Derbyshire Healthcare
NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust
Board of Directors

St Thomas Centre, Chatsworth Road, Brampton, Chesterfield, Derbyshire S40 3AW
2 October 2018 09:30 - 2 October 2018 12:00

INDEX

NHS
Derbyshire Healthcare
NHS Foundation Trust

NOTICE OF PUBLIC BOARD MEETING – TUESDAY 2 OCTOBER 2018
TO COMMENCE AT 9:30
ST THOMAS CENTRE, CHATSWORTH ROAD, BRAMPTON, CHESTERFIELD, DERBYSHIRE S40 3AW

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks, apologies for absence and Declarations of Interest Register	Caroline Maley
2.	9:35	Patient Story - High Peak and Dales Neighbourhood team	Carolyn Green
3.	9:50	Minutes of Board of Directors meeting held on 4 September 2018	Caroline Maley
4.		Matters arising – Actions Matrix	Caroline Maley
5.		Questions from governors or members of the public	Caroline Maley
6.	10:00	Chair's Update	Caroline Maley
7.	10:05	Chief Executive's Update	Ifti Majid
OPERATIONAL PERFORMANCE, QUALITY AND STRATEGY			
8.	10:20	Integrated Performance and Activity Report	Claire Wright/Amanda Rawlings/Carolyn Green/Mark Powell
9.	10:40	Quality Report - Safety - Quarterly Mortality Report	John Sykes
11:00 B R E A K			
10.	11:15	Emergency Preparedness, Resilience and Response (EPRR) self-assessment and annual report	Mark Powell
11.	11:25	Receipt of Annual Reports: - Safeguarding Children and Adults at Risk Annual Report - Looked After Children Annual Report	Carolyn Green
12.	11:35	Report on Trust Sealings	Sam Harrison
13.	11:40	Board Committee Assurance Summaries and Escalations: Mental Health Act Committee 7 September, Safeguarding Committee, 11 September, Quality Committee 11 September, Finance & Performance Committee 18 September 2018 *(minutes of these meetings are available upon request)*	Committee Chairs
14.	11:55	Report from Council of Governors meeting held 4 September 2018 (for information and noting)	
CLOSING MATTERS			
15.	12:00	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Board Forward Plan - Meeting effectiveness	Caroline Maley
FOR INFORMATION			
Glossary of NHS Acronyms			

Questions that are applicable to the agenda, and at the Chair'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.turner17@nhs.net

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.

Next meeting will be held at 9.30am on 6 November 2018 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 Chair's discretion

Derbyshire Healthcare
NHS Foundation Trust

Our vision

To make a positive difference in people's lives by improving health and wellbeing.

Making a positive difference

Our values

As a Trust, we can only provide good quality services through our dedicated staff, working together with a common purpose. Our values reflect the reasons why our staff choose to work for the NHS and Derbyshire Healthcare and the principles that bind us together in a common approach, no matter what our employed role is.

Our Trust values are:

People first – We put our patients and colleagues at the centre of everything we do.
Respect – We respect and value the diversity of our patients, colleagues and partners and support a respectful and inclusive environment.
Honesty – We are open and transparent in all we do.
Do your best – We work closely with our partners to achieve the best possible outcomes for people.

Declaration of Interests Register 2018/19

NAME	INTEREST DISCLOSED	TYPE
Margaret Gildea Non-Executive Director	• Director, Organisation Change Solutions Limited • Non-Executive Director, Derwent Living	(a, b) (a)
Gareth Harry Director of Director of Business Improvement & Transformation	• Chairman, Marehay Cricket Club • Member of the Labour Party	(d) (e)
Geoff Lewins Non-Executive Director	• Director, Woodhouse May Ltd • Director, Arkwright Society Ltd	(a, b) (a)
Ifti Majid Chief Executive	• Board Member NHS Confederation Mental Health Network • Kate Majid (spouse) Chief Executive of the Shaw Mind Foundation which is a global mental health charity	(e) (a, d)
Caroline Maley Trust Chair	• Director – C D Maley Ltd • Trustee – Vocaleyes Ltd. • Governor, Brooksby Melton College	(a, b) (a, d) (a, d)
Mark Powell Chief Operating Officer	• Chair of Governors, Brookfield Primary School, Mickleover, Derby	(e)
Amanda Rawlings Director of People and Organisational Effectiveness (DHCFT)	• Director of People and Organisational Effectiveness, Derbyshire Community Healthcare Services (DCHS) • Co-optee Cross Keys Homes, Peterborough	(e) (e)
Dr Julia Tabreham Deputy Trust Chair and Non-Executive Director	• Non-Executive Director, Parliamentary and Health Service Ombudsman • Director of Research and Ambassador Carers Federation • Member of Sir Alex Allan's Parliamentary and Health Service Ombudsman's Clinical Advice Service Review • Daughter Sophie Elizabeth Barker-Tabreham is a head hunter for Europrojects an organisation that recruits staff from the NHS for private sector companies and special projects	(a) (d) (a) (e)
Dr John Sykes Medical Director	• Undertakes paid assessments of patients at the request of the local authorities under the Mental Health Act and Mental Capacity Act and acts likewise for solicitors representing patients.	(e)
Richard Wright Non-Executive Director	• Executive Director, Sheffield Chamber of Commerce • Chair Sheffield UTC Multi Academy Trust • Board Member, National Centre of Sport and Exercise Medicine Sheffield	(a) (a) (d)

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 shareholdings 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) Detail any connection with a voluntary or other organisation contracting for National Health Services, or hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or any other body which could be seen to influence decisions you take in your NHS role. (see conflict of interest policy - loyalty interests).

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

Tuesday 4 September 2018

MEETING HELD IN PUBLIC

Commenced: 9.30 Closed: 12:10

PRESENT	Caroline Maley	Trust Chair
	Dr Julia Tabreham	Deputy Trust Chair and Non-Executive Director
	Margaret Gildea	Senior Independent Director
	Geoff Lewins	Non-Executive Director
	Dr Anne Wright	Non-Executive Director
	Ifti Majid	Chief Executive
	Claire Wright	Director of Finance & Deputy Chief Executive
	Dr John Sykes	Medical Director
	Mark Powell	Chief Operating Officer
	Carolyn Green	Director of Nursing & Patient Experience
	Samantha Harrison	Director of Corporate Affairs
	Amanda Rawlings	Director of People Services & Organisational Effectiveness
	Gareth Harry	Director of Business Improvement & Transformation
IN ATTENDANCE	Anna Shaw	Deputy Director of Communications & Involvement
	Sue Turner	Board Secretary
	Donna Dyke	Advanced Occupational Therapist South Derbyshire CTLD
	Tray Davidson	Youth & Community Worker, Early Intervention in Psychosis Service and Reverse Mentor to Chief Executive
	Mandi Davidson-Cross	Care Co-ordinator, Care at Home Frailty Service and Reverse Mentor to Medical Director
	Suki Khatkar	Specialist Nurse and Reverse Mentor to Director of Nursing & Patient Experience
VISITORS	John Morrissey	Lead Governor & Public Governor, Amber Valley
	Christine Williamson	Public Governor, Derby City West
	Kelly Sims	Staff Governor, Staff Administration and Allied Support Staff
	Jim Perkins	Appointed Governor, Derby City Council
	Martyn Bell	Trust Member, Amber Valley, South
	Sandra Austin	Trust Volunteer
APOLOGIES	Richard Wright	Non-Executive Director

DHCFT 2018/108	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** The Trust Chair, Caroline Maley, welcomed all to the meeting. Apologies for absence were noted as above. A number of guests were welcomed; these included Donna Dyke from the

	Learning Disabilities (LD) service who attended the meeting to shadow Caroline Maley. Tray Davidson, Mandi Davidson-Cross and Suki Khatar attended in their capacity as reverse mentors to the Chief Executive, Ifti Majid, Medical Director, John Sykes and Director of Nursing and Patient Experience, Carolyn Green. Attention was drawn by Caroline Maley to the Trust's Vision and Values that accompanied the agenda of today's meeting to reiterate the importance that these underpin the business of the Board. The Declaration of Interests register, as included in the Board papers, was noted and would be updated to include additional appointments associated with the Deputy Trust Chair, Julia Tabreham. Ifti Majid announced that he had been appointed as a board member of the NHS Confederation Mental Health Network. The Board considered this to be a great honour for Ifti and the Trust.
DHCFT 2018/109	**MINUTES OF BOARD OF DIRECTORS MEETING HELD ON 3JULY 2018** The minutes of the previous meeting, held on Tuesday 3 July 2018, were accepted as a correct record.
DHCFT 2018/110	**MATTERS ARISING – ACTIONS MATRIX** The Board agreed to close all completed actions. Updates were provided by members of the Board and noted on the actions matrix. All completed 'green' actions were scrutinised to ensure that they were fully complete and actions that were not complete were challenged with Executive Director leads.
DHCFT 2018/111	**QUESTIONS FROM GOVERNORS OR MEMBERS OF THE PUBLIC** No questions had been received from members of the public or governors in advance of the meeting.
DHCFT 2018/112	**CHAIR'S UPDATE** This report provided the Board with the Trust Chair's reflections on her activity with and for the Trust since the previous Board meeting on 3 July 2018. Caroline also highlighted additional activities she had been involved in; these included celebrating 70 years of the NHS at York Minster with the Trust's Engagement Officer, Shirley Houston, and Simon Rose who is an expert by experience who works with new trainees when they commence their work at the Trust. Caroline felt honoured on 23 August to have judged the Trust's Big 70 Bake-Off contest held to mark NHS70 and thanked everyone who took part. She also attended the Summer Fayre on 7 July and thanked everyone involved for their work in organising activities. **RESOLVED: The Board of Directors noted the activities of the Trust Chair since the last meeting held on 3 July 2018**
DHCFT 2018/113	**CHIEF EXECUTIVE'S UPDATE**

	This report 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 commissioners and feedback from staff. Ifti Majid drew attention to the ten year plan that the NHS will be producing in return for an increase in funding. This is a real opportunity for the profile of mental health services to increase and he was pleased to see Children's, Learning Disabilities and Substance Misuse services being linked together in discussions within the different mental health working group engagement groups that have been set up to develop the ten year plan. He believed this was a positive indication for the Trust and reported that further engagement would take place throughout September culminating in a joint NHS England and NHS Improvement board meeting to discuss the plan. Ifti referred to the meeting of the NHS Confederation Mental Health Network session that he attended with Claire Murdoch, National Mental Health Director for NHS England, as part of the mental health working group engagement when discussions focussed on concerns around the transition to adult services. Recommendations were made to raise this to 25 years' of age as this can be a very pressurised time for people within this age group. Ifti reported that he took the opportunity to emphasise during the meeting the importance of the long term management of people with mental health conditions and pressed for more focus and capacity for core services and stronger links between paediatrics CAMHS and school nursing services. He also stressed the importance of valuing transient people within our organisation such as junior doctors and student nurses so they will want to return to the Trust when they complete their degree or placement. It is clear from the IPR (Integrated Performance Report) that the Trust's services are under extreme pressure. Ifti drew attention to the 12 hour A&E breaches and the continued demand for beds and the note he had received that had been written from someone whilst waiting for a bed that was appended to his report. He felt this gave a very clear picture of the problems clinicians face on a day to day basis and the difficulties of keeping people safe when they are waiting for beds and receive care. Julia Tabreham was pleased to hear that the capacity for core services will be a focus of the mental health working groups. She referred to the approach being taken to financial control totals that was mentioned in the report and challenged how this would change how the Trust can operate its services. Ifti acknowledged that the financial architecture was not fully understood yet. He anticipated that this would mainly focus on organisations running at a deficit which will help zero their budgets. He thought this could mean that trusts might return to a self-set position but this would not be confirmed until the operational plan is released later in the financial year. Director of Finance and Deputy Chief Executive, Claire Wright, added that she did not expect sustainability funding to change but hoped that funding would be shared in a more equitable way and would not be allocated on a retrospective basis. Caroline Maley suggested that the note from the service user appended to the report be shared with Fran Steele, Delivery and Improvement Director NHSI, when she and Ifti meet with her next week.

	ACTION: Service user note to be shared with Fran Steele, NHSI **RESOLVED: The Board of Directors scrutinised the Chief Executive's update, noting the risks and actions being taken**
DHCFT 2018/114	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT** Chief Operating Officer, Mark Powell, presented the Integrated Performance Report (IPR) and provided the Board with an integrated overview of performance as at the end of July 2018. The focus of the report is on workforce, finance, operational delivery and quality performance. One of the key challenges outlined in the report was the national shortage of mental health beds. Discussion focussed on the recent growth in demand for patients with complex needs which had resulted in an increase in the number of patients with a length of stay of over fifty days. These contributing factors have resulted in bed occupancy being high and as a consequence some patients have had to be placed out of area which causes difficulties for families and carers maintaining contact with patients. The Board recognised that the solution would be to extend the scope and purpose of mental health beds and was pleased to hear that this issue had been reinforced by Ifti Majid at the recent CEO meeting. The need to reduce inpatient beds and increase community care was seen as a realistic solution based upon external modelling undertaken previously. This was a strategic priority. However taking into account national trends and local operational pressure, this may no longer be the case. It is important as a Board to retest the data and remodel. This needs to be undertaken with commissioners so the correct investment can be made in services. Renewed focus needs to be given to people with long term conditions who are often admitted as inpatients as there is not enough capacity to care for them within community care. Other areas of concern included the 1.27% increase in sickness absence in July as well as the amount of people who practice presenteeism and are coming to work despite illness, injury or anxiety. The Board was assured that support is being given to managers in reviewing sickness absence particularly on acute units and work is taking place to support individuals back into the workplace to ensure that the Trust provides a safe service. The recruitment pipeline was raised as a concern as the Trust is not fully staffed to required levels. Proactive work is taking place within People Services to improve the recruitment pipeline and the 90 days recruitment turnaround timeline aims to be reduced to 60 days. Claire Wright emphasised that the Trust is not holding vacancies and was in fact is actively over recruiting over establishment, but the current 90 day performance from recruit to commencement was not at the level that the Trust would aspire to reach. Director of People Services and Organisational Effectiveness, Amanda Rawlings, reported that the Trust has a good national profile and strong social media presence and this is resulting in a positive response to recruitment. While discussing recruitment and sickness the Board recognised that although shift patterns and rostering is being managed to cover sickness absence a number of roles cannot be recruited to because they are filled by people who

	are currently absent through sickness. The Hartington Unit was seen to be successfully attracting applicants and work is taking place to route these applicants to other services. Claire Wright referred to the finance position and reiterated that the forecast remains to achieve the control total at the end of the financial year. In order to do so the Trust's reserves were being used and that there was no room for flexibility. In concluding discussions Caroline Maley acknowledged the continuing challenge of maintaining a workforce with the required skills to deliver the Trust's complex care services. In response the Board undertook to consider risks associated with the national shortage of beds, the shortfall of staff with the required roles and skills to deliver high quality services and commissioning gaps within the next issue of the Board Assurance Framework (BAF). **ACTION: Risks associated with the national shortage of beds, the shortfall of staff with the required roles and skills to deliver high quality services and commissioning gaps within the next issue of the Board Assurance Framework (BAF)** **RESOLVED: The Board of Directors considered the Integrated Performance Report and obtained limited assurance on current performance across the areas presented.**
DHCFT 2018/115	**<u>QUALITY REPORT - RESPONSIVE</u>** This new style report covered the five key lines of enquiry that the Care Quality Commission (CQC) considers when reviewing and inspecting services, and these will be a feature of the Quality Reports going forward. 1. Are they safe? 2. Are they effective? 3. Are they caring? 4. Are they well-led? 5. Are they responsive to people's needs? This month's version provided the Board with a focused report on service responsiveness and was used to facilitate non-operational discussion linked back to the Trust's strategy and enabled Board members to recognise commissioning gaps and assess the Trust's performance on a national level whilst meeting the needs and expectations of service users and carers. Carolyn Green raised concern about the data supplied and the significant number of people who are waiting for access to service care and the limited commissioned service for autism which is currently only resourced to provide a diagnosis, and the demand for assessment that continues to exceed capacity. She was conscious that the Quality Committee would be addressing the clinical strategy for autism on 11 September and recommended that the Board consider the BAF risk level for autism standards and the strategic direction of this service. Discussion took place on the contributors to responsiveness. It was accepted that much of this is driven by the local levels of austerity, capacity and the diverse community within Derby city and the county. Waiting times are driven by capacity which suggests that an equitable provision is not possible across the

	county. It was also thought that having four commissioning groups can be problematic when considering the demand for services. This could be resolved by holding strategic discussions between the Board and commissioners to influence better access and provision within contracting rounds to ensure community provision is part of the wider pathway of urgent care work and ensure the right levels of resource in a very resource limited environment. This will enable the Trust to make a positive impact on responsiveness and provide easier access to services. The Board reflected on how discussions facilitated by the report would affect the levels of the BAF risks. It was agreed that the Quality Committee would hold strategic discussions to review the risks and mitigating actions associated with BAF Risk 1a (Safety and Quality Standards) and 1b (Mental Health Act and Mental Capacity Act compliance) aligned to physical healthcare, waiting times and commissioning for autism over the next month. The Board noted that next report will focus on safety and will be led by Medical Director, John Sykes. **ACTION: Quality Committee to review BAF Risk 1a and 1b risks and mitigating actions aligned to physical healthcare, waiting times and commissioning for autism.** **RESOLVED: The Board of Directors:** **1) Discussed the strategic issues associated with the Trust's services** **2) Considered the level of performance across the areas presented** **3) Reflected on how the Board Assurance Framework should be updated to reflect the risks discussed**
DHCFT 2018/116	**<u>EQUALITY DELIVERY SYSTEM 2 AND WORKFORCE RACE EQUALITY STANDARD SUBMISSION</u>** The annual Workforce Race Equality Standards (WRES) 2017/18 reporting template and summary was received for consideration and approval prior to sharing with lead commissioners and publishing on the Trust's website by 24 September, 2018. The report included an update on the Equality Delivery System 2 (EDS2) grading process 2018 and a refreshed REGARDS (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation) wheel poster was presented for approval. The Board noted that the WRES submission would be uploaded to the Trust's website by 24 September and would be seen as evidence that the Trust is an employer that provides a fair service to staff from a BME background. Although there are number of work streams in place that are focussing on the WRES these are in an early stage of development. While reviewing the WRES reporting template, it was observed by Geoff Lewins that out of the 12.59% proportion of BME staff employed within the organisation 4.85% have not stated their ethnicity and this is to be checked by Amanda Rawlings before submission. The Trust's reverse mentoring initiative has been seen as a positive step by both parties. Ifti Majid was pleased to see that this was being driven by the BME network, and although this remains in the early stages of development it will continue to be supported to move this initiative forward. Carolyn Green asked if the WRES submission could be expanded to record

	people from a BME or disability background that are absent from work through stress and harassment. It was agreed that this section of the WRES would be expanded to cover this area in future submissions. The EDS2 implementation plan 2018 is currently undergoing a refresh by the national team although in the interim we will carry on with the current format. The Board noted that Head of Equality, Diversity and Inclusion is working with the Deputy Director of Operational Services and Director of Nursing and Patient Experience to finalise details of a specific service equality deep dive. A provisional date has been set for 15 November pending agreement with senior accountable officers. A refreshed REGARDS poster reflecting the new values and brand was set out in Appendix 3 and was approved by the Board. Working with 'Due REGARDS' and respect because everyone matters was developed at a recent Equality Board Development session. John Sykes pointed out that most patients with a personality disorder brought on through trauma and abuse are women. This is an example of gender inequality, and broader discussions of this nature take place within the Mental Health Act Committee. Director of Corporate Affairs, Sam Harrison, welcomed the new REGARDS wheel characteristics. These values sit well within the work that the Trust is involved in and she undertook to provide the guidance within the equality impact assessment section within the Board and Board Committee report templates to support the Board's decision making process. **ACTION: Board and Committee report templates to be revised to incorporate guidance on completion of the equality impact assessment.** **ACTION: WRES submission to be expanded to record people from a BME or disability background who are absent from work through stress and harassment.** **RESOLVED: The Board of Directors:** **1) Noted the findings against the nine performance indicators and approved the WRES reporting template and summary** **2) Noted the EDS2 Implementation plans 2018** **3) Discussed and approved the refreshed REGARDS poster**
DHCFT 2018/117	**<u>PULSE CHECK RESULTS AND STAFF SURVEY PLAN</u>** This report presented by Amanda Rawlings set out the current position in relation to staff feedback received over the past nine months and highlighted the progress achieved against the focus areas for action for the current year, based on the key themes identified in both the 2017 NHS Staff Survey and Q4 Pulse Check. The report also set out the plan for the 2018 NHS Staff Survey. The Board noted that the Q2 Pulse Check survey launched on 3 September and included additional questions to help inform the Trust's zero tolerance to bullying and harassment which will give a baseline of granular detail of where issues lie and where they are being addressed. There has also been a focus on increasing the participation rate in low

	performing teams and the Organisational Effectiveness team has worked extensively around the need to provide paper copies of the survey for staff working within campus areas. Communication updates relating to the key focus areas of the Pulse Checks will also enable the Organisation Effectiveness team to meet the expectations of staff and address both local and Trust wide issues. The Board recognised that the Staff Survey and Pulse Check are important tools that allow relevant action to be taken each quarter rather than once a year and took assurance that results have shown that a gradual steady improvement has been seen in the percentage of staff who would recommend the Trust as a place to work and to receive care. The Organisational Effectiveness Team will work closely with services over the next six months and monitor progress throughout the year using the Pulse Check findings. The People and Culture Committee will continue to receive progress updates on all action areas every quarter. **RESOLVED: The Board of Directors:** **1) Received and reviewed the position the Trust is now in in relation to the staff feedback received over the past nine months, including the NHS Staff Survey and Pulse Check results, where key themes have been identified, and are being acted on** **2) Approved suggestions (in terms of survey mode) for the 2018 NHS Staff Survey plan** **3) Took assurance from next steps and the organisational and local engagement work taking place across the Trust.**
DHCFT 2018/118	**<u>BOARD ASSURANCE FRAMEWORK UPDATE ISSUE 2</u>** Director of Corporate Affairs, Sam Harrison presented the second issue of the BAF for 2018/19. Eleven risks are currently identified in the BAF for 2018/19. Two risks continue to be rated as extreme in terms of risk to achievement of the Trust's strategic objectives. These are: Risk 3a Delivery of the financial plan; and Risk 4a Retention, development and attraction of staff. The remaining nine are currently rated as high risk. There have been no changes formally agreed by the relevant Board Committees in relation to the overall rating of BAF risks since the first issue of the BAF to Board in March 2018. The continuing focus on ensuring that appropriate actions to mitigate risks are identified, scrutinised and evaluated was noted and that risk ratings are challenged with identified actions resulting in reduced risk ratings. Work continues to take place with Executive Leads to ensure appropriate mitigating actions are identified with timeframes and milestones for delivery. Due to the gap between the BAF being considered by the Audit and Risk Committee and Board, the Board noted that Risk 1b, (Mental Health Act and Mental Capacity Act compliance) Risk 4d (patient flows) have been discussed in relevant Board Committees and subjected to formal scrutiny and challenge and updates will be included in the next review cycle of BAF risks for Issue 3 due, to be presented to the Audit & Risk Committee on 4 October and Board on 2 November. The BAF risks for the responsible Board Committees continue to be presented at the start of each agenda in order to drive the agenda and discussions. Reflection of any required changes to the BAF, following discussion of agenda

	items also remains as a standing item. Sam Harrison drew attention to recommendation (3) of the Deloitte phase 3 Well Led governance review to expand the BAF to include information on mitigating actions for all high and extreme rated operational risks. This detail has therefore been included in this second issue of the BAF and will be included again in Issue 4. The Deep Dive programme for review of risks by Board Committees previously agreed with Executive Directors was referred to and was agreed by the Board. The BAF had been a focus of discussions that the CQC held with Sam Harrison as part of the recent Well Led inspection and she is waiting to receive their feedback on how the Trust manages the BAF process. The importance of linking the equality impact assessments and REGARDS aspects within the decision making process linked to the BAF was highlighted by Sam Harrison and will feature in the Issue 3 that will be presented to the Board at the November meeting. Caroline Maley was pleased to see that the report captures the results of discussions held within the relevant Committees and Executive Leads which was evidence that the BAF had been robustly scrutinised. The Board received significant assurance of the process to manage the BAF and approved Issue 2 for 2018/19. **RESOLVED: The Board of Directors:** **1) Agreed and approved this second issue BAF for 2018/19 and the significant assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives** **2) Agreed the inclusion of the summary of mitigation for current high/extreme operational risks and the format presented in response to the Deloitte Well Led recommendation** **3) Agreed the plan for completion of BAF 'Deep Dives' during 2018/19.**
DHCFT 2018/119	**<u>BOARD COMMITTEE ASSURANCE SUMMARIES AND ESCALATIONS</u>** Assurance summaries were received from the Board Committees below, and highlights provided by the respective Non-Executive Chair. **Quality Committee 10 July and 14 August – provided by Julia Tabreham:** The Committee escalated to the Board the need to resolve the issue of incomplete Serious Incident (SI) actions. It was confirmed by Mark Powell that the Committee would be informed of the work he is carrying out to resource and speed up work relating to SI investigations at its next meeting on 11 September. The Board supported the Quality Committee's request that the Trust's own case study examples be used within the Raising Concerns and Whistleblowing training programme in order to illustrate examples of good practice. The identification of a NED for Children's services was discussed. Caroline Maley clarified that that this role was not a mandatory requirement. No single NED was to be regarded as NED for Children's services, as the whole Board was responsible for oversight of all of the Trust's services.

	Audit & Risk Committee – Geoff Lewins: The report from the Clinical Audit team had also been cross referenced through the Quality Committee. Concerns were raised about the necessary resource to undertake actions to support the progress of using clinical audit in quality improvement plans and were noted by the Board. **People & Culture Committee – Margaret Gildea:** Two meetings of the Committee had taken place since the previous Board meeting held in July. The 21 August meeting had not been quorate due to apologies that had been received from the Executive members of the Committee. As a result the agenda was followed and no formal decisions were made. Reports demonstrated the discussion held during the IPR item DHCFT2018/114 above. The Committee was satisfied that the right focus was being applied with no escalations made to the Board. **Finance & Performance Committee provided by Geoff Lewins in the absence of Richard Wright:** Discussions took place at the July meeting around commissioning and compliance with MHIS (Mental Health Investment Standard). The progress being made with cluster buy-in and effectiveness remains an ongoing area for discussion and has been referred to the ELT for further review. The Trust's financial performance is continuing to look challenging; as a result the CIP (Cost Improvement Programme) is being monitored closely. No escalations were made to the Board. **RESOLVED: The Board of Directors received and noted the Board Committee Assurance Summaries**
DHCFT 2018/120	**REPORT FROM COUNCIL OF GOVERNORS MEETING HELD 3 JULY 2018** The Board noted the report from the Council of Governors meeting held on 3 July 2018 that was provided for information. **RESOLVED: The Board of Directors received and noted the report from the Council of Governors meeting held 3 July 2018**
DHCFT 2018/121	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK** The following issues were highlighted in the meeting for update or inclusion in the Board Assurance Framework: • Level of risk for autism standards • Risks associated with the national shortage of beds, the shortfall of staff with the required roles and skills to deliver high quality services and commissioning gaps • Risks and mitigating actions associated with BAF Risk 1a and 1b aligned to physical healthcare, waiting times and commissioning for autism • Chief Operating Officer will consider if the risk rating for BAF risk 4d (patient flows) should be increased in Issue 3. This will be discussed by the Finance and Performance Committee as part of its review of BAF risks.
DHCFT 2018/122	**2018/19 BOARD FORWARD PLAN**

	The forward plan was noted by the Board along with upcoming reports to be received at subsequent meetings.
DHCFT 2018/123	**MEETING EFFECTIVENESS** Attendees and visitors were thanked for their attendance. The Board considered that appropriate items had been included on the agenda which had facilitated strategic discussions and the management of risks that impact the people who use our services. Actions will be taken through the appropriate Board Committees. Clinical staff who had attended the meeting to shadow the Chair and some of the Executive Directors were invited to comment on their perspective of discussions that had taken place. They were all pleased to see at first hand the connection the Board has with the Trust's clinical staff and that concerns raised by members of their teams and patients within their care had been discussed with compassion and care.

The next meeting of the Board to be held in public session will take place at 9.30 on Tuesday 2 October 2018.

