level which focussed on qualified nursing and medical staff groups. The report also gave an overview of the recruitment action plan.<br><br>The report looked at initiatives that are underway which are aimed to improve overall recruitment. The report also covered the new approval to appoint process and paperwork process which has been developed to increase speed of recruitment. The Committee welcomed the process but considered it contained too many steps and hoped the process will evolve into a simpler system and was satisfied that this process will help provide KPI data.<br><br>An update was made on the recruitment open day that took place on 11 November. Thanks were given to Brenda Rhule and Liam Carrier who facilitated the event which had resulted in offers being made to 12 qualified nurses and 5 health visitors. The HR team would now on-board these recent recruits and make them feel they are part of the team before they commence in post.<br><br>Brenda Rhule thanked Mark Powell for attending the recruitment event as it was felt that added value was achieved by having a Board Director present to respond to questions raised by candidates.<br><br>Jim Dixon pointed out that the Finance & Performance Committee had recently reviewed the problems regarding the time it takes to receive Royal College approval for medical recruitment and that work is taking place to |

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| | speed up the approval process. He also made the point that volunteers have raised issues with the delays experienced whilst being recruited. Volunteering is a very important part of the route into work and it was agreed that Amanda Rawlings would carry out a review of administration support for volunteers with Carolyn Green.<br><br>Amanda Rawlings introduced Kim Broadhurst and Marian Ogunkoya who had recently been appointed to look at different approaches to improve staff recruitment and reduce agency spend. The Chair asked Kim and Marion what improvements they hoped to make. Marion responded that oversees recruitment will help in this area and she is working with a variety of stakeholders to develop opportunities further. Kim replied that she will work on improving skill mixing within the services which will be driven by patient need.<br><br>**ACTION: Marian Ogunkoya to contact each of the qualified nurses and health visitors and invite them to meet the teams**<br><br>**ACTION: Amanda Rawlings to discuss administration support for volunteers with Carolyn Green**<br><br>**RESOLVED: The People & Culture Committee considered and noted the Recruitment Review and Action Plan** |
| P&C/2016/ 126 | **HR METRICS**<br><br>The Workforce KPI Dashboard provided the Committee with the latest key Workforce metrics at Trust level.<br><br>One of the actions from the last meeting was to look at age range of staff leaving the Trust. The report showed that Qualified Nursing had the highest number of leavers, representing 35.16% of all leavers and appeared as the highest in all age bands 21 to 25, 26 to 30 and 31 to 35. Band 5 leavers were the highest at 39.06%, followed by Band 6 at 16.41%. Leavers in In Patient areas represented 31.25% of all leavers, with Kedleston Low Secure having the most at 5 employees, followed by Morton Ward with 4 employees.<br><br>Another action from the previous meeting was to analyse exit questionnaires, the highest score showed that travel to work was the biggest reason for staff leaving followed by inadequate staffing levels and stress at work. Dissatisfaction with the working environment was another significant reason for people leaving and it was considered that this required a more concentrated piece of work.<br><br>Amanda Rawlings was conscious that data analysis needs to be passed back to the teams to see what can be done to improve people's work satisfaction levels. It was considered that preventative issues should be better addressed as it is clear that lot of people are dissatisfied at work and this Committee will lead the challenge to improve levels of job satisfaction.<br><br>Sickness absence was covered in the report and showed that the annual rate is currently running at 5.62% which is a decrease of 0.15% compared to the previous month. The Committee was pleased to note that this was the second month running when results have shown a reduction in the annual sickness rate and long term sickness absence has also started to reduce. |

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| | At the last meeting fracture injuries were raised as a concern. Liam Carrier informed the Committee that he had looked at data for the current year but had not discovered any trends and considered that most fractures had occurred in non-work related accidents.<br><br>Richard Wright made the point that there will probably be a correlation in high sickness rates associated with people who leave because they are dissatisfied in their work and Liam Carrier undertook to look at this further.<br><br>The report showed that the number of employees who have received an appraisal within the last 12 months has increased. Compared to the same period last year, compliance rates are 3.96% higher. Kelly Sims asked how guidance could be given to teams who need support with appraisals. Anna Shaw saw this as an opportunity to provide support and help teams understand what they need to work on and provide teams with the development focus they need. Lee Fretwell pointed out that Staffside are also playing a role in supporting staff and service managers. Improvement action is now taking place and changing the culture/environment during appraisal meetings.<br><br>It was noted that compulsory training compliance rates have risen during the year to 88.22%, however since June 2016 they have been in decline. Overall compulsory training compliance remains above the 85% main contract non CQUIN target and is just below the Trust target of 90%.<br><br>**ACTION: Liam Carrier to establish whether sickness absence correlates with staff dissatisfaction**<br><br>**RESOLVED: The People & Culture Committee considered and noted the Workforce KPI Dashboard** |
| P&C/2016/ 127 | **DEVELOPMENT OF APPRENTICESHIPS**<br><br>Faith Sango's report provided the Committee with an update on how the mandatory apprenticeship levy will be utilised across the Trust. As a levy payer, the Trust will receive a 10% top-up from the government which will provide £495k to spend on apprenticeships which will enable the Trust to invest this money in training band 1 – 4 staff.<br><br>The Committee was pleased to note the progress made so far with this initiative as it was seen as a vital component to retaining staff and will help create a sustainable workforce. The Committee would oversee the implementation of government funding and ensure it is invested in training and development.<br><br>It was agreed that a further update on the Trust's state of readiness for the implementation of the Apprenticeship Levy in April 2017 would be received at the January meeting.<br><br>**ACTION: Further update report to be received on the state of readiness for the Apprenticeship Levy at the January meeting.**<br><br>**RESOLVED: The People & Culture Committee noted plans to introduce high numbers of apprenticeships across the organisation** |

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| P&C/2016/ 128 | **MINDFUL HEALTH AND WELLBEING STRATEGY**<br><br>The Committee received the first draft proposal of the Staff Health and Wellbeing Strategy and was presented by Garry Southall in Rose Boulton's absence.<br><br>The Committee noted the progress made so far in developing the strategy which has been aligned with the recently revised Trust Strategy and the emerging People Plan and that input into the final version will be provided from JNCC and Staffside. However, it was thought that the strategy did not focus enough on prevention to combat the high level of sickness absence. It was also thought that exercise programmes could form part of the Health and Wellbeing programme and that the BME perspective was missing from the strategy.<br><br>Anna Shaw and April Saunders made the point that wider activities could be included in the strategy such as support to staff through offering exercise sessions on site and offered to help contribute to this section of the strategy. Anna Shaw also informed the Committee that she intended to meet with Garry Southall and Rose Boulton to discuss how a communication plan can be developed to support the strategy.<br><br>The Committee noted the very valuable interventions contained in the strategy and accepted it would evolve further. It was agreed to increase the range of people engaged in the Health and Wellbeing Working Group to review the strategy and would submit a revised version to the April meeting.<br><br>**ACTION: Anna Shaw to meet with Garry Southall and Rose Boulton to develop a communication plan to support the strategy**<br><br>**ACTION: Revised version of the strategy to be submitted to the April meeting.**<br><br>**RESOLVED: The People & Culture Committee received the first draft of the Staff Health and Wellbeing Strategy** |
| P&C/2016/ 129 | **FORWARD PLAN**<br><br>A revised forward plan will be received the December meeting once it has been revised by Amanda Rawlings and Sue Turner. Anna Shaw asked that the Staff Recognition and Reward report be included in the forward plan.<br><br>**ACTION: Amanda Rawlings and Sue Turner to revise the forward plan. Staff Recognition and Reward report to be included in the forward plan.** |
| P&C/2016/ 130 | **ITEMS ESCALATED TO THE BOARD OR OTHER COMMITTEES**<br><br>The Committee agreed to escalate the following items to the Board.<br><br>• Board to note the progress made on GIAP - WOD7 – Monitoring of adherence to the Grievance, Disciplinary, Whistleblowing Policies – PwC Audit Report<br>• GIAP Blue forms to be completed for close off |

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| | • Board to take assurance from the scrutiny applied to GIAP WOD 7 – tracker for backlog of cases<br>• Revised Health and Wellbeing Strategy will be received in April 2017 |
| P&C/2016/ 131 | **IDENTIFIED RISKS**<br><br>• Recruitment<br>• Stress on the organisation due to sickness absence<br>• Flu CQUIN |
| P&C/2016/ 132 | **MEETING EFFECTIVENESS**<br><br>The Chair felt the agenda was far more focussed and quality of papers had improved which made the meeting more effective. |
| P&C/2016/ 133 | **MEETING CLOSE**<br><br>There being no other matters to discuss, the Chair thanked everyone for attending and closed the meeting at 3pm. |
| Date and Time of next meeting: The next meeting of the People & Culture Committee will take place on Thursday, 22 December 2016 at 2.00 pm in *Meeting Room 1 – Albany House, Kingsway, Derby.* | |

# DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

## MINUTES OF AN EXTRAORDINARY MEETING OF PEOPLE & CULTURE COMMITTEE

### HELD ON WEDNESDAY 14 DECEMBER 2016 AT 11AM
### ACTING CHIEF EXECUTIVE'S OFFICE, ASHBOURNE CENTRE, KINGSWAY

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| **COMMITTEE MEMBERS PRESENT** | Margaret Gildea | Chair of Committee & Non-Executive Director |
| | Barry Mellor | Non-Executive Director |
| | Richard Wright | Non-Executive Director |
| | Mark Powell | Acting Chief Operating Officer |
| | Amanda Rawlings | Director of People and Organisational Effectiveness |
| | John Sykes | Executive Medical Director |
| **IN ATTENDANCE** | Sue Turner | Board Secretary (minutes) |

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| **1.** | **WELCOME AND APOLOGIES**<br><br>Margaret Gildea opened the meeting, and welcomed everyone. She explained that as the meeting scheduled to take place on 22 December had been cancelled, the purpose of today's extraordinary meeting was to close down the actions in the Governance Improvement Action Plan (GIAP). |
| **2.** | **UPDATE AGAINST CORE 1, CORE 2 AND CORE 7 OF THE GIAP**<br><br>This report provided the People and Culture Committee with an overriding update against Core 1 and Core 2 of the GIAP.<br><br>The report set out the status of each action and enabled the Committee to review the blue forms for recommendations HR1, HR2, HR3, PC1 and PC6 and agree the process for sign-off prior to submission of the blue forms to the next meeting of the Board on 11 January.<br><br>**RESOLVED: The People & Culture Committee:**<br>**1) Reviewed the content of this update paper**<br>**2) Reviewed all recommendations and associated actions**<br>**3) Reviewed the blue forms for recommendations HR1, HR2, HR3, PC1 and PC6** |
| **3.** | **HR1**<br><br>"The HR and OD Departments should be under the management of one Executive Director"<br><br>Amanda Rawlings recapped the reasons behind the recommendation to combine the HR and OD departments under one Executive Director and explained why having these two functions split was ineffective.<br><br>The Committee recognised that Amanda Rawlings in her shared role with DCHS had brought the HR and OD functions together in her role as Director of People and Organisation Effectiveness and is leading the development of an integrated People and |

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| | Organisational Effectiveness structure for DCHS and DHCFT. The Committee was also pleased to note that weekly team meetings are taking place.<br><br>The Committee suggested that Amanda has an organisation structure chart that reflects the new structure.<br><br>**RESOLVED: The People & Culture Committee:**<br>**1) Received assurance that the HR and OD functions had been brought together under the leadership of Amanda Rawlings**<br>**2) Confirmed it was satisfied that this task was complete and that the blue form could be submitted to the Trust Board.** |
| **4.** | **HR2**<br><br>"Ensure external resources for the newly appointed Director of Workforce, OD and Culture are obtained in order to drive the transformation of HR and related functions through a combination of coaching, buddying, and mentoring support"<br><br>In summarising the status of recommendation HR2 Amanda Rawlings reminded the Committee that she brought a paper to the October meeting which shared her view of the People Plan, since then a further plan has been received by the Remuneration and Appointments Committee.<br><br>The Committee recognised there are more skilled staff in post within the HR Department and that over the course of January to March resource requirements will evolve to enable the right structure to be put in place. As a result the Committee agreed to approve recommendation HR2 subject to the summary narrative being amended to read that staff were recruited to additional roles rather than stating that "staff were recruited to six additional roles." A further amendment would show that ELT, People and Culture Committee and the Board in October approved a revised resource requirement plan for the remainder of 2016 and into 2017 to support the new interim Director of People and Organisational Effectiveness to enable a revised integrated HR structure to be set up to deliver the key priorities.<br><br>Amanda Rawlings explained to the committee that she is making plans to ensure the HR function is fit for the future through integration with DCHS to support the organisation. Plans are in place in the short term to senior support to Amanda to enable the HR structure to move forward.<br><br>**RESOLVED: The People & Culture Committee:**<br>**1) Received assurance that additional staff have been recruited to the HR function**<br>**2) Confirmed it was satisfied that this task was complete and that the blue form could be submitted to the Trust Board.** |
| **5.** | **HR5**<br><br>"As part of the development of the People strategy and developing the model for HR, the function should define how it measures and evaluates the impact of HR, particularly around securing organisational development. A clear set of metrics demonstrating the impact of the function should be a focus on the newly created People and Culture Committee"<br><br>Amanda Rawlings advised that the People Strategy is being replaced with a People Plan and a revised version will be submitted to the January meeting of the People and |

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| | Culture Committee. The People Plan will outline the priorities of the next 12 months and will provide evidence that key metrics are in place and that they are monitored on a monthly basis at each meeting of the Committee.<br><br>The Committee agreed that this recommendation was now complete and the summary narrative in the blue form would be amended to reflect that key metrics are in place and they are monitored on a monthly basis by the Committee.<br><br>**RESOLVED: The People & Culture Committee:**<br>**1) Received assurance that the People Plan is in place and that key metrics are monitored at each meeting of the Committee.**<br>**2) Confirmed it was satisfied that this task was complete and that the blue form could be submitted to the Trust Board.** |
| **6.** | **PC1**<br><br>"The Trust should adopt an Organisational Development and Workforce Committee"<br><br>The Committee acknowledged that the Terms of Reference for the People and Culture Committee were agreed in February when the Committee was first set up to replace the People Forum which reported to the Finance & Performance Committee. In addition to this, the Terms of Reference were reviewed and further refined in September and October.<br><br>Amanda Rawlings reminded the Committee that at the GIAP review meeting held on 11 November it was agreed that a blue form should be completed for this action as the People and Culture Committee is now well established.<br><br>While discussing the evidence to support completion of PC1 it was suggested that the blue form narrative be enhanced to mention that the Committee is now in place and has met nine times since its inception in February. It is a very inclusive committee and reference is to be made to the representation by Staffside and staff governors at each meeting. It was also considered that the People Plan along with the minutes of each meeting could be used as additional evidence that the Committee is now well established.<br><br>**RESOLVED: The People & Culture Committee:**<br>**1) Received assurance that the People & Culture Committee is well established and operating effectively.**<br>**2) Confirmed it was satisfied that this task was complete and that the blue form could be submitted to the Trust Board.** |
| **7.** | **PC6**<br><br>"Expand the current Chair and CEO reports to provide a greater depth of information regarding key priorities for stakeholder engagement, feedback provided and any barriers to progress"<br><br>The Committee discussed how the Acting CEO Reports to the Board are now more focussed on a broader national context which facilitates strategic discussion and agreed that evidence of this can be seen in the reports received at each monthly meeting along with the corresponding minutes.<br><br>The Committee raised concern that the Interim Chairman's reports made to the Board were always verbal, although the detail of his report was captured in the minutes. The |

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| | Committee agreed to include in the narrative of the blue form the recommendation that the new Acting Chair is to submit a written report summarising monthly activity to the Board at each meeting.<br><br>The discussion that took place regarding reports to the Board allowed the Committee to reflect on the quality and style of reports received by the Board and the Board Committees as there is a clear need for reports to be more concise and strategically focussed on providing evidence rather than detailed data. Reports should also contain information about decisions that have been made and should highlight risks associated with CIP.<br><br>**RESOLVED: The People & Culture Committee:**<br>**1) Received assurance that the CEO reports provide the opportunity for strategic discussion at each Board meeting.**<br>**2) Confirmed it was satisfied that this task was complete and that the blue form could be submitted to the Trust Board.** |
| **8.** | **<u>MEETING CLOSE</u>**<br><br>There being no other matters to discuss, the Chair thanked everyone for attending and closed the meeting at 11:50 |

**Derbyshire Healthcare NHS Foundation Trust**
Report to the Board of Directors – 1 February 2017

# Emergency preparedness, resilience and response (EPRR) Strategy 2017-2020

## Purpose of Report

The Trust is currently reporting non-compliance with our legal and statutory responsibilities for Emergency preparedness, resilience and response (EPRR).

In order to set out a clear direction for EPRR and to meet statutory obligations, the Trust requires a strategy from which it can demonstrate delivery of actions to meet the requirements of the Civil Contingencies Act 2004 (CCA 2004) and NHS Commissioning Board, Emergency Preparedness Framework 2015.

This document sets out the Trust's strategy for EPRR for the next 3 years. The purpose of the Strategy is to ensure the continual development of Derbyshire Healthcare Foundation NHS Trust's resilience and response to a significant / major incident and / or a severe disruption to business continuity.

## Executive Summary

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. This could be anything from an extreme weather event to an infectious disease outbreak or a major incident. This work falls under the title of 'Emergency Preparedness, Resilience, and Response' (hereafter referred to as EPRR).

The Civil Contingencies Act 2004 is a UK Act of Parliament which delivers a framework for the provision of civil protection in the UK. The Act divides responder organisations into two categories, depending on the extent of their involvement in civil protection work, and places a proportionate set of duties on each.

Under the Civil Contingencies Act 2004, Foundation1 & Acute Trusts are classified as Category 1 Responders and as such are required to comply with the full responsibilities of the Act. Community providers are not listed within the Civil Contingencies Act 2004, however, Department of Health and NHS England guidance2 expects all NHS funded providers to plan for and respond to incidents in the same way as Category 1 responders, in a manner which is proportionate to the scale and services provided.

[1] *Cabinet Office, 2004.* "An NHS foundation trust within the meaning of section 30 of the *National Health Service Act 2006* if, and in so far as, it has the function of providing—
(a) ambulance services, or
(b) hospital accommodation and services in relation to accidents and emergencies."

[2] *NHS Commissioning Board, 2013c. p6.*

The objectives of the Strategy are:

- To outline the key requirements placed on the Trust and how the Trust will meet these;
- To outline the roles and responsibilities of Trust personnel in relation to Emergency Preparedness, Resilience and Response;
- To outline the governance arrangements for the Trust's Emergency Preparedness, Resilience and Response work programme; and,
- To outline how the Trust will develop arrangements in conjunction with partner agencies.

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

**Assurances**

Whilst the Trust is starting from a position of non-compliance, having an agreed strategy in place, alongside clear actions plans provides Quality Committee with assurance that progress is being made across all areas of non-compliance.

**Consultation**

- The Strategy was received and approved by Quality Committee
- Consultation has taken place with colleagues from NHSE and DCHS regarding the development of this strategy

**Governance or Legal Issues**

- Compliance with Civil Contingencies Act 2004
- NHS England Core Standards for EPRR

**Equality Delivery System**

Any potential equality and diversity implications will be assessed and managed as plans are developed and implemented.

**Recommendations**

The Board of Directors is requested to approve the EPRR Strategy

**Report presented by:** **Mark Powell (Acting Chief Operating Officer)**

**Report prepared by:** **Mark Powell (acting Chief Operating Officer)**

Derbyshire Healthcare NHS
NHS Foundation Trust

# Derbyshire Healthcare NHS Foundation Trust

# Emergency Preparedness, Resilience & Response (EPRR): Three Year Strategy

# January 2017 - 2020

**Document History**

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| Version Date: | January 2017 |
| Version Number: | Version 1 |
| Status: | Draft |
| Next Revision Due: | January 2020 |
| Developed by: | EPRR Lead |
| Strategy Sponsor: | Chief Operating Officer |
| EQIA completed: | Yes |
| Approved by: | Quality Committee |
| Date approved: | |

**Revision History**

| Version | Revision date | Summary of Changes |
|---|---|---|
| Version 1 | | |
| | | |
| | | |

**Contents**

## 1. Introduction

This Emergency Preparedness, Resilience and Response (EPRR) Strategy has been developed by the EPRR Lead and Chief Operating Officer.

**The purpose of the Strategy is:-**

- To ensure the continual development of Derbyshire Healthcare Foundation NHS Trust's (hereafter referred to as the Trust) resilience and response to a significant / major incident and / or a severe disruption to business continuity.

**The objectives of the Strategy are:-**

- To outline the key requirements placed on the Trust and how the Trust will meet these;
- To outline the roles and responsibilities of Trust personnel in relation to Emergency Preparedness, Resilience and Response;
- To outline the governance arrangements for the Trust's Emergency Preparedness, Resilience and Response work programme; and,
- To outline how the Trust will develop arrangements in conjunction with partner agencies.

## 2. Background

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. This could be anything from an extreme weather event to an infectious disease outbreak or a major incident. This work falls under the title of 'Emergency Preparedness, Resilience, and Response' (hereafter referred to as EPRR).

The *Civil Contingencies Act 2004* is a UK Act of Parliament which delivers a framework for the provision of civil protection in the UK. The Act divides responder organisations into two categories, depending on the extent of their involvement in civil protection work, and places a proportionate set of duties on each.

Under the *Civil Contingencies Act 2004*, Foundation[1] & Acute Trusts are classified as Category 1 Responders and as such are required to comply with the full responsibilities of the Act. Community providers are not listed within the *Civil Contingencies Act 2004*, however, Department of Health and NHS England guidance[2] expects all NHS funded providers to plan for and respond to incidents in the same way as Category 1 responders, in a manner which is proportionate to the scale and services provided.

[1] *Cabinet Office, 2004.* "An NHS foundation trust within the meaning of section 30 of the *National Health Service Act 2006* if, and in so far as, it has the function of providing—
(a) ambulance services, or
(b) hospital accommodation and services in relation to accidents and emergencies."

[2] *NHS Commissioning Board, 2013c. p6.*

## 3. Area of Implementation

This strategy relates to all activities undertaken by the Trust, particularly services relating directly to patient care, but also supporting services and those of a more corporate nature. This includes all services that the Trust is commissioned to provide, including any that are undertaken or delivered outside of Derbyshire.

## 4. Intended Users

This strategy is to be followed by all staff, when called upon to assist in the development and maintenance of emergency and business continuity plans, and when called upon to respond to an incident and/or a disruption to business continuity.

## 5. NHS Standard Contract and NHS England's Core Standards

### 5.1 NHS Standard Contract

Under the 2016/17 NHS Standard Contract:

- Each Party must identify and have in place an Accountable Emergency Officer
- Each Party must have and maintain an up-to-date Business Continuity Plan
- Each Party must have and maintain an Incident Response Plan
- The Provider must:
    - assist in the development of and participate in joint planning and training exercises connected with its Incident Response Plan
- The Provider must comply with:
    - national and local civil contingency plans;
    - the *Civil Contingencies Act 2004*;
    - any other Law and/or Guidance, including the EPRR Guidance, to the extent applicable
- The Parties must, through the Local Health Resilience partnership (hereafter referred to as LHRP) and any applicable subgroups of the LHRPs, co-operate with and contribute to the coordinated development and review of any local area business continuity and major incident plans.

### 5.2 Core Standards for Emergency Preparedness, Resilience & Response

NHS England (NHS Commissioning Board) has developed a set of core standards that NHS organisations and providers of NHS funded care must meet. The Accountable Emergency Officer in each organisation is responsible for making sure these standards are met.

The EPRR Lead and the Emergency Preparedness, Resilience & Response Group will use these standards as a benchmarking tool and will monitor and assess EPRR activities against them.

## 6. Statutory Obligations

There are a number of statutory obligations relating to emergency planning under the *Civil Contingencies Act 2004* (UK Act of Parliament). These are broken down into the following areas:

### 6.1 Risk Assessment

The Trust must assess the risks of an emergency within the areas which it serves and where appropriate prepare plans to mitigate these risks.

The Government has developed a set of National Risk Assessments which cover a range of perceived threats and hazards to the UK. These are reviewed at a local level by the Local Resilience Forum to determine the local likelihood and consequence. This is done locally via a multi-agency Risk Assessment Working Group (RAWG) that has been established as a sub-group of the Local Resilience Forum (LRF). The Trust is not a member of this Group; however it links into it via the Local Health Resilience Partnership. The risk assessments undertaken by the Risk Assessment Working Group are collated into a "Community Risk Register". The Trust must take note of this when assessing the risks to service delivery and developing contingency plans.

In addition to the Community Risk Register, the Trust completes internal risk assessments in relation to Emergency Preparedness, Resilience and Response.

### 6.2 Emergency Planning

The Trust is required to have emergency plans in place in order to respond to emergencies resulting from the risks identified under the risk assessment process. The Trust's response to an emergency is based on the implementation of the Trust's *Incident Response Plan*.

### 6.3 Business Continuity

The Trust has the responsibility to ensure that in the event of a disruption it can maintain or recover critical functions to an acceptable level. These

requirements are met through the implementation of the Trust's *Incident Response Plan*, which will aim to protect and sustain the Trust's capacity through maintaining or recovering its critical functions in the event of a disruption to business continuity.

In order to achieve best practice, the Trust will develop its Business Continuity Management System (BCMS) to align with *ISO 22301*, *PAS 2015*, and the *NHS Commissioning Board Business Continuity Management Framework*.

The key purpose of the BCMS is to:

a) Protect critical functions;
b) Stabilise, continue, resume and recover critical functions, their dependencies and supporting resources; and,
c) Mitigate, respond to and manage impacts.

As part of the BCMS, the Trust will undertake, review and maintain a Business Impact Analysis (BIA) in order that the Trust's functions are mapped and assessed in terms of criticality. The Recovery Time Objective (RTO) and Maximum Tolerable Period of Disruption (MTPD) should also be assessed for each function.

RTO is the target time for resuming the delivery of a product or service to an acceptable level. MTPD is the duration after which an organisation's viability will be irrevocably threatened if service delivery cannot be resumed.

### 6.4 Warning and Informing

The Trust is required to maintain arrangements to warn the public if an emergency is likely to occur or has occurred, including the provision of information and advice to the public.

The Trust works closely with partner agencies through the Local Resilience Forum's Warning and Informing Group in order to meet this requirement.

### 6.5 Co-operation

The Trust will co-operate with partner agencies in the execution of its emergency planning duties. The principal mechanism for co-operation between responders is through the Local Resilience Forum (LRF) (for further details see 8.2.1) and a structure of role specific sub-groups and time limited task and finish groups. In addition to the LRF is the Local Health Resilience Partnership (for further details see 8.2.2).

The Trust will ensure that it participates in any relevant EPRR networks in all of the areas which it is commissioned to provide services.

The Trust has signed up to a memorandum of understanding with local health partners within the areas which it delivers services, these agreements are

managed locally by NHS England on behalf of the Local Health Resilience Partnership.

The Trust actively engages with partner agencies on matters relating to Emergency Preparedness, Resilience and Response, this helps to ensure clarity of the roles and responsibilities of relevant agencies, whilst also providing a mechanism to facilitate mutual aid, should the need arise.

### 6.6 Information Sharing

The Trust recognises that at the local level, working in collaboration with other partner agencies, including the sharing of relevant information is important to ensure that any response to a major incident is effective and well co-ordinated.

Derbyshire's Local Resilience Forum has developed an *Information Sharing Agreement for Emergency Responders* which the Trust has signed up to.

## 7. Organisational Accountability & Responsibilities

**Chief Executive is responsible for:**

- Designating the responsibility for EPRR as a core part of the organisations governance and its operational delivery programmes.
- Being aware of their legal duties to ensure preparedness to respond to a major incident or civil contingency event within their health community to maintain the public's protection and maximise NHS response.
- The identification of an Accountable Emergency Officer who is the board-level director responsible for EPRR and who will have executive authority and responsibility for ensuring the organisation complies with legal and policy requirements.

**Accountable Emergency Officer (Chief Operating Officer) is responsible for:**

- Ensuring that the organisation is compliant with the EPRR requirements as set out in the civil contingencies act (2004); the NHS planning framework and the NHS standard contract as applicable;
- Providing 6 monthly reports to the Quality Committee regarding Emergency Preparedness, Resilience and Response.
- Ensuring that the EPRR Lead, the On-Call Team and the Emergency Preparedness, Resilience and Response Group (EPRR Group) have sufficient resources available for the Trust to effectively fulfil its Emergency Preparedness, Resilience and Response responsibilities.
- Ensuring that the organisation is properly prepared and resourced for dealing with a major incident or civil contingency event.
- Ensuring the organisation, and any providers they commission, have robust business continuity planning arrangements in place which reflect best practice standards set out in the Framework for Health Services Resilience (PAS 2015) and ISO 22301.

- Ensuring the organisation has a robust surge capacity plan that provides an integrated organisational response and that it has been tested with other providers and parties in the local communities served.
- Ensuring that the organisation complies with any requirements of NHS England, or agents thereof, in respect of the monitoring of compliance.
- Providing NHS England and CCG's with such information as it may require for the purpose of discharging its functions.
- Ensuring that the organisation is appropriately represented at any governance meetings, sub-groups or working groups of the local health resilience partnership (LHRP) or local resilience forum (LRF).

**The EPRR Lead is responsible for:**

- Providing support to the Accountable Emergency Officer in order that the Trust's Emergency Preparedness, Resilience and Response obligations can be met.
- Implementing the Trust's Emergency Preparedness, Resilience and Response work programme.
- Providing regular updates to the Accountable Emergency Officer and the Trust Management Team regarding emergency planning preparedness and any potential issues highlighted through the risk assessment and horizon scanning processes.
- Reviewing arrangements in light of new and emerging recommendations, guidance and statutory requirements.
- Overseeing the development and maintenance of a Business Continuity Management System (BCMS).
- Maintaining and managing the Trust's on-call rota and on-call documentation.
- Chairing the Trust's Emergency Preparedness, Resilience and Response Group.
- Working in collaboration with partner agencies in order to facilitate a coordinated multi-agency approach to emergency planning.

**All Directors and Deputy / Assistant Directors are responsible for:**

- Providing support to the Accountable Emergency Officer and EPRR lead in order that the Trust's emergency planning obligations can be met
- Ensuring that their departments are prepared to respond to an emergency or disruption to service provision.
- Ensuring that their departments are engaged with the Business Continuity Management System.
- Ensuring that all relevant staff are trained on their roles in the event of an emergency or disruption to service provision.

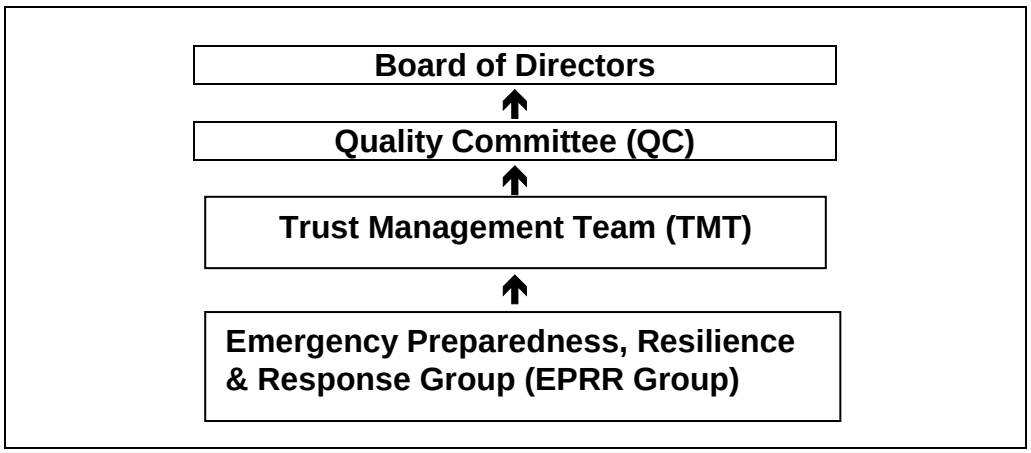
**All Staff have responsibility for:**

- Supporting the development of emergency planning arrangements and participating in training and exercises as required.

- Following the instruction of their managers and/or the On-Call Team as part of the Trust's response to an emergency or business continuity disruption.

## 8. Groups, Networks and Accountability

### 8.1 Internal Structure: Emergency Preparedness, Resilience & Response




### 8.1.1 Quality Committee (QC)

The Committee will support the Board in ensuring that high standards of governance and behaviour are maintained in the conduct of the Trust's business.

The Accountable Emergency Officer will provide assurance to the Quality Committee on matters relating to Emergency Preparedness, Resilience and Response. Key emergency plans will be presented to the Committee for their approval, this will include plan revisions. The Committee has delegated authority from the Board to approve policies and to make decisions.

### 8.1.2 Trust Management Team (TMT)

The Trust Management Team will ensure that the statutory requirements associated with EPPR are delivered via the EPRR Group.

TMT will receive 6 monthly reports from the EPRR lead. TMT has authority to approve certain contingency plans and action cards and it will receive and approve key plans such as the *incident response plan* before approval by QC.

### 8.1.3 Emergency Preparedness, Resilience & Response Group (EPRR Group)

The Emergency Preparedness, Resilience and Response Group (EPRR Group), is intended to ensure that the Trust develops planned arrangements in-line with statutory requirements and appropriate guidance, in order that it can initiate a co-ordinated response to an emergency and / or serious disruption to services.

The Group is chaired by the EPRR Lead, and is sponsored by the Chief Operating Officer (who is the Trust's Accountable Emergency Officer). The EPRR Group is to be a sub-group of the Trust Management Team.

The EPRR Group is to be given the authority to approve certain contingency plans and action cards; however key plans such as the *Incident Response Plan* would still go to TMT and QC for approval.

Whilst developing the Trust's EPRR arrangements, the Group is also intended to support work allied to the EPRR work stream, such as lockdown planning, evacuation planning, and 'Prevent'.

### 8.2 External Networks

There is a rigid structure for multi-agency emergency planning, both in terms of planning and responding to incidents.

#### 8.2.1 Local Health Resilience Partnership (LHRP)

LHRPs provide strategic forums for joint planning for emergencies for the new health system (April 2013 onwards) and support the health sector's contribution to multi-agency planning through Local Resilience Forums (LRFs). They are not statutory organisations and accountability for emergency preparedness and response remains with individual organisations.

In accordance with Department of Health guidance, LHRPs are co-chaired by a local Director from NHS England and the local Director of Public Health (or their deputy). The Trust is a member of the LHRPs in each of the areas from which it operates.

The key responsibilities of the LHRP are to:

a) Develop the local health community's EPRR Strategy and an annual work programme.
b) Facilitate the production of local sector-wide health plans to respond to emergencies and contribute to multi agency emergency planning.
c) Provide support to the NHS, Public Health England (PHE) and the Director of Public Health representatives on the LRF in their role to represent the health sector EPRR matters.
d) Provide support to NHS England's Local Area Team and PHE in assessing and assuring the ability of the health sector to respond in partnership to emergencies at an LRF level.

Time limited working groups may be set up under the LHRP in order to work on special projects and to prepare for new and emerging risks.

### 8.2.2 Local Resilience Forum (LRF)

LRFs provide a means for collaborative multi-agency planning. They are local partnerships made up of representatives from public services, including the emergency services, local authorities, the NHS, and the Environment Agency; they also have representation from the voluntary sector and certain private sector organisations, such as utility providers. They are not statutory organisations and accountability for emergency preparedness and response remains with individual organisations.

Each LRF area is determined by Police boundaries. Each LRF reports into their respective Regional Resilience Forum (RRF), who in turn report up to the Government. The Trust links into the LRF through the Local Health Resilience Partnership and engages with specific LRF planning that requires input from the Trust.

The co-chairs of the LHRP are members of the LRF; their role is to represent the health community.

The Trust is a member of specific sub-groups of the LRF (such as the Humanitarian Assistance Group) and attends others sub-groups on an ad-hoc basis.

## 9. Emergency Plans

### 9.1 DHCFT Emergency Plans

### 9.1.1 Incident Response Plan (approved via TMT and QC)

There is one key emergency plan within the Trust which is required in order to be compliant with the *Civil Contingencies Act 2004* and NHS England's Core Standards: the *Incident Response Plan*. This plan is supplemented by a number of other documents and plans which have been tailored to cover specific threats and hazards.

The *Incident Response Plan* outlines the implementation of special measures to:

- Ensure effective command and control of the Trust and its resources.
- Manage the response to a major incident / emergency, whether internal to the Trust or out in the wider communities that the Trust serves.
- Manage the response to a severe disruption to the Trust's services in order to maintain or recover service provision to an acceptable level.

A regular test of the *Incident Response Plan* is necessary to ensure that it is fit for purpose. The *Incident Response Plan* will be reviewed on an annual basis as a minimum, additional reviews of the plan will also be undertaken in the event of:-

- Significant change to Trust services;
- Significant reorganisation of partner agencies;
- As a result of lessons learnt from an incident or exercise; or
- The implementation of new legislation or guidance.

The *Incident Response Plan* will be held by key staff, including members of the On-Call Team. The *Plan* will also be made available for all staff to view via the Trust's intranet site – if required; redacted versions will be placed on the intranet to protect sensitive information.

### 9.1.2 Pandemic Influenza Contingency Plan (approved via TMT and QC)

The aim of this plan is to outline the Trust's response to an influenza pandemic, from the initial phase of supporting the health community with surveillance, to delivering care to patients who are suspected as having influenza, supporting the distribution of antivirals, and assisting in a mass vaccination campaign.

### 9.1.3 Site Contingency Plan (approved via EPRR Group)

This plan is intended to support sites when dealing with localised incidents, outlining the immediate actions to consider and contacts to be made (including escalation procedures). Within this plan is a series of action cards which cover a range of threats and risks, from bomb threats to white powder incidents. A copy of the site contingency plan will be held at every Derbyshire Healthcare Foundation NHS Trust location.

### 9.1.4 Fuel Disruption Contingency Plan (approved via TMT)

This plan outlines the key principles to consider when responding to a fuel disruption; it should be used in conjunction with the *Incident Response Plan*. The plan is made up of two parts, part one covers a range of schemes that the Trust can implement in order to conserve fuel, and part two covers how the Trust would operate under the *National Emergency Plan for Fuel* (NEP-F), should the government chose to implement it.

### 9.1.5 Framework for Responding to Industrial Action (approved via TMT)

This document is intended to outline the Trust's planned approach to maintaining the delivery of essential services during industrial action, whether it is in the form of strike action or working to rule. It is intended to supplement the Trust's *Incident Response Plan*.

### 9.1.6 Special Projects (Dependent on nature and timescale may be approved via QC or the EPRR Group)

On occasion it may be necessary to prepare specialist plans; these may be required in preparation for specific events or in response to specific risks that have been identified via the risk assessment process and horizon scanning.

### 9.2 Joint Emergency Plans (LHRP/LRF Plans)

The Trust is to engage as necessary with the development of joint emergency plans with local partner organisations. This may include but is not limited to: -

- *Humanitarian Assistance Plan*
- *Joint Pandemic Influenza Contingency Plan*
- *Mass Casualties Plan*
- *Mass Treatment Plan*
- *Mass Fatalities and Excess Death Plan*
- *Warning & Informing Plan*

### 9.3 National Emergency Plans

National emergency plans exist for certain threats and hazards, such as an influenza pandemic, a fuel strike, and heatwave. Such plans have been developed by key Government Departments with input from specialist bodies such as the Meteorological Office or Public Health England. Any local planning in these areas should dovetail in with national plans.

## 10. Training, Exercising and Competencies

### 10.1 Training & Exercising

The Trust will adopt an annual programme of exercises in-line with the requirements of the NHS Commissioning Board's *Emergency Preparedness Framework 2013* (updated on 9th September 2015) the organisation as a minimum will undertake/participate in:

- A live exercise every three years;
- An annual table-top exercise of the *Incident Response Plan*;
- A communication cascade test / call out exercise every six months; and
- A command post exercise every six months.

### 10.2 On-Call Team Training & Core Competencies

The Trust will operate a two tier On-Call Team on a 24/7 basis. The first level will be the On-Call Operations Manager (1st On Call) and the second level will be the On-Call Director or Senior Manager (2nd on-call).

The 1st On-Call Operations Manager is intended to deal with out of hour's tactical and operational issues. In the event of a severe business continuity disruption or a major incident they will assume the role of Silver Commander.

The On-Call Director/senior manager (2nd on-call) is intended to deal with high level issues where a strategic lead is required. In the event of a severe business continuity disruption or a major incident they will assume the role of Gold Commander.

The Trust's On-Call Team should meet the requirements of the *National Occupation Standards for Civil Contingencies*; in order that this is achieved the On-Call Team will be carefully selected and suitably trained.

The Trust will ensure that as a minimum every member of the On-Call Team will receive local introductory emergency response training prior to going on-call. Further to this, the Trust will implement a programme to ensure that each member of the On-Call Team receives specialist emergency response training. Under this programme each member will complete either the Strategic Leadership in a Crisis course as approved by the Department of Health, Gold/Silver Commander training (dependent on level) as approved by the Local Resilience Forum, or an equivalent course.

An *On-Call Pack* will be produced for members of the On-Call Team; this will include relevant emergency plans, On-Call Team specific action cards and key contact numbers for third parties and Trust staff (where applicable this will include On-Call details for use out of hours). The *On-Call Pack* will be reviewed and updated at least annually by the EPRR Lead.

### 10.3 Loggist Training

In the event of a major incident the Trust may call upon a Loggist to support the decision makers by recording their decisions and actions in a defensible format, such records may be used in subsequent enquiries. The Trust will ensure that at least four suitable personnel are trained to assume the role of a Loggist.