The location will be St Thomas Centre, Chatsworth Road, Brampton, Chesterfield, Derbyshire S40 3AW

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - SEPTEMBER 2018			
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
28.2.2018	DHCFT 2018/024	Deep Dive – Joint Eating Disorders Service	Carolyn Green	**Transferred to Quality Committee Actions Matrix** Introduction of a combined initiative with specialist areas to be captured in the new Eating Disorders Strategy	Nov-18	It was confirmed at Quality Committee on 11.9.2018 that the revised Eating Disorders Strategy will include aspects of obesity and will be brought to the Committee in February 2019 and has been factored into the Committee's forward plan.	Green
3.7.2018	DHCFT 2018/099	Learning from Deaths Mortality Report	John Sykes	Report on the strategy for reviewing deaths to accompany the next Mortality Report to the Board	2.10.2018	Mortality Report received covers the strategy for reviewing and learning from deaths	Green
4.9.2018	DHCFT 2018/113	Chief Executive's Update	Ifti Majid	Service user letter to be shared with Fran Steele, NHSI	2.10.2018	COO attended a meeting with NHSI and other system leaders where the letter was shared	Green
4.9.2018	DHCFT 2018/114	Integrated Performance Report (IPR)	Carolyn Green Mark Powell	Risks associated with the national shortage of beds, the shortfall of staff with the required roles and skills to deliver high quality services and commissioning gaps will be incorporated in the next issue of the Board Assurance Framework (BAF)	2.10.2018	The strategic risk on patient flow has been updated and re-assessed since the last Board meeting in light of continuous risks in this area. This is now rated as an extreme risk. The shortage of beds and ongoing workforce issues are contributory factors to the increase in this risk.	Green
4.9.2018	DHCFT 2018/115	Quality Report	Carolyn Green	Quality Committee to review BAF Risk 1a and 1b risks and mitigating actions aligned to physical healthcare, waiting times and commissioning for autism.	2.10.2018	Quality Committee has reviewed the BAF risks. Continued assessment of physical healthcare is being undertaken by the Medical Director and will be reported to the Committee.	Green
4.9.2018	DHCFT 2018/116	Equality Delivery System 2 and Workforce Race Equality Standard Submission	Sam Harrison	Board and Committee report templates to be revised to incorporate guidance on completion of the equality impact assessment	2.10.2018	Board and Committee report templates have been revised and are due to be submitted to ELT on 1 October for endorsement	Green
4.9.2018	DHCFT 2018/116	Equality Delivery System 2 and Workforce Race Equality Standard Submission	Amanda Rawlings	WRES submission to be expanded to record people from a BME or disability background who are absent from work through stress and harassment	2.10.2018	WRES submission corrected and uploaded on Trust website. The absence data recorded with FirstCare can report on who is absent from work by BME and disability. The only caveat would be that the standard DoH/ESR sickness reason that is the nearest is 'anxiety / stress / depression / other psychiatric illnesses' so we would not be able to pinpoint 'harassment' as it doesn't exist as an individual absence reason.	Green

Resolved	**GREEN**	7	
Action Ongoing/Update Required	**AMBER**	0	
Action Overdue	**RED**	0	
Agenda item for future meeting	**YELLOW**	0	
		7	100%

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 2 October 2018

Trust Chair's report to the Board of Directors

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on my activity with and for the Trust since the previous Board meeting on 4 September 2018. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

1. I have made a point of visiting as many front line services as possible, so that my leadership is grounded on the reality of what our staff face every day, and also to ensure that I have a good understanding of the services provided by the Trust.

2. On 28 August I visited the Bolsover neighbourhood team, spending the afternoon at the Old Vicarage with Kate Heardman. I was warmly welcomed by all, and given a walk around the building, which seemed to be well kept and colourful. I was, however, also able to witness some of the frustrations that staff encounter with the IT systems, both in terms of access and speed. I have raised these issues with the relevant executives as I wonder if there is a wider issue with the systems which needs to be reviewed.

3. On 11 September I hosted a visit with Helen Phillips, Chair of Chesterfield Royal to the Hartington Unit. Feedback from Helen was*: I so enjoyed our visit to the Hartington unit yesterday. The team was so inspiring. Each and every one of them in their own way putting clients first. The quality of the care provided was evident and the compassion with which it's delivered palpable. Thank you so much for inviting me and please pass on my thanks to Jo, Laura, Andrea, Claire and Teresa too.* It was a pleasure to see the Unit so positive about their services and noting their staffing is almost fully resourced, with evidence of students wishing to return to the Unit after their placements. The service user focus was clear with all the staff that we talked to, and in particular shone through the work that the recreation team does in the unit as part of the multi-disciplinary team.

4. On 12 September I visited Steve Jones and the Pharmacy team in the Ashbourne Centre. I joined their team meeting, and then had a chance to see around their work space. In the team meeting I saw the presentation of Team Briefing, and also noted that there are still some issues with staff receiving emails encouraging them to take part in the pulse survey. I was particularly pleased to spend some time with Marie, talking about the new role that she has taken on in the Dementia Rapid Response Team (DRRT) and how she is making a difference to patients and other team members. This is a good example of service development. However I was disappointed to hear that DCHS (Derbyshire Community Health Services Foundation Trust) have stopped use of their locations to deliver medication to patients in the community, which I believe may cause difficulties for patients and raise risks around medication being taken. This does not seem to align with the vision of JUCD (Joined Up Care Derbyshire).

5. My next report will include details of the quality visits I will be attending in the week commencing 24 September, as well as a visit to the Ronnie MacKeith Children's Hospital on 27 September.

Council of Governors

6. On 4 September the Council of Governors met following the public Board meeting in the morning. It was good to see so many governors attend the Board meeting, and feedback in the afternoon confirmed that governors find it useful to observe the Board meeting and see the NED (Non-Executive Director) challenge that takes place. We also welcomed a new staff governor to his first Council meeting following elections.

7. On 20 September we held the Annual Members Meeting at the post Mill in South Normanton. This meeting was well attended by governors and some members of the public and staff. Whilst it would have been good to have a higher attendance, we were asked some good questions, and it was right to celebrate the progress made over the last year. It was particularly good to have Toby Perkins MP attend this meeting and engage with the Trust and its activities and challenges.

8. The next meeting of the Council of Governors will be on 6 November following the public Board meeting. A joint Council of Governors and Board meeting is scheduled for 17 October. The next Governance Committee also takes place on 17 October.

Board of Directors

9. On 7 September, I attended the Mental Health Act Committee, which is chaired by Anne Wright. Following the meeting we met with six of the Associate Hospital Managers and discussed how we will take forward their working relationship with the Trust and the Board.

10. On 19 September Board Development focussed on the response to the CQC inspection draft reports and consideration of next steps.

11. On the afternoon 19 September, the Committee Chairs meeting took place with a focus on sharing cross committee experience and actions, as well as focus on report writing standards and the role that Committee Chairs can contribute to the overall quality of our papers. This meeting was followed by an informal NED meeting reviewing the proposals for NED visits to teams and other matters of common interest.

12. Contact with Avtar Johal, our NeXT director, has been light since the last Board meeting. The initial placement period of six months will be coming to an end at the end of September, and I will be working with NHS Improvement (NHSI) to report back on the experience that we have had and to provide feedback to Avtar himself. I will be considering with NHSI whether there is another candidate ready for a placement that meets our criteria of extending support to those from a BAME (Black Asian and Minority Ethnic group) background who wish to gain experience as a NED.

13. I continue to meet with NEDs on a one to one basis quarterly. I met with Geoff Lewins and Julia Tabreham. NED appraisals for Julia Tabreham, Margaret Gildea and myself are in progress over the course of the next month, including the gathering of 360 feedback.

System Collaboration

14. The JUCD Board meeting took place on 21 September, and was attended on my behalf by Julia Tabreham. More detail will be included in the CEO report to this Board.

Regulators: NHS Providers and NHS Confederation and others

15. On 30 August, we had our quarterly meeting with Fran Steele of NHS Improvement. Areas covered included early feedback on our CQC inspection, highlighting the acute pressures nationally and the impact on decisions around 12 hour breaches in A&E. It also included a discussion around Freedom to Speak Up and we outlined our view of how this is working within our Trust.

16. On 5 September I welcomed Sean Duggan, CEO of the NHS Confederation Mental Health Network, to the Trust. He had expressed an interest in the research and development work that we undertake, as well as visiting the Kedleston Unit and our in-patient wards. It was useful to be able to share with him the challenges that our services are facing and the national pressures which impact upon our bed management.

17. We continue to work with the CQC on the finalisation of their report on their inspection of the Trust. We anticipate the final publication shortly.

Beyond our Boundaries

18. There is no activity to report on this month.

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

- The Board can take assurance that the Trust level of engagement and Influence is high in the health and social care economy.
- Feedback from staff and other stakeholders is being reported into the Board.

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

None

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).

There are no adverse effects on people with protected characteristics (REGARDS).	x
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	

Actions to Mitigate/Minimise Identified Risks

This report reflects a wide range of activities across the Trust, and consideration relating to ensuring inclusion is embedded in operational work of the Trust. The specific services visited provide support to those with protected characteristics by the nature of their work – such as our adult community services, pharmacy support and acute in patient services.

With respect to our work with Governors - we work actively to encourage a wide range of nominees to our governor elections, and strive that our Council of Governors is representative of the communities they serve. We also provide support to any current or prospective governors to enable them to carry out their role to address any specific needs they may have. This includes providing transport for those who may not be able to access public transport due to physical needs, accommodating communication requirements and providing support workers at meetings.

Demonstrating inclusive leadership at Board level

Through the Trust's involvement in the NeXT Director scheme, hosting a placement for Avtar Johal, we are supporting the development of those who may find it more difficult to be appointed as a NED in the NHS. This placement will run to the end of September, when we will review the effectiveness of our support for Avtar and the scheme before deciding on our next steps.

Recommendations

The Board of Directors is requested to consider the content of this report, and to ask for any clarification or further information.

Report prepared and presented by: **Caroline Maley**
Trust Chair

Chief Executive's Report to the Public Board of Directors

Purpose of Report:

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

National Context

1. NHS Resolution has released a report titled: *Learning from suicide-related claims: a thematic review of NHS Resolution data.* The report, launched to coincide with World Suicide Prevention Day on 10 September 2018, examines some of the factors that contribute to suicide claims and the quality of investigations following these tragic incidents.101 deaths occurring between 2010 and 2017 were examined in detail by NHS Resolution.

   Part one identifies recurring clinical themes and areas for improvement. Five areas where there were common issues in clinical care are discussed in some detail:

   - Substance misuse
   - Communication, particularly failures in intra-agency working
   - Risk assessment
   - Observations
   - Prison healthcare

   Part two identifies four main areas of concern:

   - There was a lack of family involvement and staff support through the investigation and inquest process
   - The quality of root cause analysis undertaken as part of the Serious Incident (SI) Investigation was generally poor and did not focus on systemic issues
   - Due to the poor SI report quality, the recommendations arising from SI Investigations were unlikely to reduce the incidence of future harm
   - Reports to prevent future deaths (PFDs) were issued to trusts by the coroner with little consistency and there were poor mechanisms to ensure that changes in response to the PFDs had been made or addressed the issues highlighted

   There are nine recommendations including two recommendations explicitly for Trust Boards – highlighted in italics:

   - A referral to specialist substance misuse services should be considered for all individuals presenting to either mental health or acute services with an active diagnosis of substance misuse. If referral is decided against, reasons for this should be documented clearly.

- There needs to be a systemic and systematic approach to communication, which ensures that important information regarding an individual is shared with appropriate parties, in order to best support that individual. *Trust boards should consider how communication is best enabled within their existing systems and prepare to adapt to new models of care, which should include working models to facilitate communication across services.*

- Risk assessment should not occur in isolation – it should always occur as part of a wider needs assessment of individual wellbeing. Risk assessment training should enable high quality clinical assessments, which include input from the individual being assessed, the wider multi-disciplinary team and any involved families or carers. While acknowledging that risk can be considered as 'high', trusts should move away from stratifying risk assessments into crude 'cut offs' of risk, and encourage more descriptive formulations of risk. In order to ensure that professionals are performing to a high level, this training should be repeated every three years and risk assessment should be reviewed regularly during clinical supervision.

- The head of nursing in every mental health trust should ensure that all staff including:

    i. mental health nursing staff (including bank staff and student nurses who may be attached to the ward);
    ii. Health care assistants who may be required to complete observations; and
    iii. medical staff who may 'prescribe' observation levels undergo specific training in therapeutic observation when they are inducted into a trust or changing wards.

- NHS Resolution should continue to support both local and national strategies for learning from deaths in custody.

- The Department of Health and Social Care should discuss work with the Healthcare Safety Investigation Branch (HSIB), NHS Improvement, Health Education England and others to consider creating a standardised and accredited training programme for all staff conducting SI investigations.

- Commissioners should not 'close' any SI investigations unless the family or carers have been actively involved throughout the investigation process.

- *Trust boards should ensure that those involved in arranging inquests for staff have an awareness of the impact inquests and investigations can have on individuals and teams. Every trust should provide written information to staff at the outset of an investigation following a death, including information about the inquest process. In addition we recommend that the following mechanisms to support staff are considered:*

    - *The SI investigator should keep staff members up to date with the SI process, and the trust legal team should inform them of whether they will be called to coroner's court as soon as this information is known.*
    - *There should be formal follow-up points to 'check in' with staff that have been involved in an SI. For example, there could be a follow-up meeting*

with managers three months, six months, and one year after the SI to ensure staff are supported both throughout the process and when it has finished.

- *Introduce a system for monitoring and alerting managers when staff have been involved in more than one SI in close succession in order to highlight the potential need for additional pastoral support.*

- NHS Resolution supports the stated wish of the Chief Coroner to address the inconsistencies of the PFD process nationally

Given the specific expectation of trust boards identified in the report I recommend that the Trust Board asks the Quality Committee to review our plans for compliance with the required actions reporting their assurance back to the Board.

2. The CQC has published a new report reviewing sexual safety on acute mental health wards. The report makes difficult reading given the topics reviewed but it is vital our Board understands the implications for both our strategy and tactical delivery of services. Main findings include:

- The CQC found sexual safety presents a major challenge in mental health services and that service users do not always feel protected.

- The findings reinforce risk factors noted in previous outcomes from CQC inspections such as high ward occupancy, increasing acuity of service users, old and unsuitable buildings, staff shortages and poor staff training.

- Incidents were classified by trusts as 'low' or 'no' harm in 95% of cases which the CQC considers to be a serious underestimation of harm. Staff were noted as victims in about 33% of cases reported.

- Co-produced guidelines adopted nationally are required

- Trusts should appoint a member of their board to oversee work towards creating a culture on mental health wards that promotes sexual wellbeing, encourages disclosure and supports those effected by incidents.

- While the impetus for the review has concerns associated with mixed sex wards the CQC's analysis shows incidents happened in all types of provision. The CQC does not recommend the abolition of mixed sex wards as a solution to improve sexual safety.

This last finding is of specific note to our Trust due to our predominant dormitory provision and partial mixed sex ward stock. I have therefore included below direct copies of this section from the report (ref. p17 and 18. shown in italics)

Those we consulted with agreed that dormitory accommodation, or other arrangements where bedrooms are shared (by patients of the same sex), are unacceptable and do not offer privacy or dignity.

Significant investment would be needed to change all inpatient provision to single-sex wards and remove all shared rooms. It might also reduce flexibility of overall bed provision, meaning that more people would be admitted to wards a long way from their home areas which can also lead to increased clinical risk. Also, those we consulted

with told us that it is harder to recruit staff to work on single-sex wards.

The diversity on a mental health ward reflects the diversity of the country. It is important that the ward environment meets the needs of everyone – and does not make predetermined gender-based assumptions. This may be particularly important for those people who identify as LGBT+

Healthcare professionals and representatives of arms-length bodies that we consulted with agreed that CQC should not simply recommend that all mental health wards become single-sex. As well as the cost and potential impact on out-of-area placements, this would not affect the significant proportion of incidents that involve people of the same gender or a staff member as the person who was affected by the unwanted behaviour.

However, we believe that where a patient has a history of sexual abuse or exploitation a clear care plan must be put in place and, where it is in the person's interests and/or they express a preference, they should be cared for in a single-sex ward. For wards that admit both men and women, the arrangements to keep the sleeping and bathroom areas apart must work in practice and communal areas should be closely supervised.

This report needs urgent consideration as part of our future strategy around our urgent care pathway, demand for beds and estate considerations.

Local Context

3. World Suicide Prevention Day (WSPD)

Between 8 and 18 September many of our staff volunteered their time on weekends and evenings to support WSPD and our efforts to prevent suicides in Derbyshire. Staff attended five football, matches across the county talking to fans about their experiences of suicide, with signposting for support available for those who needed or requested it. Deaths by suicide are now down in Derbyshire, each year over three consecutive years and have almost halved since 2014. Events like WSPD which we have been running since 2014 have played a part. The theme this year was 'working together to prevent suicide' very apt given the great multiagency working that we have seen develop in Derbyshire over the last few years to take a unified approach to this strategy.

4. The Joined up Care Derbyshire (JUCD) Board met on 21 September. Key issues discussed included:

- Risks associated with winter pressures, particularly in the acutes: Work continues urgently on the capacity plans to mitigate the escalating demand that is expected (and is to some extent already being experienced.)

- Several pieces of work will be coherently aligned to help inform the future structure and planning in the system

    - Systems Opportunity Programme is a STP development opportunity for its trajectory to move to ICS, working with NHSI/E
    - Strategic review of Acute and MH hospital capacity building on Newton Europe

- High volume service users analysis – will map resource consumption help all four health providers

- Financial pressures which are increasing

- The enormous importance of prevention and the need to address the inequalities related to deprivation and the longer term impact that will have on health and social care if it is not addressed. The population is living longer but with more years of ill health. For example for diabetes associated death rates have fallen by 56% but illness and disability associated with diabetes has increased by 75%. To address the prevention agenda adequately will need holistic approach and this will be incorporated into the future structure and mapping planning

5. Emma Frudd our LGBT+ network chair, members of the LGBT+ Network, other colleagues and membership team, along with Board LGBT+ champion Claire Wright attended Derbyshire Pride on 8 September in Derby City centre. It was a vibrant and thoroughly positive event that was enjoyed by all despite some inclement weather. The Trust is proud to showcase our successes to date and our further ambitions in our LGBT+ commitments and the event was a great opportunity to raise awareness of our services, build relationships and connect with our LGBT+ community, in addition it proved to be a great opportunity to showcase our employment opportunities which we will build on much further at future Pride events.

Within our Trust

6. On Monday 17 September, I and a selection of Executives along with our Reverse Mentors attended a Multi-Faith Tour in Derby (arranged by the Open Centre). This was an incredible learning experience and we visited a Hindu Temple, a Mosque, Baptist Church and Sikh Gurdwara. At each place of worship we were able to spend time with a local faith expert which helped us understanding more about the process of worship but also the local communities and sparked discussion about access to and representation in our services. I would strongly recommend Board members who have not already done so book onto the tour.

7. Our staff Forum on 12 September focussed on recruitment and staff safety both building related and lone working related. It is good to report that this forum has developed into a much more effective meeting with improved representation from teams and a shared ownership of solutions. Work is underway jointly to create an infographic showing the impact the discussions and action planning in the forum has had over the last year.

8. At the Trust's Team Derbyshire Healthcare Leaders event on 14 September we welcomed Peter Homa to talk to our leaders. Peter recently retired from being Chief Executive of Nottingham University Hospitals NHS Trust after eleven years in post. Following retirement, Peter was appointed foundation Chair, NHS Leadership Academy. It was really powerful for our core leaders to interact with Peter and hear his journey to a system and national leader and certainly many of the challenges he described overcoming struck a chord with leaders in our Trust. It is important and beneficial as part of our management and leadership strategy that we engage nationally recognised leaders to externally validate the approaches we are taking in our organisation through sharing their stories. This forms a key part of the tenant of continuous leadership development within our strategy.

9. 20 September was a landmark day for the Trust as we held our first ever staff Conference. The focus for the day was all about 'The Power of the Team'. To help inspire and influence colleagues we had two remarkable, influential women present to the Conference, take questions and interact with colleagues during exercises. Natalia Cohen spoke about her experience as part of the first female rowing crew to cross the Pacific and Linda Moir spoke of her experience leading customer services for Virgin Atlantic and heading up the programme for volunteers at the London Olympic Games. As well as exercises focussed on understanding how colleagues can influence the development of their teams both internally and with stakeholders we started the conversation of an 'agreement' or 'charter' between all of us employees and the organisation. (As an employee I can expect…… and as an employee I will ……..) This generated great discussion with the most favourable name so far for this agreement being the *Team Derbyshire Healthcare Promise*

10. We also held our Annual Members Meeting at the Post Mill Centre, South Normanton on 20 September. This statutory event was attended by Board Members, Governors, Trust members and a few members of the public including the MP for Chesterfield Toby Perkins. Presentations covered the achievements of the last year, the quality account, financial report and a look forward at the coming year. Importantly there were plenty of questions from attendees for Board members with themes around access to services, Trust influence nationally, transition from CAMHS (Child and Adolescent Mental Health Services) to Adult services, psychotherapy services, patient engagement and substance misuse.

11. Ward and team visits since the last Board have picked up again after the summer. I have held *Ifti on the Road* engagement events at Ripley Resource Centre and St Paul's House. I also visited our Liaison Service and the Beeches perinatal services talking to leaders there about team development opportunities.

    Key themes that emerged from these sessions included:

    - Fragmented parts of the pathway not closely aligned to Neighbourhoods.
    - Some great feedback about local leadership and the compassionate and supportive approach adopted.
    - Helpful conversation that links to our leadership and management strategy

around autonomy of local leaders to act and a sense that there is a requirement to escalate to many decisions.

- Some issues raised about pressure on admin staff and opportunities to adjust working hours.
- Some good feedback from a Band 5 OT(Occupational Therapist) about work she was doing to set up a Trist wide peer support group for B5 OTs
- I had the privilege of meeting colleagues from our Healthy Schools Team and understanding more about their roles and achievements – as well as watching a video they created to support access.
- Heard about some of the challenges and good points of open plan working.

In addition Gareth Harry visited the Hartington Unit on 24 August. He was really impressed by the work undertaken and planned to update the physical environment of the unit. The OT team outlined the Boxercise work they have been doing with patients. He was frankly blown away by the quality of the ceramic art produced by patients on the unit, especially the new frieze that is being installed. There was discussion about some of the staffing challenges as it was the Friday of the Bank Holiday but he was impressed by the ward managers' planning processes and control of the situation. The calm and therapeutic environment.

Feedback from each visit has been logged on our engagement spreadsheet, actions allocated and shared with our freedom to speak up guardian.

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

- 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 and members of the public is being reported into the Board

Consultation

- The report has not been to any other group or committee though content has been discussed in various Executive meetings

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

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).

There are no adverse effects on people with protected characteristics (REGARDS).	
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	x

Actions to Mitigate/Minimise Identified Risks

This document is a mixture of a strategic scan of key policy changes nationally and locally that could have an impact on our Trust and the reporting of internal actions and feedback I have received relating to the strategy delivery.

Any implementation of national policy in our Trust would include a repeat Equality Impact Assessment even though this will have been completed nationally.

That said some of the reports both nationally and within the Derbyshire system have the potential to have an adverse impact on people with protected characteristics for example as identified in the report any work looking at how are wards are constituted could have an adverse effect on people identifying themselves as trans gender.

I have referenced several examples of good practice where senior leaders are taking active steps to understand more about local communities. Attendance on the multi-faith trail and attendance at Derby Pride as two examples.

Any equality impact assessment carried out will determine a response to the three aims of the general equality duty:

- identifying barriers and removing them before they create a problem,
- increasing the opportunities for positive outcomes for all groups, and
- using and making opportunities to bring different communities and groups together in positive ways.

Recommendations

The Board of Directors is requested to:

1) Scrutinise the report, noting the risks and actions being taken
2) Seek further assurance around any key issues raised.

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 October 2018

Integrated Performance Report Month 5

Purpose of Report

This paper provides Trust Board with an integrated overview of performance at the end of August 2018. The focus of the report is on workforce, finance, operational delivery and quality performance.

Executive Summary

The Trust continues to perform well against many of its key indicators, with maintenance or improvements continuing across many of the Trust's services. These can be seen within the body of this report.

There are a number of areas where performance is below Trust standards or trends are showing an overall change in performance. In order to ensure that there is a focused discussion on key issues these have been listed below.

1. Regulatory Compliance dashboard

    - Agency Spend
    - Sickness absence
    - Appraisals
    - Mandatory Training
    - Out of Area placements

2. Strategy Performance dashboard

    - Cost Improvement Plan
    - Agency Spend
    - CPA review in last 12 months
    - Delayed Transfers of Care (DTOC)
    - Neighbourhood waiting times
    - Number of patients with a Length of Stay (LOS) greater than 50 days

At the end of the report further information is provided regarding some aspects of data quality assurance.

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 relates directly to the delivery of the Trust's strategy by summarising performance across the four key performance measurement areas.

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

As an integrated performance report the content 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; some content supporting the overview presented is regularly provided to, Finance and Performance Committee, People and Culture Committee and Quality Committee.

Governance or Legal Issues

Information supplied in this paper is consistent with the Trust's responsibility to deliver all parts of the Single Oversight Framework and the provision of regulatory compliance returns.

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation).

There are no adverse effects on people with protected characteristics (REGARDS).	
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	X

Actions to Mitigate/Minimise Identified Risks

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.

Recommendations

The Board of Directors is requested to;

1. Confirm the level of assurance obtained on current performance across the areas presented.
2. Determine whether further assurance is required, at which Committee this needs to be provided and by whom.

Report presented by:	**Mark Powell, Chief Operating Officer**
	Claire Wright, Director of Finance/Deputy CEO
	Amanda Rawlings, Director of People and Organisational Effectiveness
	Carolyn Green, Director of Nursing and Patient Experience
Report prepared by:	**Peter Charlton, General Manager, IM&T**
	Rachel Leyland, Deputy Director of Finance
	Liam Carrier, Workforce Systems & Information Manager
	Rachel Kempster, Risk and Assurance Manager
	Peter Henson, Performance Manager

Integrated Performance Report Month 5

1. Regulatory Dashboard

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	DQ
Finance	Finance Score	Finance Scorecard	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Capital Service Cover	YTD	2	2	G	→		
			Forecast	2	2	G	→		
		Liquidity	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Income and Expenditure Margin	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Income and Expenditure variance to plan	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Agency variance to ceiling	YTD	1	1	G	→		
			Forecast	1	2	R	→		
	Single Oversight Framework	Agency costs as % of total pay costs	YTD	2.9%	3.0%	R	→		
			Forecast	2.9%	3.1%	R	→		
		NHS I Segment	YTD		2		→		
Quality and Operations	KPIs	CPA 7 Day Follow-up (M)	Aug, 2018	95.00%	100.00%	G	↑		
			Jul, 2018		92.98%	R			
		Data Quality Maturity Index (DQMI) - MHSDS Data Score (Q)	Aug, 2018	95.00%	96.45%	G	→		
			Jul, 2018		96.48%	G			
		IAPT RTT within 18 weeks (Q)	Aug, 2018	95.00%	100.00%	G	→		
			Jul, 2018		99.86%	G			
		IAPT RTT within 6 weeks (Q)	Aug, 2018	75.00%	97.68%	G	↑		
			Jul, 2018		95.93%	G			
		Early Intervention in Psychosis RTT Within 14 Days - Complete (Q)	Aug, 2018	53.00%	79.31%	G	↓		
			Jul, 2018		84.00%	G			
		Early Intervention in Psychosis RTT Within 14 Days - Incomplete (Q)	Aug, 2018	53.00%	77.78%	G	↓		
			Jul, 2018		100.00%	G			
		Patients Open to Trust In Employment (M)	Aug, 2018		10.18%	G	→		
			Jul, 2018		10.30%	G			
		Patients Open to Trust In Settled Accommodation (M)	Aug, 2018		58.04%	G	→		
			Jul, 2018		58.83%	G			
		Under 16 Admissions To Adult Inpatient Facilities (M)	Aug, 2018	0	0	G	→		
			Jul, 2018		0	G			
		IAPT People Completing Treatment Who Move To Recovery (Q)	Aug, 2018	50.00%	52.74%	G	↓		
			Jul, 2018		58.81%	G			
		Physical Health - Cardio-Metabolic - Inpatient (Q)							
		Physical Health - Cardio-Metabolic - EI (Q)							
		Physical Health - Cardio-Metabolic - on CPA (Community) (Q)							
		Out of Area - Number of Patients Non PICU (M)	Aug, 2018		22		↑		
			Jul, 2018		13				
		Out of Area - Number of Patients PICU (M)	Aug, 2018		14		↑		
			Jul, 2018		13				
		Out of Area - Average Per Day Non PICU (M)	Aug, 2018	6.5	15.4	R	↑		
			Jul, 2018	7.9	6.2	G			
		Out of Area - Average Per Day PICU (M)	Aug, 2018	23.7	8.1	G	↑		
			Jul, 2018	23.7	7.9	G			
		Written complaints – rate (Q)	Q1 2018/19		0.02		↓		
			Q4 2017/18		0.03				
		Staff Friends and Family Test % recommended – care (Q)	Q4 2017/18		73%		→		
			Q2 2017/18		73%				
		Occurrence of any Never Event (M)	Aug, 2018	0	0	G	→		
			Jul, 2018		0	G			
		Patient Safety Alerts not completed by deadline (M)	Aug, 2018		2		↑		
			Jul, 2018		0				
		CQC community mental health survey (A)	2017		7.3/10		↑		
			2016		7.0/10				
		Mental health scores from Friends and Family Test – % positive (M)							
		Potential under-reporting of patient safety incidents (M)							
Workforce and Engagement	KPIs	Turnover (annual)	Aug, 2018	10.00%	10.25%	G	→		
			Jul, 2018		10.29%	G			
		Sickness Absence (monthly)	Aug, 2018	5.04%	6.35%	R	→		
			Jul, 2018		6.48%	R			
		Sickness Absence (annual)	Aug, 2018	5.04%	5.48%	R	→		
			Jul, 2018		5.43%	R			
		Vacancies (funded fte)	Aug, 2018		11.81%		→		
			Jul, 2018		11.74%				
		Appraisals All Staff (number of employees who have received an appraisal in the previous 12 months)	Aug, 2018	90.00%	77.54%	R	↓		
			Jul, 2018		79.45%	R			
		Medical Appraisals (number of medical employees who have received an appraisal in the previous 12 months)	Aug, 2018	90.00%	96.00%	G	→		
			Jul, 2018		97.00%	G			
		Compulsory Training (staff in-date)	Aug, 2018	90.00%	82.97%	A	→		
			Jul, 2018		82.60%	A			
		NHS Staff Survey (A)	Work		60.92%				
			Treatment		72.77%				

Key:
Period Current Month / Previous Month

Achieving target
Not achieving target
Within tolerance
No Target Set

Target

↑ → ↓ Trend compared to previous month/quarter with tolerance of 1%

1.1 Finance Position

The overall score of a '1' is in line with plan year to date and forecast outturn.