## 11. Monitoring and Performance Management

Emergency Preparedness, Resilience and Response forms part of the Board Assurance Framework, and as such a strategic risk for Emergency Preparedness, Resilience and Response can be found on the Trust's risk register.

Formal reports will be provided to the Trust Management team and Quality Committee. These are intended to:

- Inform the Committee of progress on the work programme;
- Advise of potential risks and their likely impact; and,
- Report back on learning from significant incidents that have occurred or have been avoided.

In addition to this, high-level emergency plans and policies will be presented to the Trust Management team and Quality Committee for their approval.

The Trust is required to provide assurance to its commissioners and NHS England on aspects relating to emergency planning, particular those incorporated into the NHS Standard Contract and in NHS England's *Core Standards for Emergency Preparedness, Resilience & Response*.

The EPRR Lead and the Chief Operating Officer will undertake an internal assessment of the Trust against NHS England's *Core Standards for Emergency Preparedness, Resilience & Response*. This will be used to inform the work programme and will be used as a tool to measure progress. The lead Clinical Commissioning Group and NHS England will also measure the Trust's progress against the *Core Standards for EPRR*.

## 12. References

British Standards Institute, 2012. *ISO 22301:2012 Societal Security – Business Continuity Management Systems – Requirements*

British Standards Institute, 2010. *PAS2015 Framework for Health Services Resilience*

Cabinet Office, 2004. *Civil Contingencies Act 2004*

Cabinet Office, 2006. *National Health Service Act 2006*

NHS Commissioning Board, 2013a. *Business Continuity Management Framework*

NHS Commissioning Board, 2013b. *Command and Control Framework – For the NHS during Significant Incidents and Emergencies*

NHS Commissioning Board, 2013c. *Core Standards for Emergency Preparedness, Resilience and Response (EPRR)*

NHS Commissioning Board, 2013d. *Emergency Preparedness Framework 2013*

NHS Commissioning Board, 2013e. *The Role of 'Accountable Emergency Officers' for Emergency Preparedness, Resilience and Response (EPRR)*

**y Impact Assessment**

## Equality Impact Analysis (EIA) Form for *EPRR Strategy*

To be completed and attached to any policy document when submitted to the appropriate committee for consideration and approval.

| | | Yes/No | Comments |
|---|---|---|---|
| **1.** | **Does the document/guidance affect one group less or more favourably than another on the basis of:** | No | |
| | Race | No | |
| | Ethnic origins (including gypsies and travellers) | No | |
| | Nationality | No | |
| | Gender (including gender reassignment) | No | |
| | Culture | No | |
| | Religion or belief | No | |
| | Sexual orientation | No | |
| | Age | No | |
| | Disability - learning disabilities, physical disability, sensory impairment and mental health problems | No | |
| **2.** | **Is there any evidence that some groups are affected differently?** | No | |
| **3.** | **If you have identified potential** | No | |

| | | | |
|---|---|---|---|
| | **discrimination, are there any valid exceptions, legal and/or justifiable?** | | |
| **4.** | **Is the impact of the document/guidance likely to be negative?** | No | |
| **5.** | **If so, can the impact be avoided?** | -- | |
| **6.** | **What alternative is there to achieving the document/guidance without the impact?** | N/A | |
| **7.** | **Can we reduce the impact by taking different action?** | N/A | |
| **Completed by: Karen Billyeald** | | **Date: January 2017** | |

If you have identified a potential discriminatory impact of this policy document, please refer it to the Policy Sponsor together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Assistant Director Engagement

Derbyshire Healthcare NHS
NHS Foundation Trust

# Older People Inpatients Review

## 1st February 2017

Bev Smith – Senior Nurse
Carole Clay – Senior Nurse
Pete Emery – Senior Nurse
Lisa Stone – Area Service Manager

# Older People Inpatient Wards

## Cubley Court, Kingsway Site

- 36 bedded assessment and treatment unit for both men and women with an acute organic illness
- Currently there is a male and female side.

## Wards 1 and 2, London Road Community Hospital Site

- 16 bedded assessment and treatment wards for people over the age of 65 with functional mental health problems.
- Mixed sex wards with gender-specific sleeping areas, with a mix of single and twin rooms which all have en-suite facilities.


In all areas care plans are person-centred and involve the individual where possible, and all care plans are reviewed regularly.



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# Challenges

- CQC visit in June highlighted the following areas of concern:
- Security
- Mental Capacity Act
- Discharge Planning



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# Successes

- Supporting staff who have faced adversity in other teams
- Staff DEEDS
- Charity Walks
- Recognising individual's skills and knowledge
- Admission and discharges
- Development Days
- Positive E-Roster Management



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# Future Work

- Environment Positive Planning
- Potential mix of Cubley Wards
- All older people's wards on the Kingsway site



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**Derbyshire Healthcare NHS Foundation Trust**
Report to Board of Directors 1 February 2017

# Suicide Prevention Strategy

**Purpose of Report:**

To provide the Trust Board with a brief as to the approach aimed at preventing suicide.

**Executive Summary**

The Trust's Suicide Prevention Strategy was published in April 2016.

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

**(Board) Assurances**

The central plank of the strategy is to have all clinical staff trained in a nationally validated suicide awareness and response approach by September 2017. To date 50% has been achieved and the Suicide Prevention Strategy Group is overseeing a targeted approach to those groups with poor compliance.

**Consultation**

There was extensive consultation with stakeholders. It reflects the national and regional strategy.

**Governance or Legal Issues**

Connecting with people was agreed as the preferred provider for training (the trainers) following an option appraisal by the Procurement Team and Standing Financial instructions have been adhered with.

**Equality Delivery System**

At risk groups have been identified and supportive networks developed for some of them.

**Recommendations**

The Board of Directors is requested to:

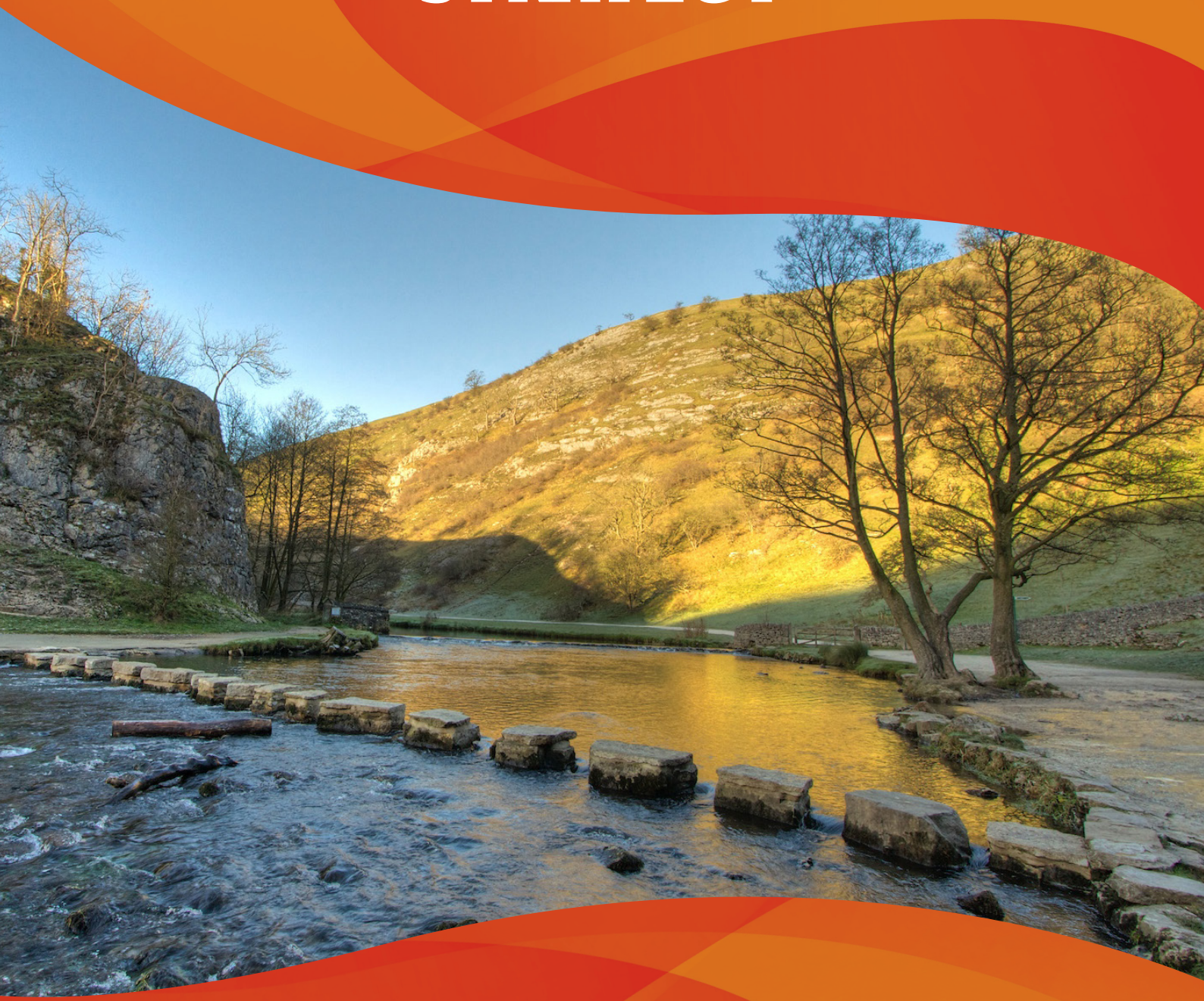
1) Note the approach taken to suicide prevention
2) Note the progress being made with suicide prevention training

| | |
|---|---|
| **Report presented by:** | **Dr John Sykes**<br>**Medical Director** |
| **Report prepared by:** | **Dr John Sykes**<br>**Medical Director** |

Derbyshire Healthcare NHS
NHS Foundation Trust

Enc J

# SUICIDE PREVENTION STRATEGY



## April 2016

DHCFT
@derbyshcft
www.derbyshirehealthcareft.nhs.uk



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# Contents

# Foreword

As a medical practitioner, psychiatrist and more recently medical director it has been my privilege over the last 30 or so years to learn how individuals come to terms with their own mortality and how families and others close to the deceased cope with the struggle of living without somebody they loved.

The dilemmas and conflicted emotions involved are intensely magnified when we are trying to help those who are feeling suicidal or are trying to support the families who have been bereaved in this way. The truth is we will never know in most cases why a particular individual took their own life and crucially what could have made a difference to their terminal actions. It seems that psychiatry, psychology, nursing and all the other professions who are trying to help will not have anywhere near all the answers and in this way suicide prevention is everybody's business.

We also know that none of us are immune to intense emotional distress given a certain set of adverse circumstances and so preventative work cannot be divorced from our own life experiences and we need to break the taboo that still surrounds the discussion of matters directly relating to suicidal intent. There has been a useful discussion around avoiding terms such as "commit" or "complete" suicide for this reason.

Nationally, the debate has oscillated from one pole concerning the right for people to die, having access to assisted suicide, and the other pole of zero tolerance for any deaths due to suicide. It is my view that as compassionate human beings (who may also be highly skilled professionals) the key is for us to see life as far as possible through the patient's eyes and then to help them find hope and a way forward in a world they may see as only offering them extreme choices.

For all these reasons I think this strategy needs to be owned by every one of us and not seen as an action plan that can be broken down and delegated. It represents the essential stuff of human existence.

**Dr John Sykes**

**Consultant Psychiatrist, Medical Director**
**Derbyshire Healthcare NHS Foundation Trust (DHCFT)**

"The impact of suicide is far-reaching and our increasing suicide rates in Derbyshire are of great concern. As a representative for mental health service receivers in the county I welcome the long awaited Suicide Prevention Strategy by Derbyshire Healthcare NHS Foundation Trust.

The strategy has been heavily influenced by people with lived experience and this brings a unique perspective and depth for professionals to utilise. I hope that there will be a full implementation of the areas identified for action and a true commitment to supporting those whose lives are affected by suicide."

**Catherine Ingram**
**Chief Executive**
**Derbyshire Voice**

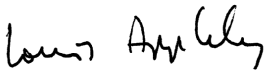
"When someone takes their own life, the effect on their family and friends is devastating. Many others involved in providing support and care will also feel the impact.

The national suicide prevention strategy for England, revised and published in 2012, has built on the progress of its predecessor. The national suicide rate reached an all-time low in 2006-7 but worldwide economic pressures then took their toll on the mental health of the population. The new strategy was designed to reflect the changing pattern of suicide, such as the rising rate in middle-aged men and the emergence of new suicide methods. In particular it highlighted the need to support bereaved families and those worried about a suicidal person in their household.

Every one of the 4,800 lives lost to suicide each year in England is a tragedy. The causes are complex and often individual - some people are known to be at risk for many years, for others a sudden crisis proves impossible to bear. Prevention too can be complex, with the potential for helping someone shared between services, communities, families and friends. The message of this strategy is clear: no suicide is inevitable.

"For some suicidal people, it is hard to ask for help because of the shame and embarrassment that can accompany mental ill-health. Stigma can kill and overcoming it is literally vital. It is a job for all of us - service users, professionals, the media, society as a whole - not just through campaigns but through everyday attitudes and actions.

The recent mental health task force report set the aim of a 10% reduction in suicide by 2020 and every local area will have to play its part if this is to be achieved. The Derbyshire Healthcare Foundation Trust strategy has been designed to translate the national strategy into a local initiative. It sets out what contribution the trust can make to prevention - the actions it can take locally, the role it can play in the wider community. It is an approach that other parts of the country, whether their rates are high or low, can adopt."



## Professor Louis Appleby

**Chair, National Suicide Prevention Strategy Advisory Group**

# Executive summary

The Derbyshire Healthcare Suicide Prevention Strategy, written in consultation with key stakeholders, sets out our aims for reducing the incidence of suicide across the Trust. Using the National Suicide Prevention Strategy as our anchor, and through reference to the countywide Derbyshire Suicide Prevention Partnership Strategy, this document describes key strategic aims, and ways to achieve them.

Whilst reducing suicides in those who use our services sits at the heart of our strategy, we are mindful of the need to promote engagement with those outside our service, and our approach must be suitably wide-ranging; a strategy that does not consider how we can work collaboratively with statutory, third sector, and other key groups cannot hope to address this complex issue in its entirety.

The document sets out seven key strategic priorities. For each priority, we have sought to illustrate why it is important, both in terms of how it relates to the wider national picture and suicide prevention research, and also how it relates to the individual experiences of service receivers.

**The seven strategic priorities are:**

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring
7. Build the resilience of local communities to prevent and respond to suicides

Within each strategic priority, the document identifies important outcomes, and sets out ways in which we can not only achieve them, but also measure the extent to which they have been achieved. Through the incorporation of our DHCFT values and Core Care Standards, we intend the strategy to be truly accessible to every stakeholder. As such, the key message of the DHCFT Suicide Prevention Strategy is that we all have a part to play; suicide is everyone's business.

# Introduction

"At that particular time in my life, all I could think of, was ending it - I just couldn't go on. I couldn't exist anymore; I was so sad and desperate, I felt like a burden to everyone and that the world would be a better place if I were not in it.

I made a plan. I was an inpatient at this time, and was allowed weekend leave.

That weekend, my housemates were all meant to be away at that time. I had spoken to a nurse before leaving, saying that I felt quite suicidal. It was not taken seriously and I went home and took my medication.

To cut a long story short, unexpectedly, one of my friends came back and he found me - still alive, but not really there. Hence, I ended up in Accident and Emergency. The staff were quite horrid to me, one even saying that I deserved to have a tube thrust down my throat as I lay there sobbing. Their attitudes did not get any better.

Things were done to me, but, I wasn't spoken to. A few days later, I was, again, back on the acute ward. The staff did not really speak to me. I felt ignored and helpless. I felt that they had not understood me at all - I was alone.

On reflection, if a suicide prevention strategy was in place, and staff had had training within the realms of 'suicide', they would perhaps have acted differently. If I just had someone to talk to, I may have acted differently also. It may have prevented me from trying to kill myself."

**TS**

March 2016

Suicide is a major public health issue across the globe. When each and every suicide is a personal tragedy for the person, their family and the community, it sometimes seems inappropriate to speak of numbers. Despite this, the figures paint a picture of both a global problem and a worrying trend.

The World Health Organisation estimates that there are at least 800,000 suicides per year, though many countries do not collect good data and the stigma of suicide ensures that this is highly likely to be an underestimate.

One person in the world dies by suicide every 40 seconds, according to a comprehensive report from the World Health Organisation, which talks of a massive toll of tragic and preventable deaths.

In Derbyshire itself the most recent figures show an alarming 87% increase in deaths by suicide within one year in Derbyshire county, with the Derby city figure showing a 25% increase (Deaths from Suicide and undetermined injury in Derby and Derbyshire. 2015, Public Health Intelligence and Knowledge Services).

Suicide is the act of intentionally causing one's own death. Suicide is often carried out as a result of despair. Although the cause is frequently attributed to a mental disorder such as depression, bipolar disorder, schizophrenia, borderline personality disorder or substance use, around 75% of those who die by suicide were not in contact with mental health services at the time of their death. A range of other factors such as financial difficulties, interpersonal relationships, and bullying can play an important role.

Suicide prevention efforts include reducing access to means of suicide such as medications, treating high-risk groups with mental illness, alcohol or substance use, and providing better information to those bereaved by suicide. This requires a coordinated response from all health, social care and third sector groups. Truly, suicide is everyone’s business. Our Trust has a vital role to play in suicide prevention working in partnership with other agencies.

The DHCFT strategy, written after extensive consultation with stakeholders, is influenced by both the National and Regional Strategy developed with Public Health Derbyshire. Our seven key strategic priorities have been developed, reviewed and rewritten on the basis of feedback gained and shared locally, nationally and internationally.

Our strategy also benefits from local Derbyshire expertise particularly in the fields of self harm and compassionate care. We have been influenced by our Trust values and core care standards.


**Our Trust values**

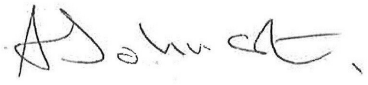

**Our core care standards**

**People who use the services of the Trust have the right and expectation to the following core care standards:**

- **Assessment** We will find out with you what your needs are
- **Care planning** You will have a clear care plan
- **Review** We will check that things are working for you
- **Co-ordination** Your care will be co-ordinated
- **Discharge & transfer** We will make sure your transfer or discharge works well
- **Families and carers** We will work with families and carers
- **Involvement and choice** You will be involved as much as you want and are able to be
- **Keeping yourself and others safe** We will help you and others to be as safe as you can be.

Our expectation is that DHCFT's operational and clinical leadership use this strategy document to guide the development of future suicide prevention work. No suicide is inevitable. There are numerous ways in which services can improve practice to reduce suicides. Healthcare services have a particular role in preventing suicides in high-risk groups and those people presenting in distress or in crisis.

Our DHCFT suicide prevention strategy sets out not only what we must do to reduce suicides but also how, when, why and who will help us get there.



**Dr Allan Johnston**

**Consultant Psychiatrist**
**Chair of the DHCFT Suicide Prevention Strategy Group**

# Strategic priorities

## Strategic priority 1:
## Reduce the risk of suicide in key high-risk groups

> **It is important to point out that suicide often occurs, not necessarily because that person wants to die, but because they cannot tolerate the suffering with which they have endured. It is at such times of desperation when one's depression is so overwhelming that suicide appears as the only realistic and permanent means of ending that person's pain.**
>
> **It is difficult to argue that there is any issue more important in mental health than that of suicide prevention. After all, it is literally a matter of life and death.**
>
> **Service user RW**
> March 2016

A number of population groups have been identified as being at increased risk of suicide compared to the general population. Limitations on the data available means that the groups identified within the national strategy are not an exhaustive list. The national strategy identifies the following groups as being at increased risk of suicide:

- Young and middle-aged men
- People in the care of mental health services, including in-patients
- People with a history of self-harm
- People in contact with the criminal justice system
- Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.

In addition, within Derbyshire County, the highest rate of suicide in 2013 was observed amongst older adults.

| Identified strategic outcomes | Actions or objectives |
|---|---|
| Support frontline workers that have contact with individuals in higher risk groups to have the skills and confidence to identify and respond to individuals at risk of suicide | 1. Training – all clinical staff will be trained by September 2017 receiving the nationally validated suicide awareness and response training<br><br>2. Supervision – all staff to receive supervision as per DHCFT Supervision Policy 2016<br><br>3. Supporting staff – Resilience and coping through post incident debrief/ support<br><br>4. All clinical staff to have the opportunity to discuss complex cases within a multi-disciplinary team environment |
| Ensure that known trigger factors for suicide are explored in groups at increased risk of suicide | 1. Training to promote the use of risk mitigation when working with individuals<br><br>2. Team approach to safety plans – all clinical staff trained and using safety plans. Known triggers for the individual will be identified and, working collaboratively with the person, plans will be developed to mitigate the risks<br><br>3. Care Programme Approach (CPA)— which supports an individual approach to timely assessment and review of care and interventions<br><br>4. Consider the use of standardised evidence based assessments to assist staff, for example Becks scales, where licences are available |

| | |
|---|---|
| Build evidence for partnership working and information sharing between organisations in contact with individuals | 1. Information Technology/Electronic Patient Records will be used to ensure effective and timely communication for example emailed letters<br><br>2. Information Sharing agreements e.g. Information Sharing and Suicide Prevention: Consensus statement (RCPsych, 2014)<br><br>3. Suicide Prevention Partnership Forum meetings e.g. Representatives of DHCFT to attend the Derbyshire Suicide Prevention Partnership Forum (DSPPF) and support the annual conference. Quarterly meetings and monthly data group<br><br>4. Use of Varm (Vulnerable Adults Risk Management) meetings and other inter-agency clinical meetings to robustly manage risk across inter-agency boundaries |
| Develop a strategic approach to self-harm and guidance to support people who self-harm.<br>Provide professionals with the skills to talk to with people who self-harm | 1. Trust approach to NICE guidance for self harm<br><br>2. Derbyshire Healthcare Suicide Prevention Strategy Group (DHCFT SPSG) to identify lead for the development of a DHCFT approach<br><br>3. Co produce information / literature for people who self harm |
| Ensure access to mental health services, especially for those experiencing imminent suicide risk including out of hours | 1. Audits to measure access to services, both quantitative and qualitative<br><br>2. Service specifications describe issues relating to accessing services<br><br>3. Review operational policies for access e.g. for CRHT, front door presentations (FDPs), MHLT |

| | |
|---|---|
| Offer suicide prevention safety planning and means restriction to individuals experiencing suicidal thoughts | 1. Audit patient 'Safety Plans'<br><br>2. Audit CPA care plans<br><br>3. All clinical staff will receive suicide awareness and response training which promotes risk mitigation. Keeping people safe and managing access to means of suicide is central to this<br><br>4. Review ligature points as per ligature review policy; as a minimum annually or more regularly on new information or new risks identified<br><br>5. Review of safety planning and suicide means restriction within the investigation of serious untoward incidents<br><br>6. Consider the development of co-produced training in suicide prevention safety planning and means restriction as a recovery college course |

## Strategic priority 2:
## Tailor approaches to improve mental health in specific groups

**"As a child I had been physically and sexually abused but unfortunately I never felt safe or trusting enough to talk to anyone in mental health services, especially in the first few years of becoming ill when I was hospitalised quite regularly."**

**Service user RW**
March 2016

**"Many people who receive mental health services have experienced trauma and thus are at an increased risk of suicide. DHCFT has committed to the cultivation of a trauma-informed culture that is evident within strategy, policy, practice and education at every level of the organisation.**

**Trauma-informed services start with a trauma-informed workforce and we have prioritised the concept of 'Do no Harm' in our services, whereby the potential for the healthcare setting and care interventions to re-traumatise people is understood by all staff and informs care and treatment."**

**Samantha Kelly**
Consultant Nurse

The national strategy highlights the importance of adopting a population approach to improving mental health to reduce suicides. As well as improving the mental health of the whole population, there are certain groups that may require a tailored approach to address their vulnerabilities or known problems with access to services. The groups identified in the national strategy that require a tailored approach are:

- Children and young people such as looked after children, care leavers, and young people in the youth justice system
- Survivors of all types of trauma, abuse or violence, including sexual abuse
- Veterans of armed forces
- People who misuse drugs, alcohol or Novel Psychoactive Substances ("legal highs")

- Lesbian, gay, bisexual and transgender people
- Black, Asian and minority ethnic groups, including asylum seekers
- Addressing the needs of people following child sexual exploitation.

| Identified Strategic outcomes | Actions or Objectives |
|---|---|
| Early identification of children and young people with emotional and mental health needs in a variety of settings, and referral processes for them to receive appropriate support | 1. DHCFT Children's services e.g. Health Visitors, Paediatricians, school nurses, Children and Adolescents Mental Health Services (CAMHS) – work collaboratively with external agencies e.g. Social Care, General Hospitals, voluntary sector<br>2. Staff working for DHCFT will receive training with regard to Safeguarding and children<br>3. DHCFT staff will follow and contribute fully to the agreed Derbyshire wide Safeguarding Policies and Procedures<br>4. Safeguarding supervision<br>5. Access to support (e.g. age ranges of services)<br>6. Think Family information to be given to all carers as appropriate |
| Develop the potential to provide young people with skills to enable them to develop emotional resilience to promote positive mental health throughout their life | 1. Explore with public health commissioners as part of the contract including investment and capacity issues<br>2. DHCFT Children's services e.g. health visitors (HVs), paediatricians, school nurses, CAMHS<br>3. Think Family |

| | |
|---|---|
| Increase identification of and relationship between physical health conditions amongst individuals with depression and other long-term mental health needs | 1. DHCFT Children's Services awareness of this need e.g. HVs, paediatricians, school nurses, CAMHS<br>2. Audit care plans for physical health<br>3. Training in physical healthcare for mental health staff<br>4. Physical Care Committee policy |
| Identify and support those at increased risk of isolation, vulnerability or stigma | 1. Training e.g. anti-stigma, equality and diversity<br>2. Use of Voluntary Sector Single point of Access (vSPA) services |
| Family, carers and friends of people being cared for by mental health services to be given information on how to access services promptly and at all times if they have a concern that someone is feeling suicidal | 1. Care plans audit<br>2. Use of contact cards<br>3. Friends and Family Test<br>4. Review outward-facing internet presence for easy access to information on crisis services |
| Increased awareness and understanding of the relationship between trauma, health and wellbeing | 1. Development of trauma training by 2016<br>2. Suicide awareness and response training – all clinical staff to be trained by September 2017<br>3. Compassion Focussed Therapy (CFT) training<br>4. Supervision<br>5. Shared educational resources<br>6. Services avoiding re-traumatisation |

## Strategic priority 3:
## Reduce access to the means of suicide

**"I think that suicide prevention could be greatly improved by having experienced individuals involved in talking to suicidal people in order to support them at times of crisis and even when this is an emergency. We know exactly how it feels to want to die and can use this knowledge to help others to want to live.**

**It is no surprise that doctors and farmers have a disproportionate rate of suicide because they have such ease of access to the means. The international example of suicide in the USA shows a high prevalence of suicide by firearms because of the prevalence of guns. The job of suicide prevention strategies is to look at the most used means and try to ameliorate the rate."**

**Service user RW**
March 2016

Suicide can arise out of an impulsive action in response to a sudden crisis or extremely difficult circumstances. If the means for completing suicide are not easily available or made more difficult to access then the impulse may pass. Reducing access to means is therefore an effective way of preventing suicide. The national strategy highlights that the suicide methods most amenable to intervention are:

- Those that occur at high-risk locations
- Those on the rail network
- Self-poisoning
- Hanging and strangulation.

| Identified areas for action | Actions or Objectives |
|---|---|
| Exchange information about high-risk locations in Derbyshire with DSPPF and wider groups. Work in partnership to mitigate this risk | 1. Adherence to Public Health England 'cluster and contagion' guidance document, working with Derbyshire Suicide Prevention Partnership Forum (DSPPF)<br><br>2. DSPPF strategy to share information via monthly Data Group |

| | |
|---|---|
| | 3. Serious Incident Group (SIG) of DHCFT actions shared with DHCFT SPSG when relevant |
| Exchange information about high-risk methods in Derbyshire with Suicide Prevention Forum and wider groups. Work in partnership to mitigate this risk | 1. DSPPF strategy to share information<br><br>2. DHCFT SIG actions shared with DHCFT SPSG when relevant |
| Proactively review Trust data for methods of suicide and devise ways to respond locally and share information | 1. SIG group annual report - internal and external data reviewed and shared with DHCFT SPSG<br><br>2. Collaborate with other DHCFT groups, for example Quality Leadership Teams, to implement action plans and disseminate information |
| Reduce access to means in healthcare and other settings, especially opportunities for hanging and strangulation | 1. Review ligature points as per ligature review policy; as a minimum annually or more regularly on new information or new risks identified<br><br>2. DHCFT clinicians/prescribers to limit the number of prescribed medications to individuals at risk of suicide/self harm and consider prescribing medications which are less toxic if taken in overdose<br><br>3. Individualised safety care plans considering access to means<br><br>4. At times when individuals are inpatients and at high risk, staff to follow the DHCFT observation and search policy |

## Strategic priority 4:
## Provide better information and support to those bereaved or affected by suicide

**A friend of mine was in bereavement following his partner's suicide. A few months later he tried to take his own life.**

**Thankfully he did survive, although this has left him severely scarred. In his experience his psychiatrist had made him worse by how he chose to speak to and "treat" him.**

**It was a surgeon at Nottingham Queens Medical Centre who performed his skin grafts that he found compassionate and helped him to feel some sense of future purpose. Help is At Hand is a very good document.**

**Service user RW**
March 2016

Those bereaved by a suicide are at increased risk of mental health and emotional concerns, and may also be at increased risk of suicide themselves. This effect can be lifelong. Provision of timely and effective support and information is therefore important to help the grieving process and prevent longer-term distress. Suicides can also have a profound effect on local communities, including friends, work colleagues and neighbours, but also teachers, healthcare professionals, witnesses to the incident and emergency service workers.

Within Derbyshire Healthcare NHS FT we need to ensure that there is:

- Effective and timely support provided to those affected by suicide - to both relatives of patients who have died by suicide and patients whose relatives have died by suicide
- An effective local response is in place in the aftermath of a suicide
- Information and support are provided to families, friends and colleagues who are concerned about someone who may be at risk of suicide (e.g. Think Family).

| Identified areas for action | Actions or Objectives |
|---|---|
| Promote staff education and awareness of importance of supporting those bereaved by suicide | 1. Suicide awareness and response training – all clinical staff to be trained by September 2017<br><br>2. Serious Incident (SI) process including supporting the bereaved |
| Engage with those bereaved by suicide to determine their immediate and longer-term needs in the aftermath of a suicide.<br>These needs can reoccur at any time | 1. Family Liaison workers and named clinical service leads in partnership to provide first contact<br><br>2. Awareness of and ability to access information for the bereaved e.g. "help is at hand"<br><br>3. Links between Family Liaison workers and groups engaged in supporting those bereaved by suicide e.g. Papyrus and Survivors of Bereaved by Suicide (SOBS)<br><br>4. Recognition and exploration of potential long-term needs e.g. anniversary of bereavement |
| Ensure DHCFT supports the needs of our staff affected by suicide | 1. Serious Incident process<br><br>2. Schwartz Rounds – occur regularly in the north and south of the county<br><br>3. Develop a clinically accountable culture and change the experience of staff who fear a blame culture<br><br>4. Training and support for staff affected by suicide themselves |

5. Organisational awareness of effects of trauma on staff

6. DHCFT provides psychological support to all staff and groups of staff who have experienced distress following suicide

7. Make available up-to-date managers guidance for supporting staff through a Serious Incident investigation and the Coroners' process, in line with Morecambe Bay guidance reissued by NHS Improvement in May 2016 ('Duties relating to coroner requests') and any subsequent publications process

## Strategic priority 5:
## Support the media in delivering sensitive approaches to suicide and suicidal behaviour

**"It's only through my work for the Trust that I've started to realise the importance and power of language when it comes to communicating about issues of self-harm and suicide.**

**I'm now much more aware of our responsibility to educate those outside the Trust, so we find a common way to discuss these issues that is open and honest without ever being graphic or sensational."**

**Richard Eaton**
Communications Manager

The media has a significant influence on behaviours and attitudes towards suicide. Encouraging responsible reporting and portrayal of suicide can reduce the risk of so-called "copycat" suicides but also provides an opportunity to promote support and information.

Social media and the internet are often associated with negative aspects of suicide, such as the availability of sites that promote and encourage suicide and e-bullying amongst young people. However, there are also opportunities to harness the positive effects both can have in supporting those in distress.

| Identified areas for action | Actions or Objectives |
| --- | --- |
| Review DHCFT communications and reporting of suicides and suicidal behaviour by local media | 1. Provide advice for staff e.g. Samaritans Media Guidelines. Communications within DHCFT to provide advice for all staff who speak to the media regarding suicide |
| Media enquiries relating to suicide are directed towards Suicide Prevention Strategy Group via the Chair of DHCFT SPSG | 1. Communications department within the Trust have a list of DHCFT SPSG members and contact details for current chair |
| Use communications approaches to promote support available to those in distress and those concerned about an individual | 1. Social media (e.g. Twitter)<br><br>2. World Suicide Prevention Day annual event to be actively supported by Trust staff<br><br>3. DSPPF attendance by DHCFT SPSG members |
| Derbyshire Healthcare NHS Foundation Trust website to have supportive information or links to helpful websites | E.g. Samaritans, Relate, Citizens Advice Bureau (CAB), 111 - the NHS non-emergency telephone triage service |

## Strategic priority 6:
## Support research, data collection and monitoring

**"It is refreshing to see a collaborative approach to suicide prevention research, with the Trust able to demonstrate that the research activities are contributing to the care, delivery and training agendas both within this service as well as with our partners. One of the key principles of the NHS Constitution that the Centre for Research and Development employs is its commitment to "innovation and to the promotion and use of research to improve the current and future health and care of the population". We work with our clinical services and external contacts to develop knowledge with an aim to improve patient care and community wellbeing.**

**The strength of the Trust's approach is linking everyday clinical activity and recording, into a research approach (for example our partnership in the Multicentre Study of Self-harm in England), whilst also helping to inform services and clinical colleagues of research findings.**
**The work of the Centre for Research and Development delivers against the Trust strategy and its vision and values, as well as the NHS Constitution pledges on research."**

**Keith Waters**
Director of Centre for Self Harm and Suicide Prevention

Local information will form the foundation of suicide prevention work in DHCFT. This information will allow the DHCFT SPSG to continually develop a strategic direction for suicide prevention work through the identification of trends and changes in the pattern of suicide. This will allow local work to adapt, and enable the development and evaluation of interventions that reflect changes in need. In order to build a comprehensive picture of local needs, reliable, accurate and timely data will be collated from a variety of sources, and will not be reliant solely on official sources of data on completed suicides that are published over a year in arrears. Developing metrics will also allow for monitoring of the impact of local suicide prevention work to be undertaken.

As well as local data, national and international research can be used to assess the effectiveness of interventions to reduce suicides, including near misses, as well as enhance the understanding of suicide risk in population groups.

| Identified areas for action | Actions or Objectives |
| --- | --- |
| Be an active member of the DSPPF to develop a meaningful picture of local suicide prevention needs, that is reported | 1. Reporting of suicides to public health at DSPPF via monthly Data Group<br><br>2. Bring and exchange quantitative and qualitative information to DSPPG<br><br>3. Timely response in Reporting to National Confidential Inquiry into Suicides and Homicides (NCISH) by responsible clinician/lead clinician |
| Contribute to the local suicide data to help inform the planned available online summary | 1. DSPPF meetings attended by DHCFT SPSG staff<br><br>2. Data analysis with public health |
| Exchange information across DHCFT and with partners to raise awareness of local suicide needs and influence the work of other groups including service receivers and third sector groups. Individuals and teams to evaluate local intelligence and share this within the Trust | 1. Suicide awareness and response training<br><br>2. Service receiver information comes to DHCFT SPSG<br><br>3. Third sector and voluntary groups<br><br>4. Other public services e.g. East Midlands Ambulance Service NHS Trust<br><br>5. Disseminate information regarding the importance of local data e.g. teams identifying patterns, information on DHCFT intranet site |

| | |
|---|---|
| To be a part of the process of disseminating recommendations and information from reviews of suicide deaths | 1. Individuals and teams to evaluate local intelligence and share this within DHCFT<br><br>2. DHCFT SPSG to lead on dissemination of information from sources e.g. NICE, SIG, Coroners' verdicts<br><br>3. DHCFT SIG to consult DHCFT SPSG regarding recommendations when relevant<br><br>4. Complete analysis of findings from National Confidential Inquiry into Suicide and Homicides reports and disseminate through Serious Incident group and DHCFT clinical and management structures |
| Support the work of the research department and input into multi-centre monitoring of self harm | 1. Trust commitment to research |

## Strategic priority 7:
## Building the resilience of local communities to prevent and respond to suicides

**"Some years ago a man jumped from a roof. I would like to have a couple of people with mental health and suicide 'experience' who are available to 'talk down' the person in such a situation. I believe this could be pioneering and progressive towards reducing suicide rates.**

**However, the worst thing about the day referred to above, and what proved to be a cause of his eventual jumping, was that a huge crowd had gathered on the pavements and road below who continually shouted insensitive comments up at him. Some of these comments were shamefully encouraging him to jump. Why had the crowd not been cleared from the street? How could we seriously expect to prevent such a suicide when faced with an obstacle like that one on that day?"**

**Service user RW**
March 2016

**"There is always an opportunity, as well as a responsibility, to learn from difficult events and for change to occur. Following the above incident, we were able to provide training and support for car park staff, individuals responsible for the management and design of the car park and engage with police negotiators across the East Midlands.**

**By undertaking in this collaborative work, we have been able to increase awareness of suicide and help guide and support those who may work with distressed individuals at risk of suicide.**

**The local suicide prevention strategy groups identified approaches that could help both in terms of identifying potential locations where people in distress may go to but also in raising awareness. People working in these locations are able to seek guidance and support on prevention methods.**

**Nationally the work of Network Rail, which includes the construction of barriers at potential locations and the use of signage to encourage help seeking, has been an example of learning from difficult events.**

**In addition to this, the work of chaplains and street triage at known locations, and the recent document from Public Health England "Preventing suicides in public places: a practice resource", are also able to show that measures have been put in place to learn from suicides and prevent them.**

**On a closing note, the 'Find Mike' campaign, where Jonny Benjamin was reunited with the stranger who talked him down from a bridge, demonstrates the importance of making contact with those in distress and the power of lay people's awareness and involvement in prevention approaches - and thus the importance of training, support and guidance for people working at all levels.**

**Keith Waters**
Director of Centre for Self Harm and Suicide Prevention
Clinical Advisor - Suicide Prevention, East Midlands Health Science Network

Suicide Prevention is everyone's business. We are all responsible for building local networks of support that have the potential to help those who are in distress and may feel that they have nowhere else to turn. An important part of this will be the need to raise awareness of suicide within local communities and building people's confidence to support and provide comfort for those in distress. It will also serve to reduce the stigma around suicide.

| Identified areas for action | Actions or Objectives |
|---|---|
| Promote mental health anti-stigma campaigns, such as Time to Change, amongst local organisations to dispel myths about mental health and suicide that persist amongst professionals and the general public | 1. Training for Acute Hospital care staff e.g. Emergency Department staff<br><br>2. Schwartz rounds<br><br>3. DHCFT Human Resource processes to build community resilience including with staff |
| Use opportunities like World Suicide Prevention Day to build community resilience | 1. World Suicide Prevention Day annual event to be actively supported by Trust staff<br><br>2. Media promotion of the event |
| Use our membership of the Derby Suicide Prevention Partnership Forum to influence other agencies' approach to suicide and mental health stigma | 1. Attendance at DSPPF<br><br>2. Accountability to DSPPF strategy<br><br>3. DHCFT SPSG members to work alongside DSPPF to develop training and support for primary care staff |
| Staff stigma – staff to feel able and supported to be open about their own mental health and wellbeing | 1. Staff survey analysis |
| Develop links with local communities to build resilience | 1. Partnership working with a wide range of groups e.g. sports club, faith groups |

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# Abbreviations and Glossary

**111 Telephone Service:**
111 is the free NHS non-emergency number. Call 111 and speak to a highly trained adviser, supported by healthcare professionals. They will ask you a series of questions to assess your symptoms and immediately direct you to the best medical care for you. NHS 111 is available 24 hours a day, 365 days a year. Calls are free from landlines and mobile phones.

**Care Programme Approach:**
The Care Programme Approach (CPA) is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs. You might be offered CPA support if you: are diagnosed as having a severe mental disorder

**Children and Adolescent Family Therapy Services (CAMHS)**
CAMHS is a specialist NHS service. In Derby and the south of Derbyshire it is run by DHCFT. It offers assessment and treatment for children and young people have emotional, behavioural or mental health difficulties.

**Citizens Advice Bureau (CAB):**
Provides the advice people need for the problems they face and improves the policies and practices that affect people's lives.
CAB provides free, independent, confidential and impartial advice to everyone on their rights and responsibilities. They value diversity, promote equality and challenge discrimination.

**Compassion focused therapy (CFT):**
A form of psychotherapy developed that integrates techniques from cognitive behavioural therapy with concepts from evolutionary psychology, social psychology, developmental psychology, Buddhist psychology and neuroscience. The central therapeutic technique of CFT is compassionate mind training, which is used to help people develop and work with experiences of inner warmth, safeness and soothing, via compassion and self-compassion. Compassionate mind training helps transform problematic patterns of cognition and emotion.

**Crisis Resolution and Hone Treatment Team (CRHT):**
Crisis Resolution and Home Treatment teams provide crisis assessment and intensive home treatment to individuals with mental health problems who present in a 'crisis'.