All metrics are forecast to achieve their planned outturn with the exception of agency variance to ceiling - this is forecast at '2' which is worse than the plan of '1'.

1.2 Agency cost as percentage of total pay

Comparing the actual expenditure on Agency to the ceiling, we are below the ceiling value by £15k (1%) at the end of August. This generates '1' on this metric within the finance score. Agency expenditure is forecast to be above the ceiling by 6.5% which is generating a score of '2' which is worse than the plan. Agency expenditure is forecast to be above the ceiling by £198k. (This includes contingency costs estimated at £350k.)

The plan of 2.9% reflects the ceiling of £3.030m as a percentage of the total pay budget. The agency expenditure is forecast to be higher than plan but the total pay expenditure is forecast to be less than the plan.

The forecast agency expenditure equates to 3.1% of the pay budgets (3.2% last month). National NHSI benchmarking information from 2017/18 showed agency expenditure at 4.5% of pay budgets with Midlands and East region at 5.2%.

1.3 Sickness Absence

The monthly sickness absence rate in August 2018 is 0.13% lower than the previous month and 0.51% higher when compared to the same period last year (August 2017).

The latest available Trust annual sickness absence rate is running at 5.48% which is 0.03% higher than in August 2017. Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounted for 36.06% of all sickness absence during August 2018, followed by Surgery at 11.06% and other musculoskeletal problems at 9.37 %. Compared to the previous month long term sickness absence has increased by 0.15% and short term sickness absence has reduced by 0.28%.

Sickness absence Return to Work Interview compliance continues to remain high running at 82%.

The following list highlights Wards and Teams in the Trust with the highest levels of sickness absence in the past three months (June 2018 to August 2018). These teams are most in need of support and attention for sickness absence. To fall into the focus list a Ward/Team must have at least 10 employees.

Rank	Previous Rank	Ward/Team	HC	Absence %	Short term	Long term	Days lost	Absence spells
1	1	**RDH Ward 36 Adult Acute Inpatient 'IP'**	27	29.34%	**3.59%**	**25.75%**	486	14
2	5	City & County South CRHT	34	16.04%	**3.70%**	**12.34%**	301	16
3	4	Hope & Resilience Hub	22	14.77%	**3.80%**	**10.97%**	190.5	14
4	2	**Enhanced Care Ward 'IP'**	32	14.16%	**6.87%**	**7.29%**	256	29
5	9	**Cherry Tree Close Residential Rehab 'IP'**	22	14.14%	**4.81%**	**9.33%**	180.75	11
6	8	**RDH Ward 35 Adult Acute Inpatient 'IP'**	28	12.83%	**8.14%**	**4.70%**	218.25	28
7	6	Derby City Drug Team	17	12.22%	2.51%	**9.71%**	125	4
8	3	**Hartington Unit Tansley Ward Adult 'IP'**	25	11.36%	**2.57%**	**8.79%**	151	12
9	8	**RDH Ward 33 Adult Acute Inpatient 'IP'**	24	10.92%	2.59%	**8.33%**	162.75	14
10	12	Catering MH	21	10.58%	0.96%	**9.62%**	159	6
11	29	Sth DD Neighbourhood - Adult	26	9.27%	**3.03%**	**6.24%**	135	15
12	18	CfldCentral Neighbourhood - Adult	29	9.18%	1.81%	**7.36%**	154.25	16

1.4 Appraisals

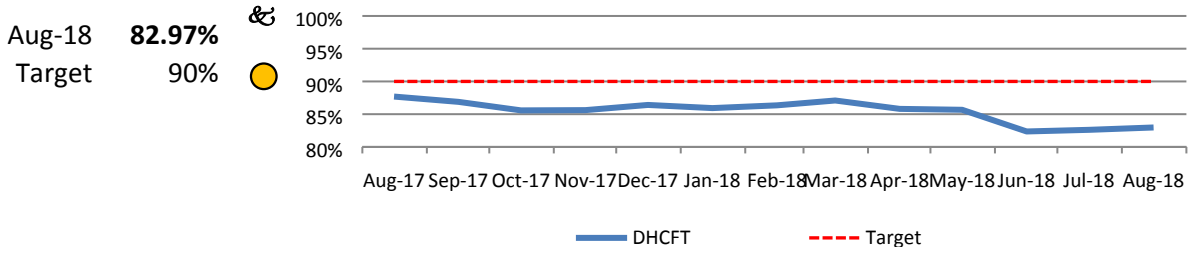
The number of employees who have received an appraisal within the last 12 months has decreased this month by 1.91% to 77.54%. Compared to the same period last year, compliance rates are 4.51% higher.

According to the latest staff survey results, the national average for combined Mental Health/Learning Disability & Community Trusts is 92% (Derbyshire Healthcare NHS FT scored 89% on this staff survey finding).

Local benchmarking data for Trusts in Derbyshire, Leicestershire, Lincolnshire, Nottinghamshire and Northamptonshire show an average appraisal compliance rate of 84.08%. During August 2018 150 appraisals were due for renewal. Over the next month (Sep 2018) 166 appraisals (6.67%) will be due for renewal.

1.5 Training

Compulsory training compliance rates for August 2018 have increased by 0.36% to 82.97%. Four compulsory training elements are above target, four are approaching target and four are well below target.



Compulsory Training Breakdown	Compliance (%)		Number required to achieve 100%	Variation to previous month	Previous Month
C Safeguarding - Children Level 1 (once only)|	97.98%		38	-0.54%	98.52%
C Fire Safety - Level 1 (2 Yearly) All Staff|	91.92%		199	0.39%	91.53%
C Data Security Awareness (Previously IG) (Annual)|	91.11%		219	-0.30%	91.41%
C Safeguarding - Adults Level 1+2 (All Clinical) (3 yearly)|	90.82%		167	0.74%	90.08%
C Safeguarding - Adults Level 1 (Non Clinical) (3 Yearly)|	86.56%		84	1.74%	84.82%
C Promoting Safer & Therapeutic Services Clinical Staff (3 yearly)|	85.21%		268	0.79%	84.42%
C Promoting Safer & Therapeutic Services Non-Clinical Staff (3 ye:	84.46%		97	1.93%	82.53%
C Moving & Handling Level 1 (3 yearly)|	81.78%		448	-0.16%	81.94%
C Health, Safety & Welfare (3 Yearly) All Staff|	75.66%		600	-0.21%	75.87%
C Equality, Diversity and Human Rights - Level 1 (3 yearly) All Staf	72.76%		671	-1.11%	73.87%
C Fraud Awareness (3 yearly)|	67.67%		796	2.29%	65.38%
C Safeguarding - Children Level 1 (Annual)|	66.37%		189	2.07%	64.30%

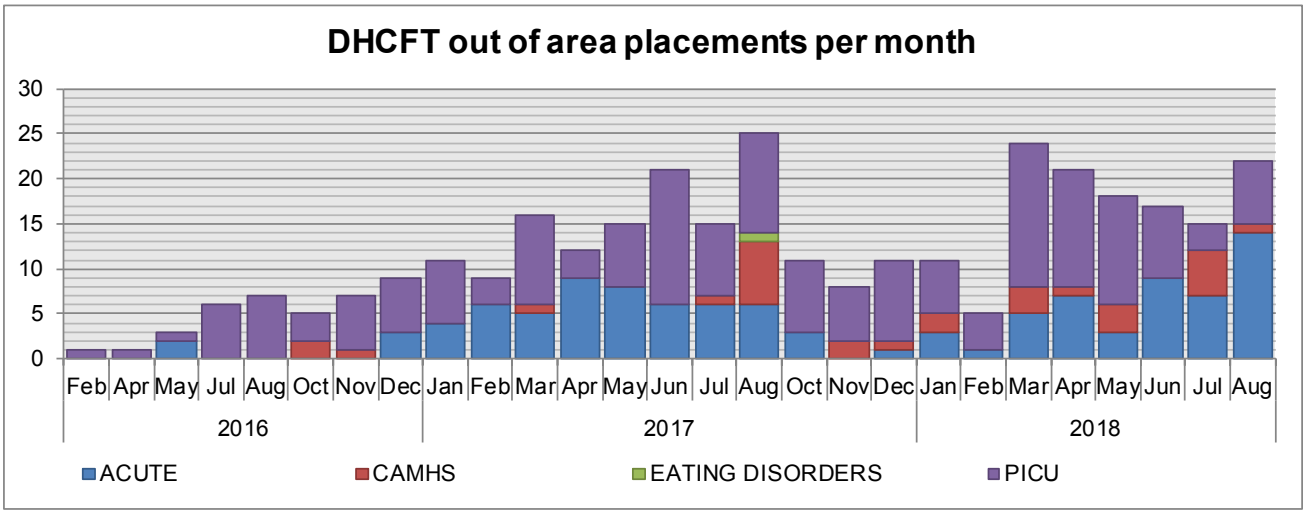
In addition, now that People Services are in place colleagues are available to work alongside operational colleagues to understand and address any barriers to completion. Moreover, supportive sessions are being conducted across the organisation to engage with staff and in particular bank staff to understand ESR and undertake eLearning.

The table below provides Board members with an overview of key actions being undertaken to lower sickness absence rates and vacancies and improve rates of training and appraisals.

KPI	What are we doing to improve performance?	What has worked and hasn't worked?	What next?
Sickness Absence	*Full analysis of FirstCare reports are ongoing to determine hot spot areas for short and long term sickness absence, highlighting those areas most in need of support and attention. Developing plans to support areas that are experiencing high sickness, whether that be short or long term. Encouraging teams to ensure that sickness and well being plans are on the agenda at operational team meetings and updated positions being provided to General Managers.*	*There is a focus on ensuring individual plans for staff absent from work are in place and Occupational Health Referrals are completed in a timely manner.*	*Engagement sessions with leaders to discuss main reasons for high sickness absence and to further explore proactive wellbeing strategies. Working to provide dedicated support to hot spot teams where there are outstanding Return to Work interviews required/outstanding. Feedback received from leaders within hot spot areas around concerns that staff are close to burnout and proactive support is required to prevent absence, request from managers to consider phased return to work in reverse in exceptional cases to allow individuals with time off to support work life balance . Divisional People Leads to support operational teams on raising the profile of People Management Policies, including Flexible Working, Chronic Illness and Special Leave in addition to supporting leaders and managers on their roles and responsibilities for effective strategies on absence management.*
Vacancies	*The vacancy percentage has increased since April 2018 due to the government investment into mental health services. We are actively recruiting by making use of our social media platform, university links and promotion of the recruitment microsite. We are completing a full review of vacancies and where the gaps are using staff flow data to inform our workforce plans so that we can better plan, understand where we need to focus and what are the risk areas, reviewing advert wording, building microsite as well as promoting international recruitment for medical. Further work is required in terms of reaching out to medical students and junior doctors for future preparation and development that will meet service needs*	*Linking in with universities - a number of students have been recruited to our Inpatient wards including Radbourne Unit and are due to commence in Sept/Oct. Medical recruitment remains a challenge but we continue to advertise all vacancies*	*Working to speed up the recruitment process from start to completion, regional work and collaboration to inform strategic planning, working closer with operational managers looking at rotational posts and different ways of working, seeking views from candidates to try and reduce non-attendance at interview*
Appraisals All Staff	Crisis staffing levels in certain clinical areas has contributed to the decrease in compliance levels last month. There is a focus on trying to support the teams with the lowest appraisal scores which has included additional clinical leadership to allow managers to leave the ward to focus on outstanding appraisals.	*Feedback continues to be that the process needs to be condensed and simplified.*	*Consultation with leaders and teams is currently under way to develop a new appraisal process which aims to simplified and more meaningful which is expected to result in an compliance. Divisional People Leads to support operational teams with strategies for achieving and monitoring the required expectations.*
Compulsory Training	*Many of the components within the compulsory training offer is undertaken by eLearning and there have been several issues with eLearning and the server on which this hosted and this has contributed to a lower than expected compliance rate. However in the last week this has now been rectified and staff should be able to successfully complete the required eLearning package. Following this it is expected there will a steady increase in compliance.*		*A work stream will be commencing to begin to review all the passports and streamline these against all roles, this has already commenced with ITM service. This will commence across all services. This will provide colleagues with a clearer expectation.*

1.6 Out of Area Placements

Work is underway to increase capacity on our acute wards and enable repatriation of patients placed out of area. This is though against a situation nationally where demand for acute mental health beds continues to grow.

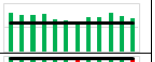
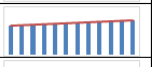
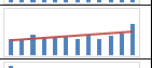
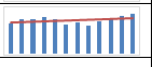


The urgent care improvement plan contains a number of key deliverables to help improve the flow of patients through our wards, these include;

- Weekly clinical meetings in place where each ward manager/ Responsible Clinician review and agree discharge plans/blockages for patients with a lengths of stay of 50+ days.

- Clinical lead reviewing patients with LOS 40 + days and working alongside multidisciplinary teams to challenge / support the proactivity of discharge plans and support escalation processes where there are blockages.

2. Strategy Delivery

Category	Metric	Period	Target	Actual	Variance	Trend	Last 12 Months
Finance Scorecard	Finance Scorecard	YTD	1	1	G	→	
		Forecast	1	1	G	→	
	Control Total position £000	YTD	681	776	G	↑	
		Forecast	2331	2331	G	↑	
	CIP achievement £m	YTD	1.957	1.751	R	↑	
		Forecast	4.871	4.871	G	→	
		Recurrent	4.871	1.979	R	↓	
	Agency £m	YTD	1.265	1.247	G	↑	
		Forecast	3.030	3.228	R	↓	
	Cash £m	YTD	22.096	27.027	G	↑	
		Forecast	21.608	21.908	G	→	
Quality and Operations Scorecard	RTT Incomplete Within 18 Weeks (%)	Aug, 2018	92%	93.8%	G	↓	
		Jul, 2018		94.8%	G		
	CPA Review in last 12 Months (on CPA > 12 Months)	Aug, 2018	95%	94.6%	R	→	
		Jul, 2018		95.5%	G		
	Delayed Transfers of Care (%)	Aug, 2018	0.8%	1.6%	R	→	
		Jul, 2018		1.9%	R		
	North Neighbourhood Average Wait (weeks)	Aug, 2018		8.3		→	
		Jul, 2018		8.3			
	North Neighbourhood Current Waits (number)	Aug, 2018		1813		↓	
		Jul, 2018		2003			
	City Neighbourhood Average Wait (weeks)	Aug, 2018		6.7		↓	
		Jul, 2018		7.1			
	City Neighbourhood Current Waits (number)	Aug, 2018		1448		↑	
		Jul, 2018		1436			
	South Neighbourhood Average Wait (weeks)	Aug, 2018		9.6		↓	
		Jul, 2018		10.8			
	South Neighbourhood Current Waits (number)	Aug, 2018		1838		↑	
		Jul, 2018		1767			
	CAMHS Average Wait (weeks)	Aug, 2018		13.4		↑	
		Jul, 2018		9.4			
	CAMHS Current Waits (number)	Aug, 2018		351		↓	
		Jul, 2018		365			
	Community Paediatrics Average Wait (weeks)	Aug, 2018		20.6		↑	
		Jul, 2018		17.3			
	Community Paediatrics Current Waits (number)	Aug, 2018		808		↓	
		Jul, 2018		816			
	Number of Adult Acute Inpatients (Hartington and Radbourne) LoS > 50 Days	Aug, 2018		84		↑	
		Jul, 2018		80			
Workforce and Engagement Scorecard	RETAIN - Staff engagement score	2017 Annual	To see an improvement in the staff engagement score	3.740	G	↑	
		2016 Annual		3.690			
		Q1 Jun 2018		72%	G	→	
		Q4 Mar 2018		72%			
	DEVELOP - Recruitment of preceptorship staff	2017/18	Number of students recruited into preceptorship	31	R	↓	
		2016/17		46			
	ATTRACT - Retention of preceptorship staff	2017 Annual	Number of students recruited into preceptorship who stay for at least one year	91%	G	→	
		2016 Annual		91%			
	LEADERSHIP & MANAGEMENT - Employee relations cases	Q1 Jun 2018	To see a reduction in the number of cases	40	G	↓	
		Q4 Mar 2018		48	R		
		Q3 Dec 2017		45	R		
		Q2 Sep 2017		37			

Key:

Period Month

Previous Month

Achieving target

Not achieving target

No Target Set

Target

Trend

↑ → ↓ Trend compared to previous month with tolerance of 1%

2.1 Control Total position

The surplus in the month of £145k was £19k above plan, so the year to date favourable variance has increased to £95k. The forecast remains to achieve the control total at the end of the financial year.

We currently anticipate that in order to do so we will need to use all 'reserves'. There remain financial pressures to manage in order to achieve the control total, in particular the costs of adult acute out of area placements.

2.2 Cost Improvement Programme (CIP)

At the end of August £4.2m of CIP has been assured in the ledger (£1.8m YTD) which leaves an unassured gap of £660k. There are several schemes still to be actioned which are being forecast to deliver. Of the forecast savings 41% is to be saved recurrently.

£m	Annual	REC	NR
Target	**4,871**		
Assured in the ledger	4,211	1,721	2,490
Schemes being forecast	660	258	402
Gap	**0**	0	0
		1,979	2,893
		41%	59%

2.3 Delayed Transfers of Care (DTOC)

A number of recent escalation meetings have taken place with senior social care leads in order to review and improve the DTOC process.

A small number of focused actions have been agreed in order to help improve performance in this area, this include, but not limited to, a revised escalation process to address response delays, alongside email alerts for Social care colleagues when a response is required.

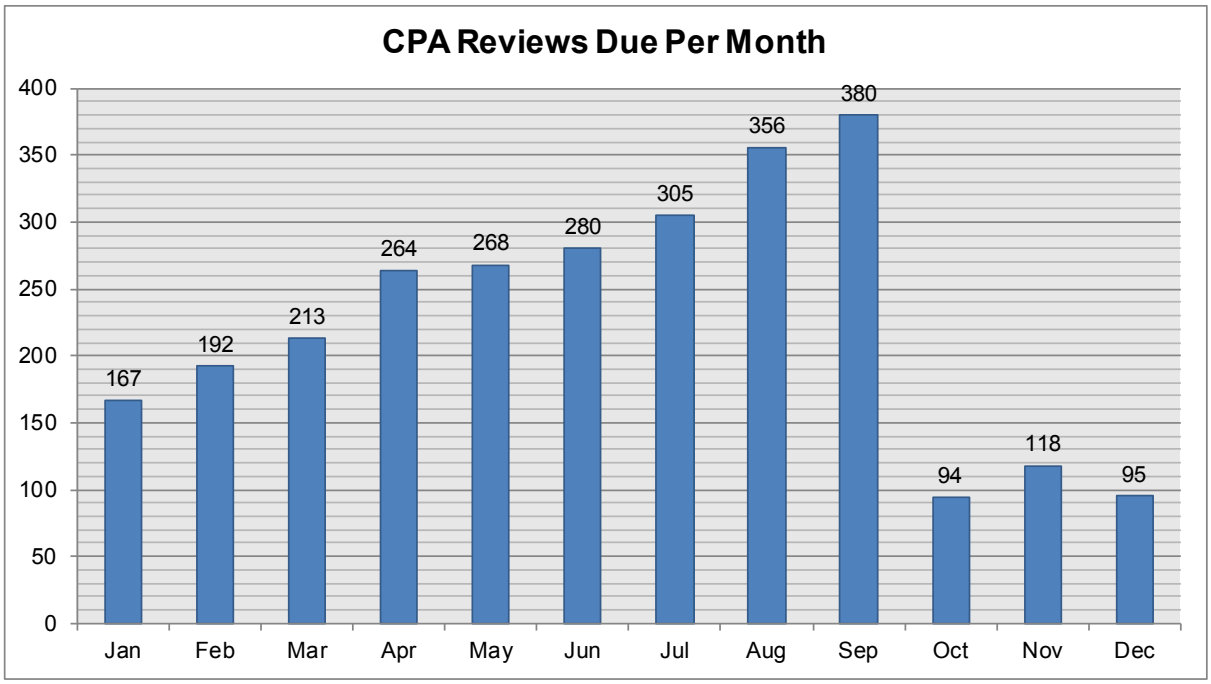
2.4 Neighbourhood Waits

The review of neighbourhood services continues to be undertaken with specific outcomes seeking to address current issues across community mental health services. The review of neighbourhood services case for change paper has been drafted. The proposals within, if accepted, will have a positive impact on capacity within community services, but also may result in some patients not receiving the service that is currently offered to them.

In addition, the Waiting list policy has been actioned, which sets out the need for colleagues to communicate effectively with referrers and those on the waiting list. This is in turn being underpinned by having a consistent approach to managing waiting lists.

2.5 Care Programme Approach (CPA) Reviews

Undertaking 12 month reviews of those patients on CPA remains a key objective. There are times where it is difficult to meet this objective. During August this standard was not achieved. One reason for this is as a result of a concerted effort a few years ago to improve compliance with this standard around this time of year. The effect of this is shown in the graph below where more reviews are required during July-September. The impact of this is being reviewed by operational teams to establish whether there is a safe way to smooth this out over the next 12 months.



2.6 Number of patients with a length of stay greater than 50 days

The urgent care improvement plan contains a number of key deliverables to help improve the flow of patients through our wards, these include;

- Weekly clinical meetings in place where each ward manager/ Responsible Clinician review and agree discharge plans/blockages for patients with a lengths of stay of 50+ days.

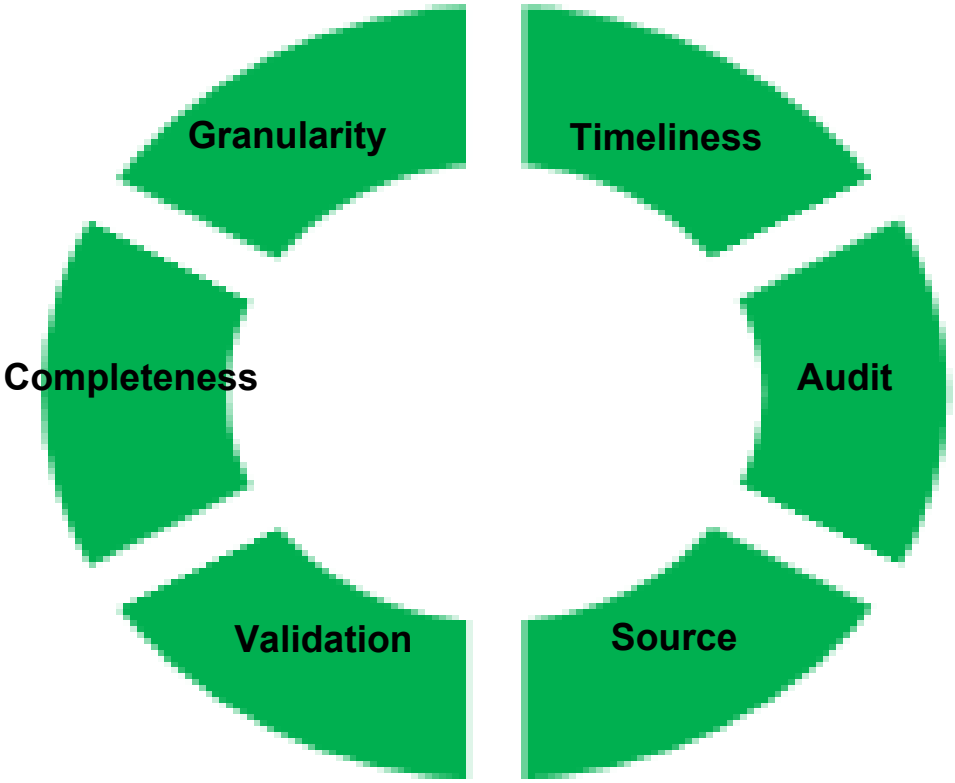
- Clinical lead reviewing patients with LOS 40 + days and working alongside multidisciplinary teams to challenge / support the proactivity of discharge plans and support escalation processes where there are blockages.

Data Quality Kitemark

Background

A number of Trusts prepare data quality kitemarks to support members' review and assessment of performance indicator information reported in integrated performance reports (IPRs). Alternative methods include a simpler data quality scoring in a range, such as 1-5 which are more reliant on judgement. The kitemark is used to assess the system against six domains: timeliness; audit; source; validation; completeness; and granularity to provide assurance on the underlying data quality.

Approach



The Trust has adopted this Data Quality Kitemark. The assessment of each domain will be based on the following criteria;

Data Quality Indicator	Definition	Not yet assessed	Sufficient	Insufficient
Timeliness	Is the data the most up to date and validated available from the system?	Not yet assessed	The data is the most up to date available.	Data is not available for the current month due to the time taken to extract/prepare from the system.
Audit	Has the system or processes used to collect the data been subject to audit (Internal Audit/ External Audit / self-audit) in the last 12 months?	Not yet assessed	The system and processes involved in the collection, extraction and analysis of the data have been audited and presented to the oversight committee.	No formal audit has taken place in the last 12 months. Exceptions have been identified and corrective action has not yet been implemented.

Data Quality Indicator	Definition	Not yet assessed	Sufficient	Insufficient
Validation	Prior to publication, is the data subject to validation, eg spot checks, random sample checks, involvement of a clinician, the associated service or approval by Executive Director?	Not yet assessed	The data is validated against a secondary source. The indicator owner can assure the data is a true reflection of performance, supported by a sign off process and underlying information.	No validation has taken place. The information owner cannot assure that the data truly reflects performance. A random sample may reveal errors.
Source	Is the source of the data fully documented and understood?	Not yet assessed	All users understand how to extract the data in line with the indicator definition. The data source is well documented in the event that there is a change in personnel producing the indicator.	The data source is poorly documented and could be inconsistently extracted.
Completeness	Is the indicator a reflection of the complete performance of the Trust	Not yet assessed	All the appropriate activity has been included within the indicator	A material amount of activity has not been included within the indicator that may alter the Trust level performance.
Granularity	Can the data be disaggregated into smaller parts? Eg evaluated at a division or ward level as well as a Trust level.	Not yet assessed	Data can be drilled down to a division or ward level in order to understand and drive performance improvement.	Data is only available at a Trust level.

Each indicator on the Operational component of the NHSI Dashboard has been reviewed and rated against these dimensions. As issues are identified and addressed, the ratings will change to reflect the work undertaken.

KPI Data Quality Reviews

A review will be undertaken every six months of five to ten indicators to review their compliance with the defined indicators of quality. This will be done to complement any reviews undertaken by internal or external audit. The results will be shared with the Finance and Performance Committee together with any remedial action required.

Derbyshire Healthcare NHS Foundation Trust
Report to Trust Board – 2 October 2018

Quality Report - Safety

Purpose of Report

- To ensure that the Board is focused on safety aspects of quality and that there is transparency for the public.
- To frame this in the context of national strategy.
- To review the CQC's key line of enquiries (KLOE) regarding safety.
- To summarise assurance received to date and the issues and any risks that are arising from this.

The report on Responsiveness was received by the Board in September 2018 and the domains of Caring / Effectiveness / Well-led are to follow.

Executive Summary

Strategy

The Five Year Forward View of mental health emphasises the need to develop proactive / preventative interventions so as to decrease the negative impact on individuals and families. As regards safety there is a particular focus on physical health care especially cardiovascular risks in those with mental health problems but also the psychological needs of those with long term physical health conditions. Working together with other services/agencies is seen as key to achieving these aims. The foundations are to include the development of physical healthcare pathways and suicide prevention plans. These will be delivered by an integrated workforce. Many of the other elements of the five year forward view however could be seen as being related to safety given the significant morbidity / mortality rates associated with mental health problems; for example better life chances for those recovering from substance misuse or alcoholism are likely to improve safety.

Likewise the other CQC domains - caring, effectiveness and well-led – reflect the safety agenda. The most important of all these aspects is caring. This is because although a caring approach in itself may not be enough, it is nonetheless a prerequisite for the successful application of effective treatments and leadership. Nothing good will happen if we are not caring and staff need to see this reflected in our approach to management as well as clinical care.

NHS Improvement is in the process of refining a single oversight framework (SOF), which involves the trust making monthly or quarterly returns depending on the domain. Initial drafts have been received by the trust and have been scrutinised.

- All providers are to provide information on patient safety alerts outstanding and the occurrence of any Never Events.
- Mental health providers are to provide information on admission of under 16 year olds to adult wards, and safety incidents in terms of incidents as a ratio to estimated total person bed days. This perhaps reflects a bias towards a focus on inpatient services.

There will also be a focus on organisational health indicators particularly workforce issues, such as the number of staff recommending the Trust as a place to work and information on leavers / absenteeism / agency costs.

The Trust Strategy, which was refreshed this year, is in line with the above national approaches with an emphasis in partnership working via the Derbyshire-wide STP (Joined Up Care Derbyshire). This is a quality-enabling strategy describing how quality priorities will be translating into operational plans. The quality priorities include physical healthcare (which is a subject of a national CQUIN) and the related issue of smoking cessation. It also includes a focus on relapse prevention (including contingency plans and advanced directives) and effectiveness (including development of care pathways based on NICE guidelines). Such initiatives obviously have safety implications.

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.	

Assurances

This report concentrates on the CQC's Six Key Lines of Enquiry regarding safety, which are:

S1. Safeguarding
S2. Staffing
S3. (a) Information systems/(b) IG and records/(c) transitions/(d) care planning
S4. (a) Medicines management and (b) physical healthcare
S5. (a) Infection control/ (b) safety planning/ (c) risk assessment
S6. (a) Learning the lessons and (b) major incident planning

These KLoEs were described in the original Quality Position Statement paper received at Board. The Trust has recently been the subject of a CQC inspection (summer 2018) the results of which are embargoed. The Trust routinely has CQC inspections of its units, wards and teams. The big five "themes" that emerge from these are:

- Patient involvement in care planning
- Family care involvement in care planning
- Capacity assessments to underpin these
- Physical healthcare monitoring
- Processes around inpatient leave arrangements

The Quality Improvement Cycles have been developed to improve these areas. The essential element to a quality improvement cycle are:

1. To reorder the electronic patient record as necessary in order to produce reliable compliance reports. These then tell us what is being done or not done. Developing reliable reports is often an intricate and time consuming process but should flow automatically once established.

2. The application of audit to determine the quality of the work being done. This requires the involvement of staff usually clinicians to scrutinise individual care records. It can only therefore be done intermittently.

3. To performance manage the action plans that stem from the audits often complemented by education / training / coaching.

4. Monitoring of compliance reports and re-audit to confirm improvement.

5. Identification of overarching themes for further service development particularly if quality does not improve.

This quality improvement work needs to take place in a compassionate work environment, which encourages reflective practice, appreciate enquiry and learning from excellence so as not to undermine the morale of staff who are working at full stretch in face of a constant clamour for improvement.

Further assurance is provided through national audits, which include benchmarking information.

The “doing” process is through the operational arm of the Trust led by the Trust Management Team and linked to work plans of the COATs which are burgeoning. The Quality Committee has discussed methods of obtaining assurance from the operational arm of the Trust, which will be high level but not burdensome on the already tightly stretched operational services. The Quality Committee has oversight of safety issues reporting exceptions against the strategy and escalating to the board as necessary.

CIP and QIP plans are subject to Quality Impact Assessment with safety being seen as sacrosanct.

High level risks are reported in the Board Assurance Framework, which has been subject to much development. There has been some recent debate at the Quality Committee as to whether existential risks, eg staffing, need to be considered differently from other high risks such as compliance with the Mental Health Act / Mental Capacity Act.

Consultation

The individual KLoE reports have been prepared by the Domain leads and will have been subject to varying degrees of consultation.

Governance or Legal Issues

Hippocrates – “First do no harm”

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).

There are no adverse effects on people with protected characteristics (REGARDS).	
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	X

Actions to Mitigate/Minimise Identified Risks

The experience of people from ethnic minorities has been subject to reverse commissioning and some scrutiny at the Mental Health Act Committee. People from ethnic minorities tend not to access services at an early stage and present late and in crisis. They are more likely to be detained than white people in hospital. Black people are more likely to be subject to seclusion and other restrictive practices. These factors have obvious implications for safety. It has also been noted locally and nationally that services that are predominantly for women, ie perinatal, eating disorder and “personality disorder” have been under-developed and under-resourced for decades despite being associated with an extreme morbidity and mortality rates. Some of this has been addressed through commissioning but has not been recognised by the Trust as a gender equality issue to date.

Recommendations

The Board of Directors is requested to:

1) Discuss the content of this report
2) Confirm the level of assurance received
3) To update the BAF accordingly

Report presented by: **Dr John Sykes**
Medical Director

Report prepared by: **Dr John R Sykes**
Medical Director

The Reports:

Keyline of enquiry S1
Safeguarding - Karen Billyeald - Assistant Director - Safeguarding Adults

Keyline of enquiry S2
Managing staffing risks – Celestine Stafford - People & Organisational Effectiveness Manager

Keyline of enquiry S3
(a) - information systems - Nicola Fletcher - Assistant Director of Clinical Professional Practice
(b) - records IG - Alex Rose – Records Manager, William Presland - Information Standards Lead
(c) - care planning - Karen Billyeald
(d) - transitions - Scott Lunn - Clinical Lead Children's Services

Keyline of enquiry S4
(a) - medicines management - Steve Jones - Acting Chief Pharmacist
(b) - physical healthcare monitoring - Richard Morrow - Assistant Director of Public and Physical Healthcare

Keyline of enquiry S5
(a) - track record infection control - Richard Morrow (summary prepared by JRS)
(b) - safety planning / risk assessment - Nicola Fletcher
(c) - restrictive interventions - Kyri Gregoriou – Head of Nursing

Keyline of enquiry S6
(a) - learning the lessons/incidents/thematic reviews/mortality - Rachel Williams - Lead for Patient Safety & Patient Experience
(b) - major incident planning - Karen Billyeald

DHCFT Quality Position Statement

Safeguarding – Adults at Risk & Children

Overview

The Trust's Safeguarding Unit is currently in a position of compliance or semi-compliance with its statutory and legal obligations.

Generally, training compliance is good and we know where we need to focus our efforts to be able to provide universal assurance.

All relevant policies and procedures for child and adult safeguarding are in date and we comply with the Safeguarding Boards policies and procedures to ensure that we meet our legal and statutory obligations in these regards.

The Trust contributes to a number of Serious Care Reviews. Learning Reviews and Homicide Reviews and Police Operations at any one time, all Trust reports are completed and run to given timescales.

The Trust Safeguarding Committee, at its September 2018 meeting confirmed that they were significantly assured by the reports of activity and the Annual Reports.

The Safeguarding Unit is in the process a more integrated approach across Children and Adult Safeguarding.

Commissioners have demonstrated a significant level of support for the City Multi Agency Safeguarding Hub [MASH] by its commitment to a further two years of funding for the MASH Health Advisor posts that are employed by the Trust.

Both Adult and Children safeguarding performance dashboards are progressing well to capture local and nationally required data.

Current Position

Safeguarding Children Dashboard – Quarter 1 2018-19

Item	Dashboard Requirements		Q1 2018-2019
1	Number of advice calls received and reported to off TPP and PARIS (specific and themes).		280
2	Number of supervision sessions, group supervision.		148
3	Number of attendance at MDMs, team meetings and ward rounds.		23
4	Number of MASH sessions covered by the safeguarding children team		4

Item	Dashboard Requirements		Q1 2018-2019
5	Number of strategy discussions / meetings.-staff activity Sub sets: Section 47 Discussions by Named Nurses Case Conferences by 0-19 & Named Nurses Strategy Discussions by 0-19 & Named Nurses		5 Strats 42 S47s 3 IC/ 5
6	Number of safeguarding meetings attended by the safeguarding team		11
7	Number of safeguarding children training/workshops delivered		2
8	Number of child protection medical - suspected NAI		77
9	Number of LADO referrals		
10	Number of CHANNEL referrals		3
11	Number of MARAC cases with children discussed at MARAC:		86
12	Number of DV incidents processed		
13	Number of referrals to CSC		4
14	Number of : SCRs – Serious case reviews SILRs Homicide reviews		
15	Number of children in private foster care		
16	Number of LAC	Born In Lives In	137
		Born In Lives Out	230
		Born Out Lives In	1
		Unknown Caseload	1
		Total	**369**
17	Number of children reported missing		
18	Number of child deaths:	CAMHS	1
		Children's Services	23
		Total	24
19	Number of children on a child protection plan : physical sexual Emotional Neglect		
20	Number of children referred for risk of FGM		1
21	Number of children on a child in need plan		809
22	Number of children in an adult bed		0
23	Number of young carers		9

Item	Dashboard Requirements		Q1 2018-2019
24	Number of audits		11
25	**Number of adults accessing substance misuse services who are parents:**		
	Number of Parents Known to Substance Misuse - open in year period		2051
	Number of Parents in Receipt of Substance Misuse in Reporting Quarter		1978

Safeguarding Dashboard – Quarter Two

	Duty / Requirement	Metric	Definition of Metric	Target Group Size / Team - Average	Target	Jul
1. Statutory Duties Regulatory Body Requirements - Safe? Effective?						
1	Data received from Tracy Shaw	**Adult Safeguarding Level 1 Training (3 yearly update)**	Adult Protection training allows staff to be able to identify early any safeguarding risks and to know what actions to take	J: 625 A: S:	85%	85.12%
2	Data received from Tracy Shaw	**Safeguarding Adults Level 1 + 2 (2 yearly)**	Adult Protection training allows staff to be able to identify early any safeguarding risks and to know what actions to take	J: 1824 A: S:	85%	89.91%
3	Data received from Tracy Shaw	**Safeguarding Level 3 (2 yearly)**	Enquirers training in order to be compliant with Care Act and Derbyshire Adult Safeguarding Policy and Procedures	J: 132 A: S:	85%	60.61%
4	Data received from Chris Elkin	**Number of urgent DoLS authorised -** Urgent DoLS are authorised by the Trust on the day we request an assessment (as we are the managing authority)	Accurate recording of number of DoLS applications ensures compliance and appropriate application of legislation	N/A	N/A	3
5	Data received from Chris Elkin	**Number of standard DoLS applied for to the LA**	Accurate recording of number of DoLS applications ensures compliance and appropriate application of legislation	N/A	N/A	3
6	Data received from Chris Elkin – To be included in quarterly total report only See quarter-end report	**Number of people with an authorised DoLS granted by Supervisory body as at end of quarter**	Accurate records and monitoring of numbers ensures good governance and compliance with legislation	N/A	N/A	N/A
7	Data received from Chris Elkin – To be included in quarterly total report only See quarter-end report	**Number of referrals to coroner for people who have passed away and have an authorised DoLS granted by Supervisory body as at end of quarter**	Accurate records and monitoring of numbers ensures good governance and compliance with legislation	N/A	N/A	N/A
8	Data received from Hannah Cook/Tracy	**DoLS training for frontline / clinical staff**	DoLS awareness ensures compliance with	J: 1005 A:	85%	89.45%

Duty / Requirement		Metric	Definition of Metric	Target Group Size / Team - Average	Target	Jul
	Shaw		legislation in relation to people who lack capacity to make decisions at appropriate time	S:		
9	Kelly Sims to provide data on breaches reported by CQC (through inspection reports), based on inspection dates	**Compliance with CQC requirements, Regulation 13, (Safeguarding people who use services from abuse)**	All providers are required to reach compliance with CQC Essential Standards of Quality and Safety in all Areas of the Service	See notes	0	0
10	See notes from KB	**The provider will complete SSASPB Safeguarding Adults Self-Assessment and share actions with the CCGs**	To support Health Services to meet Safeguarding Adult responsibilities and to demonstrate improved outcomes in preventing harm	N/A	N/A	N/A
11	See notes from KB	**Number of adult safeguarding referrals made where allegation is within their own service**	Numbers of referrals from health staff to Social Care. Some providers beginning to collect this. Reliable source data is LA. However this is not currently broken down into health providers	N/A	N/A	N/A
12	See notes from KB	**Number of adult safeguarding referrals made by staff where allegation relates to other care providers**	Numbers of referral from health staff to Social Care. Some providers beginning to collect this. Reliable source data is LA. However this is not currently broken down into health providers	N/A	N/A	N/A
13	Request data from Carolyn Green	**Numbers of staff referred to their professional body due to safeguarding concerns**	Total number staff referred due to concerns about their ability to practice safely	N/A	N/A	
2. Regulatory Body Compliance - Safe? Effective? Caring? Responsive? Well-led?						
14	Data received from Hannah Cook/Tracy Shaw	**Total training compliance**	Total average of lines 15, 16, 17	J: 485 A: S:	85%	68.87%
15	Data received from Hannah Cook/Tracy Shaw	**Triangle of Care – Training compliance / numbers trained in quarter**	Compliance with the Carer's Trust accreditation scheme	N/A	N/A	N/A
16	Data received from Hannah Cook/Tracy Shaw	**Triangle of Care - % of teams with completed self-assessments**		N/A	N/A	N/A
17	Data received from Hannah Cook/Tracy Shaw	**Positive and Safe – Training compliance for PACE & SCIP and Positive and Safe**		J: 485 A: S:	85%	68.87%
3. Partnerships - Responsive? Well-led?						
18		**Provider has a fully resourced and authorised PREVENT Lead**	Provider identify name of lead	N/A	N/A	KB
19	Data received from Tracy Shaw - All new staff attending induction	**Number of staff who have received induction / basic awareness in Prevent**	All staff should have a basic awareness of Prevent	J: 639 A: S:	See Notes	93.27%
2	Data received from	**Prevent Wrap Training**	Number of identified staff	J: 1825	85%	91.89%

	Duty / Requirement	Metric	Definition of Metric	Target Group Size / Team - Average	Target	Jul
0	Tracy Shaw	**to be delivered to all front-line staff (3 yearly update)**	group who require WRAP training from an accredited WRAP facilitator	A: S:		
21	Data received from Hannah Cook/Tracy Shaw	**EPRR Silver Command Training – compliance in quarter**	EPPR requirements for compliance with national core standards	N/A	N/A	N/A
22	Data received from Hannah Cook/Tracy Shaw	**EPRR Gold Command Training – compliance in quarter**		N/A	N/A	N/A
23	Data received from KB	**Full attendance at MARAC meetings (fortnightly)**	Fulfilling our Public Protection responsibilities alongside partner agencies.	N/A	100%	
24	Data received from KB	**Full attendance at MAPPA 3 meetings (monthly)**	Fulfilling our Public Protection responsibilities alongside partner agencies	N/A	100%	
25	Data received from KB	**Full attendance at DSAB, City and County**	Fulfilling our responsibilities as full and equal members	N/A	100%	See notes
26	**MASH KPIs - Children and Young People Performance Data** MASH provide data	**The number of Adult Safeguarding information sharing requests for Health received**	This is a pilot project. Evidence to be gathered to ascertain demand for and effectiveness of this partnership initiative to present to Commissioners	N/A	N/A	139
27		**Monitor the number and type of requests for information coming through to the Derby City MASH Health team from Children Social Care**	Record of number of request for information for children and young people	N/A	N/A	25
28		**Time to conduct research (mins)**	Record of the time taken to gather information / analysis	N/A	N/A	
29		**Monitor the number of strategy discussions for safeguarding children**	Record of the number of strategy discussions pertaining to children and young people	N/A	N/A	25
30		**How many children, young people, parents/ carers were discussed**	Record of the number of children, young people and parents discussed	N/A	N/A	115
31		**Time in strategy meetings (mins)**	Record of time in strategy meetings	N/A	N/A	
32		**Number of professionals liaised with**	Record of the number of professionals liaised with for the strategy discussions / meetings	N/A	N/A	9
33		**Number of complex strategy meetings that involve both children and adults**	Requested for 2018/19 onwards	N/A	N/A	
34	**MASH KPIs – Adult Performance Data** MASH provide data	**Time to conduct research (mins)**	Record of the time taken to gather information / analysis	N/A	N/A	
35		**Monitor the number of strategy discussions for adults at risk**	Record of the number of strategy discussions pertaining to adults at risk	N/A	N/A	6
36		**How many adults were discussed**	Record of the number of adults at risk discussed	N/A	N/A	17
37		**Time in strategy discussion/ meetings (mins)**	Record of time in strategy discussion /meetings	N/A	N/A	

	Duty / Requirement	Metric	Definition of Metric	Target Group Size / Team - Average	Target	Jul
38		**Number of professionals liaised with**	Record of the number of professionals liaised with for the strategy discussions / meetings	N/A	N/A	117
39	**MASH KPIs - Domestic Violence Performance Data** MASH provide data	**Number of domestic violence standard cases discussed at triage**	Record of the number of *standard* domestic violence discussed	N/A	N/A	192
40		**Number of domestic violence medium cases discussed at triage**	Record of the number of *medium* domestic violence discussed	N/A	N/A	119
41		**Number of hours spent in domestic violence triage meetings**	Record of time spent in domestic violence triage meetings	N/A	N/A	
42		**Time taken to conduct research for domestic violence cases (mins)**	Record of the time taken to gather information / analysis for domestic violence cases	N/A	N/A	
43	**MASH KPIs – Other Performance Data** MASH provide data	**Training, shadowing, supervision (hours)**	Number of hours for training, shadowing and supervision	N/A	N/A	14.5
44		**Tasks received from DHCFT safeguarding service**	Number of hours for processing tasks from DHCFT	N/A	N/A	
45		**Number of times when the Safeguarding Health advisor / Named Nurse was not available within the MASH Service (hours)**	Number of hours that the MASH service did not have face to face presence in the MASH Service	N/A	0	0
4. Workforce - Safe? Well-led?						
46	Data received from Hannah Cook/Tracy Shaw	**All training compliance – Safe, Well-led**	Same data as line 17	J: 485 A: S:	85%	68.87%
47	Data received from Katie Jordan	**Number of DBS risk assessments carried out**	Target group includes all new starters/routine checks each month Data to include all DBS checks for new staff and (separately recorded) all DBS checks for existing staff. Exceptions reporting required if any non-standard checks are made	J: 24 A: S:	100%	22

The Challenges

- Achieving full training compliance is a key challenge mainly due to capacity issues for staff being released to attend training when it is being provided
- For children's, the TJAI [Joint Targeted Agency Inspection] City and County is generating a great deal of work within the safeguarding unit
- The large number of Serious Case Reviews, Homicide and Learning Reviews across City and County are a challenge due to the capacity available within the Safeguarding Unit.

- The Section 11 and SAAF (Safeguarding Adults Assurance Framework) audits that are required by law prove to be a challenging process in terms of gathering the evidence, completing the process and taking part in the visits, purely in terms of time and resource.
- There are a number of teams within the Trust across Children and Adult Services with a significant number of new and inexperienced staff requiring higher levels of support from the safeguarding team to work through safeguarding processes
- The phenomena of on-line and also non-recent abuse have significantly impacted on the workload on a daily basis of the Safeguarding Unit staff team. The specific pressures relating to Complex Case 1 Operation Thalia have been well documented elsewhere.
- The safeguarding work around new and emerging communities is both challenging and interesting, requiring new knowledge to be developed and operationally applied.

The Opportunities

- The intention within the Safeguarding Unit is to integrate what is currently a child and family helpline to incorporate adult related calls. This requires a minor review of current job descriptions and a consultation process to take place within quarter 2.
- We would like to actively encourage shadowing and secondments into the safeguarding Unit, both as part of a conscious succession plan and also to create opportunities for individual staff members to develop skills and knowledge to take back to their teams.
- The recent development of an adult safeguarding Link Worker network is cause for optimism and there are approximately 30 named staff members on the network from across all service lines.
- Whilst the Section 11 and SAAF processes are a challenge, they are recognised as opportunities for the Unit to showcase its best practice and innovation.
- A more aspirational opportunity is being considered to amalgamate the children's and adult safeguarding operational groups within the Trust.
- For Family Inclusivity to continue to be the golden thread that runs through all of our safeguarding practice.

Conclusion

- We anticipate that our training compliance, where it is below target, will rise to meet target requirements.
- To complete reviews of job descriptions and be in consultation regarding the help-line changes.
- For the successful completion of Section 11 and SAAF visits to be achieved by the end of December
- To be in a state of preparedness for the JTAI notification.

DHCFT Quality Position statement

Information Systems – Electronic Patient Records

Overview

Within DHCFT there are three Electronic patient record (EPR) systems; Paris which is used by mental health services (including CAMHS) and learning disability services; SystmOne, used by Substance Misuse services, Children's and Health Visiting services and IAPTUS which is used by IAPT (Improving Access to Psychological Therapies) services.

The EPRs play a key role in supporting patient safety and as such, we need to focus on making them as functional and supportive a group of systems as is possible.

SystmOne and IAPTUS address less complex business processes and as such have few issues. However, the initial roll out of Paris involved replicating the paper record that staff were used to and as such, the version of Paris we currently have is complex. It can be difficult to locate key documents and staff report it being difficult and time consuming to use.

In comparison with other trusts, DHCFT has a higher degree of reliance on the PARIS EPR to support its clinical process in comparison to other Trusts. For example, the support of co-ordinating out of area patients, controlling the requirements for Care and Treatment Reviews and meeting commissioner and NHS England reporting requirements without the reliance on time consuming duplicate recording all occur through Paris. This does however require the Trust to ensure that the information the EPR holds is accurate and recorded in a timely manner. This can prove to be a challenge.

Our current strategic position is one of system simplification and improvement of technical literacy. The work undertaken so far in 2018 has been directed at less replicating of paper files, reducing the complexity and repetitive recording in key fields on the Paris system and maximising the benefits of each of systems that we have.

Current position

The most recent information relating to digital maturity is for 2017 where DHCFT compares favourably both nationally and regionally.

The areas where we are above the national and regional performance are on governance, information governance, transfers of care and business and clinical intelligence. Our areas of challenge are resourcing and remote and assistive care.

National picture

Results by Section

Showing results by section for the 2017 NHSE DMA.

Regions: London, South of England, North of England and Midlands and East of England;

Sections: Strategic Alignment; Leadership; Resourcing; Governance; Information Governance; Transfers Of Care; Decision Support; Remote & Assistive Care; Asset & Resource Optimisation; Enabling Infrastructure; Business & Clinical Intelligence;

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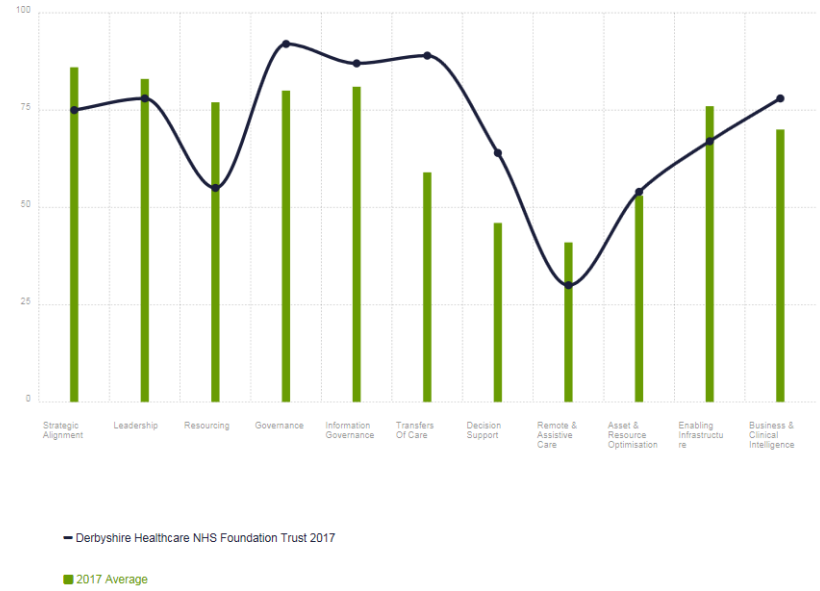


Regional Picture

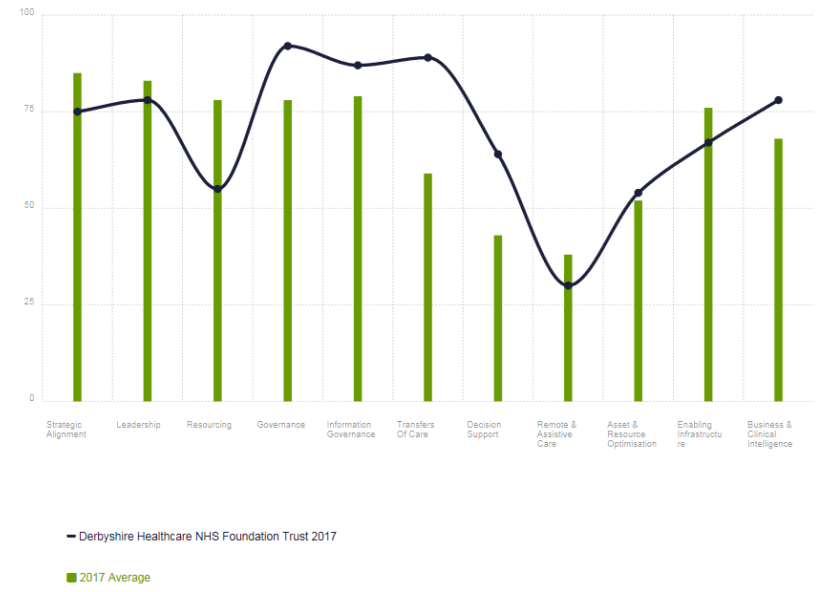
Results by Section

Showing results by section for the 2017 NHSE DMA.

Regions: Midlands and East of England;

Sections: Strategic Alignment; Leadership; Resourcing; Governance; Information Governance; Transfers Of Care; Decision Support; Remote & Assistive Care; Asset & Resource Optimisation; Enabling Infrastructure; Business & Clinical Intelligence;

.



The EPRs are over seen by a clinical reference group that meets fortnightly and reviews any changes and monitors the ongoing work on the different records through a system of matrix management.

There is a governance process around the amendments to any of the EPR systems and staff are encouraged to participate in this process, should they request amendments or suggest invitations to the systems. Staff are updated quarterly about the work of the group through an intranet site and briefings on Connect. Additional information is briefed out through Team brief/ Connect.

The CRG has also been to visit another mental health trust that uses Paris to look at their system and share learning and ideas.

The Challenges

E-prescribing – E-prescribing is another significant patient safety improvement. Civica, (the firm that developed Paris) have an e-prescribing module in development. DHCFT were trying to arrange a visit to see the Civica e-prescribing solution in a live inpatient environment in early 2018. There have been delays to the Civica project and they are not now due to begin their pilot until January 2019. We are expecting to be able to see it in a live environment in spring 2019.

Technical literacy of the organisation – we have staff at differing levels of literacy and confidence in their use of Information Technology and also with the respective EPR systems. We have a Clinical Systems lead who supports staff in the clinical environment, as well as trainers who visit and support staff in the workplace to increase confidence and skill. However, we need to improve staff literacy further and support them to make the best use of the current systems and their time logging case notes.
We also need to think about smart solutions to clinical recording problems and increase our use of assistive technology where this will be helpful.