**Derbyshire Healthcare NHS Foundation Trust (DHCFT):**
We are a leading provider of mental health, learning disabilities and substance misuse services in Derby city and Derbyshire county. We also provide a wide range of children's services. We employ over 2,400 staff based in 100 locations. Across the county and the city, we serve a combined population of approximately one million people.

**Derbyshire Suicide Prevention and Partnership Forum (DSPPF):**
The Derbyshire Suicide Prevention Partnership Forum allows representatives from a number of different organisations to work together on achieving the common goal of reducing the number of people who die from suicide in Derby City and Derbyshire County. All members of the group have committed to champion suicide prevention work within their organisations and networks.

**Derbyshire Voice:**
A user led organisation and a registered charity and company who have played an important part in developing this strategy and generally working to improve mental health services. As of April 2016 our service receiver representation is provided by Derbyshire Mental Health Alliance.

**DHCFT Serious Incident Group:**
An internal DHCFT group of senior clinicians and managers who meet weekly to review all serious incidents. Investigations will be commissioned and reviewed. Immediate action will be taken as required.

**DHCFT Suicide Prevention Strategy Group (SPSG)**
DHCFT internal group linking to the wider Derbyshire group attended by clinicians from DHCFT and service users.

**DHCFT Family Liaison Workers**
Derbyshire Healthcare employs workers who provide support and help to families including those bereaved by suicide.

**Front Door Presentations (FDP):**
These are individuals who present to the either the Radbourne Unit, Derby or the Hartington Unit, Chesterfield who have not been formally referred but are requesting an assessment.

**Help is at Hand:**
A booklet for people who have been unexpectedly bereaved by suicide and other sudden and traumatic deaths. Called 'Help is at hand', it includes advice on coping with emotions, practical matters and how friends and family can help. It also provides information to help healthcare and other professionals understand the impact of suicide and how they can provide support

**Mental Health Liaison Team:**
Our Psychiatric Liaison Teams provide comprehensive advice, support and a signposting service to patients over the age of 17, where potential mental health and/or drug and alcohol issues are identified. Following referral from a health professional in Accident and Emergency or an inpatient ward within the general hospital, the team will offer a high-quality intervention, assessment and discharge process that covers all aspects of mental health - including drug and alcohol use and self-harming.

The team has been established by integrating the former Mental Health Liaison & Self Harm Team with the Older Adults Mental Health Liaison Team and the Hospital Alcohol and Drugs Liaison Team to create a 24/7 single point of access service at the Royal Derby Hospital and Chesterfield Royal Hospital.

Research shows that untreated mental health issues can lead to people spending longer in hospital and to poorer physical health outcomes. By working with other clinical colleagues, the Liaison Team is making sure that patients get the right help, at the right time, in the right place. They also provide a vital educational resource to staff throughout the hospital - to raise awareness and understanding of mental health needs and recognising the signs and symptoms.

**The National Institute for Health and Care Excellence (NICE):** publishes guidelines in four areas: the use of health technologies within the NHS (such as the use of new and existing medicines, treatments and procedures); clinical practice (guidance on the appropriate treatment

and care of people with specific diseases and conditions); guidance for public sector workers on health promotion and ill-health avoidance; and guidance for social care services and users.

**National Confidential Inquiry into Suicide and Homicide:**
Research into suicide and homicide by mental health patients across the UK and the sudden unexplained death of psychiatric in-patients. As the UK's leading research programme in this field, the Inquiry produces a wide range of national reports, projects and papers – providing health professionals, policymakers, and service managers with the evidence and practical suggestions they need to effectively implement change

**Papyrus:**
PAPYRUS is the UK charity dedicated to the prevention of young suicide.

**Relate:**
An organisation that help people (including providing therapy) make the most of their relationships, past, present or future. They can help you even if people are not currently in a relationship.

**Schwartz Rounds:**
A forum for clinical and non-clinical staff from all backgrounds and levels of an organisation to come together once a month and explore the impact that their job has on their feelings and emotions. A team/individual who have/has cared for a patient tell their story and this is followed by discussion, open to all, exploring issues that have arisen. It is not about problem solving – rather it is a dedicated time for reflection and a safe place to voice feelings not often shared, such as frustration, anger, guilt, sadness, joy, gratitude and pride.

**Suicide awareness and response training:**
This is evidence-based training in suicide and self harm prevention. It aims to increase empathy, reduce stigma and enhance participants' ability to compassionately respond to someone who has suicidal thoughts or following self harm. Such training supports the development of a common language, promoting a more integrated response across statutory services, third sector providers and communities.

**Survivors of Bereaved by Suicide (SOBS):**
Survivors of Bereavement by Suicide exist to meet the needs and break the isolation experienced by those bereaved by suicide. They are a self-help organisation and aim to provide a safe, confidential environment in which bereaved people can share their experiences and feelings, so giving and gaining support from each other. They also strive to improve public awareness and maintain contacts with many other statutory and voluntary organisations. They offer a unique and distinct service for bereaved adults across the UK, run by the bereaved for the bereaved.

**Think Family:**
Think Family' strategies promotes co-ordinated thinking and delivery of services to safeguard children, young people, adults and their families/ carers. Neither children, young people nor adults exist or operate in isolation. This presents a unique and positive opportunity to adopt a 'Think Family' approach to the planning and enabling of the delivery of services which are safe, effective and of high quality.

**Trauma:**
"The physical, cognitive, emotional and behavioural response someone has to an event or experience he or she perceives as traumatic"

**Voluntary Sector Single Point Of Access (vSPA):**
The service links local people at most risk of hospital admissions to the extensive range of support services that exist across the Voluntary Care Sector (VCS).

Individuals can be referred to vSPA by any health or social care professional, including GPs, community support teams, hospital discharge teams and staff working in social care. VCS organisations will also be able to refer their clients to the vSPA service for even more support.

**Vulnerable Adult Risk Management (VARM):** is a multi-agency risk management process to enable professionals to come together to develop creative and assertive plans to support Adults at Risk who have mental capacity and who are at risk of serious harm or death through self-neglect, risk taking behaviour or by refusing previous offers of support from services.

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**Derbyshire Healthcare NHS Foundation Trust**
Report to Board of Directors 1 February 2017

# Governance Improvement Action Plan (GIAP)

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

Therefore, the purpose of this paper is as follows:

1. To provide Board members with an update on progress on the delivery of the GIAP, including the identification of tasks and recommendations that are off track.
2. To receive assurances on delivery and risk mitigation from Board Committees and Lead Directors.
3. To enable Board members to constructively challenge each other to establish whether sufficient evidence has been provided for completed actions.
4. To decide whether tasks and recommendations can be closed and archived.

**Executive Summary**

This paper provides the Board with an update on the progress of delivering the GIAP.

The governance of each core area is as follows:

| Core | Committee | Lead Director |
|---|---|---|
| Core 1 - HR and associated Functions | People and Culture | Interim Director of People and Organisational Effectiveness |
| Core 2 - People and Culture | People and Culture | Interim Director of People and Organisational Effectiveness |
| Core 3 - Clinical Governance | Quality | Director of Nursing and Patient Experience |
| Core 4 - Corporate Governance | Audit & Risk | Director of Corporate Affairs |
| Core 5 - Council of Governors | Council of Governors | Director of Corporate Affairs |
| Core 6 - Roles and Responsibilities of Board Members | Remuneration and Appointments | Director of Corporate Affairs |
| Core 7 - HR and OD | People and Culture | Interim Director of People and Organisational Effectiveness |
| Core 8 - Raising concerns at work | People and Culture | Director of Corporate Affairs |
| Core 9 - Fit and Proper | Remuneration and Appointments | Director of Corporate Affairs |
| Core 10 - CQC | People and Culture | Interim Director of People and Organisational Effectiveness |
| Core 11 - NHS improvement undertakings | Board of Directors | Director of Corporate Affairs |

The summary table below provides Board members with an overview of performance against all 53 recommendations, set against each respective core area.

| Core | Number of Recommendations | Off Track | Some Issues | On Track | Completed |
|---|---|---|---|---|---|
| Core 1 - HR and Associated Functions | 5 | 0 | 0 | 2 | 3 |
| Core 2 - People and Culture | 6 | 0 | 0 | 4 | 2 |
| Core 3 - Clinical Governance | 3 | 0 | 2 | 0 | 1 |
| Core 4 - Corporate Governance | 13 | 0 | 0 | 8 | 5 |
| Core 5 - Council of Governors | 3 | 0 | 0 | 0 | 3 |
| Core 6 - Roles and Responsibilities of Board Members | 5 | 1 | 0 | 4 | 0 |
| Core 7 - HR and OD | 8 | 0 | 1 | 7 | 0 |
| Core 8 - Raising concerns at work | 1 | 0 | 0 | 1 | 0 |
| Core 9 - Fit and Proper | 1 | 0 | 0 | 0 | 1 |
| Core 10 - CQC | 2 | 1 | 0 | 0 | 1 |
| Core 11 - NHS improvement undertakings | 6 | 0 | 0 | 3 | 3 |
| **Total** | 53 | 2 | 3 | 29 | 19 |

There is one blue form to present to the Board in February – ClinG2, as attached.

**GIAP Recommendations Approval Pipeline, January – May 2017**
As reported to the January Board meeting, a pipeline of planned completion of blue action forms for all GIAP recommendations has been developed. This report is presented monthly to ELT to ensure oversight of progress and escalation and management of any issues arising. The approval pipeline as at 24.01.17 is attached for information.

The body of the report provides detail on areas that are currently rated as ‘off track’ or ‘some issues’.

| **Strategic considerations** Delivery of the GIAP links directly to NHS Improvement’s enforcement action and associated licence undertakings | |
|---|---|
| 1) We will deliver **quality** in everything we do providing safe, effective and service user centred care | **X** |
| 2) We will develop strong, effective, credible and sustainable **partnerships** with key stakeholders to deliver care in the right place at the right time | |
| 3) We will develop our **people** to allow them to be innovative, empowered, engaged and motivated. We will retain and attract the best staff | **X** |
| 4) We will **transform** services to achieve long-term financial sustainability | |

**Board Assurances**
This paper should be considered in relation to key risks contained in the Board Assurance Framework namely:

3a: There is a risk that the NHSI enforcement actions and CQC requirement notice, coupled with adverse media attention may lead to significant loss of public confidence in our services and in the trust of staff as a place to work
3b: Risk of a fundamental loss of confidence by staff in the leadership of the organisation at all levels

**Consultation**
Core areas have been discussed at respective Board Committees.

**Governance or Legal Issues**
This paper links directly to NHSI enforcement action and associated licence Undertakings.

**Equality Delivery System**
Delivery of elements of the GIAP is likely to have a positive impact on outcomes for certain REGARDS groups.

**Recommendations**

The Board of Directors is asked to:

1) Note the progress made against addressing GIAP recommendations
2) Discuss the areas rated as 'off track' and 'some issues', seeking assurance where necessary on the mitigation provided
3) Formally approve the 1 blue form as presented and confirm that this is provides assurance of completion, namely:
   - ClinG2
4) To note the GIAP recommendations approval pipeline and its role in supporting effective oversight of progress
5) Agree at the end of the Public Board meeting whether any further changes are required to the GIAP following presentation of papers, outcomes of item specific discussions and/or other assurances provided throughout the meeting.

**Report presented by:** **Kelly Sims (CQC and Governance Coordinator)**

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

## 1. Introduction

The Board summary table provides Board members with an overview of performance against all 53 recommendations, set against each respective core area.

Detailed below are updates against Core areas where there have been notable decisions made with respect to actions required to confirm completion of recommendations and scheduled dates identified for these to be brought to respective Committees and the Trust Board:

**Core 1 – HR and Associated Functions**
Following discussion at the People and Culture Committee it was agreed that blue completion forms would be prepared in March for HR3 and HR4.

**Core 2 – People and Culture**
It was agreed at the January meeting of the People and Culture Committee that due to progress made with the actions and recommendations, blue completion forms for recommendations PC2, PC3, PC4 and PC5 will be presented to the February meeting.

**Core 3 – Clinical Governance**
Following discussion at the Quality Committee, held in January, the blue form was approved for ClinG2. The timeline for assurance evidence for ClinG1 was agreed to be extended with the target date for receipt of the blue form as April Quality Committee. It was agreed that a blue form should be prepared for the committee for the February meeting relating to ClinG3.

**Core 4 – Corporate Governance**
At the Audit & Risk Committee in January the schedule for receipt of blue forms for five recommendations was noted. All remaining forms are to be presented to Audit & Risk Committee in March 2017.

**Core 6 – Roles and Responsibilities of Board Members**
Update presented to 1 February Committee with proposal that RR1 be designated as ‘some issues’ (formerly ‘off track’). A verbal update will be provided to the Board.

## 2. Red Rated 'Off Track' recommendations

There are 2 recommendations rated as Red as detailed in the table below (2 last month):

| Core Area | Recommendation | Action(s) | Mitigation |
|---|---|---|---|
| Core 6 - Roles and Responsibilities of Board Members | RR1 - Implement proposals to improve succession planning at Board level, including ensuring that Governors are adequately engaged in this process. Alongside this, develop processes for succession planning for Senior Leader positions | Develop and approve Board level, key divisional and corporate leaders succession plan | A mitigation plan was agreed at October's Remuneration & Appointments Committee, with succession planning process being led by Amanda Rawlings and Ifti Majid. Further development of the succession plan was discussed at the November and December Remuneration and Appointments Committee and proposed to be deferred until the new year due to priorities of other work areas.<br><br>The status was reported and noted at the January Board meeting and it is proposed to review the status of this recommendation, given that the Committee and the Board have agreed that this will be reported to the Committee in April 2017, to 'Some Issues' reflecting the reprioritised timeline. This also reflects the active succession arrangements that have been set in place effectively over recent months. Verbal feedback from Remuneration and Appointments Committee 1 February meeting to be given to the Board meeting. |
| Core 10 – CQC | CQC2 - The Trust should continue to proactively recruit staff to fill operational vacancies | Implement the recruitment plan and monitor effectiveness against an agreed vacancy rate trajectory | A revised recruitment plan has not yet been fully developed. However, two posts have been appointed to within the HR team to add capacity to speed up the recruitment process.<br><br>Discussion at ELT on 19.12.16 clarified actions required to complete this recommendation and embed in ongoing Trust work.<br><br>Further discussion with Interim Chief Operating Officer on 22.12.16 has identified proposed evidence of actions to address this recommendation to include: Recruitment Plan as presented to the PCC, evidence of weekly agency meetings with attendance by Executive Directors. Assurance to be |

| Core Area | Recommendation | Action(s) | Mitigation |
|---|---|---|---|
| | | | provided through completion of internal audit recommendations on agency controls. Monthly reporting is in place to the confidential Trust Board to highlight progress and impact on actions. A relocation expenses policy was approved by ELT on 19.12.16. A specific recruitment plan for each staff group is to be developed. Evidence to be presented to People & Culture Committee February meeting for proposed sign-off with blue completion form planned for March Board (subject to Committee approval). |

## 3. Amber rated 'some issues' rated recommendations

There are 3 recommendations rated as Amber as detailed below (3 last month):

| Core Area | Recommendation | Action(s) | Mitigation |
|---|---|---|---|
| Core 3 - Clinical Governance | ClinG1 - Refresh the role of Quality Leadership Teams to increase their effectiveness as core quality governance forums | 1) Agree and implement a QLT forward plan process to ensure all required papers are received at each meeting<br>2) Develop and implement a standard escalation template to be used by QLTs<br>3) For a 6 month period DoN and MD to attend QLTs to provide coaching and oversight of meeting effectiveness | QC agreed that in order to progress this recommendation to completion it would need to see evidence of escalation templates, minutes of meetings, work plans linked to the Quality Committee forward plan, attendance embedded on the minutes and risk register. QLT leads will need to attend QC on a rotational monthly basis but detailed QLT updates from each Team will be provided monthly. When the Committee has received all this information from each QLT consistently on a monthly basis for four months the Committee indicated they would be prepared to sign off this recommendation.<br>Reviewed at December Quality Committee – confirmed that this remains 'some issues' pending evidence to be received over further months. Position confirmed to remain as 'some issues' at January meeting. |
| | ClinG3 - Increase the effectiveness of the Quality Committee by ensuring clear alignment of the committee with the quality strategy and associated objectives, and ensuring a clear focus on seeking assurance | Ensure that Quality Committee agenda is structured so that it focuses on topics to deliver quality strategy and goals | QC agreed that there needed to be more focus on revising the agenda template to confirm how papers supported delivery of the Trust Strategy, in ensuring completion of actions and having a clear forward plan<br>At October's meeting QC agreed that the Action Log required richer narrative when capturing actions and accountabilities. Overall, the Committee expects to sign off this recommendation off by the end of the calendar year<br>Reviewed at December Quality Committee – confirmed that this remains 'some issues'. Following discussion at January Quality Committee and subsequent Exec Director Lead meeting agreed blue form to be prepared for February Quality Committee. |

| Core Area | Recommendation | Action(s) | Mitigation |
|---|---|---|---|
| Core 7 - HR and OD | WOD7 - The Trust should monitor the adherence to the grievance, disciplinary, whistle-blowing policies and the current backlog of cases concluded | The backlog of cases made known to the CQC at the time of the inspection are concluded | Progress continues to be made resolving all cases in line with Trust policy. Robust review undertaken and regular review by Executive Leadership Team. Status to be reviewed at December PCC with a view to status becoming 'on track'.<br><br>Reviewed at January PCC as there was no formal December PCC meeting. Agreed that blue form can be prepared for February 2017 PCC. |

# GIAP Recommendations: Approval Pipeline January - May 2017

| Core | Total | Off Track | Some Issues | On track | Com-plete* | Update | Programme for Blue Forms to Board | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Jan | Feb | Mar | Apr | May |
| Core 1 - HR and associated Functions<br>Director of People and Organisational Effectiveness | 5 | 0 | 0 | 2 | 3 | Forms approved by Board in Jan. PCC Jan agreed:<br><br>**HR3** – to PCC in March<br>**HR4** – to PCC in March | **HR1**<br>**HR2**<br>**HR5** | | | HR3<br>HR4 | |
| Core 2 - People and Culture<br>Lead - Director of People and Organisational Effectiveness | 6 | 0 | 0 | 4 | 2 | PCC Jan agreed:<br><br>**PC2 -** to PCC in Feb<br>**PC3 -** to PCC in Feb<br>**PC4** - to PCC in Feb<br>**PC5 -** to PCC in Feb (following review by SH and AR) | **PC1**<br>**PC6** | | PC2<br>PC3<br>PC4<br>PC5 | | |
| Core 3 - Clinical Governance<br>Lead - Director of Nursing | 3 | 0 | 2 | 0 | 1 | **ClinG1:** Jan QC reviewed timescale to April for QC assurance on evidence<br><br>**ClinG2**<br><br>**ClinG3:** Update to Feb QC on actions, including potential effectiveness survey for members, feedback from observation and clear link to strategy | | *ClinG2* | *ClinG3* | | *ClinG1* |
| Core 4 - Corporate Governance<br>Lead – Director of Corporate Affairs | 13 | 0 | 0 | 8 | 5 | Forms approved by Board in Jan (5)<br>Jan A&R agreed:<br><br>**CorpG1** – to Mar A&R<br>**CorpG3** – to Mar A&R<br>**CorpG4** – to Mar A&R<br>**CorpG5** – to Mar A&R<br>**CorpG6** – to Mar A&R<br>**CorpG7** – to Mar A&R<br>**CorpG8** – to Mar A&R<br>**CorpG11** – to Mar A&R | **CorpG2**<br>**CorpG10**<br>**CorpG12**<br>**CorpG13**<br>**Corp G9** | | | CorpG1<br>CorpG3<br>CorpG4<br>CorpG5<br>CorpG6<br>CorpG7<br>CorpG8<br>CorpG11 | |
| Core 5 - Council of Governors<br>Lead – Director of Corporate Affairs | 3 | 0 | 0 | 0 | 3 | All areas Complete (signed off December 2016) | | | | | |
| Core 6 - Roles and Responsibilities of Board Members<br>Lead – Director of Corporate Affairs | 5 | 1 | 0 | 4 | 0 | **RR1 –** to Apr RAC<br>**RR2 –** to *Apr* RAC<br>**RR3 –** to *Apr* RAC<br>**RR4 –** March RAC<br>**RR5** – to *Apr* RAC | | | | RR4 | RR1<br>*RR2*<br>*RR3*<br>*RR5* |
| Core 7 - HR and OD<br>Lead - Director of People and Organisational Effectiveness | 8 | 0 | 1 | 7 | 0 | Jan PCC agreed:<br>**WOD1** - to Feb PCC<br>**WOD2** - to Mar PCC<br>**WOD3 -** to Feb PCC<br>**WOD4** - to Feb PCC<br>**WOD5 -** to April PCC<br>**WOD6** - to Mar PCC<br>**WOD7** - to Feb PCC<br>**WOD8** - to Feb PCC | | | WOD1<br>WOD3<br>WOD4<br>WOD7<br>WOD8 | WOD2<br>WOD6 | WOD5 |
| Core 8 - Raising concerns at work<br>Lead - Director of People and | 1 | 0 | 0 | 1 | 0 | To Feb PCC - to confirm how completion/ embeddedness to be | | | RC1 | | |

| Core | Total | Off Track | Some Issues | On track | Com-plete* | Update | Programme for Blue Forms to Board | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Jan | Feb | Mar | Apr | May |
| Organisational Effectiveness | | | | | | defined (and become business as usual) | | | | | |
| Core 9 - Fit and Proper<br>Lead – Director of Corporate Affairs | 1 | 0 | 0 | 0 | 1 | Complete. Approved by Board in November 2016. | | | | | |
| Core 10 – CQC<br>Lead – Acting Chief Operating Officer | 2 | 1 | 0 | 0 | 1 | Jan Board approved CQC1. CQC 2 to be reviewed by Feb PCC | **CQC 1** | | CQC2 | | |
| Core 11 - NHS improvement undertakings<br>Lead - Chief Executive/Director of Corporate Affairs | 6 | 0 | 0 | 3 | 3 | Assurance and embeddedness is dependent on removal of enforcement undertakings and external assurance (e.g. Deloitte review) | | | | | M1<br>M2<br>M3<br>M4<br>M5<br>M6 |
| **Total** | **53** | | | | | Approved prior Jan: **4** | **11** | **1** | **12** | **13** | **12** |

*Agreed as completed by relevant oversight committee

| **Recommendation**<br>**ClinG2 – The Trust would benefit from a robust and thorough policy review programme** | **Current BRAG Rating**<br>**Completed** | **Recommended BRAG Rating**<br>**Assurance Received** |
|---|---|---|

**Detail**

Extra resource to support this action was approved by ELT and a member of staff was seconded to the role for six months in order to review policies.