Paris – there is a continued need to reduce the complexity of this EPR and make crucial documents easy to find, whilst gathering the relevant detailed information to inform our reporting and monitoring arrangements.

The Opportunities

Observations – we have developed and are rolling out and ‘ease of entry’ solution to recording of clinical observations.

Paris availability to IAPT services – we have enabled ‘read only’ access to the IAPT providers that we work with.

Ability to directly communicate with Primary care – we have enabled relevant staff in primary care to read SystmOne and Paris records to access Outpatient and discharge summaries.

Revisions to Paris – we are working on the simplification of the structure of Paris to increase ease of access and are revising key forms and processes such as the clerking in proforma,

safety plan and care plan. A significant piece of work has been the ongoing simplification of the recording of physical health information. All this work is a significant demand on our Paris development time, so other developments, unless mandatory, have been put on hold.

OIS (Online Information system) – this development has enabled Dual Diagnosis work to be picked up by different EPR systems across the organisation. This is a significant step towards improving patient safety through improved access to clinical information.

Conclusion

The next 12 months are an opportunity to maximise the benefits of the EPR systems that we currently have and maximising the value that can be generated out of our existing EPRs.

We need to continue to improve the technical literacy of all our staff and simplify the Paris record as outlined above.

The use of EPRs is crucial element of maintaining and improving patient safety and the improvements identified above support this.

DHCFT Quality Position statement

Subject –Managing staffing risks

Overview

There is a national shortage of suitably qualified medical and nursing staff, specifically registered mental health nurses and specialist nurses. There is risk in this area within Derbyshire Healthcare due to challenges around the attraction and retention of staff in some areas, such as medical and inpatient nursing which impacts on our ability to deliver high quality care to the people we serve. There is continuous priority focus in this area with People services and operational managers working together to drive this agenda forward and overcome the challenges.

We have made much progress over the last five months (since the implementation of the new People Services Team) we still have a significant challenge within medical and registered professional/specialist roles such as nursing.

We are promoting a multi-generational offer that gives flexibility in order to attract and retain staff as well as focusing on inclusion and equality in accessing roles.

Like many other trusts Derbyshire Healthcare manage recruitment centrally. The people resourcing team coordinate recruitment via the TRAC system that links to NHS jobs to support the end to end recruitment process.

The people resourcing team also manage bank/temporary staffing and medical staffing using an electronic rostering and banks system – provided by allocate software.

This model of this team enables full overview of staffing risk looking at both the longer term gaps/vacancies and the shorter term gaps that are a result of unavailability such as sickness, staff movement and so on.

Standard recruitment is ongoing through the dedicated recruitment team such as attractive adverts, use of a innovative microsite, social media advertising and local career events, in addition there is additional activity to focus on forward planning and longer term strategies such as links with universities and international recruitment, regional collaborative approaches and career events to bring people into the NHS.

Current position

Despite the challenges the vacancy factor is lower than regional averages
Nursing vacancies currently at 10.62% and medical vacancies at 11.07%.

Derbyshire Healthcare are continually attracting candidates to posts and feedback has been given that candidates are attracted to the Trust values and Trust reputation.

The current hotspots are RMN nurses for inpatient areas and the bank are supporting gaps in nursing with fill rates above the national average of 80% with fill rates of between 80-85% over the last 3 recent months.

Medical consultants are a further hotspot and this currently is resulting in significant medical locum spend which we are addressing through focused action planning, promotion of medical roles and workforce planning to support the medical positions with other roles such as ACP's and NMP's.

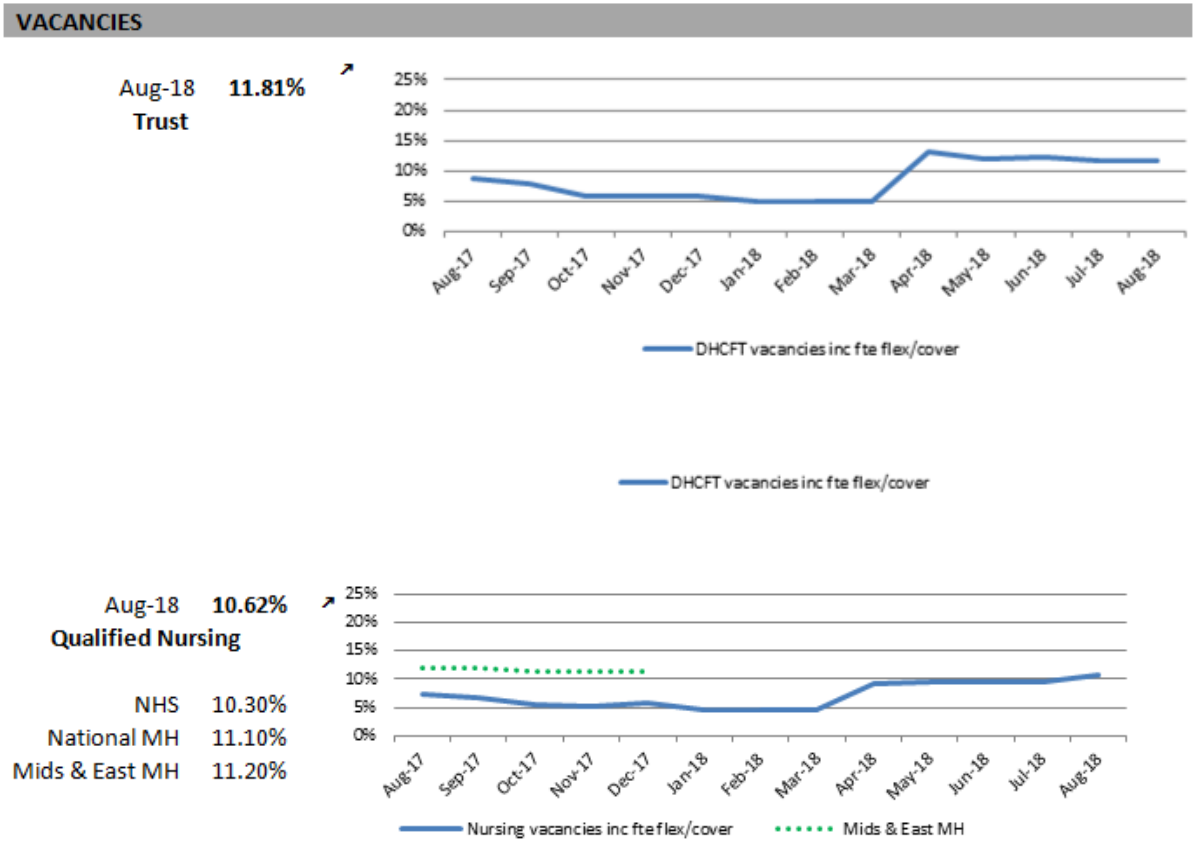
Whilst most of our agency spend is incurred on medical locums, medical staffing, especially consultant posts, are challenging to recruit to nationally due to the number of vacancies being high nationally and the situation where individuals can receive higher pay by doing locum work. This is a situation that is under review by NHS improvement.

The team are producing a regular workforce supply in-depth report to the People & Culture Committee and Trust Management Team for discussion and assurance.

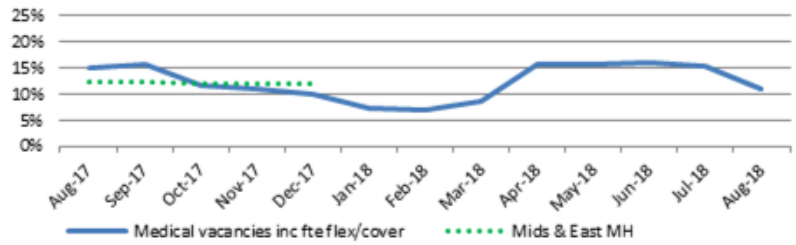
The current staffing situation is showing on the whole that there is enough recruitment activity taking place to fill the majority of current vacancies within the next 2-3 months (following pre-employment checks alongside ongoing advertisements).However this position changes daily due to turnover and new posts advertised so needs to be under close monitoring .This is the same with safe staffing priorities where activity levels and patient acuity can change constantly.

Summary of recent benchmarking data

Recruitment



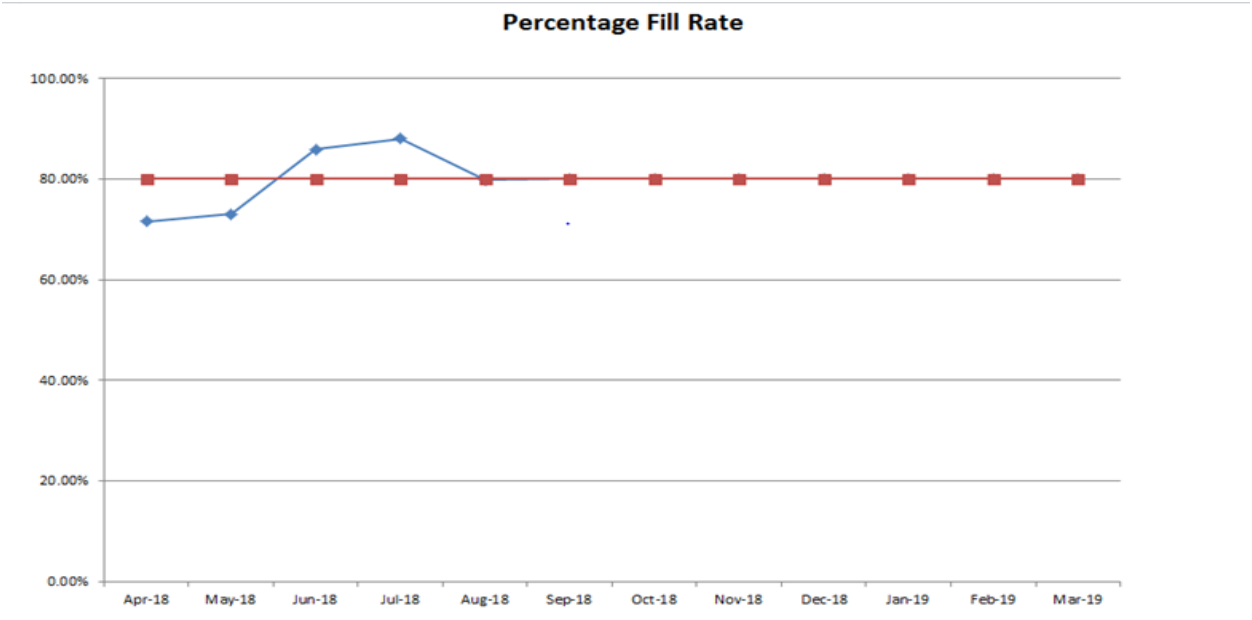
Aug-18	**11.07%** ↘
Medical	
NHS	7.90%
National MH	12.00%
Mids & East MH	12.10%



The Trust vacancy rate includes funded Fte (full time equivalent) surplus for flexibility including sickness and annual leave cover. During 2017/18 funded Fte vacancies reduced by 3.04%. In April 2018 the Trust funded fte vacancy rate increased due to budgetary changes from 2017/18 to 2018/19. 2017/18 has a reduced budgeted establishment in relation to planned disinvestments and Cost Improvement Programmes, of which were not delivered to plan. The 2018/19 funded establishment includes new investment for several services. During August 2018 the Trust funded Fte vacancy rate has increased by 0.07%, Qualified Nursing funded Fte vacancy rates have increased by 1.06% and the Medical Fte vacancy rate has reduced by 4.42 %. During the period September 2017 to August 2018 249 employees have left the Trust and 345 people have joined the Trust through external recruitment (TUPE transfers are excluded from both figures).

Temporary staffing

The bank was brought in house in March 2018 and the fill rates have increased to on or above benchmark in recent months (the red line indicates national benchmark). There has been a recent drop in fill rates to the benchmark position which is a known trend within bank supply as workers often chose not to work in the summer/school holiday months.



The Challenge

Staffing resource challenges are against the backdrop of external factors such as national shortages of suitably experienced clinicians, fiercely competitive healthcare recruitment markets across the UK, attrition, high agency rates, increasingly attractive healthcare career opportunities outside the NHS or the immediate regional localities. It is therefore likely that there will be constant change that requires ongoing monitoring and actions and this will sit within the People Resourcing Team who will maintain close working with operational managers.

What are the key findings and issues relating to your topic currently?

Staffing is high on the NHS agenda and is crucial to delivery of safe and effective patient care. Whilst challenges are a national issue the Trust is below the national vacancy average regionally and nationally.

The organisation has a robust reporting framework and there is a staffing team in place that is currently developing to meet the changing staffing demands with close monitoring of KPIs to constantly improve performance.

On the whole activity is positive but hotspots and risks remain which are addressed with action plans in place.

The Opportunities

A two-year workforce plan introducing new roles and skills mix reporting into the strategic workforce meeting to track delivery of plan, close working with the Director of People services and Director of Operations, review of staff survey and pulse check data to assist retention, CQC feedback and action planning.

Develop integrated workforce models for key hard to fill posts where have been unable to attract suitable medical staff. There is a current focus on Associated Nurses, NMP and ACP's.

Further develop our multigenerational offer to attract staff for key national occupational shortages, and for development and retention of staff in key areas - flexible working offer needs further promotion, in-house bank being expanded, build on the recruitment microsite to promote offers, targeted recruitment to key priority roles. Tracking and reports to the Trust Management Team and People & Culture Committee.

Developing a rotation role and programme across inpatient and community services in order to proactively manage the flow workforce across these areas – work commenced between people services and operations.

Conclusion

Staffing will remain a risk and a priority for the trust over the next 12 months .The short term approaches will reduce the daily operational risk but longer term plans in place will support a sustainable workforce supply. The strategic and creative vision to be developed as part of workforce planning .Whilst there is known challenge there is also exciting opportunity.

Information Governance

Overview

The Information Governance department, now known as Data Security & Protection (DS&P) oversees all aspects of data governance for the Trust. As well as reporting to the Information Commissioner's Office (ICO) and NHS Digital the department provides expert service and guidance on all aspects of data governance, the Data Protection Act 2018 and GDPR (General Data Protection Regulation) to staff. The department also oversees the DS&P Toolkit, an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's ten data security standards. In 2017/18 the Trust was the best achieving mental health trust in the UK. The DS&P Toolkit does not currently allow direct comparison with other trusts, however the department is committed to maintaining the standards of excellence in 2018-19.

Current position

The department is approaching the end of Q2. There have been no reportable incidents to the ICO in Q1 or Q2. The DS&P Toolkit is on target with no outstanding assertions. The toolkit requires 100 mandatory evidence bases to be completed, which in turn feed 40 Assertions in the 10 Data set standards. At the end of Q2 the Toolkit has 66 evidence bases completed and 15 Assertions, against a predicted 60 evidence bases and 13 Assertions. The department has also worked with Derby City Council on Information Sharing Agreements and is developing close links with other third parties including Derbyshire Constabulary

The Challenges:

The Trust continues to work with the new law, GDPR and the Data Protection Act 2018 aims to maintain its status as the best achieving mental health Trust in the UK for data governance. The team are focused on all aspects of the toolkit. The new toolkit poses some significant changes, with a new focus on aspects of cyber security and new tasks including a Data Security Improvement Plan and an annual Penetration test. The department has introduced new controls to ensure the toolkit is progressing as planned and will be successfully completed on time.

As before, 95% of staff are required to successfully complete their annual DS&P training in time for April 2019. The department has introduced new procedures to help understand when staff relapse their training, and adopt a new procedure which will remove access if the training is not completed within 6 weeks expiry. The department has also introduced new, streamlined training for staff as well as the more traditional classroom based training.

The department will also respond and investigate all data security related Datix issues and work to improve processes to reduce the possibilities of repeated instances.

KLoE S3(b)

The Opportunities:

The Trust is recognised as the Number 1 mental health trust in the UK for information governance. The Trust aims to remain at Number 1 by successfully completing the toolkit.

The department seeks to continually improve its own procedures, introducing new working methods to streamline

The Staff training has been overhauled to make it relevant to the staff and include key messages to ensue understanding around GDPR. This forms part of the compulsory annual training which all staff must undertake. Over the next 12 months all staff should have undertaken relevant training which includes GDPR. The department self-assessed against the ICO's readiness test and is working on the two highlighted areas: contracts and CCTV, which the assessment highlighted as needing additional work.

The department will continue to monitor ICO updates and case law where possible and continue to provide an evolving, dynamic service of training and guidance to all staff.

Conclusion:

The department will continue to provide a service to support all staff in all areas of data security and protection. The department feels it is on target with its aims for 2018-19 and is capable of offering a flexible service which can respond to the immediate needs of the Trust.

DHCFT Quality Position Statement

Care Planning

Overview

The CQC Inspection Visit in June 2016 highlighted some shortcomings in the Trust's adherence to principles of good practice in care planning.

Learning from very serious incidents also related directly to the quality and content of care plans, safety plans in particular.

Over the past two years a great deal of work has been carried out to address the areas of concern.

The Care Programme Approach [CPA] has been established over many years but, arguably, has lost potency more recently. Consequently, whilst the Trust has maintained compliance overall with key performance indicators relating to CPA, decision making and the content and quality of care plans has also caused concern.

Nationally, CPA is subject to a review and the Trust is involved in the consultation process to develop a CPA that would be fit for the future.

Relevant Trust Policies are CPA;

Current Position

There has been a significant investment over the past 10 months in reviewing and updating the Trust's CPA Policy and Procedures. Phase 1 was delivered in February 2018. Phase 2 has proved more challenging, more of which in the next section.

There has been significant amount of audit activity across all service lines looking at specific domains:

- The level of involvement of the patient/service receiver in the care plan
- The recovery focus of the care plan
- Capacity and Consent
- The quality of safety planning
- The involvement of carers in the care planning process
- Outcomes and satisfaction

A Care Planning Audit Tool has recently been launched and the results are beginning to be analysed. All service managers have been given data for their own teams and asked to develop an action plan. Initial results about Safety Planning show the following outcomes:

KLoE S3(c)

Question	Yes	No	Not stated	Does not have capacity
Is there evidence of safety planning?	78%	21%	1%	n/a
Are the person's risks/ safety needs clearly identified?	80%	19%	1%	n/a
Have all significant risks/ safety needs been added as an Alert?	40%	57%	2%	n/a
Has the person been involved in formulating and reviewing the safety plan / risk screen?	60%	36%	1%	3
Has the family/carer been involved in formulating and reviewing the safety plan?	40 %	56%	2%	n/a
Is there a contingency plan?	54%	45%	1%	n/a
Has this document been shared with the person and relevant professionals?	66%	32%	2%	n/a

It is fair to say that the Trust struggles to achieve consistently good standards across all service lines and specialities.

More recently, a dip sample of patient experience of CPA has been carried out in in-patient services and, again, standards and success are inconsistently achieved.

The Challenges

- The particular area of CPA has proved to be highly charged in terms of patient, carer and staff member views and opinions. There has been much debate in the CPA Strategy Group and lots of views accounted for.
- The Trust has to find ways to achieve good standards of care planning across all teams and service lines.
- Where the Trust has commissioned a dedicated resource in the past, for example, to successfully embed principles of good practice to meet the requirements of the Mental Capacity Act, this has proved to be a successful model. This may be the approach that is needed to attain a greater level of consistent success with care planning.

The Opportunities

- The Trust has an opportunity to develop both an approach to CPA that encapsulates key feedback from patients, service receivers, carers and staff members
- It also has an opportunity to deliver a renewed model of care that works to levels of need, some requiring CPA to be applied and others to be met through sound and effective care planning.

Conclusion

The next quarter will be, potentially, the most significant in the entire year as we respond to our recent CQC Inspection visit and strive to develop levels of care based on levels of need and an approach to CPA that demonstrates that we have learned important lessons from the most serious of incidents and are able to apply these competently and consistently.

Karen Billyeald – Assistant Director for Safeguarding Adults
Darryl Thompson – Deputy Director of Nursing

DHCFT Quality Position Statement September 2018

Transitions - Improving the Experience of Young people When Moving on From CAMHS (Child and Adolescent Mental Health Service) to Adult Mental Health Services (AMHS)

Overview

The transition CQUIN (Commissioning for Quality Innovation) aims to incentivise improvements to the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services (CYPMHS). 2017-2018 Year 1 was a year of preparing information, resources and systems, then piloting their use and effectiveness. We have approached this as a joint CQUIN across the STP footprint and therefore a partnership plan has been developed between CRHFT and DHCFT.

2017-2018 achievements so far:

1. Project group and leads established and meet monthly
2. Membership includes expert by experience
3. Readiness Questionnaires now in operation across CAMHS (Child and Adolescent Mental Health Service) were co designed with young people
4. Experience Questionnaires now in operation across CAMHS and Adult Mental Health Services were co designed with young people
5. Process maps have been agreed by CAMHS and Adult mental Health Services to support the moving on experience of young people.
6. Pilot services targeted in South Derbyshire (SD) CAMHS and North Derbyshire (ND) CAMHS and fed back to inform whole service roll out in April 2018.
7. Feedback from the service experience questionnaires (See CQUIN 2017/2018 Q4 Report) have been used to inform the implementation plan.
8. We have now embedded the questionnaires in the Electronic Patient Records to improve access to the feedback questionnaires, improve completion compliance and ensuring sustainability to the programme.
9. A Children's Transition 5 year Strategy paper developed between CRHFT and DHCFT (to be agreed).
10. Agreed job description for Specialist transition Advisor (SD CAMHS)
11. Case note audit across 250 cases in SD and ND CAMHS provided rich source of data about joint planning meetings and discharge letters.
12. Walk rounds to services asking for feedback as well as feedback from service lines to the operational and clinical meetings attended by the project group members.

Summary of Learning from Year 1

The young people's feedback from Q4 was invaluable to hear about their experience when moving on from CAMHS to Adult mental Health Services. Some of the key themes highlighted were:

- Improve attendance at the Joint Planning Meetings
- Improve the communication received about adult services

- Improve internet / web information about adult services
- Have a video showing adult services venues and where to go on arrival?
- Agree a transition plan that is timely
- Information about the moving on process
- Flexibility of transition age – dependant on need

System feedback from staff and the case note audits Q4

- Staff felt they needed more communication about the CQUIN and what was expected.
- Improve attendance from adult mental health services at the planning meetings and transition meetings
- Improve on the discharge reports and evidence that they were completed collaboratively.
- Improve on what is expected during the transitional period and how to include this on the moving on plan
- Review the care plan and moving on plan as a combined document? Do they work together?
- Improve on the completion of adult CPA documentation by CAMHS if transitioning to Adult mental Health Services
- The ADHD (Attention Deficit Hyperactivity Disorder) and ASD (Autism Spectrum Disorder) pathway remains an area of development including all of the above. Specific focus on the development of an improved pathway between consultant Psychiatrists from Children's to Adult services.

As part of the moving on plan review and in accordance with the CQUIN theme we highlighted 3 additional core standards that have been co-produced with young people to capture young people experience and report on the quality standards that have been developed by young people. These standards were developed to reflect the young people's transition/moving on goals. On the sample collected the standards reflected 100% of the young person's goals.

- **Standard 1 -** To move on from CAMHS in a timely manner and continue to receive support until you move on.
- **Standard 2 -** To be communicated with as agreed during the move on from CAMHS?
- **Standard 3 -** That information shared about you was discussed with you?

In Q4 2017/18 10 out of 12 reported that this were achieved.

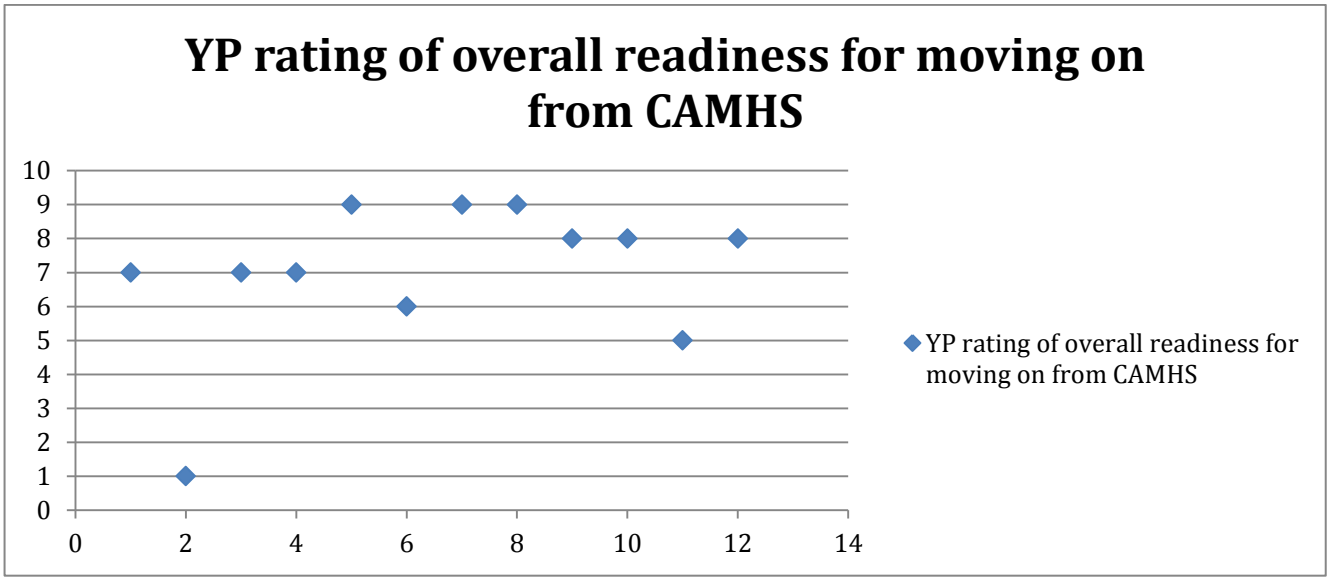


Fig. 4 – Q4 2017/18 Average Readiness rating is 7 out of 10

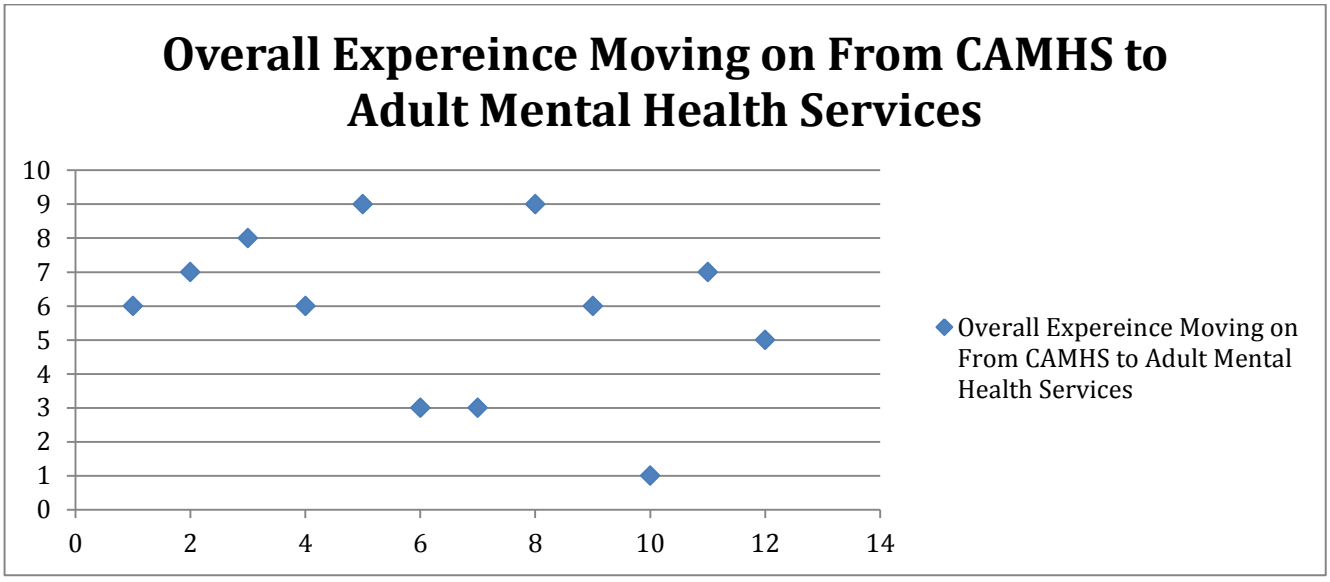


Fig. 6 – Q4 2017/18 Average Overall experience rating is 5.8 out of 10 with 8 out of 12 reporting that the moving on plan was helpful.