The policy tracker was presented to the Audit & Risk Committee in July 2016 to provide assurance on the process.

The Risk Manager has reviewed the number of Trust policies and benchmarked against other organisations. There was room to consolidate a number of policies and due to changes to professional clinical practice there were a number of new policies required.

Progress reports have been provided to the Quality Committee in June 2016 and October 2016 with respect to progress against the policy review programme as a whole.

This recommendation is listed on the GIAP for oversight by the Audit & Risk Committee but with overall oversight falling to the Quality Committee. The Audit & Risk Committee has therefore been updated on progress with the actions required to address the recommendation and progress has been challenged and scrutinised as part of GIAP reporting to this Committee. Reporting on progress culminated in a report presented to the December 2016 Audit & Risk Committee by both Rachel Kempster (Lead for policy governance within the Trust) and Susan Spray (HR lead) to provide assurance that all aspects of the recommendation had been addressed. The Audit & Risk Committee therefore confirmed that they were assured that the required work had been completed and a blue form should be prepared.

Deloitte reviewed progress on this recommendation as part of their phase 1 report and the December to the Audit & Risk Committee addresses the gap in reporting identified as part of this review (section 2.4).

It was agreed at the December Quality Committee that this recommendation has been completed and a blue form could be prepared and submitted to in January 2017.

**Evidence**

3.4 Progress report against CLING2 action, presented to December's Audit & Risk Committee

**On-going Monitoring Arrangements**

The Quality Committee will continue to monitor compliance.

| | | | |
|---|---|---|---|
| **Executive Director Responsible** | Director of Nursing | **Responsible Assurance Committee** | Quality Committee |

**Derbyshire Healthcare NHS Foundation Trust**
Report to Board of Directors 1 February 2017

## Board Assurance Framework (BAF) update for 2016/17 (Issue 4)

**Purpose of Report:** To meet the requirement for Boards to produce an Assurance Framework. This report details the fourth issue of the BAF for 2016/17.

**Executive Summary**

- Since Issue 3 of the BAF for 2016/17 two further risks have been added to the BAF and one, following review by the Board, has been removed.

  New risks added:
  - 1d) The Trust does not fully comply with the statutory requirements of the Mental Health Act (MHA) Code of Practice and the Mental Capacity Act (MCA) which has resulted in a 'requires improvement' action from the CQC and impacts on person centred care.
  - 1e) Lack of compliance with the Civil Contingencies Act as a category 2 responder. Risk identified through 2016/17 EPRR Assurance Process

  Removed risk:
  - 3c) There is a risk that turnover of the Board members could adversely affect delivery of the organisational strategy due to loss of specialist organisational knowledge, capacity and stability. Review by the Board in December 2016 determined that the risk had been mitigated with recent appointments and so could be removed from the BAF.

  Movement of risk ratings:
  - Risk 1b) 'There is a risk that the Trust does not operate inclusivity and may be unable to deliver equity of outcomes for staff and service users' has been reduced from 'high' to 'medium' following review by the Executive Leadership Team and the evidence of action taken as evidenced on the CQC portal.
  - Risk 3a) 'There is a risk that the NHSI enforcement actions and CQC requirement notice, coupled with adverse media attention may lead to significant loss of public confidence in our services and in the Trust of staff as a place to work' has been reduced from 'high' to medium following the deep dive review undertaken by the Audit & Risk Committee in January 2017 which recognised the impact of increased strength of controls and assurances and the effect of actions completed.
  - Risk 4a) 'Failure to deliver short term and long term financial plans could adversely affect the financial viability and sustainability of the organisation' has been reduced from a risk rating of 'extreme' to 'high' due mainly to the partial close of the CIP gap

- A link to the operational risk register has again been included in this issue, with the reference number for related high/extreme operational risks on the Datix risk register cited against the relevant line in the BAF together with a headline summary of the risk.

- All dates for 'deep dives' of individual BAF risks are planned for the year and are target to be achieved. Deep dives for all risks rated as high or extreme will be undertaken by the Audit & Risk Committee but this is subject to change dependent upon the current risk rating of each risk.

The Audit & Risk Committee and Board will continue to receive the BAF four times during the year, in line with NHS Improvements governance guidance

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

**Assurances**
This paper provides an update on all Board Assurance Risks

**Consultation**
Individual Executive Directors – November/December 2016
Executive Leadership Team - 9 January 2017
Audit & Risk Committee – 17 January 2017

**Governance or Legal Issues**
Governance or legal implications relating to individual risks are referred to in the BAF itself. The work being undertaken as part of the Governance Improvement Action Plan (GIAP) clearly reads across to the risks raised in the BAF.

**Equality Delivery System**
None

**Recommendations**

The Board of Directors is requested to approve this fourth issue of the BAF for 2016/17, agreeing the two new risks added to the BAF and the removal of one risk

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

**Report prepared by: Rachel Kempster, Risk and Assurance Manager**

## Board Assurance Framework (BAF) update for 2016/17, (fourth issue)

There has continued to be significant review and update of each risk since it was last reviewed by the Board in November 2016. Changes since Issue 3 are highlighted in blue text in the detailed spreadsheet attached.

### 1) New risks

Since Issue 3 (November 2016), two additional risks have been added to the BAF. These are summarised below:

| | Risk title | Executive Director Lead | Current risk rating (impact x likelihood) | Rationale |
|---|---|---|---|---|
| 1d | The Trust does not fully comply with the statutory requirements of the Mental Health Act (MHA) Code of Practice and the Mental Capacity Act (MCA) which has resulted in a 'requires improvement' action from the CQC and an impact on person centred care. | Medical Director | **HIGH** **(3x5)** | Previously included as part of risk 1a. Need for separate risk identified following findings form CQC comprehensive inspection and assessment of medium level risk following internal audit reports. |
| 1e | Lack of compliance with the Civil Contingencies Act as a category 2 responder. Risk identified through 2016/17 EPRR Assurance Process | Acting Chief Operating Officer | **HIGH** **(5x3)** | Evaluation of non-compliance with EPRR Assurance Process for 2016/17 by CCG and NHS England |

The following risk has been removed from the BAF following review by the Board in Dec 16 which determined that the risk had been mitigated with recent appointments.

| | Risk title | Executive Director Lead | Current risk rating | Rationale |
|---|---|---|---|---|
| 3c | There is a risk that turnover of the Board members could adversely affect delivery of the organisational strategy due to loss of specialist organisational knowledge, capacity and stability. | Director of Corporate Affairs and Trust Secretary | **MEDIUM** **(4x3)** | Current changes to Board appointments |

The risk rating of three risks has been reduced.

| | Risk title | Executive Director Lead | Current risk rating | Previous risk rating | Rationale |
|---|---|---|---|---|---|
| 1b | There is a risk that the Trust does not operate inclusivity and may be unable to deliver equity of outcomes for staff and service users. | Interim Director of People and Organisational Effectiveness | MEDIUM (4x2) | HIGH (4x4) | Likelihood reduced to 2 due to actions taken as evidenced on CQC portal |
| 3a | There is a risk that the NHSI enforcement actions and CQC requirement notice, coupled with adverse media attention may lead to significant loss of public confidence in our services and in the trust of staff as a place to work. | Acting Chief Executive | MEDIUM (4x3) | HIGH (5x3) | Impact reduced from 5 to 4 due to the impact of increased strength of controls and assurances and the effect of actions completed |
| 4a | Failure to deliver short term and long term financial plans could adversely affect the financial viability and sustainability of the organisation | Executive Director of Finance | HIGH (5x3) | EXTREME (5x4) | Likelihood reduced from 4 to 3 mainly due to partial closure of CIP gap |

## 2) BAF risks summary

A summary of all risks currently identified in the BAF is shown below

| BAF ID | Risk title | Director Lead | Risk rating |
|---|---|---|---|
| 1a | Failure to achieve clinical quality standards required by our regulators which may lead to harm to service users and/or staff | Executive Director of Nursing and Patient Experience | HIGH (4x4) |
| 1b | There is a risk that the Trust does not operate inclusivity and may be unable to deliver equity of outcomes for staff and service users. | Interim Director of People and Organisational Effectiveness | MODERATE (4x2) |
| 1c | Risk to delivery of safe, effective and person centred care due to the Trust being unable to source sufficient permanent and temporary clinical staff | Interim Director of People and Organisational Effectiveness | HIGH (4x4) |
| 1d | The Trust does not fully comply with the statutory requirements of the Mental Health Act (MHA) Code of Practice and the Mental Capacity Act (MCA) which has resulted in a 'requires improvement' action from the CQC and an impact on person centred care. | Medical Director | HIGH (3x5) |
| 1e | Lack of compliance with the Civil Contingencies Act as a category 2 responder. Risk identified through 2016/17 EPRR Assurance Process | Acting Chief Operating Officer | HIGH (5x3) |
| 2a | Risk to delivery of national and local system wide change. If not delivered this could cause the Trusts financial position to deteriorate resulting in regulatory action | Acting Director of Strategy | HIGH (4x4) |
| 3a | There is a risk that the NHSI enforcement actions and CQC requirement notice, coupled with adverse media attention may | Acting Chief Executive | MODERATE |

| BAF ID | Risk title | Director Lead | Risk rating |
|---|---|---|---|
| | lead to significant loss of public confidence in our services and in the trust of staff as a place to work. | | (4x3) |
| 3b | Risk of a loss of confidence by staff in the leadership of the organisation at all levels | Interim Director of People and Organisational Effectiveness | HIGH (5x3) |
| 4a | Failure to deliver short term and long term financial plans could adversely affect the financial viability and sustainability of the organisation | Executive Director of Finance | HIGH (5x3) |
| 4b | Failure to deliver the agreed transformational change, at the required pace could result in reduced outcomes for service users, failure to deliver financial requirements and negative reputational risk | Acting Director of Strategy | HIGH (5x3) |

A line to the operational risk register has again been included in the BAF again this month, with the reference number for any related operational risks (with a current risk rating of high or extreme) cited against the relevant line in the BAF. The cross reference back to the BAF risk has also again been included this month. A headline summary of these risks is included at the end of the BAF spreadsheet.

### 3) 'Deep dives'

'Deep dives' are now embedded into the BAF process to enable review and challenge of the controls and assurances associated with each risk. These are undertaken by the lead responsible committee for each risk. As in 2015/16, where risks on the BAF remain high or extreme the 'deep dive' is presented to the Audit & Risk Committee to enable sufficient challenge to the highest risks facing the organisation.

The programme for deep dives for 2016/17 is planned as follows. The plan is currently on track.

| Risk ID | Subject of risk | Director Lead | Committee |
|---|---|---|---|
| 1a | Clinical Quality | Carolyn Green | Audit and Risk Committee: Dec 2016 Completed |
| 1b | Equality | Amanda Rawlings | People and Culture Committee: January 2017 |
| 1c | Clinical workforce | Amanda Rawlings | Audit and Risk Committee: March 2017 |
| 1d | Compliance with MHA/MCA | Dr John Sykes | Audit and Risk Committee: March 2017 |
| 1e | EPRR compliance | Mark Powell | Audit and Risk Committee: March 2017 |
| 2a | System change | Lynn Wilmott-Shepherd | Audit and Risk Committee: March 2017 |
| 3a | Regulatory compliance | Ifti Majid | Audit and Risk Committee: Jan 2017 Completed |
| 3b | Loss of confidence in leadership | Amanda Rawlings | Audit and Risk Committee: Jan 2017 Completed |
| 4a | Financial plan | Claire Wright | Audit and Risk Committee Oct 2016 Completed |
| 4b | Transformation | Acting Director of Strategy | Audit and Risk Committee Jul 2016 Completed |

# BOARD ASSURANCE FRAMEWORK 2016/2017 v4.2

**Definitions:**
**Strategic Outcomes:** What the organisation aims to deliver
**Principal Risk:** What could prevent this objective being achieved. Specify impact.
**Director Lead:** Lead Director for reporting into the BAF. Other Directors may also have responsibility for managing the risk
**Key controls:** What controls/systems we have in place to assist in securing delivery of our objective (Describe process rather than management groups)
**Assurances on Controls:** Where can we gain evidence that our controls/systems on which we place reliance, are effective
**Positive Assurances:** We have evidence that shows we are reasonably managing our risks and objectives are being delivered
**Gaps in Control:** Where are we failing to put control/systems in place? Where are we failing in making them effective?
**Gaps in Assurance:** Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective

Key:
Internal Audits Reports15/16
Internal Audits Reports16/17
Clinical Audit Programme 16/17
Changes since last reviewed by Board, Nov 2016
Cross reference to ID of related operational high/extreme risk (see summary at end of report)