Current Challenges

2018/2019 Q2 and Q4 CQUIN milestones:-

1. *Sending provider to undertake case note audit assessing those who transitioned out of CYPMHS in Q1 and Q2 (reporting on the number of discharge reports completed collaboratively and the number of joint planning meetings attended by CAMHS and Adult mental Health Services)*
2. *Sending provider to undertake assessment of discharge questionnaires for those who transitioned out of CYPMHS in Q1 and Q2*

3. *Receiving provider to undertake assessment of post transition questionnaires of those who transitioned to AMHS or other relevant services from CYPMHS in Q1 and Q2*
4. *Sending and receiving providers to present to commissioners a joint report outlining overall CQUIN progress to date.*

To date we have achieved 100% of the CQUIN milestone payments. It has now been reported to the Improving Transition Steering group and the Deputy Director of Nursing (CQUIN Lead) that we are at risk of not meeting the CQUIN target for Q2. This is primarily due to the readiness questionnaire and experience questionnaire not being available on Paris until recently and that transition to adult services from CAMHS remains very low at approximately 5% (70 young people a year) and therefore changes of practice are harder to embed when used so infrequently.

We have had very good engagement from all Adult services Area and local services management but the timescales of transition and the competing clinical priorities for the teams constantly puts pressure on a timely transition.

The safe care during the transition also remains a risk as there have historically been a high number of young people who do transition not attending appointments and there care episode ending.

In recognition of these challenges CAMHS have now job planned a member of staff to focus on the transition pathway and support staff completing the required forms and developing tools and resources to improve the young person's experience. This role is job planned for six months only and will cross over into adult services. The successful implementation of this short term post will help to achieve our Q4 CQUIN milestones of 2018/19.

Summary

Last year's feedback and Q4 report highlighted that there was still a lot of work to do to change culture and practice. This is a long term ambition and In consideration of the CQUIN targets and timescales around improving the experience of children and young people moving on from CAMHS we will have only scrapped the surface and see this as an opportunity to really embed some key quality standards across CAMHS (Children's and Adult services not excluded). Therefore we have started to develop a Children's Transition Strategy paper which aims to outline some key issues highlighted in this report and would welcome an opportunity to discuss this further.

A Point of Interest:

September 2018 - HSIB second national investigation report: CAMHS to AMHS

Healthcare Safety Investigation Branch has published its second full investigation report to support a new learning culture around mistakes in the NHS. The investigation reviewed the transition of care from child and adolescent to adult mental health services to understand how variations in the transition impacts the safe and effective care of young people. This investigation followed the Healthcare Safety Investigation Branch being notified of an 18-year-old who died by suicide shortly after transitioning from child and adolescent to adult mental health services. The investigation identified possible issues regarding the transition process.

As a result of the investigation the Healthcare Safety Investigation Branch identified the following key findings:

- *Young people using child and adolescent mental health services would benefit from a flexible, managed transition to adult mental health services which has been carefully planned with the young person, provides continuity of care and follow-up after transition. A duration of shared-care would help to ensure readiness and continuity for the young person.*
- *Young people and their families may also benefit from the use of tools in their transition planning to allow for structured conversations and to empower them to ask questions and take ownership of their diagnosis, needs and treatment.*
- *In the acute and mental health trusts visited, there were no standardised methods or tools used to manage transition. However, we did find that acute trusts were more likely to plan transition over a longer period of time and to use tools to bring some standardisation to the process.*
- *There is evidence that moving to a flexible model which has the capacity to provide mental health services up to the age of 25, can minimise some of the barriers and reduce the risks associated with transition.*
- *Research suggests that young people want flexible services which do not have strict 'cut-off' points. Flexible services are especially important for young people with emotional problems, complex needs, mild learning disability, attention deficit hyperactivity disorder, and autism spectrum disorder, for whom there are limited available services in the adult mental health setting.*
- *Significant efforts are being taken to improve early intervention services for young people. Research indicates that early intervention reduces the impact on both the young person and subsequently the NHS through improved outcomes and a reduction in the need for longer-term resources.*

In our own trust we have had similar cases examples where the transition of care at 18 was at the most inappropriate time. The flexibility of care arrangements for young people open accessing our services up to the age of 25 needs to be kept on the agenda as this has been widely recognised as a key area of concern for over 15 years (including reference in the NSF) where we have taken very little action.

Scott Lunn
Children’s Services Division Clinical Lead

DHCFT Quality Position Statement

Medicines Management

Overview

This document addresses the following:

- Medicines Optimisation – the organisation's responsibility to support people to use medicines in a way that improves their health outcomes by promoting informed choice, helping people to take their medication correctly, avoiding the unnecessary use of medicines and improving medicines safety.
- Pharmacy – the department within the Trust responsible for delivery of pharmaceutical services and support

Medicines Optimisation is currently guided by the Medicines Optimisation Strategy 2018-21. Progress in achieving excellence in medicines optimisation is reported in dashboard form to the Trust Management Team (TMT) on a recurrent quarterly basis, and subsets of this information will be presented to the Clinical and Operation Leadership Teams (COATs) for the clinical divisions on a routine basis beginning in autumn 2018.

Expenditure on, and patterns of use of medicines are reported regularly as a dashboard including trust-wide and division-specific reports.

The Medicines Management Committee maintains oversight of medicines policy and practice across the Trust, and reports to the Quality Committee.

Development of the pharmacy department is currently guided by the Pharmacy Strategy 2018-21. This is structured around the four domains of Team, Clinical activities, Governance activities and Infrastructure activities. This is in-line with the national direction for mental health pharmacy and Lord Carter's 2018 report. The most significant aim of the pharmacy strategy is to develop a specialist pharmacy presence in the community mental health setting.
Both strategies are currently within the initial months of their life cycle.

An annual medicines optimisation report incorporating information on progress against the medicines optimisation strategy, medicines expenditure and patterns of use, the work of the Medicines Management Committee and the work of the Pharmacy Department is planned for submission to the Quality Committee each April.

Current Position

Medicines Optimisation:
Progress has been made in embedding the dashboard into the routine work of the TMT and the Medicines Management Committee, with work now underway to embed an associated action plan into these groups as well as the divisional COATs.

A common theme in a number of medicines optimisation criteria is the lack of engagement from trust staff with following policies and processes or complying with medicines-related training requirements. This is the reason for many of the “yellow” ratings; where systems exist but are not being correctly utilised or implemented.

The Trust participates in the clinical audit programme of the Prescribing Observatory for Mental Health (POMH-UK). The results of which demonstrate that our performance tends towards the average, with weaknesses in areas such as the physical monitoring of patients who receive mental health medicines.

Our medicines use data confirms that adherence to the Derbyshire-wide formulary is good. The Chief Pharmacist has presented medicines expenditure and use information to the Trust Medical Advisory Committee, Trust Management Team and the Medicines Management Committee and this also informs the regular discussions between pharmacy and the finance department about adherence to budget and budget setting.

Historically, the approach taken to assurance around medicines management/optimisation has been for pharmacy to support audit, but then rely on ward and team staff to implement action plans resulting from these. It is becoming apparent that this model does not fully deliver the required level of assurance and more active intervention by the pharmacy team would lead to a better outcome. However this requires the department to have sufficient resources to provide enhanced (and wider) support.

Pharmacy

The pharmacy team at the time of writing consists, in addition to the Chief Pharmacist, of 36.12 whole time equivalent staff across a range of roles from Band 2 up to Band 8b, however 7.6 WTE (21%) are currently unavailable due to maternity leave, acting-up into other roles, vacancies and sick leave and this has typified 2018.

At any one time we also support one pre-registration pharmacist as part of their undergraduate study at the University of Nottingham. Our team complement also includes two apprentice pharmacy technicians.

The pharmacy department is facing the upcoming end of a 20-year contract to provide services to Derbyshire Community Health Services NHSFT (and its predecessor organisation) in south Derbyshire. The change in contracting arrangements in no way reflects upon the quality of the pharmacy service provided by our team and is a financially-based decision. The effect of planning for this change is that a number of posts have been disestablished as they have become vacant and two team members will transfer to DCHS under TUPE arrangements on the 1st November 2018.

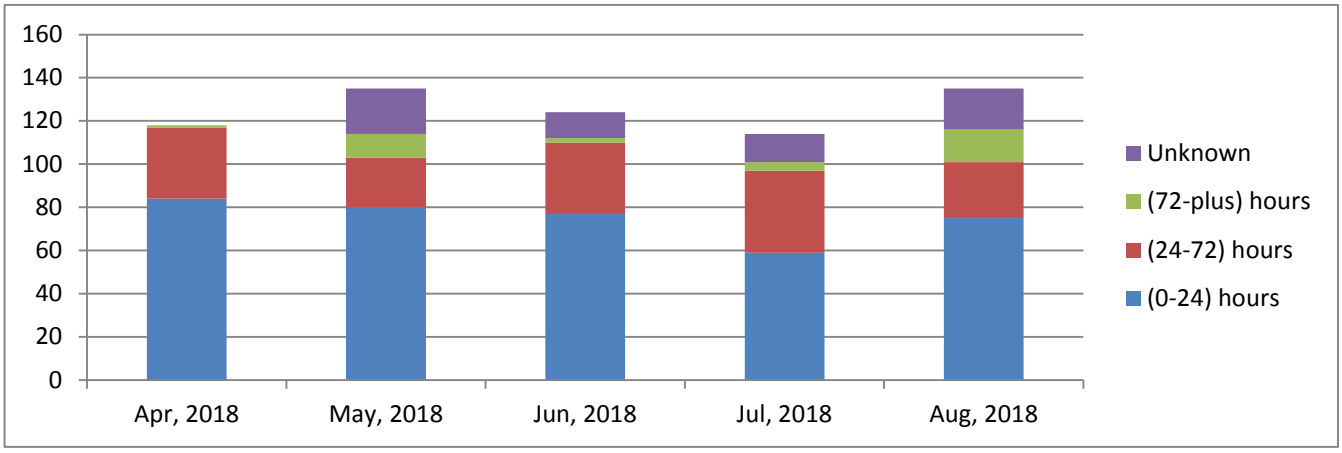
Progress this year has been challenged by the absence of senior pharmacists:

Chief Pharmacist:	Left in October 2017
Deputy Chief Pharmacist:	In post
Assistant Chief Pharmacist:	Acting-up as Chief Pharmacist (no backfill)
Advanced Pharmacist:	In post, but away on Maternity leave since Dec 2017, returning Jan 2019

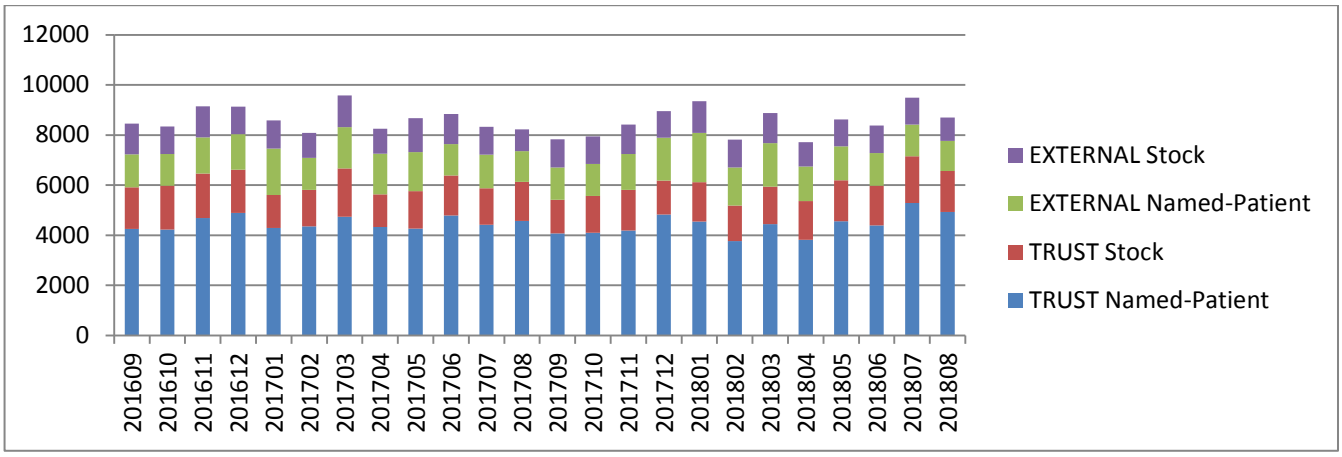
Advanced Pharmacist:	In post, but was on sick leave (not work related) May-August 2018
Advanced Pharmacist:	Left in June 2018 and post disestablished as DCHS cost reduction

Despite the difficulties that 2018 has presented, the pharmacy department has continued to provide the essential services for which we are responsible, for example:

Medicines reconciliation on inpatient wards:



Dispensing of medication from the Kingsway Hospital site



(Average of 8570 items each month, with an increasing proportion of workload being items supplied to our own Trust)

Pharmacy and the Medicines Management Committee are responsible for the maintenance of a large number of policies and procedures, which are currently all compliant with their review cycle.

Pharmacy services remain well established in inpatient areas, however there is a need for both clinical pharmacy advice and technical expertise to be made available in community settings where they can be of benefit in supporting the recovery and resilience of people taking medicines for their mental wellbeing.

The Challenges

ePMA: (electronic prescribing and medicines administration) is an essential development to improve patient safety and to move away from riskier and more labour-intensive paper processes. The decision-support element of an ePMA IT system will also facilitate the embedding of best-practice guidance such as that from NICE and the dissemination of relevant learning that emerges from medicines-related serious incidents. This is a desperately required paradigm shift that will enable progress to be made in a number of areas where lack of quality improvement has been a long-standing issue, including unrecorded medicines doses. Implementation of ePMA is the only criterion of the Medicines Optimisation Strategy currently rated “red”.

There have been delays in pursuing implementation of ePMA but it is hoped that these will be resolved soon, permitting a plan to be in place in early 2019 and for implementation to be completed by the end of 2020.

Implementation and maintenance of ePMA will require pharmacy support in order to successfully deliver all that is required of it, which creates a need for a specific pharmacy resource to be identified as part of project planning.

Rapid tranquilisation: While there have been improvements in practice, notably in prescribing, audits show a persistent lack of the following: post-injection monitoring, evidence of senior medical review, evidence of debriefing and updating of care plans. The pharmacy department does not currently have a sufficiently large or robust clinical pharmacist resource to provide the consistent follow-up of each rapid tranquillisation incident. Such follow-up would facilitate reflection and review and include education and training to support individual staff development necessary to improve overall performance, and to contribute to clinical supervision for those involved. Pharmacy’s current role is largely limited to retrospective audit, which we have seen to have little meaningful impact.

Environmental temperature monitoring: Although improved, there remain areas that do not consistently record clinic room temperature and/or refrigerator temperatures. Performance is seen to be better in areas with a regular pharmacy presence and weaker in areas more remote from pharmacy support. Pharmacy audits consistently reveal weaknesses such as this however action plans are not implemented by teams. Current pharmacy resources are insufficient for us to take a more active role.

Medicines supply chain: For a number of years the medicines supply chain has demonstrated significant weaknesses, with medicines critical to patients’ mental health have become temporarily or permanently unavailable, or have increased in price by a significant amount (in some cases prices increasing by 10x). At the time of writing there are significant difficulties in obtaining clomipramine capsules and lorazepam injection.

Pharmacy resources and succession planning: Pharmacy staffing has been under significant pressure over the last 12-18 months. While being short staffed has ensured that no roles are “at risk”, there has been an effect on staff morale. Turnover rates have at times exceeded 25% which is not sustainable as even when successors come into post there is a need for induction and training that creates pressure on the existing team members. Newly qualified pharmacists require around two years to gain the post-graduate education and experience required to confidently deliver specialist mental health support to clinical teams. Supporting their development this includes a cost in staff time and financially. Other members of the pharmacy team will typically take three months to induct fully and it takes two years for an apprentice pharmacy technician to qualify. Where we do provide training and development, strategies are needed to improve retention.

The Opportunities

DRRT/CRHT: Pharmacy medicines management technician (MMT) posts have been created in the Dementia Rapid Response Teams and the Crisis Resolution and Home Treatment teams utilising funding from those teams’ budgets. Over the coming year there is opportunity to create and embed effective working practices to help those teams to manage medicines more effectively, efficiently and safely to the ultimate benefit of the patients who use these services. The MMTs will also signpost areas and occasions where clinical pharmacists would be able to offer further support to teams and patients.

Medicines Optimisation Strategy, Dashboard and Action Plan: This represents an opportunity to raise awareness of, and plan improvements in, medicines optimisation across the Trust through a single framework to which all can contribute. Where we previously saw multiple individual action plans there can now be a single plan tied back to the dashboard and in turn to the Medicines Optimisation Strategy and to the Trust Strategy. This paves the way for medicines optimisation to be a greater part of the *lingua franca* of our organisation’s individual components. This is essential to generating meaningful and sustainable quality improvement. Development of more specific metrics for some medicines optimisation criteria will assist to process of providing assurance.

Model Hospital: The “model hospital” is an electronic benchmarking system operated by NHS Improvement (NHS-I). It currently allows benchmarking of medicines and pharmacy KPIs between acute trusts, but from April 2019 will begin to do the same for mental health trusts as it further matures. The following are among the specific mental health parameters to be benchmarked as part of phase 1 implementation:

- Pharmacy staff (WTE) working in generic CMHTs
- Pharmacy staff (WTE) working in CAMHS community teams
- Pharmacy staff (WTE) working in Home Treatment teams
- Pharmacy staff (WTE) working in clozapine clinics
- Pharmacy staff (WTE) working in forensic services
- Pharmacy staff (WTE) working in Early Intervention in Psychosis teams
- % of clozapine clinics with pharmacy staff
- % of Pharmacy Technician time spent on clinical pharmacy activities
- % of Pharmacy Assistant (support worker) time spent on clinical pharmacy activities
- Total number of MDT meetings (where individual patients are reviewed) attended per week

- Average number of consultant/registrar/other ward rounds with pharmacy input per week
- Average cumulative hours per week spent providing clinical pharmacy support for Home Treatment teams / Community teams
- Does the organisation have pharmacists that regularly go out and see patients in their own homes, community clinics or other community setting?

The extension of model hospital into mental health services will allow us to better understand how the service we provide compares to the best in the country and how our pharmacy team should best be developed in coming years. In particular, deployment of pharmacy skills and resources into community-based settings can be used to support patients' recovery and resilience; reducing relapse rates and the pressure on our urgent care infrastructure.

Derbyshire-wide pharmacy workforce development: Plans are in formation to support the development of pharmacy training posts involving rotation between a wide range of practice areas in Derbyshire including acute hospitals, care homes, GP practice and mental health. This is part of a national programme to address shortages in the pharmacy workforce. If we are able to maintain a sufficiently robust pharmacy department we will be able to participate in and influence these initiatives, exposing a greater number of aspiring pharmacy professionals to the rewards and professional satisfaction of the mental health arena. This will also support the department's aspiration to be the mental health pharmacy employer of choice in our region.

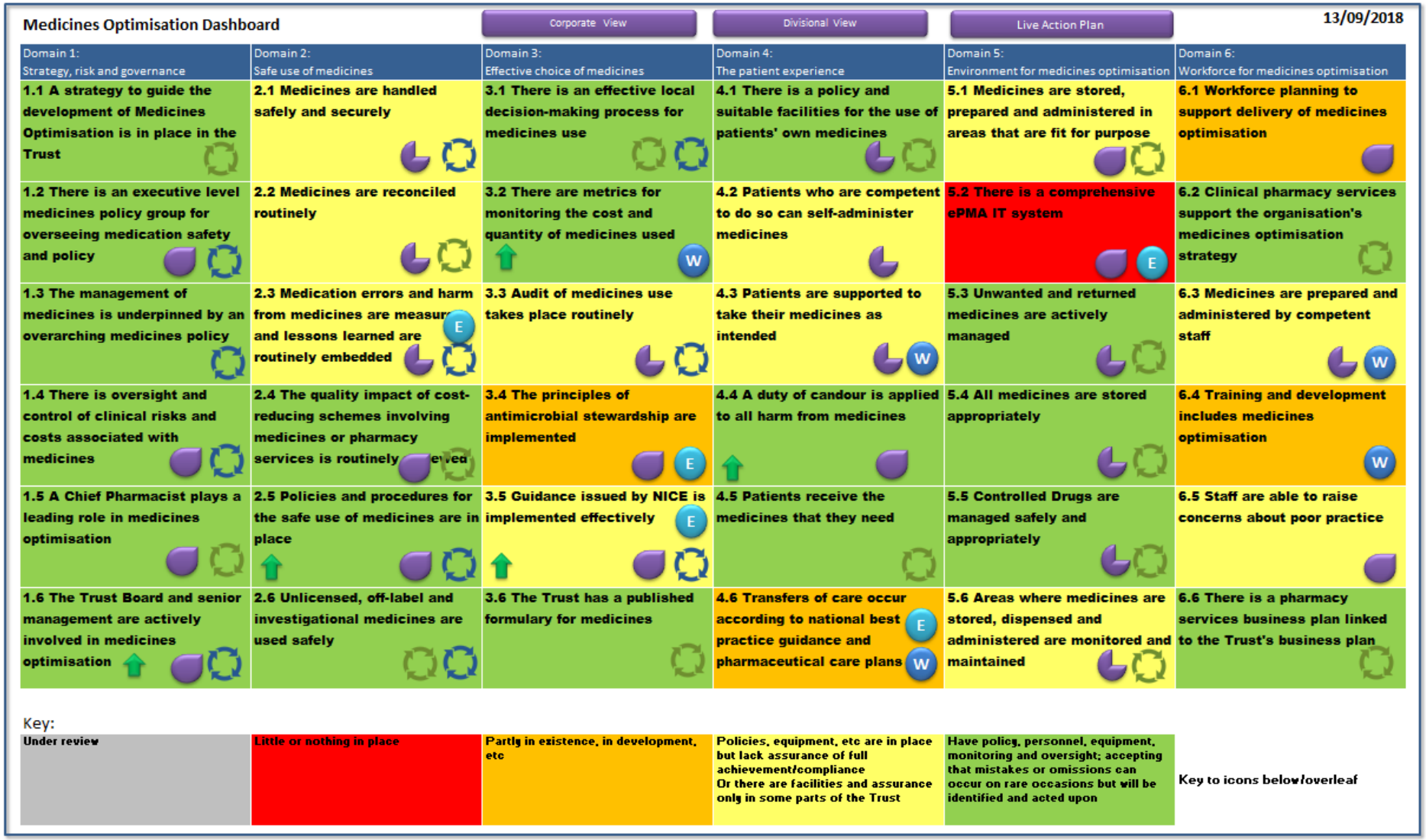
Conclusion

The calendar year 2018 has been once of very significant challenge to the pharmacy department due to acute shortages of senior pharmacists and the need to draw to a close the provision of pharmacy services to DCHS with the associated loss of income. This has limited our ability to drive improvements in medicines optimisation as fully as we would have liked. Without active intervention by the pharmacy team the pace of improvement in medicines optimisation is slow, or negligible in some areas.

Investment in the pharmacy team would release significant potential to improve medicines management practice and optimise medicines use for a greater number of patients. In particular, community based patients could receive support not currently available, to support their recovery and resilience, with benefits to the current pressure on urgent care.

During the year clear strategies have been established for both medicines optimisation and the development of pharmacy services up to March 2021. Information about medicines optimisation and medicines expenditure have been incorporated into dashboards that facilitate efficient and effective discussion and decision making. These require further evolution and wider embedding in order to provide evidence and assurance that the organisation manages its medicines well, and to the benefit and safety of its patients.

Appendix 1: Medicines Optimisation Dashboard



Medicines Optimisation Dashboard

Corporate View | Divisional View | Live Action Plan

13/09/2018

Domain 1: Strategy, risk and governance	Domain 2: Safe use of medicines	Domain 3: Effective choice of medicines	Domain 4: The patient experience	Domain 5: Environment for medicines optimisation	Domain 6: Workforce for medicines optimisation
1.1 A strategy to guide the development of Medicines Optimisation is in place in the Trust	2.1 Medicines are handled safely and securely	3.1 There is an effective local decision-making process for medicines use	4.1 There is a policy and suitable facilities for the use of patients' own medicines	5.1 Medicines are stored, prepared and administered in areas that are fit for purpose	6.1 Workforce planning to support delivery of medicines optimisation
1.2 There is an executive level medicines policy group for overseeing medication safety and policy	2.2 Medicines are reconciled routinely	3.2 There are metrics for monitoring the cost and quantity of medicines used (W)	4.2 Patients who are competent to do so can self-administer medicines	5.2 There is a comprehensive ePMA IT system (E)	6.2 Clinical pharmacy services support the organisation's medicines optimisation strategy
1.3 The management of medicines is underpinned by an overarching medicines policy	2.3 Medication errors and harm from medicines are measur… and lessons learned are routinely embedded (E)	3.3 Audit of medicines use takes place routinely	4.3 Patients are supported to take their medicines as intended (W)	5.3 Unwanted and returned medicines are actively managed	6.3 Medicines are prepared and administered by competent staff (W)
1.4 There is oversight and control of clinical risks and costs associated with medicines	2.4 The quality impact of cost-reducing schemes involving medicines or pharmacy services is routinely …ewed	3.4 The principles of antimicrobial stewardship are implemented (E)	4.4 A duty of candour is applied to all harm from medicines	5.4 All medicines are stored appropriately	6.4 Training and development includes medicines optimisation (W)
1.5 A Chief Pharmacist plays a leading role in medicines optimisation	2.5 Policies and procedures for the safe use of medicines are in place	3.5 Guidance issued by NICE is implemented effectively (E)	4.5 Patients receive the medicines that they need	5.5 Controlled Drugs are managed safely and appropriately	6.5 Staff are able to raise concerns about poor practice
1.6 The Trust Board and senior management are actively involved in medicines optimisation	2.6 Unlicensed, off-label and investigational medicines are used safely	3.6 The Trust has a published formulary for medicines	4.6 Transfers of care occur according to national best practice guidance and pharmaceutical care plans (E) (W)	5.6 Areas where medicines are stored, dispensed and administered are monitored and maintained	6.6 There is a pharmacy services business plan linked to the Trust's business plan

Key:

Under review	Little or nothing in place	Partly in existence, in development, etc	Policies, equipment, etc are in place but lack assurance of full achievement/compliance Or there are facilities and assurance only in some parts of the Trust	Have policy, personnel, equipment, monitoring and oversight; accepting that mistakes or omissions can occur on rare occasions but will be identified and acted upon	Key to icons below/overleaf

Quality Position Statement for Physical Healthcare

Overview

The Trust revised its physical health strategy at the beginning of 2018/19. The strategy lays out our long term commitment to improve the physical health and well-being of the people accessing our services across all age ranges. This is to reduce the mortality gap which national research indicates is currently between 15 and 20 years for people with long term mental health conditions. As the Trust serves a wide population we have looked at the potential for early intervention and ways in which all services can ensure that the people they work with have the best opportunity to live a healthy and fulfilling life.

There are some clear key questions which we need to be able to answer across service lines to assure that we are working to deliver effective care;

- What are we treating someone for (diagnosis, working diagnosis, clinical impression)?
- What are we treating someone with? (medication, clinical interventions)
- What investigations have we undertaken / requested? (Bloods, ECG, lipids, assays, ADL functional assessments, specialist physio etc.)
- What interventions have we undertaken / recommended? (results, review, plan, intervention)
- What difference have they made? (clinical outcomes, harm reduction measures, weight changes, health improvement)

Current position

The Trust currently provides a range of physical health screening and interventions. We audit interventions such as smoking cessation and alcohol support advice provided by our in-patient services.

We submit this data as part of the CQUIN (Commissioning for Quality Innovation) framework which demonstrates that we are achieving a high standard of assessment and intervention against national standards. We also provide annual audits regarding physical healthcare interventions for our SMI (severe mental illness) community to NCAP (National Association of Primary Care) and CCQI (Centre for Quality Improvement) who collate the information from a randomised sample and benchmark our data nationally. This also contributes toward our CQUIN targets.

We provide local audits as well to look at compliance with falls assessment, tissue viability assessments, infection control management and proactive interventions for managing these issues.

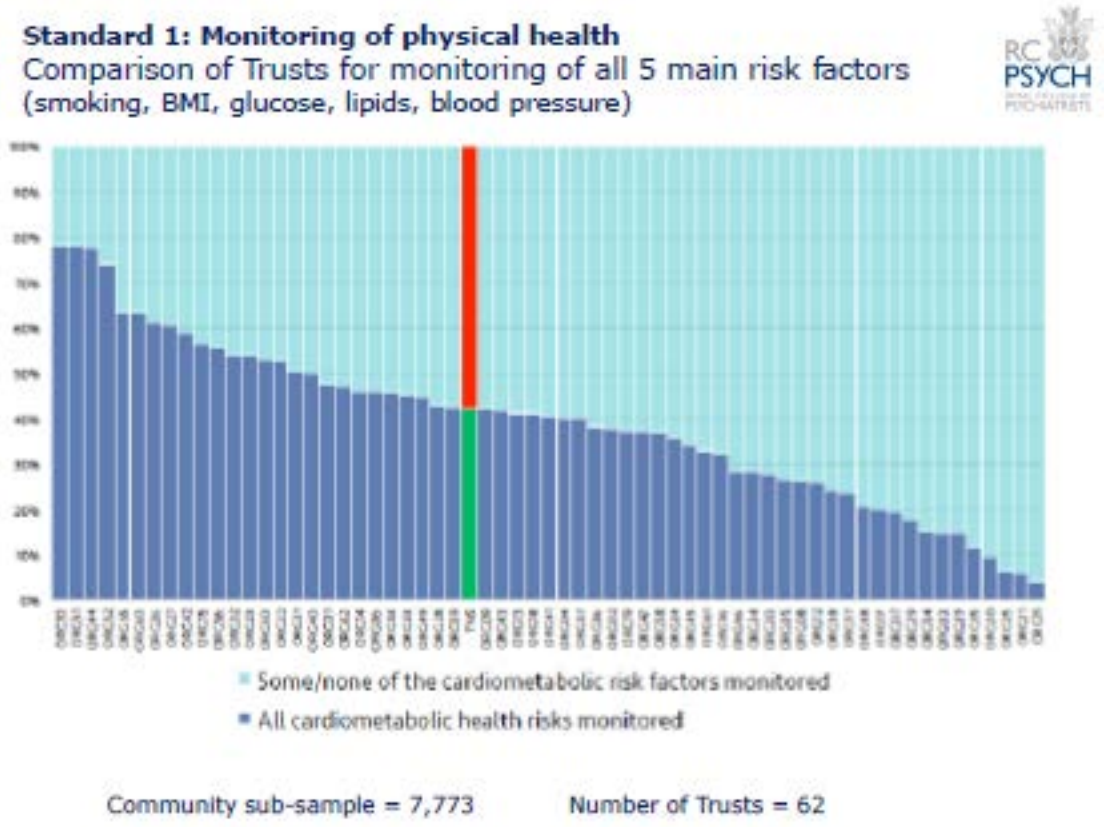
In order to develop reporting compliance we are developing the reporting and recording framework to make inputting information, tracking care and interventions easier and reducing the number of places that information is stored within the system.

The physical health in mental health e-learning package which is intended to support clinicians to understand the purpose and impact of monitoring and intervening in physical heath interventions has been launched and we are currently 65% and increasing compliant with this. There have been some issues with the package which have required resolution in order that clinicians can successfully access and complete the course.

The Challenges

Our audits showed that our reporting framework has limitations in identifying and collating key information. This is due to the way in which the system has been configured and the number of unique templates requested by clinical teams. Some information is extractable and some is not. Diagnosis and medication interventions are challenging to reliably extract across caseloads and these give a clear indication of the level and nature of physical health interventions required.

The rigorous audits carried out for NCAP and CCQI showed our overall compliance was poor. The LESTER tool for example has multiple fields and they have to be completed in accordance with a schedule. Any missing or incomplete element impacts upon our overall score. EIP (early intervention in psychosis) North has managed to obtain compliance of 48% which is above national average for EIP services at 43%. Adult community and In-patient services however have much poorer compliance which brings down the trust average significantly. The key areas for improvement are lipid monitoring and lifestyle advice recording.



The Opportunities

The current pilot in Early Interventions North is to initiate a more refined, reportable and trackable physical health intervention tool which enables us to monitor compliance with LESTER tool schedule. This enables clinicians to see at a glance what is required, when and care plan accordingly. It also enables a live report of compliance which can be augmented with quality audit.

In order to improve community physical health intervention a dedicated team are being recruited as this appears to be the model which has enabled services at the top of the RCP graph to deliver effectively. This group are being recruited into Derby City, Chesterfield and Amber Valley initially. The revised tool will enable us to track the effectiveness of the teams compared to our current position.

The key elements are to have measurable interventions linked to clear cohorts of patients. A reporting framework which enables clinicians, teams and divisions to understand their performance and their gaps and increased focus on the importance of physical health interventions from the clinicians working within our services.

Conclusion

The Trust has a number of challenges to overcome to improve the position. The current approach is to improve the access to monitoring through dedicated clinical staff in key areas. In addition and to support this to make sure that the reporting and recording framework is as easy to access and reliable a possible and to ensure that staff are suitably skilled to provide intervention through dedicated intervention packages.

We are ensuring that our audit mechanism for this year is robust and will have dedicated support from nursing and quality team to ensure consistency and inter-rater reliability. The improvement work within the EPER and dashboards will help manage performance moving forwards. The EIP pilot is also part of a NHSI quality improvement programme and we are currently process mapping lipid monitoring with a view to improving this through a quality improvement strategy. The Physical care committee has been repurposed and is meeting with increased frequency to overs and support the progression of the strategy and actions to deliver it.

KLoE S5(a)

DHCFT Quality Position Statement

Infection Control

Overview

The annual report was presented to the Quality Committee in June 2018 giving significant assurance.

The current audit programme has been reviewed against national infection control guidance and is compliant.

Robust cleanliness measures are in place.

There is strong performance when there are infection control incidents.

Current position

The number of reported cases of key alert organisms is very low.

PLACE scores are higher than the national average.

E-learning issues have been resolved and training compliance is being monitored.

The Local Authority have given our kitchen a 5 star rating for cleanliness.

The Challenges

The influenza vaccination uptake is relatively low – 50% against CQUIN (Commissioning for Quality Innovation) target of 75%.

Training compliance should be better – 73.5% at 31/1/2018.

Vigilance is required around cleaning services, laundry, pest control and maintenance, some of which are provided by external contractors.

The Opportunities

Continued focus on strong, visible leadership; the role of the Infection Control nurses is pivotal.

Upgrade of the estate improves the environment and encourages high standards from staff and patients. Playing our part in the healthcare system to reduce the burden from:

- Sepsis
- Norovirus
- MRSA (Methicillin Resistant Staph Aureus)
- Clostridium Difficile
- CPE (Carbapenemase Producing Enterobacteriaceae)
- Influenza

Summary prepared by Dr John R Sykes

DHCFT Quality Position statement

Safety Planning and Risk Assessment

Overview

Since March 2017 our developments around safety planning have focussed on addressing the rationale for changing from the FACE risk assessment to safety planning and the addressing the subsequent difficulties with the current safety plan form. Clinicians have reported that the current form is too lengthy, takes too long to complete and does not encourage the triangulation of the clinical assessment to the development of a crisis plan and agreed intervention. A number of activities have been undertaken that looked at the quality of safety plans across all clinical areas along with audit work to establish a baseline understanding of quality and compliance.

We are developing a new assessment that is more succinct but that still meets the clinical standard required for robust safety planning and have used input from clinicians to inform its development. A pilot assessment has been rolled out in CAMHS and the proposed new assessment for all services is under development.

The new safety plan is currently available in Paris PLY, ready to add information from the relevant clinical specialities. There is an expectation that the core document will be the same across all the different specialities with separate sections that allow for clinically specific assessment to build a full picture of the person's safety needs that includes their views and those of their carer/ family. The next stage of development is consultation with the clinical specialities planned over August/ September 2018 to define the clinically specific information for inclusion on the assessment.

A frequent review of risk has also been launched to assist those services that review risk several times during their shorter clinical contact such as wards and the Crisis Resolution and Home Treatment (CRHT).

A clinical standard for the completion of safety box entries has been developed and communicated to medical staff. An audit is in process to look at compliance against this clinical standard.

Current position

Safety box completion

	Year 2018-2019		Quarter 1 2018 -2019		Quarter2 2018 - 2019	
	Current Safety Box Risk	Current Safety Box Risk Target	Current Safety Box Risk	Current Safety Box Risk Target	Current Safety Box Risk	Current Safety Box Risk Target
Trust	7676 - 91.21%	90%	4207 - 89.89%	90%	3469 - 92.85%	90%

Safety box completion is on an upward trajectory and an audit of the content and compliance with the clinical standard for safety boxes is underway.

Safety Plan Completion

Division	Proportion of safety plan completed from total case load (pts with open episode)	Percentage safety plan completed from total case load (standard is 90%)
Campus	514/703	73%
Central services	2195/4856	45%
Neighbourhood	10322/24084	43%
Total (YTD)	13031/29643	44%

Safety plan completion is inconsistent across the different divisions and we need to see an improved compliance across all areas.

We are also revisiting the way we report safety plan compliance to ensure that the way we measure the compliance aligns with the standard outlined in policy

The Challenges

Completing the work in the timescale available, given the need to meaningfully engage with staff in the process.

Staff have been very specific about their frustrations with the current safety plan. Engagement events and speaking with individuals and teams have identified consistent issues about the current plan that are going to be addressed by the new assessment. This engagement has proved invaluable in understanding staff concerns and we need to ensure that the revised assessment reflect their comments. This will take time.

Alongside this we have the operational and organisational pressure to compete the work within a reasonable time frame. The assessment content has to be agreed, ratified and incorporated into the assessment before it is piloted and amended as necessary.

Training for staff – eLearning vs face to face

The current learning for safety plan completion takes staff through the process for completing the form only. We also have the Connecting with People training which looks at assessing and working with people around their suicidal ideas. We no longer have clinical risk training face to face and are exploring ways in which we can provide this to staff who find it difficult to attend face to face training.

Auditing in Campus, LD (Learning Disability) and CAMHS (Child and Adolescent Mental Health Services)

We have carried out an audit of safety plans in neighbourhood services and need to repeat this process in the Learning disability, CAMHS and campus services by the end of 2018/19. This will give us a baseline understanding of the quality and clinical improvement issues that need supporting in each area.

The Opportunities

Complete the Auditing of safety assessments in Campus, LD and CAMHS services

We already have the audit tool so this process needs to be completed by the end of 208/19. The process will be led by the Heads of Nursing.

Improving patient safety

Consistent safety planning across the organisation that reflects the clinical needs of the particular clinical specialities is key to improving patient safety. We need staff to have the best tools and feel skilled to be able to complete a collaborative safety assessment wherever possible.

Be more person centred and 'Think Family' focussed

The planned safety assessment builds on feedback gathered from ten CAMHS pilot that we need to have the person's voice alongside that of their family/ carers in any safety assessment that we complete. The new assessment reflects this.

Staff engagement

The work undertaken to change and improve the safety assessment has been done following feedback from staff. The solution is based on their feedback and hopefully the tool will respond to the concerns that they raised.

Improved quality of safety planning

The new assessment will support clinical formulation around risk and there is an expectation that there will be an improvement in the quality of the completed assessment and that they will also include the patient and carer voice. These changes will form part of the audit so we will be able to measure the improvement over time.

Training will empower staff around their clinical decision making and promote clinical formulation around risk

We need to support and skill up our staff to be able to complete good quality safety assessments and providing good quality training will be crucial to this process. However, staff have consistently reported difficulties with attending classroom based training so we need to review what is the best method of delivery to enhance skills and competence.

Conclusion

We continue to use the existing safety plan document and safety box methods of assessment safety needs within the organisation. The levels of completion fall short of our reporting targets, but we have evidence to say that the quality of those completed within the neighbourhood services is mostly sound, where the large majority (76%) and above where deemed to be of 'good enough' standard when measured against a set criteria.

We have established baseline data of compliance elsewhere, which stands us in good stead to review our improvement work over the coming months and have projects and structures in place to complete this work.

We need to repeat the safety plan audit in the campus, CAMHS and LD services to produce a trust wide picture of clinical quality.

We need to complete and analyse the results of the safety box audit and report the findings and agree actions at the Safety plan group.

We need to be clear with our staff what the clinical standard and expectation is of the safety planning process whilst we are completing development work on the new form.

KLoE S5(c)

Restrictive Interventions

Overview

Current policies and procedures created in line with KLOES5 are highlighted as **Positive and Safe Management of Violence and Acute Psychological Distress.** , **Seclusion and Long Term Segregation Psychiatric Emergency Policy and Procedures. Observation of Patients Policy and Procedures** and **Guidelines for the Use of Medication in the Management of Violence and Aggression.**

The safety and welfare of staff, service receivers, families, carers, contractors and visitors who are in contact with Trust services is of paramount importance. This policy promotes safe practice, particularly focusing on reducing the risks associated with challenging behaviour in the form of violence, aggression and harassment.

This policy encompasses six key principles:

- Complying with the European Convention on Human Rights.
- Understanding people's behaviour allows their unique needs, aspirations, experiences and strengths to be recognised and their quality of life to be enhanced.
- Involving people, their families, carers and advocates in decisions about their care wherever practicable and subject to the person's wishes and confidentiality obligations.
- Treating people with compassion, dignity and kindness
- Supporting people to balance safety from harm and freedom of choice.
- Protecting and preserving positive relationships between the people who deliver services and the people they support.

The principles in which staff must understand and adhere to:

- Restrictive interventions should never be used to punish or for the sole intention of inflicting pain, suffering, intimidation or humiliation.
- There must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken.
- The nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm.
- Any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need.
- Any restriction should be imposed for no longer than absolutely necessary.
- What is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent
- People who use services, carers and advocate involvement is essential when reviewing plans for restrictive interventions.
- Restrictive interventions should only ever be used as a last resort.

In order to monitor and provide assurance for the principles above highlighted within the policy key information is required in order to provide assurance. These are:

- Ensuring that de-escalation and alternatives are used prior to the use of restraint or seclusion.
- The use of seclusion or restraint must only be used as a last resort and not as a method of punishment.
- Staff must have adequate training available in managing violence and aggressions.
- All patients who are restrained or place in seclusion must have regular reviews and the least restrictive option must be adhered.
- Seclusion, Rapid Tranquilisation, restraint and appropriate visual and physical monitoring must be audited in regular intervals.
- Carers, service users and advocates must be involved in care planning.

Current position

As part of the information above regular audits are carried out to provide assurance and to monitor improvements in quality. Most recent audits are:

- Seclusion Audit 2018
- Mental Health Act Committee Assurance Summary Report
- Audit into Seclusion and Rapid Tranquillisation
- Audit of Locked Doors Report 2018

Within this audits the use of de-escalation, the use of seclusion, the use of rapid tranquilisation and appropriate follow up are clearly monitored and actions identified from the audit. A regular audit is completed quarterly and is reviewed by the Mental Health Act Committee for assurance.

The Challenges

Within the last report the key findings indicated that there was a lack of consistency in relation to de-escalation prior to the use of rapid tranquilisation or seclusion. There appears to be a lack of clear documentation within the DATIX and PARIS EPR around rational for seclusion or rapid tranquilisation and may be more of a reactive action to an escalation of behaviour. With the nature of an acute ward setting it is likely that at times a patient will become unmanageable to the point of the need of seclusion and this may occur very quickly however, unless a patient is unknown to services, the risk of violence and aggression or behaviours that cannot be managed on the ward are generally known prior to admission and so can be planned for, with clear and robust management strategies in place. A possible contribution for the low numbers of alternatives to restrictive practice is the reducing levels of staffing, which is preventing staff from spending therapeutic time with patients and thus resulting in escalations in behaviour. Another contributing factor may be due to the fast turnaround of staff resulting in changing levels of experience of staff on the ward and varying levels of training that has been completed.

There may also be some learning in relation to the accessibility of the seclusion suite on the Radbourne unit. As there is a seclusion suite available to the staff and is easily accessed, there appears to be a much quicker progression of a patient being placed into seclusion. Evidence of this can be identified at the Hartington unit where there is no seclusion suite and the numbers of patients being placed and managed

through seclusion processes is minimal. With the demographic of patients being the same across both units, this does bring about the question; *are other forms of seclusion being used but not being identified as seclusion?* Further audits and investigations are required to establish this however; another possible source of evidence is highlighted by the use of PICU(Psychiatric Intensive Care Unit)/ECW (Enhanced Care Ward) beds (in and out of area). The Hartington Unit has a much lower number of patients being transferred to ECW or PICU compared to the Radbourne unit. Again there may be an argument around demographic of patients being different for each unit however, there is a constant specified number of Derby south patients within the Hartington unit and data surrounding PICU referrals does not stated that all or the majority of their referrals are of Derby south patients. Therefore, there is further information required into current cultures, practice and learning across all three campus in order to identify the driving factors to current practice.

In relation to the Kingsway Campus there are very minimal episodes of seclusion or restrictive practice. The Kedleston Unit has had one episode of seclusion which lasted less than 24 hours within the last 12 months. Within the Kedleston Unit all patients have a clear risk assessment and care plan identified in relation to their risk history. This is shared with them at the point of creation and is reviewed frequently. Whenever possible, family and carers are also involved. The use of the HCR-20 (Historical Clinical Risk Management-20) tool for all patients also ensures that a thorough assessment of risk is carried out including possible signs of escalation and plans management and prevent.

For the older adult wards there are some episodes of seclusion identified however, there does appear to be appropriate rationale behind this and alternatives to restrictive practice are frequently utilised. There also appears to be patient focused management of challenging behaviours on the Cubley wards where patients have been managed in isolation at specific times of the day where there have been previous incidents. These have always been discussed within the MDT (Multidisciplinary teams) and with carers and family members and has always been done to reduce risk to other patients and staff and also to reduce the levels of distress the patient is presenting. There are however, a large number of incidents of violence and aggression towards staff on the Cubley wards and there appears to be a lack of post incident debriefs or management plans due to the diagnostics of patients and their lack of capacity. Further work will need to be carried out in relation to this.

The Opportunities

1. Seclusion simulation training is ongoing and the initial feedback from staff is very positive.
2. 8 hour seclusion notifications are now being sent to Heads of Nursing.
3. Brosett Violence Checklist to be rolled out across all wards areas as a tool which aids prediction of aggression; this helps staff to intervene earlier as a preventative measure.
4. Development of sensory modulation suite – ECW. The aim is to run a research project to evaluate the impact on violence and aggression, use of rapid tranquilisation and patient experience

5. Further work is being carried out and implemented by AHPs (Allied Health Professional) in order to increase the availability of activities across all campus.
6. Further training may need to be made available in relation to the use of rapid tranquilisation and the use of seclusion – further audits being carried out by the pharmacy department.
7. Further review of patients who have been seclusion within the campus clinical meetings. Peer reviews to be carried out on patient who are frequently secluded when an inpatient.
8. Further Audits to be carried out by clinical lead's and to attend MDM's (Multi-Disciplinary Meeting) regularly.
9. Current service evaluation on admission pathways will commence within the next 4-6 weeks with plans to implement new procedures for bleep holders creating improved plans of care prior to admission including identifying risk management.
10. Audits and deep dive to be completed in relation to violence and aggression on all campus and how they are being managed.
11. Procedures being completed by Police Liaison Office to aid in supporting staff during difficult incidents where police are involved.
12. Further work being carried out on Smoke free environments and managing any violence and aggression attached to this. Further audits to be carried out.
13. Audit into Cubley's and levels of violence and aggression including staffing levels review.

Conclusion

In conclusion to the information above it is clear that there needs to be improvement in relation to the reduction and management of restrictive practice. There appears to be some improvement needs around the education and use of seclusion where there is and where there is not a seclusion room available. The management and pre-planning of patient risk that may require restrictive practices such as rapid tranquilisation should be improved to be more active and less reactive without encouraging restrictive practice. Further education and training is also required for the changing staffing groups and bank staff to ensure a consistency across practice. Furthermore, there needs to be a clear governance process in place to ensure that when restrictive practice is being use there are pathway and procedures to make sure that they are for the shortest time frame possible and that documentation in relation to the identified practice is clear, regular and of a high standard. In order for this to be fully functional and safe a full MDT approach is required. With the altering demographics across the three inpatient Campus there may also be some role in patient demographic focused training. For example the use of restrictive practice will alter on an older adult organic ward to a low secure unit and this may require training to support staff. Within the next 12 months the aim is to ensure that all patients who receive any form of restrictive practice to have a clear care plan and risk management plan, an improved overview of the use of seclusion, improved documentation and improved knowledge for all staff.

Report completed by:

Kyri Gregoriou - Head of Nursing – Radbourne and Hartington.
David Harrison - Professional practice and compliance lead for restrictive practice

KLoE S5(c)

DHCFT Quality Position statement

Learning From Deaths and Serious Incidents

Overview

In line with the CQC's (Care Quality Commission) recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a new national framework for NHS Trusts - *'National Guidance on Learning from Deaths'.* The purpose of the new framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and improved embedded learning.

Following on from this the Trust has implemented a number of actions to meet the National Guidance, these are outlined below;

Progress to date includes:

Learning from Deaths Procedure

A *Learning from Deaths Procedure* has been produced to meet the key points set out in the national guidance with regard to what the document must contain. It has been agreed by the Mortality Review Group and was submitted and approved by the Quality Committee in September 2017.

Mortality Review Group

The Mortality Review Group has been meeting on a monthly basis since February 2017. The Group is chaired by the Medical Director (Executive Lead) .The Mortality Review Group has been focusing on developing the systems and processes to support review and learning from deaths. Progress to date includes:

- Appointment of a Mortality Technician to support the process for review and learning from deaths
- Development of the processes for learning from deaths, culminating in the finalising of the *Learning from Deaths Procedure*, following review and learning from policies from other Trusts
- A flow chart developed to clearly outline this process for staff
- A literature review was undertaken , following which the Group have agreed the 'red flags' for mortality review and 'red flags' for incident reporting which have been included in the *Learning from Deaths Procedure* and the *Untoward Incident Reporting and Investigation Policy and Procedure.*
- The development of a mortality database which collates information on all deaths of patients who have been open to services within the last 12 months. This includes: age, gender, date of death, ethnicity, address, last primary diagnosis, last activity date with trust, team last open to, GP, diagnosis, cause of death (where known). Data is available from January 2017
- Undertook a review of methods for undertaking case note reviews and agreed to pilot two different methods to ascertain the most informative system of review and quantify

the capacity necessary to accomplish this at the scale required. The Trust now uses a method called PRISM which has been amended to meet the Trust needs.
- Undertook a pilot of deaths reported as incidents against the draft 'red flags' for mortality and incidents, to ensure the proposed process will be safe and effective
- Regular audits continue to be undertaken to ensure compliance with policy and procedure.

Bereaved Families and Carers

The National Quality Board has made a number of recommendations in relation to engagement with families during the process. The Trust has a duty to engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to and investigating a death.

The Trust has a Family Liaison Team, who make contact with all families (when contact details are known) of all deaths reported through the incident reporting process (Datix), as part of the legal requirements for Duty of Candour and to support and involve families in the investigation process.

Obtaining Cause of Death (COD) information:

As a Trust we are not readily able to obtain cause of death information, the Mortality Technician, currently liaises with local coroners and General Practitioners (GP) to obtain this. However, external agencies such as GPs are not always aware of a death and/or do not have the relevant information / permissions required. Once a patient has been marked as deceased on GP notes, GPs then lose access to the patient records; this then becomes owned by NHS digital. The Trust has applied for a licence from NHS Digital and access to obtain such information. Dr John Sykes as the Caldicott Guardian for Derbyshire Healthcare and Rachel Williams Lead Professional for Patient Safety and Experience have been delegated responsibility for the data. It is proposed that the Trust's Mortality Technician will access and analyse the data for public health purposes.

Current position and Benchmarking

As of 31 August 2018 the Trust currently has 78 deaths to review under the Learning from deaths Procedure that meet the criteria defined below. The Mortality Review Group has currently case reviewed 75 deaths. These reviews were undertaken by a multi-disciplinary team and it established that of the 75 deaths reviewed, 68 have been classed as unavoidable and 7 are on hold pending cause of death

The Mortality Review Group is currently reviewing deaths of patients who fall under the following 'red flags', these categories will change during September 2018:

- Patient on end of life pathway, subject to palliative care
- Patient prescribed anti-psychotic medication
- Referral made, but patient not seen prior to death
- Death of patient on Clozapine

Summary of recent benchmarking data:

Trust	Period	Total deaths	Serious incidents	LD deaths	CDOP deaths	Deaths reviewed using SJR/CNR
Derby	April-June 2018/19	515 April-June 2018	58	6	23	75 reviewed using CNR method from January 2018 to date
Northampton	April-June 2018/19	120 April-June 2018	0	4	1	Deaths reviewed using Structured Judgement Review: 7
Nottingham	April-June 2018/19	There were **1737** deaths reported from 1 April 2016 to 31 March 2018	Q3= 18 Q4= 16	unknown Q3	unknown	9 reviewed using CNR process 152 With regards to Case Note Reviews (CNR) current status is the Trust has had two cohorts of volunteers who have agreed to pilot the reviews. The first cohort will meet at the end of May 2018 to review the reports and reflect on process. The second cohort will meet at the end of June 2018. The Trust will review the outcomes of this pilot before allocating any more for reviews.
Lincolnshire	April-June 2018/19	253 April-June 2018	10	12	unknown	During 2017/18, 28 cases of deaths have been allocated for SCJR. Of the 28 cases allocated, 13 have been reviewed.
Coventry & Warwickshire	April-June 2018/19	253 April-June 2018	10	12	unknown	During 2017/18, 28 cases of deaths have been allocated for SCJR. Of the 28 cases allocated, 13 have been reviewed.

The Challenges

Challenges include:

- Reviewing of all deaths as outlined in the national guidance, as this is a significant change to practice. Please note there is no national recommended standard to this review for Mental Health.

- Delay in obtaining cause of death- due to information governance requirements and setting up a new way of working, this will reduce reliance information sharing by the coroner and give direct access with NHS Digital. This is currently in progress.

- Medical colleague availability to undertake case note reviews

- The sensitivity of our incident recording system means that the total numbers of deaths are potentially higher than comparable trusts.

- Time constraints- the operational focus to review this with purpose to ensure the organisational quality improvement and learning is timely. Our governance groups will inevitably require a period of time to review the data to understand what conclusions we can draw and identify further information to analysis and improve practice.

- So far the mortality reviews are giving assurance through lack of concern as no learning points have been identified.

The Opportunities

- A more positive approach to mortality reviews based on appreciative inquiry (AI) which is a strength based approach to organisational learning and change that is different to the traditional problem solving approach. It is intended to support the adoption of learning from excellence (LFE). The premise is to simply identify what we do well and how we do more of it. For example, mortality reviews show a very person centred approach to clinician intervention but this is rarely related to the frameworks of care planning or safety planning. This reinforces the impression that person centred care and engagement is somehow seen as a separate process to assessment. In reviews we have only come across one example of a care plan written in the first person.

- The medical team (North) will be attending Mortality case note reviews on a weekly basis by utilising a rota system this will increase availability of medics to undertake reviews.

- An Executive Serious Incident group will convene every six weeks to consider the overarching themes.

Serious incidents

Overview

The Patient Safety team has undergone a number of changes over the past 12 months. A new Professional Lead for Patient Safety and Experience was appointed in June 2017 , this coincided with the appointment of 2 new Investigation Facilitators. A number of changes have been made to the systems and processes in relation to Serious Incidents including better and more cohesive working relationships between Operational teams, Complaints, Family Liaison and People Development. The patient safety team are responsible for all incidents graded as major or catastrophic, any incident graded below this are dealt with through the risk team managed by the Risk Manager.

The Trust has an updated Untoward Incident Reporting Policy and Procedure and also ensures that it meets the requirements of the Serious Incident Framework.

Below are examples of changes made to the processes (this list is not exhaustive):

- Changes to the alerts within Datix, alerts are now received by Patient Safety department of any incident of allegation against a staff member regardless of the grading.
- Regular publication of Practice Matters
- Regular publication of Blue Lights
- Excellent working relationships with the CCG
- Changes to the ‘back office’ of Datix so that information and reports can be quickly and efficiently produced
- Better working relationships with other areas within the Trust and office
- Updated Untoward Incident Reporting Policy and Procedure which clearly outlines when a death should be reported on to Datix
- Reclassification of Action themes
- Actions from Serious Incidents are becoming SMARTER.
- All incidents have been reviewed to ensure accuracy of data in Datix

Current position and benchmarking

- There has been a slight increase in the number of incidents reported externally in 2017/18 with 89 compared to 58 for 2016/17.
- It is important to note that the number of deaths reported through the Datix system has increased significantly from 89 (2016/17) to 159 (2017/18),
- There have been 8 Homicides reported between April 2017 and 2018
- The Contract Performance Notice relating to the Complaints and Incident reporting was completed 3 months ahead of schedule (January 2018)
- Duty of Candour - there have been 15 Duty of Candour incidents during 2017/2018 and all have been responded to.
- Schedule 28 Reports, there have been no Schedule 28 Regulations received during 2017/18.