## Strategic Outcomes 1. We will deliver quality in everything we do providing safe, effective and person centred care

| | Principal Risk | Director Lead and named responsible Committee | Risk Rating | Impact (1-5) | Likelihood (1-5) | Key Controls | Gaps in control | Assurances on Controls (Internal) | Positive Assurances | Gaps in Assurance | Action plan: To increase effective controls. To gain assurance. | Action: due/review date | Progress on action | Risk Register ID |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1a | Failure to achieve clinical quality standards required by our regulators which may lead to harm to service users and/or staff | Executive Director of Nursing and Patient Experience<br><br>Quality Committee | 16 HIGH | 4 | 4 | 1) Quality Framework (Strategy) outlining how quality is managed within the trust<br>2) Board committee structures and processes ensuring escalation of quality issues<br>3) Quality governance structures and processes in to manage quality related issues<br>4) Quality visit programme<br>5) Incident, complaints and risk investigation and learning, including robust mechanisms for monitoring resulting actions plans<br>6) Agreed clinical policies and standards, available to all staff via Connect. Policy governance reporting to Quality Committee.<br>7) Engagement with clinical audit and research programmes<br>8) 'Duty of Candour' monitoring and reporting processes<br>9) Annual skill mix review<br>10) CQC and GIAP action plans | Clinical buy in to review of NICE guidelines<br><br>Embeddedness of QLT's<br><br>Embedded personalised care planning, physical health cheeks and clinical standards<br><br>Compliance with medicines management policy, including storage compliance and gaps in capacity of pharmacy team (3302) (3301) (20844)<br><br>Demands of the Derbyshire population out strips capacity (3260) (20908) (20928), in particular community teams (20988), paediatrics, psychological therapies and fast track PREVENT referrals.<br><br>Ability to recruit and retain adequate numbers of staff to ensure safe practice i.e. inpatient wards at Radbourne and Hartington Units, (3386) (3410) (2797) (2801) (3409) (2797) paediatricians (3262), CMHT (20857) 20819) (20988), psychology (20867) (3385), CAMHS/children in care (21020)<br><br>Clinical dashboards to monitor early warning signs of service failure (1565)<br><br>Non commissioned services for Derbyshire based PICU beds (3314) and a secure and effective forensic pathway, and CAMHS Tier 4 beds<br><br>Learning from Serious Case and Homicide Reviews<br><br>Embedded security and safeguarding culture | Service improvement mapping and contributions i.e. positive and safe, reduction in the use of seclusion<br><br>Clinical Audit Programme and action plans where gaps identified<br><br>Audits of compliance with NICE Guidelines<br><br>National Audits i.e. National Audit of Schizophrenia and POMH UK Audits<br><br>'Clinical interest' led audits focused on local resolution of issues | National Community Patient Survey results (above average results)<br><br>National Inpatient survey (above average results)<br><br>Benchmarking data identifying higher than average qualified to unqualified staffing ration on inpatient wards<br><br>CQC inspection comprehensive review identified good feedback from families, individuals and carers re service experience. | CQC inspection comprehensive review detailed a number of gaps in assurance (21013).<br><br>Clinical audits identifying gaps due to inconsistent application of process i.e. capacity and consent, nutritional screening, DNAR, DEWS scoring, recording of allergies. Re-audits of rapid tranquilisation and seclusion identifying gaps in adherence to policy remain.<br><br>Supporting staff retention through practice development and embedding uptake of clinical supervision and appraisal rates.<br><br>HealthWatch survey report re delayed complaint response times and impact on patient experience. | Further engage clinical leadership (though QLT's in particular) in the review and implementation of NICE guidelines. | 28/02/2017 | Paper to QC planned for Feb 2017 identifying resource and infrastructure support required to fully support and report on implementation of NICE guidance. | 20830 |
| | | | | | | | | | | | Embedding of actions resulting from incidents and complaints into the medium to long term through Quality Leadership Teams. Improve systems and processes to identify links between incidents and learn lessons, including embedded learning from Serious Care Reviews and Homicide Reviews. | 28/02/2017 | Redesigned agenda/structure and forward plan in place for QLT's. Implementation of 'Datix dashboards' from Jan 2017, configured to ensure local oversight and learning from incidents. Head of Nursing/Patient Experience reports to demonstrate embedded learning. | |
| | | | | | | | | | | | Implement improvement plan for medicines management, as highlighted in Board deep dive into medicines management (Sept 2015) and hence to commissioners. | Completed | Medicines management groups have significantly improved performance and assurance in this area. Medicines management position statement and assurance provided to Quality Committee. | |
| | | | | | | | | | | | Implement measures to ensure medicines are being stored at the correct temperatures. | Completed | The capital investment plan for reducing temperatures in rooms used for the storage of medicines (through the installation of portable air conditioning units) has been delivered. | |
| | | | | | | | | | | | Raise risks with commissioners regarding community team capacity and forensic community offer. Recruit to new investment and action planning around 12 hour A&E breaches. | Completed | The risk / concerns log and register of issues is reviewed, each QAG group. STP plans to mitigate. | |
| | | | | | | | | | | | Implementation of clinical dashboards to monitor early warning signs of service failure | Completed | Routine reporting to Board and Quality Committee as of Nov 16. | |
| | | | | | | | | | | | Implementation of action plans resulting from gaps identified through clinical audit projects | Completed | The clinical audit team are working with QLT's to address the issues raised and to ensure there is swift and effective feedback on the audit process. Now part of business as usual. | |
| | | | | | | | | | | | Increase uptake of clinical and managerial supervision and level 3 safeguarding training | 31/03/2017 | Improvement in Nov, Dec 2016 and further sustained improvement is required in Jan 2017 | |
| | | | | | | | | | | | Reinstate practice development groups | 31/03/2017 | Confirmation of practice groups at Kingsway and Hartington. additional evidence of embeddedness at Radbourne and neighbourhood teams is required | |
| | | | | | | | | | | | PICU bed manager being appointed to review pathway. Cluster analysis of incidents requested via CCG through STEIS incident reporting. | Completed | Post has been appointed to and PICU access has reduced. | |
| | | | | | | | | | | | Implement emergency planning measures re staffing on inpatient wards at Radbourne and Hartington. | Completed | Emergency planning successfully completed and mitigated | |
| | | | | | | | | | | | Improve compliance with fire warden training | Completed | Completed plan and delivered. Compliance monitoring through monthly Integrated Performance Report to Board in place. | |
| | | | | | | | | | | | Security and safety action plan to be implemented | 31/03/2017 | Action underway led by Safeguarding Committee, supported by Health and Safety Committee. | |
| 1b | There is a risk that the Trust does not operate inclusivity and may be unable to deliver equity of outcomes for staff and service users. | Interim Director of People and Organisational Effectiveness<br><br>People and Culture Committee (Audit Committee)<br><br>Rating likelihood reduced to 2 due to actions taken as evidenced on CQC portal | 8 MODERATE | 4 | 2 | 1) Full time expertise in post<br>2) Launch of a new Equalities Forum<br>3) Additional resource to support development of the equalities agenda<br>4) Reporting of approach and ogress reported to Board and the People and Culture Committee<br>5) Urgent non compliance addressed and reported to the People and Culture Committee | Embedded focus on equalities across all trust committees<br><br>Embedded focus on equalities across all directorates | | | | External verification on EDS 2 planned for the 23/3/17 | 31/03/2017 | Trust has responded to the PSED and non compliance found by the CQC and is now focusing increasing organisational competence | 20936 |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1c | Risk to delivery of safe, effective and person centred care due to the Trust being unable to source sufficient permanent and temporary clinical staff | Interim Director of People and Organisational Effectiveness<br><br>People and Culture Committee (Audit and Risk Committee) | HIGH | 4 | 4 | 1) Recruitment policies and processes<br>2) Recruitment campaigns<br>3) Reporting of numbers of vacancies and time to recruit to People and Culture Committee<br>4) Weekly senior management review of agency spend<br>5) Overarching framework developed to offer incentivisation to fill very hard to fill posts<br>6) Revised recruitment process including approval to appoint, TRAC and EDBS to speed up the recruitment process | System wide recruitment tracker<br><br>Detailed recruitment plan for professional groups. Staffing risks identified in operational risks: (3386) (3410) (2797) (2801) (3409) (3262) (20857) 20819) ((20867) (3385) (20988), (21020) and consultant agency spend risks (20918) (20916) (20924) (20966)<br><br>Sufficiently well stocked bank and adequate resource to manage bank office function | | | 2016/17 Consultant job planning (high risk) | Embed the revised recruitment process to increase the speed of recruitment | 31/03/2017 | Work commenced to align the current recruitment with DCHS, eDBS, TRAC (electronic approval to appoint process) partnership working with DCHS. The existing approval to appoint process being streamlined. Ready to launch March 2017 | 20976 |
| | | | | | | | | | | | Recruitment plan by post developed | 28/02/2017 | On track to achieve | |
| | | | | | | | | | | | Recruit to/remodel medical workforce (20918) (20924) (20966) (21044) | Completed | The People and Culture Committee and sub groups are driving forward the agency review and actions are meeting weekly to review current performance and put in place improvement action plans. There are new recruitment packages being rolled out in 2017 and additional relocation incentives. | |
| 1d (NEW) | The Trust does not fully comply with the statutory requirements of the Mental Health Act (MHA) Code of Practice and the Mental Capacity Act (MCA) which has resulted in a 'requires improvement' action from the CQC and an impact on person centred care. | Medical Director<br><br>Mental Health Act (MHA) Committee | HIGH | 3 | 5 | 1) MHA and MCA policies and procedures<br>2) MHA Committee oversight of dynamic application of MHA/MCA<br>3) MHA Committee oversight of workplan of compliance checks, clinical audits and training<br>4) Lead director accountability and designated MCA medical lead | Training plan trajectory and consistent recording o ESR<br><br>Assurance of junior doctor supervision taking place, which includes focus on MHA/MCA compliance<br><br>Monitoring of application of MHA against equality standards<br><br>Consistent application of seclusion and segregation<br><br>Delays by local authorities in undertaking DoLS assessments<br><br>Reporting of hospital managers duties and decisions of panels | Range of compliance checks and supporting clinical audit programme:<br>- Consent to admission<br>- Section 17 leave<br>- Use of Section 5(2)<br>- S58 (T2/T3) and SOAD requests<br>- Community Treatment Orders and S132<br>- DoLS applications, assessments and outstanding waits | | Findings from CQC comprehensive identifying significant lack of knowledge by staff in recording of capacity and consent.<br><br>2016/17 Mental Capacity Act - review of patient notes (medium risk)<br><br>2016/17 Section 132 Rights (medium risk) | Quarterly reports from MCA medical lead and Mental health Act Manager to MHA Committee to demonstrate level of adherence to compliance checks and findings from supporting clinical audit programme | 31/03/2017 | Compliance checks underway, to report to MHA Committee March 2016. Clinical audit plan to be agreed March 2017. New assistant Head of Nursing undertaking compliance checks to ensure person centred care embedded. Post of clinical skills tutors to go back out to advert. | 21039 |
| | | | | | | | | | | | Ensure all doctor appraisals include focus on MHA/MCA compliance and improve recording of supervision for junior doctors.<br><br>Develop 'hint' cards to support junior doctors in application of MHA/MCA | 31/03/2017 | All doctors appraisals from 16/17 onwards now include the requirement for evidence of compliance with the MHA/MCA. Plan underway to improve recording of junior doctor supervision, key requirement to support MHA/MCA compliance | |
| | | | | | | | | | | | Compare ethnicity data of people who have been held under a section of the MHA against background population in line with equality standards | 31/05/2017 | Overall cohort is too small in comparison to general population statistics to complete in year, so year end analysis to be completed and presented to MHA Committee May 2017. | |
| | | | | | | | | | | | Develop prompts to local authorities with outstanding DoLS applications. Continue to monitor and report compliance to the MHA Committee | 31/03/2017 | Now routinely reported as part of the MHA Managers report to the MHA Committee | |
| | | | | | | | | | | | Medical Director to review Seclusion and Long Term Segregation policy with Director of Nursing to ensure consistent understanding in application of seclusion and segregation | 28/02/2017 | Review undertaken, policy to be amended. FAQ to be issued by the end of Jan 17. | |
| | | | | | | | | | | | Commence Hospital Manager reporting to MHA Committee | 31/03/2017 | Regular verbal updates to commence as standing agenda item from March 2017 | |
| 1e (NEW) | Lack of compliance with the Civil Contingencies Act as a category 2 responder. Risk identified through 2016/17 EPRR Assurance Process | Acting Chief Operating Officer<br><br>Quality Committee | HIGH | 5 | 3 | 1) Emergency Plan, published under own section on Trust intranet<br>2) Designated EPRR lead<br>3) Action plan agreed with NHS England<br>4) Quality Committee oversight and escalation, on behalf of Board. | Capacity of EPRR lead to deliver full requirements of the EPRR Assurance Process | | | Challenge from Southern Derbyshire CCG re non compliance with EPRR core standards compliance framework | Capacity support to be provided by DCHS and NHS England | 31/03/2017 | DCHS have agreed to provide a member of their team 1 day per week to support the delivery of the Trust's plan<br>Resources provided by NHSE for Hazmat training | 21036 |
| | | | | | | | | | | | Hardwick CCG and DHCFT to respond to Southern Derbyshire CCG's challenge re non compliance | Completed<br><br>28/02/2017 | Response from Hardwick CCG and DHCFT that NHS England are supporting action plans in place to mitigate gap and risk identified. Challenge and confirm meeting with Hardwick CCG planned for Feb 2017 to reassess progress against standards. Assurance meeting confirmed with CCG on 7th February | |
| | | | | | | | | | | | Develop and deliver action plan to close gap/risk | 31/03/2017 | Comprehensive action plan developed and being implemented. Director led oversight group in place to oversee and manage action plan, 1st EPPR steering group held on 10/01/17. EPRR Strategy, Incident Response Plan and Core standards action plan all discussed, with actions agreed ahead of the next meeting. | |

## Strategic Outcome 2: We will develop strong, effective, credible and sustainable partnerships with key stakeholders to deliver care in the right place at the right time

| | Principal Risk | Director Lead and named responsible Committee | Risk Rating | Impact (1-5) | Likelihood (1-5) | Key Controls | Gaps in control | Assurances on Controls (Internal) | Positive Assurances | Gaps in Assurance | Action plan: To increase effective controls. To gain assurance. | Action: due/review date | Progress on action | Risk Register ID |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2a | Risk to delivery of national and local system wide change. If not delivered this could cause the Trusts financial position to deteriorate resulting in regulatory action | Interim Director of Strategic Development<br><br>Finance and Performance Committee (Audit and Risk Committee) | 16 HIGH | 4 | 4 | 1) Programme of public consultation to support system wide changes<br>2) Stakeholder and relationship management in order to develop and maintain partnerships<br>3) Trust fully involved in Mental Health programme of work for the STP<br>4) Trust involvement with Strategic Options Case (SOC) for closer collaboration with DCHS<br>5) Executive to executive and Board to Board discussion with DCHS on opportunities for collaboration in line with national guidance re reviews of 'back office' functions | Unclear system wide governance to oversee delivery of national priorities<br><br>Lack of clarity around collaboration and competition<br><br>Issues of communication owing to NHSE directives<br><br>Long term local strategic partnerships to deliver quality, sustainable services (21002) | NHSE agreement of Derbyshire STP short term<br><br>Regular STP reports to confidential Trust Board<br><br>Regular system wide service change proposals reported to Trust Board | NHSE 'Checkpoint' undertaken. Assurance received to progress to final plan. | | Delivery of NHSI operational plan | Completed | NHSI Operational Plan for 2017/19 approved by Trust Board and sent to NHSI within the agree timeframe. | 20832 |
| | | | | | | | | | | | Agree system wide Sustainability and Transformation Plan (STP) | Completed | STP plan for Derbyshire was submitted on the30/6/16 in line with national expectations. | |
| | | | | | | | | | | | Implementation of Sustainability and Transformation Plan (STP) | 31/03/2017 | The STP was submitted on 21/10/2016. The mental health business cases are being developed and the pace of implementation will increase once the system wide structure is in place - this was due to commence late November 2016 for senior level posts. However, this was postponed and further details of the structures and governance processes are expected in January 2017 | |
| | | | | | | | | | | | Engagement with STP business case workstreams to ensure local ownership of DHCFT specific plans | Completed | All STP business cases were completed in time for the submission date. Further work to develop full business cases for March 2017 | |
| | | | | | | | | | | | Delivery of DHCFT and DCHS strategic options case to confidential Board Oct 2016 | Completed | Approved at extraordinary Confidential Board October 2016 | |
| | | | | | | | | | | | Phase 1 (back office functions) business case to be developed | Completed | Phase 1 business case was developed. Further work on implementation is in place | |

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

| | Principal Risk | Director Lead and named responsible Committee | Rating | 5) | (1-5) | Key Controls | Gaps in control | Assurances on Controls (Internal) | Positive Assurances | Gaps in Assurance | Action plan: To increase effective controls. To gain assurance. | Action: due/review date | Progress on action | Risk Register ID |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3a | There is a risk that the NHSI enforcement actions and CQC requirement notice, coupled with adverse media attention may lead to significant loss of public confidence in our services and in the trust of staff as a place to work.<br><br>Furthermore, failure to deliver the governance improvement action plan could lead to a risk of further breaches in licence regulations with Monitor and the CQC and further regulatory action<br><br>Impact reduced from 5 to 4 following deep dive review Jan 17 which recognised increased strength of controls and assurances and impact of actions completed. | Acting Chief Executive<br><br>Audit and Risk Committee | 12 MODERATE | 4 | 3 | 1) Governance committees and structures, with clear responsibility to lead on specific GIAP actions<br>2) People and Culture Committee, with clear responsibility to lead on specific GIAP actions, including full review of progress Nov 16<br>3) Governance processes to deliver the governance improvement action plan including reporting to ELT and monthly reporting to Board<br>4) Engagement and communication with workforce<br>5) Formal reporting to regulators on a monthly basis.<br>6) Ongoing engagement with regulators<br>7) CQC assurance reporting to the Quality Committee<br>8) 'Blue Form' final sign off of GIAP actions to Board | Identified in the governance improvement action plan.<br><br>Deloitte well led report, CQC reports, Yates report | Well led self assessment<br><br>Reporting through CQC portal providing live assurances against actual performance.<br><br>Scrutiny by Board of 'blue forms' detailing assurances on completed GIAP actions.<br><br>Media monitoring report provided monthly to Board | NHSI agreement of governance improvement action plan<br><br>DHCFT Quality Summit, +ve feedback<br><br>Deloitte and CQC reports<br><br>2016/17 Governance and improvement action plan//well led review (planned)<br><br>2016/17 Performance Management Framework (planned )<br><br>2016/17 CQC action plan (planned)<br><br>2016/17 Compliance with HR policies and procedures (medium)<br><br>2016/17 BAF and Risk Management (planned) | Initial outcomes from Deloitte and CQC reviews<br><br>Fully delivered GIAP and CQC improvement plans | Implement actions from Governance Improvement Action Plan.<br><br>To be undertaken via weekly review of the GIAP at the ELT, robust monitoring of progress through identified board committees, monthly monitoring reports to Board, monthly reporting to NHSI and the CQC. | Monthly | Number of 'off track actions' significantly reduced. Last planned 'blue form' to Board due May 2017 | 20834 |
| | | | | | | | | | | | Internal audits to be undertaken on key areas identified in the governance improvement action plan, i.e. compliance with policies and procedures | Completed | Audit focusing on specific HR policies in line with GIAP actions completed. Agreed report and associated management actions in place. | |
| | | | | | | | | | | | Fully deliver GIAP and CQC improvement plans | 31/05/2017 | Ongoing improvement work detailed earlier in presentation, monitored on a monthly basis by Board Committees, Board and externally by the PRM process with NHSI/CQC. Last 'blue form' on GIAP action planned for May 2017. CQC feedback re warning notice planned end Jan/Feb 17. | |
| | | | | | | | | | | | Agree framework with Deloitte over remaining quarters of the year to undertake a full well led review | 31/03/2017 | The GIAP and CQC Improvement plans have not yet fully delivered and hence we are not ready to have external assurance from Deloitte/CQC that gaps have been closed. Planned for Q4 16/17. | |
| | | | | | | | | | | | NHSI to undertake licence review Q4 16/17 | 31/03/2017 | Working with Deloitte and NHSI on revised plan for further review. Expected Q1 17/18 | |
| 3b | Risk of a loss of confidence by staff in the leadership of the organisation at all levels | Interim Director of People and Organisational Effectiveness<br><br>People and Culture Committee (Audit and Risk Committee) | 15 HIGH | 5 | 3 | 1) Director of People and Organisational Effectiveness in post to deliver on the people agenda and strengthen the HR function and organisational culture going forward<br>2) Roll out of the leadership development programme<br>3) Engagement Group<br>4) Increased focus on vacancy management<br>5) Increased focus on vacancy management<br>6) Implementation of the People Plan<br>7) Living the trust values | Robust approach to delivery of the People Plan and GIAP action plan<br><br>Strong partnership working with staff side<br><br>New board members familiarisation with the trust | Executive and board visits to staff<br><br>Launch of the pulse check<br><br>Staff survey action plan<br><br>Closure of actions from 2016/17 audits on grievance and disciplinary processes | HEE annual quality visit<br><br>Final closure in CQC/NHSI governance standards (as identified in GIAP action plan). 19 'blue forms' for HR actions completed to date<br><br>2016/17 Compliance with HR policies and procedures (medium). Actions completed | Safer staffing data identified in 2015/16 HR Processes: Recruitment.<br><br>Staff survey results | Implement actions from Governance Improvement Action Plan<br><br>To be undertaken via weekly review of the GIAP at the ELT, robust monitoring of progress through identified board committees, monthly monitoring reports to Board, monthly reporting to NHS Improvement and the CQC. | Monthly | Performance Review Meeting with NHSI 2/9/16 noted progress made on GIAP and plans in place to mitigate actions 'off track'. | 20835 |
| | | | | | | | | | | | Implement actions from internal audit report (2015/16 HR Processes: Recruitment) in relation to safer staffing reports. | Completed | Reported to P&CC and Audit and Risk Committee | |
| | | | | | | | | | | | Proactive management and delivery of the staff survey actions | 31/03/2017 | | |
| | | | | | | | | | | | Complete the leadership development training to ensure consistent approach to delivering on HR policies and processes | 31/03/2017 | | |
| | | | | | | | | | | | Implement Pulse Checks across the trust to provide rapid feedback on the climate across teams | 31/03/2017 | | |

## Strategic Outcome 4. We will transform services to achieve long-term financial sustainability

| | Principal Risk | Director Lead and named responsible Committee | Risk Rating | Impact (1-5) | Likelihood (1-5) | Key Controls | Gaps in control | Assurances on Controls (Internal) | Positive Assurances | Gaps in Assurance | Action plan: To increase effective controls. To gain assurance. | Action: due/review date | Progress on action | Risk Register ID |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4a | Failure to deliver short term and long term financial plans could adversely affect the financial viability and sustainability of the organisation | Executive Director of Finance<br><br>Finance and Performance Committee (Audit and Risk Committee)<br><br>Rating likelihood reduced to 3 in Dec 2016 due mainly to CIP gap partial closure | 15 | 5 | 3 | 1) Monthly Financial Performance Reporting to Public Trust Board meetings providing assurance on financial performance, including integrated performance reporting to enhance triangulation when assessing finance, quality, workforce and operational performance<br>2) Reporting to Finance and Performance Committee to gain assurance on all aspects of financial (and other resources) management on behalf of the Board, including oversight of CIP delivery and contractual performance<br>3) Project Assurance processes and systems for in-year monitoring of CIP delivery and escalation procedures<br>4) System of delegated budgetary responsibility - in line with standing financial instructions and scheme of delegation<br>5) F&P and PCOG meeting monitoring of contractual performance that impacts on contractual payments including activity levels, CQUIN and contract levers/penalties.<br>6) Service Line Reporting and other financial reporting systems and action planning at Finance & Performance, Performance and Contracts Overview Group (PCOG), Divisional meetings -and other groups | Control Totals for required surplus imposed by Regulator do require stretch levels of CIP delivery<br><br>Additional regulatory reporting and controls having negative impact on capacity and flexibility in financial planning<br><br>Outcome of contract negotiations for 17/18 and 18/19 requires provider CIP and commissioner disinvestment through QIPP - schemes not yet defined<br><br>Potential risk of loss of assets due to 'cash transfer' discussions that could impact on liquidity/ resilience / stability / viability/ risk ratings<br><br>As yet unknown financial impact of transaction with Derbyshire Community Health Services FT (LTFM as part of business cases will be developed) | Monthly financial reporting systems on current and forecast performance include "challenge and review" each month before reporting<br><br>Pre-submission scrutiny of annual operational financial plan prepared and submitted to NHSI<br><br>Pre-submission scrutiny of health system Sustainability and Transformation Plan (STP) ( 5 year plan)<br><br>Budget-setting operational requirements are signed-off by those responsible for their delivery (and the Trust Board)<br><br>In-year financial forecasts are co-owned by finance and the individuals responsible for their delivery<br><br>Existence of contingency reserve and the contingency reserve access request process<br><br>Large proportion of income guaranteed through block contract for 1617 . Block contract secured for 17/18 and 18/19 | External Audit: the Audit Findings for DHCFT (year ended 31 March 2016) . Issued with Unqualified Opinion Confirmed NB - VFM assessment and governance (see gap in assurance)<br><br>External Audit: Bespoke Key Financial Indicators 2015 report show that aside from the gap in assurance for liquidity (as the only red indicator) - the other indicators are amber or green (benchmarked against MH FT peers) . Strongest indicator is EBITDA. Generally improving position on metrics or benchmarked position<br><br>2016/17 Key Financial Systems - Data Analysis (low risk) | Re: External Audit benchmarking for Financial KPIs and resilience: Main area to improve is liquidity<br><br>ET/Governance reviews/investigations and subsequent regulatory impact created negative external assurance (e.g. need to develop integrated reporting and update F&P TOR and had negative impact on External Audit VFM Assessment for 1516 annual accounts and report)<br><br>Residual gaps in assurance related to exceeding agency controls on: % cost ceilings, pay rate caps, use of approved frameworks and high cost off payroll compliance<br><br>ELT 16th May 2016 determined that the remaining CIP gap of c £2m as at that date was significant enough to increase the probability that a significant level of non-delivery of CIP will impact on the ability to achieve the financial plan for 16/17 (remaining CIP/cost avoidance gap is mostly mitigated in most likely forecast as at Month 8 and risk likelihood reduced)<br><br>SoF Use of Resources Rating overall metric score capped at 3 because of agency metric of 4 (worst)<br><br>Number of high risk audits (16/17 Agency Controls and 16/17 Consultant Job Planning) and worsened HOIA opinion for part year 16/17 | To minimise control gap around future payment systems: Attendance at events, keeping up to date with current thinking from Regulator, discussions with commissioners (joint exec ownership between DoF and Director of Strategic Development) | Completed | Discussions with Commissioners for the next two year contracts as part of STP planning are to keep block contracts | 20833 |
| | | | | | | | | | | | To minimise gap in control re control total required by NHSI - continue financial planning and financial control and ensure CIP delivery. Due the worsened level of assurance over CIP delivery as at mid May there have been additional CIP emergency meetings and action planning meetings. Progress is reported to ELT every meeting, and to F&P May and Board. 6. Extraordinary F&P meeting took place in June 2016 to focus on CIP. | 31/03/2017 | Gap is still not closed as at month 6 reporting - currently at £657k. Actions continue to be reported to ELT and F&P and board. CIP Gap is mostly mitigated in most likely scenario as at month 8 | |
| | | | | | | | | | | | To minimise control gap for regulatory capacity and inflexibility in planning - ensure long term financial plans are deliverable and effectively monitored, continue to improve liquidity. | Completed | Long term STP submission being developed.<br>STP submitted and operational plan for 1718 and 1819 submitted | |
| | | | | | | | | | | | To improve assurance gap on External Audit benchmarking indicators: continue to improve liquidity and build cash reserves (e.g. through retention of disposal proceeds), maintain tight financial control | 31/03/2017 | Progress continues - see latest board financial reporting for current metrics | |
| | | | | | | | | | | | To improve assurance gap related to financial components of governance gaps: achieve delivery of the relevant governance improvement actions and compliance with findings recommendations from Deloitte et al | Completed | Papers provided to F&P and Board during the year are being amended as required. E.g. Enhanced financial dashboard reporting actioned from Feb 16 board onwards. Also from March board 16 onwards Trust Board receive a new integrated performance report. PCOG and F&P reports from Feb/March 16 included additional content on forward financial risks and trends. | |
| | | | | | | | | | | | To improve assurance related to agency usage: Internally monitor and manage reduction in use of agency staffing and monitor the delivery of improvement trajectories and also report progress on trends to relevant committees and Trust Board. (Action owner = Ops director)<br>Also achieve further evidence of assurance on rostering and longer term workforce planning to reduce reliance on agency (reported through People committee) (Action owner= Workforce Director) | 31/01/2017 | Weekly meetings have now been escalated to exec led - led by Mark Powell and Amanda Rawlings with consultant input including medical director. New reporting required by NHSI is also being completed which includes highest paid and longest running. We have not yet met goal and much relies on successful recruitment strategies and workforce planning. Review again at Q3 (reported mid January) | |
| 4b | Failure to deliver the agreed transformational change, at the required pace could result in reduced outcomes for service users, failure to deliver financial requirements and negative reputational risk | Interim Director of Strategic Development<br><br>Finance and Performance Committee (Audit and Risk Committee) | 15 | 5 | 3 | 1) New 5 year Strategy 2016 - 2021 outlining strategic direction for Trust<br>2) Tight plans for implementing transformational change , with clear objectives and metrics for internal and external reporting.<br>3) Programme of engagement events with staff and stakeholders to consult with and agree the programme for implementing transformational change<br>4) Commissioner involvement and support of transformational process | Plans have not as yet identified full CIP for year and pipeline going forward.<br><br>Embedded coaching culture to deliver empowered leadership and accountability<br><br>Capacity to deliver transformational plan, exacerbated by regulatory actions, alongside other project demands.(21030)<br><br>Sufficient engagement with staff side | Board reporting on strategy implementation with associated board discussion and challenge | 2015/16 Transformation | Gaps in assurance on CIP schemes<br><br>2016/17 Data Security and Handling (medium risk). | Develop transformational project plans submitted for current and future years with assurance on cost out in line with Trust strategy and national policy. | 31/03/2017 | System wide plans assume a 2% efficiency within provider Trusts. Efficiencies to be realised from back office efficiencies, agency spend, rotas, estates etc. Work is on-going to identify these efficiencies | 20831 |
| | | | | | | | | | | | Develop a performance framework to support empowered leadership and accountability to ensure decision making is undertaken at the right level. | Completed | A new Trust wide accountability framework agreed by Trust Board. Further detailed work on how it will work in practice is being undertaken by ELT and SLT. The development of a Trust wide management team (TMT) agreed, to commence Jan 2017 as planned. | |
| | | | | | | | | | | | Regular engagement with staff side through meetings with Interim Director | 28/02/2017 | Key contact has been off sick. Contact has been made with colleagues to offer a meeting. There has been no response, although dates still remain in the diary to allow updates. | |
| | | | | | | | | | | | Review capacity to deliver transformational agenda | 28/02/2017 | A paper has been forwarded to ELT. Discussions about sharing capacity have been had with key contacts in other organisations | |
| | | | | | | | | | | | Progress implementation plans via agreed business planning process | 28/02/2017 | Business planning process underway with read across to STP outline cases. Capacity remains an issue | |

Abbreviations

| | |
|---|---|
| ACAS | Advisory, Conciliation and Arbitration Services |
| CEO | Chief Executive Officer |
| CIP | Cost Improvement Programme |
| COSRR | Continuity of Services Risk Rating |
| CQC | Care Quality Commission |
| CQUIN | Commissioning for Quality and Innovation payment |
| CRG | Clinical Reference Group (accountable to QLT's) |
| DEWS | Derbyshire Early Warning System - tool to identify sharp physical health decline |
| DCHS | Derbyshire Community Healthcare Services |
| DNAR | Do Not Attempt Resuscitation order |
| DoLS | Deprivation of Liberty Standards |

**Cross reference to ID of related operational high/extreme risk**

| ID | Directorate | Date of next review | Risk Subtype | Title | Risk level (current) | BAF risk |
|---|---|---|---|---|---|---|
| 1565 | Campus - Radbourne Unit | 31/01/2017 | Clinical - Points of Ligature | Risk of death through strangulation | High Risk | 1a |
| 2797 | Campus - Radbourne Unit | 31/12/2016 | H&S - Violence and Aggression | Violence and Aggression_Ward 34. Increased due to number of vacancies | High Risk | 1a |
| 2801 | Campus - Radbourne Unit | 18/12/2016 | H&S - Fire Safety | Increase risks of fire related to smoking ban_Ward 34 | High Risk | 1a 1c |
| 3260 | Neighbourhood Services | 31/07/2016 | Commissioning Risk | Lack of ADHD service for adults | High Risk | 1a |
| 3262 | Community Paediatrics | 31/01/2017 | Clinical - Staffing levels | Long waiting lists following reduction in staffing levels | High Risk | 1a 1c |
| 3301 | Pharmacy | 30/09/2016 | Clinical - Medication/ Pharmaceutical | Medicines Management - Non-Compliance with Medicines Management standards | High Risk | 1a |
| 3302 | Pharmacy | 30/09/2016 | Clinical - Staffing levels | Pharmacy on call services | High Risk | 1a |
| 3314 | Neighbourhood Services - City | 31/12/2016 | Commissioning Risk | Lack of pathway for patients discharged from prisons | High Risk | 1a |

| | |
|---|---|
| DoF | Director of Finance |
| EBITDA | Earnings before interest, taxes, depreciation and amortization |
| ELT | Executive Leadership Team |
| ESR | Electronic Staff Record |
| EPRR | Emergency Preparedness, Resilience and Response |
| F&P | Finance and Performance Committee |
| FRR | Financial Risk Rating |
| FSRR | Financial Sustainability Risk Rating |
| GIAP | Governance Improvement Action Plan |
| HR | Human Resources |
| IAPT | Improving Access to Psychological Therapies |
| NICE | National Institute for Health and Care Excellence |
| NHSI | NHS Improvement ( formally Monitor) |
| PARIS | Electronic Patient Record solution provided by Civica |
| PCOG | Performance and Contracts Overview Group |
| PICU | Psychiatric Intensive Care Unit |
| POMH-UK | Prescribing Observatory for Mental Health |
| PYE | Part Year Effect |
| QAG | Quality Assurance Group (led by Commissioners) |
| QC | Quality Committee |
| QIA | Quality Impact Assessment |
| QLT | Quality Leadership Teams (accountable to Quality Committee) |
| SOAD | Second Opinion Appointed Doctor |
| SLA | Service Level Agreement |
| STP | Sustainability and Transformation Plan |
| TOMM | Trust Operational Management Meeting |
| VFM | Value for Money |

| | | | | | | |
|---|---|---|---|---|---|---|
| 3385 | Neighbourhood Services - City | 31/12/2016 | Clinical risk - Other | Waiting Times for Psychological Assessment and Intervention | High Risk | 1a 1c |
| 3386 | Campus - Radbourne Unit | 31/12/2016 | Clinical - Staffing levels | Vacancies, reduced leadership, capacity for succession planning | High Risk | 1a 1c |
| 3409 | Campus - Radbourne Unit | 18/01/2017 | H&S - Work Related Stress | Increased team stress due to vacancy levels_Ward 34 | High Risk | 1a 1c |
| 3410 | Campus - Radbourne Unit | 11/01/2017 | Clinical - Staffing levels | Vacancy levels above 30% | High Risk | 1a 1c |
| 20819 | Neighbourhood Services - City | 31/01/2017 | Operational - Business Continuity | Waiting lists for assessment and interventions | High Risk | 1a 1c |
| 20844 | Pharmacy | 31/10/2016 | Clinical - Medication/ Pharmaceutical | Lack of Facilities to Assure Compliance with Medicines Management Standards - Clinical Areas (Trust-Wide) | High Risk | 1a |
| 20857 | Neighbourhood Services - North | 27/01/2017 | Clinical risk - Other | Transfer of patients through the change in neighbourhood boundaries | High Risk | 1a 1c |
| 20867 | Learning Disabilties Services | 01/06/2017 | Clinical - Therapeutic activity | Lengthy waiting times for psychological involvement | High Risk | 1a 1c |
| 20908 | Substance Misuse Services | 06/10/2016 | Clinical risk - Other | Communication of information regarding patients on discharge from Royal Derby Hospital | High Risk | 1a 1c |
| 20918 | Neighbourhood Services - North | 30/12/2016 | Clinical - Staffing levels (exceeding agency cap) | Uncovered consultant Vacancy | High Risk | 1a 1c |
| 20924 | Campus - Kingsway Site | 01/02/2017 | Clinical - Staffing levels (exceeding agency cap) | Lack of Medical Cover | High Risk | 1a 1c |
| 20928 | Neighbourhood Services - North | 31/10/2016 | Clinical - Staffing levels | Long waiting times for MAS Diagnosis | High Risk | 1a |
| 20966 | Campus - Radbourne Unit | 06/10/2016 | Clinical - Staffing levels (exceeding agency cap) | Lack of consultant cover | High Risk | 1a |
| 20988 | Neighbourhood Services - City | 30/12/2016 | Clinical - Staffing levels | Not enough nurses to manage the initial assessments, waiting list for community intervention and to cover long term sickness | High Risk | 1a 1c |
| 21002 | Campus - Admin & Management Team | 03/12/2016 | Commissioning Risk | Patient transport | High Risk | 2a |
| 21013 | Campus - Radbourne Unit | 31/01/2017 | H&S - Violence and Aggression | Sec 136 suite | High Risk | 1a |
| 21020 | Children in Care | 30/01/2017 | Clinical - Staffing levels | Staffing Levels | High Risk | 1a 1c |
| 21031 | Neighbourhood Services - City | 13/01/2016 | Clinical risk - Other | Non-Adherence to Waiting List Management Policy and Procedure | High Risk | 4b |
| 21044 | Neighbourhood Services - North | 01/03/2017 | Clinical - Staffing levels | reduction in medical support | High Risk | 1c |

**Derbyshire Healthcare NHS Foundation Trust**
Report to Board of Directors – 1 February 2017

## Report from Council of Governors - 19 January 2017

The Council of Governors met on 19 January 2017 at the Ashbourne Centre, Kingsway, Derby. The meeting was chaired by Caroline Maley, Acting Trust Chair. Twelve governors were in attendance. The Council of Governors discussed agenda items, including:

### ACTING CHIEF EXECUTIVE'S REPORT

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

The report was delivered by Claire Wright on behalf of Ifti Majid who was giving a presentation to the Health and Wellbeing Board on Mental Health. Governors debated the issue of national funding for mental health and the wider parity of esteem agenda. Governors discussed the outcome of the contract negotiations. The Board assured governors that any proposed disinvestment requires an extremely rigorous quality impact assessment and, in many cases, consultation. The Board reported on engagement with Healthwatch and on actions to address issues identified by them. The challenges in recruitment were noted to be ongoing.

The report included an update reiterating the joint commitment on working with Derbyshire Community Health Services NHS Foundation Trust. The role of governors was outlined and governors confirmed that they understood this and reaffirmed their commitment to progressing with the outline and full business cases. Governors raised the anticipated changes to the Council of Governors through the acquisition by merger and were assured that changes will be discussed as part of the future journey. Timescales are still indicative for the process. The Acting Chair confirmed that governors will continue to be informed regularly throughout the process.

### INTEGRATED PERFORMANCE REPORT

Claire Wright highlighted key areas contained in the report which gave the governors an overview of performance as at the end of November 2016 with regards to workforce, finance, operational delivery and quality improvement. Staffing pressures were highlighted and governors were reminded of the actions in place to take forward improvements in recruitment and retention.

### NON EXECUTIVE DIRECTOR UPDATES

Richard Wright, Julia Tabreham and Maura Teager updated governors on activities within their portfolios. Updates were received via the Acting Chair on behalf of Barry Mellor and Anne Wright. The Acting Chair also summarised her first 19 days in role.

### NOMINATIONS & REMUNERATION COMMITTEE REPORT

The Committee had received the Interim Chair's appraisal. Fit and Proper Person tests had been successfully concluded for four recently appointed Non-Executive Directors (NEDs). NED salary benchmarking was reviewed and found to be in line with comparators regionally and nationally. The Acting Trust Chair shared her proposal for allocation of NEDs to Board Committees, which was supported. An amended role

description for the Senior Independent Director was reviewed and agreed. The Acting Trust Chair advised that consultation had taken place with the Board and NEDs on interest expressed in the SID role, leading to the appointment of Margaret Gildea.

**INTERIM CHAIR'S APPRAISAL**

The Acting Trust Chair presented a summary of the Interim Trust Chair's appraisal for the period December 2015 to December 2016, as led by the Senior Independent Director in liaison with the Lead Governor and in accordance with agreed process. The overall rating was agreed to be outstanding/fully satisfactory.

**GOVERNANCE COMMITTEE REPORT**

The Governance Committee reported on its activities in December 2016 and January 2017. The Committee is well attended and working well. Increased focus has been scheduled on membership and engagement over the coming months.

**DEPUTY LEAD GOVERNOR ROLE**

Carole Riley was appointed as Deputy Lead Governor effective 19 January 2017 to 7 March 2017 when arrangements for a substantive appointment to both the Lead Governor and Deputy Lead Governor role will be made.

**ACTIVE IN MIND PRESENTATION**

The Council of Governors received a presentation from Active In Mind (AIM), a partner organisation working with the Trust to enable and encourage all who are suffering from mental health problems or anguish, their carers and supporters to enjoy physical activities and nature in order to improve their physical and mental well-being.

**GOVERNANCE IMPROVEMENT ACTION PLAN UPDATE**

Samantha Harrison presented an update on the delivery of the Governance Improvement Action Plan (GIAP) and governors were assured on the process being followed by the Board on oversight of completion and embeddedness of recommendations. Governors were informed that good progress continues to be made.

**STAFF ENGAGEMENT SURVEY**

The Staff Survey closed on 2 December. A full report will be delivered to the Council of Governors in March.

**19 JANUARY 2017 - CONFIDENTIAL MEETING**

There was a brief Confidential meeting, chaired by Caroline Maley, Acting Trust Chair and attended by ten governors. Minutes of the extraordinary confidential meetings held on 24 November and 14 December were received.

**RECOMMENDATION**

The Board of Directors is requested to note and receive assurance on the breadth of key topics presented to and discussed by the Council of Governors.

| | |
|---|---|
| **Report prepared by:** | **Donna Cameron**<br>**Assistant Trust Secretary** |
| **Report presented by:** | **Samantha Harrison**<br>**Director of Corporate Affairs & Trust Secretary** |

# 2016-17 Board Annual Forward Plan

| Exec Lead | Item | Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives | Apr-16 | May-16 | Jun-16 | Jul-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | **Deadline for papers** | **18 Apr** | **16 May** | **20 Jun** | **18 Jul** | **26 Aug** | **26 Sep** | **24 Oct** | **28 Nov** | **3 Jan** | **23 Jan** | **20 Feb** |
| CM | Apologies given | | X | X | X | X | X | X | X | X | X | X | X |
| SH | Declaration of Interests | FT Constitution | X | X | X | X | X | X | X | X | X | X | X |
| CM | Minutes/Matters arising/Action Matrix | FT Constitution | X | X | X | X | X | X | X | X | X | X | X |
| CG | Actions and learnings from patient stories. | | X | X | X | X | X | X | X | X | X | X | X |
| CM | Board Forward Plan | Licence Condition FT4 | X | X | X | X | X | X | X | X | X | X | X |
| CM | 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** | | | | | | | | | | | | | |
| CM | Chairman's report | Licence Condition FT4 | X | X | X | X | X | X | X | X | X | X | X |
| IM | Chief Executive's report | Licence Condition FT4 | X | X | X | X | X | X | X | X | X | X | X |
| MP/ CW | APR NHSI Annual Plan submissions and governance statements, including financial plan and budgets (subject to change for NHSI deadlines each year) *Confidential* | FT Constitution/NHSI Risk Assurance Framework (RAF) | X | | | | | | | | | | X |
| CW | NHSI Compliance Return (Public) (subject to change (incorporated into Integrated Performance Report) | NHSI Single Operating Framework | | X | X | | | | X | | X | | X |
| JS | Information Governance Updates | Strategic Outcome 1<br>Strategic Outcome 3<br>Information Gov toolkit | X | | | | | X | | | | | |
| AR | Staff Survey Results and Action Plan | Strategic Outcome 3 and 4 | X | | | | | | | | | | X |
| SH | Review SOs, SFIs, SoD | FT Constitution<br>Standing Orders | | | | X | | | | | | | |
| SH | Trust Sealings | FT Constitution<br>Standing Orders | | X | | | | | | | | | |
| SH | Annual Review of Register of Interests | FT Constitution<br>Annual Reporting Manual | X | | | | | | | | | | |
| SH | Board Assurance Framework Update | Licence Condition FT4 | X | | | | X | | X | | | X | |
| SH | Raising Concerns (whistleblowing) | Strategic Outcome 1<br>Public Interest Disclosure Act | | | X | | | | | | | | |

# 2016-17 Board Annual Forward Plan

| Exec Lead | Item | Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives | Apr-16 | May-16 | Jun-16 | Jul-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SH | Committee Assurance Summaries (following every meeting)<br>- Audit & Risk<br>- Finance & Performance (Confidential)<br>- Mental Health Act<br>- Quality Committee<br>- Safeguarding<br>- People & Culture | Strategic Outcome 3 | X | X | X | X | X | X | X | X | X | X | X |
| SH | Governance Improvement Action Plan | Licence Condition FT4 | X | X | X | X | X | X | X | X | X | X | X |
| SH | Fit and Proper Person Declaration | Licence Condition FT4 | | X | | | | | | | | | X |
| MP | Emergency Planning Report | | | | | | | | X | | | | |
| SH | Board Effectiveness Survey | | | | | | | | | | | | X |
| SH | Report from Council of Governors Meeting | | X | | | | X | X | | X | | X | |
| LWS | Measuring the Trust Strategy | | | | | | | | | | | | X |
| **OPERATIONAL PERFORMANCE** | | | | | | | | | | | | | |
| CG, CW, AR, MP | Integrated performance and activity report to include Finance, Workforce, performance and Quality Dashboard | Licence Condition FT 4<br>Strategic outcome 1<br>Strategic Outcome 3 | X | X | X | X | X | X | X | X | X | X | X |
| MP | Agency Controls | | | | | | | | | X | X | X | X |
| **QUALITY GOVERNANCE** | | | | | | | | | | | | | |
| CG | Position Statement on Quality (Incorporates Strategy and assurance aspects of Quality management)<br>Includes Annual Review of Recovery Outcomes in October and Annual Looked After Children Report in December | Strategic Outcome 1<br>CQC and Monitor | X | X | X | X | X | X | X | X | X | X | X |
| CG/JS | Safeguarding Children Annual Report | Children Act<br>Mental Health Standard Contract | | | | | | | X | | | | |
| CG/JS | Safeguarding Adults Annual Report | CQC<br>Mental Health Standard Contract | | | | | | | | X | | | |
| CG | Control of Infection Report | Health Act<br>Hygiene Code | | X | | | | | | | | | |

## 2016-17 Board Annual Forward Plan

| Exec Lead | Item | Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives | Apr-16 | May-16 | Jun-16 | Jul-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CG/JS | Integrated Clinical Governance Annual Report including MHA/Governance/Complaints and Compliments/SIRIs/Patient Safety/NHS Protect (LSMS) and Emergency Preparedness/H&S (including H&S and Fire Compliance and Associated Training) | CQC and H&S Act | | | | | | | X | | | | |
| CG | Annual Community Patient Survey | Clinical Practice<br>CQC | | | | | | | X | | | | |
| JS | Re-validation of Doctors | Strategic Outcome 3 | | | X | | | | | | | | |
| CG | Progress from Quality Visits | | | | X | | | | | X | | | X |
| CG | Annual Review of Recovery Outcomes * | | | | | | | X | | | | | |
| CG | Annual Looked After Children Report * | | | | | | | | | X | | | |

* Incorporated in Quality Position Statement