- Never Events, the Trust has reported one never event during 2017/18 in relation to medication error.
- The number of overdue investigations has decreased from 26 to 3 currently overdue

Benchmarking

On a six monthly basis the Trust receives a high level summary report benchmarking the Trust against other trusts. In March 2018, the presentation of this data changed and is now provided as an excel spreadsheet providing more detail, following review of this data the Risk Management Team noticed a high number of incidents of 'severe harm' in comparison to other (larger) trusts of which the internal Datix system did not match.

Organisation name	Severe	Death
DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	31	26
NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	1	13
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	2	10
SOUTH STAFFORDSHIRE AND SHROPSHIRE HEALTHCARE NHS FOUNDATION TRUST	0	1

Subsequently the Risk department noticed an issue in the mapping to the NRLS system and that this was incorrectly set from the initiation of Datix and the degree of injury/harm data had been incorrectly mapped to the actual incident outcome for the output to the NRLS.

For example all incidents reported on Datix as a Major Outcome, were reported as Major Injury Harm which is incorrect, many incidents which are reported as a Major Outcome don't lead to Major Injury/Harm – such as Information Governance (IG) breaches, absconsion, allegations etc.

The table (1) below shows the figures reported to the Trust for the time period being considered which aligns with the figures produced in the benchmarking data above.

Table (1) Incidents reported on NRLS (Data source: https://report.nrls.nhs.uk/explorerTool/default.aspx)

	Severe	Death
01 Apr 15 - 30 Sep 15	38	13
01 Oct 15 - 31 Mar 16	36	24
01 Apr 16 - 30 Sep 16	45	17
01 Oct 16 - 31 Mar 17	26	15
01 Apr 17 - 30 Sep 17	8	26
01 Oct 17 - 31 Mar 18	Not yet submitted	

Table (2) Incidents reported on the Incident Reporting system (Data source: Datix system as at 06/09/2018)

	Severe	Death
01 Apr 15 - 30 Sep 15	8	15
01 Oct 15 - 31 Mar 16	6	26
01 Apr 16 - 30 Sep 16	15	17
01 Oct 16 - 31 Mar 17	6	16
01 Apr 17 - 30 Sep 17	7	27
01 Oct 17 - 31 Mar 18	11	17

The above data (table 2) is the correct incident figures for the Trust with the correct mapping for the time period in question, it is not possible to amend the data produced by the NRLS but moving forward this data provided by the trust will be accurate. Since the Risk Management team identified the issue they have worked to re-map ALL incidents so that the Actual Incident Outcome and degree of Injury/Harm are now correctly aligned to the National Reporting and Learning System (NRLS) mapping.

The next report from the NRLS is due to be published at the end of September 2018 (for incidents reported between 1 October 2017: 31 March 2018). This report will be correct.

Challenges

- Number of available staff to undertake Serious Incident Investigations
- Quality of Serious Incident Investigations ie grammar, spelling, lack of information
- Ensuring a minimal number of overdue Serious Incident Investigations remain to the Clinical Commissioning Group
- Reducing number of overdue actions from Serious Incidents
- Initial Service management reviews not completed within five days with important patient data missing.
- Supporting staff appropriately when they are involved in a Serious Incident

Opportunities

- To introduce the concept of “second victims” when staff are traumatised following incidents. The SI group/mortality group will consider how to take this concept forward in order to support staff more. One way of doing it would be to wrap up support to individuals and teams at an early stage and certainly as part of initial feedback from SI investigations and to involve them more in formulating initial conclusions so they feel that the process is formative and supportive and not assessment based and blaming.

- The Patient Safety team will continue to work with Operational teams to reduce the number of overdue actions

- Buddying system for new and pre-existing Serious Incident Investigators to improve quality.

- Increased number of Root Cause Analysis Training days available therefore increasing number of investigators who have had the appropriate training.

- Patient Safety Team to recommence operational teams/meetings to discuss role

Learning the lessons

A recurrent theme in Serious Incident investigations is the issue of care planning. A key element of this is whether a patient is placed on care programmes approach or not. National and local policy points towards “complexity” and “risk” as being key factors for consideration. The problem is, of course, that many, if not most of patients who are retained in our service following initial assessment could potentially fulfil these criteria.

The SI executive group looked at this issue in some detail when considering a mental health homicide report. Learning points were as follows:

- It is proposed to produce case vignettes which will be sent to neighbourhood teams to consider for CPA as part of their usual procedures. They will be invited to comment on what drives their decision making. Is it based on purely person centred factors or resource allocation or a combination of the two?

- The Medical Director has issued a Top 5 list of factors to consider during risk assessment and has invited feedback.

- Further guidance regarding to CPA procedures once we have received CQC feedback and patient/carer/family involvement in care planning will be audited.

In a separate meeting the safety planning group considered the recent audit results of community team safety planning and this in turn was reported to the Quality Committee. Although the situation seems to be improving patients and carer/family involvement in safety planning is still below what we would expect. It is thought that many clinicians still see processes such as safety planning as an administrative exercise to be completed outside of the real event of patient engagement and have not embraced the notion that assessment can be therapeutic in its own right if the patient and family are fully involved in it.

Learning points from this:

- These issues will be explored during the John Dawkins visit (23 August) to see if lessons can be learnt internationally.
- Likewise research on self-harm and suicide reduction will be reviewed and presented at the Sean Duggan visit (5 September).

Finally the Big 5 themes identified by the Mental Health Act Committee following regular CQC inspections ie:

- Patient involvement in care plans
- Carer/family involvement in care plans
- Capacity assessments to underpin the above
- Section 17 leave
- Physical healthcare monitoring

are similar to many of the themes picked up in SI investigations and will be part of a newly proposed overview structure for CQC regular visits that has been considered at the Mental Health Act Committee.

The learning from this is as follows:

- There are common themes, particularly regarding care planning, spanning SI investigations, mortality reviews, CQC MHA visits and safety planning. Action planning from the various groups and committees needs to be complementary with a simple coherent message and method for clinicians. This will be taken forward under the new approach to CPA with outstanding areas to consider being:

  * the approach taken to patients who do not reach the threshold for CPA
  * the clinical pathway for those with so called “personality disorder”

  These issues will be picked up by the various groups mentioned as we go forward and again reflected in how we learn the lessons.

Electronic patient record

Investigations highlighted that clinicians did not have 24/7 access to vital clinical information and have now rolled out an electronic patient record in all areas which was completed in April 2017.

Interface between services

Clinicians can now access SystmOne for substance misuse services as well as our mainstream PARIS. IMT&R have implemented a solution which records directly into the patient’s SystmOne record; both as an alert visible on the top bar of all records (this has an associated description when the cursor hovers over the icon), and a note in the patient record at the point of referral into, and discharge from, Mental Health Services. A hyperlink has also been created for the alert which takes the clinician to WebMPI.

Joint care planning

Now that clinicians have 24/7 access to electronic patient records and can access more than one system we are developing a policy for joint care planning.

Review of Crisis and Home Treatment services and overall capacity in neighbourhoods

As a result of serious incidents clustering around our Crisis and Home treatment teams there has been a review of the functioning of these teams and our overall neighbourhood capacity. CRHT services have been subject to an extensive internal, peer-reviewed evaluation following concerns raised both internally and externally in relation to capacity, demand and safety of the services, particularly in the Derby City and South County team. Recommendations from the review are informed by the evidence base around CRHT, including current and future nationally developed service and practice standards and are consistent with the strategic aims of the Trust. These recommendations have been approved and we are now in the implementation stage, which is expected to take approximately nine months.

Safety planning training/suicide prevention training

In response to the rising number of suicides in Derbyshire which have been increasing from below the national average to the national average, which itself is increasing, we have instigated suicide prevention training.

The Trust's strategy for the prevention of suicide was launched in July 2016 and implementation of the 10 priorities for 2017- 2018 is well established. The accredited Connecting with People suicide awareness and response training has now been delivered to over 60% of the identified workforce, and more recently, a bespoke training package has been developed in partnership with Public Health and Connecting with People, for delivery to GPs and primary care practitioners across Derby and Derbyshire. Validated clinical tools are soon to be uploaded to PARIS to support clinical decision making in the assessment of suicide risk, which can be used by people who have completed the training. It is hoped that the tremendous success of our World Suicide Prevention day event held at Derby County football ground last year will be repeated this year, with events being held at both Derby County and Chesterfield football grounds. Finally, a self-harm project group is developing guidance to help us provide safer, more compassionate care to people who self-harm.

In order to improve on our patient centred approach we have instigated safety planning training to complement Think Family training.

Near misses

A number of near misses were noted following releases from Nottingham prison. This was escalated by Derbyshire Healthcare Board to Nottinghamshire Care Trust. We have also escalated one particular case to NHS England who are commissioning a near miss homicide review. In order to improve our own response we work closely with Commissioners who now have the responsibility for placing people in PICU (Psychiatric Intensive Care Unit) beds, where clinically necessary. However, for a number of years we have employed a Complex Case Manager who works together with Commissioners to ensure that people are placed appropriately and that their care is regularly reviewed. Patients only remain in PICU beds for as long as clinically appropriate. The care of people in the community who have been released from prison or high secure units with a learning disability or serious mental illness has

been highlighted as a commissioning gap i.e. there is no forensic community provision for either mental health or learning disability service users.

Commissioners recognise this as high risk and through the Transforming Care Board, which is responsible for people with a learning disability being appropriately cared for in the community. We have secured investment to begin to develop a very small community forensic service for service users with a learning disability. It must be noted that this will be a very small service and does not in any way provide the level of service that is nationally recommended, nor does it provide for mental health service users. This remains a significant commissioning gap.

Conclusion

The Mortality and Patient safety team will continue to improve systems and processes in line with any new guidance or policy which is issued by external organisations to ensure that the Trust is meeting all relevant standards.

The team will continue to work closely with Operations to assist them to meet the deadlines/requirements for serious incident investigations and CCG (Clinical Commissioning Group) to meet their reporting requirements.

DHCFT Quality Position statement

Emergency Preparedness, Resilience and Responsiveness [EPRR]

Overview

The Trust has maintained a position of full compliance against the national standards throughout the year and, we believe, that thus will be sustained going into this year's self-assessment bearing in mind the changes that have been introduced.

All EPRR policies are currently up to date and those that are approaching review are being reviewed.

The Trust is required to be compliant against the National Core Standards in order to meet the requirements of the Civil Contingencies Act, 2004.

Current position

The Trust EPRR Steering Group is responsible for overseeing continued compliance against the Core Standards. The Director of Operations and the Assistant Director for Safeguarding Adults will be undergoing scrutiny by the CCG and NHSE of the completed self-assessment against the Core Standards on 8 October 2019.

The Trust has declared one Major Incident in the past 12 months relating to a Fire System fault impacting the Radbourne Unit.

The Trust has coped well with significant disruption impacting the Radbourne Unit relating to power and water supplies over the past 4 months.

The Trust continues to be fully engaged with relevant groups and work streams as required by our local commissioners and by leads at NHS England.

From the Steering Group we continue to enlist the help of colleagues and EPRR leads in partner organisations as required to maintain our compliance and to further develop specific pieces of work e.g. NHS England supporting with planning training exercises scheduled for November / December 2018.

The Challenges

The key challenge to sustaining our compliant position relates to a current lack of a dedicated staffing resource to manage the EPRR workload. It is hoped that this will improve in quarters 3 and 4.

We have more work to do with regard to Business Impact Assessments and Business Continuity Plans in order to attain consistently good standards across all of our service lines. We know where we need to focus our efforts going forward.

Our learning from the Major Incident regarding the Radbourne Unit Fire System demonstrated a state of readiness to deal with unforeseen events but has prompted us to think how we

would cope in the event of a sustained Major Incident occurring at the start of a weekend for example.

The Opportunities

As a Steering Group we are pleased with the progress that we have achieved since we began our work in October 2016. We have reviewed our meeting frequency from monthly to 2-monthly and we intend to continue to take opportunities to learn from our partner agencies, attend local and regional forums and take an active role in County and Regional Training Exercises.

The work that has been undertaken with Trust Psychology colleagues to review and update the Human Aspects Major Incident Response Team [MIST] screening processes, letters and guidance for children, young people and adults has been well received in the EPRR community. We continue to work closely with the County lead for Human Aspects.

Conclusion

We continue to work hard to maintain our good standing in the EPRR community. Capacity is a challenge at times but our attendance at relevant meetings is more than satisfactory and we have maintained a fully compliant position thus far.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 October 2018

Learning from Deaths - Mortality Report

Purpose of Report

To meet the requirements set out in the 'National Guidance on Learning from Deaths[1]' which outlines that the Trust is required to collect and publish on a quarterly basis specified information on deaths.

Executive Summary

In line with the CQC's recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a new national framework for NHS Trusts - *'National Guidance on Learning from Deaths'*. The purpose of the framework is to introduce a more standardized approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and improved embedded learning

Progress to date includes:

- Since April 2017 the Trust has received 3314 death notifications of patients who have been in contact with our service.
- From 1 April 2017 to 31 August 2018, 297 deaths were reported through the Trust incident reporting system (Datix). Of these, 286 were reviewed through the process of the Untoward Incident Reporting and Investigation Policy and Procedure of which 92 warranted a further investigation. 193 reported incidents were closed by the Serious Incident Group.
- The Trust has recorded 18 inpatient deaths, of all which have been reviewed under the Untoward Incident Reporting and Investigation Policy and Procedure.
- As a way to access a national database for cause of death, our application for NHS Digital continues and the Trust is currently awaiting an outcome. This continues to be a slow process to ensure that the Trust meets all of NHS Digital legal requirements.
- 75 deaths have been reviewed through the Learning from Deaths Procedure
- 286 deaths have been reviewed under the Untoward Incident Reporting Policy and Procedure
- It is not possible with present resources to investigate or (case note) review all deaths. The “red flag” sampling method for mortality (case note) reviews is providing assurance through a lack of concern – no untoward issues have been identified in the 70+ reviews conducted so far. This has been agreed, by the Quality Committee, as a proportionate use of clinical and administrative resources. The lack of progress with NHS Digital to access the Cause of

[1] National Guidance on Learning from Deaths. National Quality Board. March 2017

Death in all cases is frustrating and has been raised by the Medical director at national meetings. Apparently the issue is under consideration. Likewise the decision not to involve or inform families of mortality (case note reviews) has been endorsed by the Quality Committee. Contacting families so long after a death would be likely to cause alarm and distress. If anything untoward was to be found a full SI investigation would be triggered and families informed and involved at that stage.

Challenges include:

- Undertaking a case note review of all deaths as outlined in the national guidance, within available time. The Trust approach and its limitations are described above. We do not appear to be an outlier with this approach but there is great variability across the country
- Delay in obtaining cause of death
- Medical colleague availability to undertake case note reviews- this has been escalated to the Executive Leadership Team
- The sensitivity of our incident recording system means that the total numbers of deaths are potentially higher than comparable trusts.

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	
3) We will develop our **people** to allow them to be innovative, empowered, engaged and motivated. We will retain and attract the best staff.	
4) We will **transform** services to achieve long-term financial sustainability.	

Assurances

- Our approach to ensuring that we're meeting the guidance supports Board Assurance risks. Failure to achieve the clinical quality standards required by our regulators with regards to learning from deaths may lead to harm to service users
- This report provides assurance that the Trust is following recommendations outlined in the National Guidance on learning from Deaths – *A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care*

Consultation

Deputy Director of Nursing and Quality Governance and Medical Director

Governance or Legal Issues

There are no legal issues arising from this Board report.

The Care Quality Commission Regulations this report provides assurance to are as follows:

- Outcome 4 (Regulation 9) Care and welfare of people who use services
- Outcome 14 (Regulation 23) Supporting Staff
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
- Regulation 20 Duty of Candour

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).

There are no adverse effects on people with protected characteristics (REGARDS).	x
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	

Actions to Mitigate/Minimise Identified Risks

We are making an assertive effort to ensure that there is attendance from the multi-disciplinary team to attend Case Note Reviews to ensure quoracy. This is being monitored through the Mortality Review Group and Executive Serious Incident Group

Recommendations

The Board of Directors is requested to accept this Mortality Report as assurance of our approach, and agree for it to be published on the Trust website prior to end of October 2018, as per national guidance.

Report presented by: **John Sykes**
Medical Director

Report prepared by: **Rachel Williams**
Lead Professional for Patient Safety and Patient Experience

Aneesa Alam
Mortality Technician & Legal Services Support

Learning from Deaths - Mortality Report

1. Background

In line with the CQC's recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a new national framework for NHS Trusts - 'National Guidance on Learning from Deaths[2]'. The purpose of the new framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and improved embedded learning.

The Guidance has outlined specific requirements in relation to reporting requirements. From April 2017, the Trust is required to collect and publish every quarter specified information on deaths. This is through a paper and Board item to a public Board meeting in each quarter, to set out the Trust's policy and approach (by end of Q2) 2017-2018 and publication of the data and learning points by Quarter 3 2017/18. The Trust should include the total number of inpatient deaths and those deaths that the Trust has subjected to case record review. Of these deaths subject to review, we are asked to consider how many of these deaths were judged more likely than not to have been due to problems in care.

The report presents the data so far from April 2017 incorporating new data for the periods June, July and August 2018.

2. Current position and progress

- As a way to access a national database for cause of death, our application for NHS Digital continues and the Trust is currently awaiting an outcome .This continues to be a slow process to ensure that the Trust meets all of NHS Digital legal requirements.

- The Mortality Review Group continues to undertake regular case note reviews however medic availability remains a challenge.

- Regular audits continue to be undertaken to ensure compliance with policy and procedure.

[2] National Guidance on Learning from Deaths. National Quality Board. March 2017

3. Data Summary of all deaths

Month	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Total Deaths Per Month	198	211	230	182	198	195	182	166	230	260	204	225	175	193	147	194	124
Inpatient Deaths	0	2	0	4	0	1	0	1	1	1	3	1	1	0	2	1	0
LD Referral Deaths	2	1	1	3	3	4	0	5	4	4	3	3	2	4	0	6	4
CDOP ** deaths	4	4	6	9	11	6	5	3	5	9	5	4	7	10	6	1	5

Correct as at 31.08.18

* *Learning Disabilities*

** *Child Death Overview Panel*

Since April 2017 the Trust has received 3314 death notifications of patients who have been in contact with our service. The figure elsewhere in this paper (4,078) is for all deaths from 1 January 2017. Initially, the Trust recorded all deaths of patients who had contact within the last 12 months but this was changed after discussion with Commissioners to contact within the last six months. This took effect from 20 October 2017.

4. Review of Deaths

Total number of Deaths from 1 April 2017 – 31 August 2018 reported on Datix?	297 (of which 20 are reported as "Unexpected deaths")
Number reviewed through the Serious Incident Group	286 (1 was not reviewed by Serious Incident Group and 10 pending for a review).
Number investigated by the Serious Incident Group	92 (205 did not require an investigation)
Number of Serious Incidents closed by the Serious Incident Group	193 (104 currently opened to Serious Incident Group, as at31 August 2018)

The Trust has recorded 18 inpatient deaths, of all which have been reviewed under the Untoward Incident Reporting and Investigation Policy and Procedure.

Only deaths which meet the criteria below are reported through the Trust incident reporting system (Datix) and these are also reviewed using the process of the *Untoward Incident Reporting and Investigation Policy and Procedure*.

Any patient open to services within the last six months who has died and meets the following:

- Homicide – perpetrator or victim.
- Domestic homicide - perpetrator or victim
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatient who died within 30 days of discharge from a DHCFT hospital
- Death following an inpatient transfer to acute hospital
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLs) authorisation
- Death of patient following absconsion from an inpatient unit
- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family / carer / The Ombudsman, or where staff have raised a significant concern about the quality of care provision
- Death of a child (this will also be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death
- Death of a patient with historical safeguarding concerns, which could be related to the death
- Death where a previous Coroners Regulation 28 has been issued
- Death of a staff member whilst on duty

- Death of a child under the age of 18 of a current or previous service user who has died in suspicious circumstances
- Where an external organisation has highlighted concerns following the death of a patient whether they were open to the Trust at time of death or not

5. Learning from Deaths Procedure

As of 31 August 2018 the Trust currently had 78 deaths to review under the Learning from Deaths Procedure that meet the criteria defined below. The Mortality Review Group has currently case reviewed 75 deaths. These reviews were undertaken by a multi-disciplinary team and it established that of the 75 deaths reviewed, 68 have been classed as unavoidable and 7 are on hold pending cause of death.

The Mortality Review Group is currently reviewing deaths of patients who fall under the following 'red flags', these categories will change during September 2018:

- Patient on end of life pathway, subject to palliative care
- Patient prescribed anti-psychotic medication
- Referral made, but patient not seen prior to death
- Death of patient on Clozapine

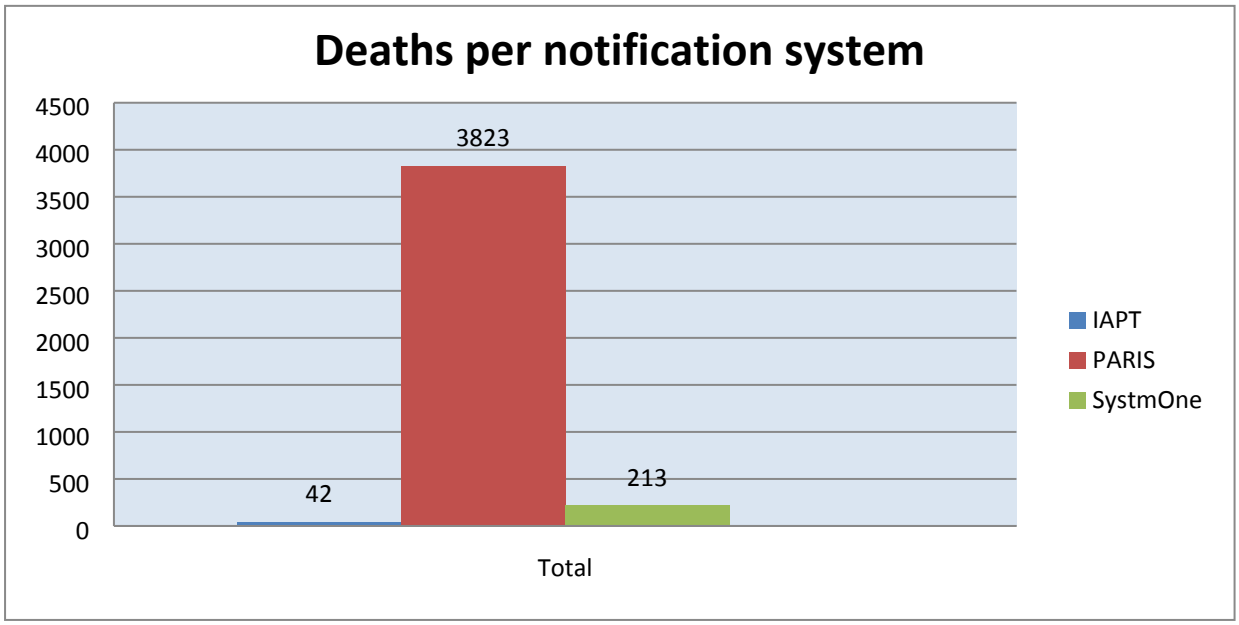
Initial analysis of death notification information shows the most prevalent causes of death are:

- Alzheimer's Dementia / Vascular Dementia
- Old Age
- Ischaemic Heart Disease

Undertaking Case Note Reviews of deaths remains a challenge due to lack of medical colleague availability. This lack of availability has resulted in a 28 Case Note Review meetings being cancelled.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 January 2017

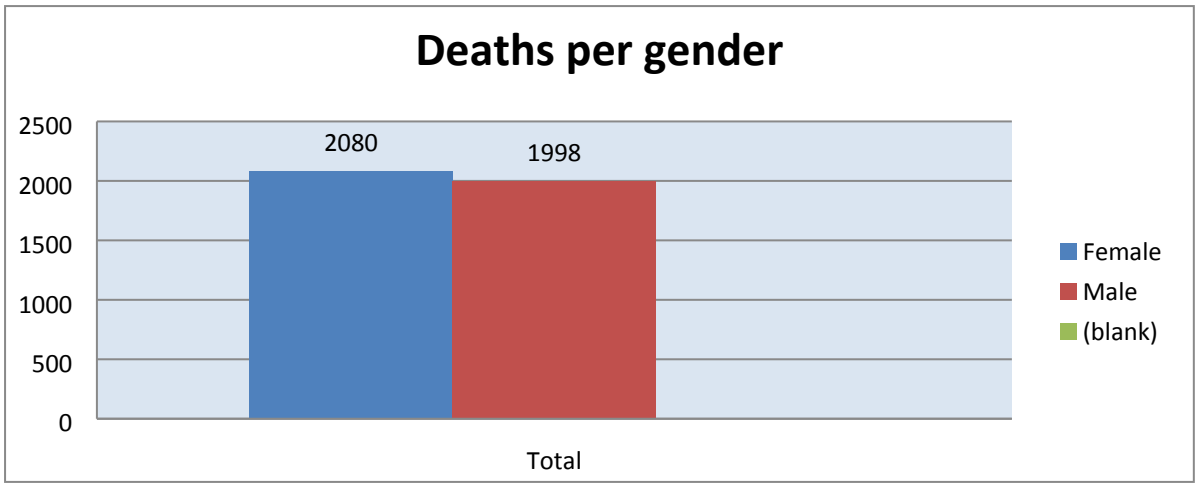


	IAPT	PARIS	SystmOne	Grand Total
Count of Source System	**42**	**3823**	**213**	**4078**

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from PARIS, as we would expect as this clinical record system is aligned to our largest population of patients and a population at greatest risk of death due to the proportion of older people in our care. 213 death notifications were pulled from SystmOne and 42 from IAPT.

6.2 Deaths by gender since 1 January 2017

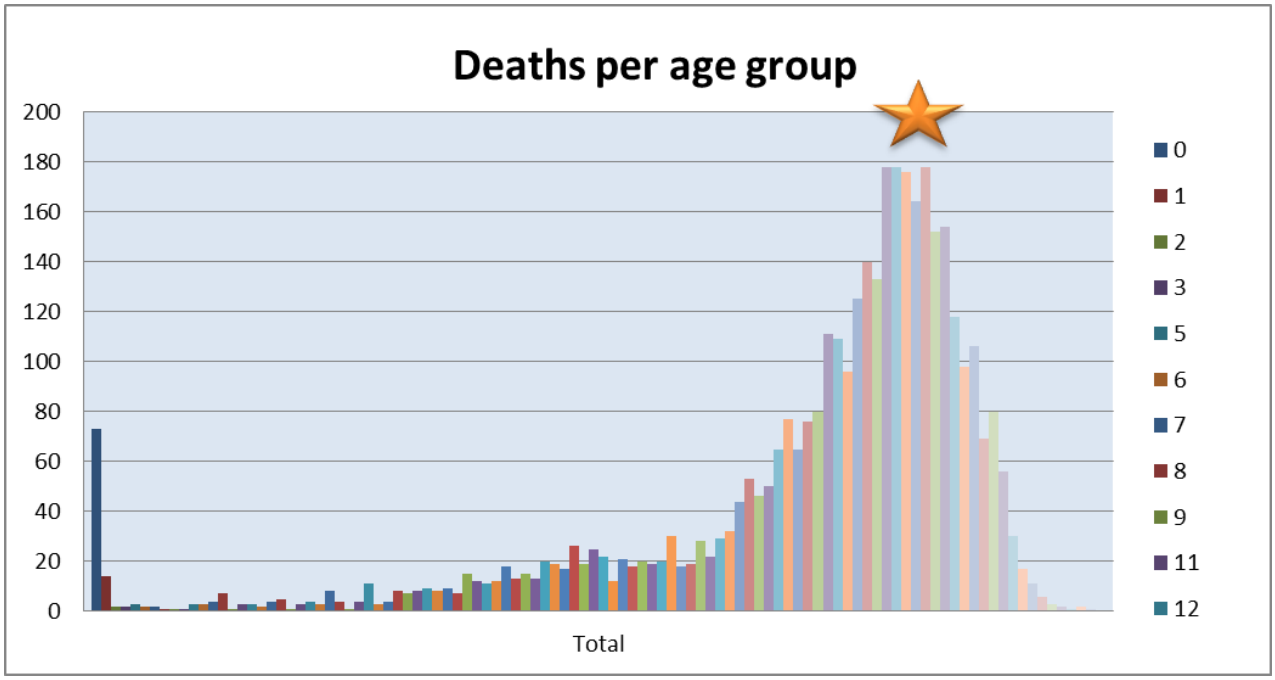
The data below shows the total number of deaths by gender since 1 January 2017. There is very little variation between male and female deaths; 1998 male deaths were reported compared to 2080 female.



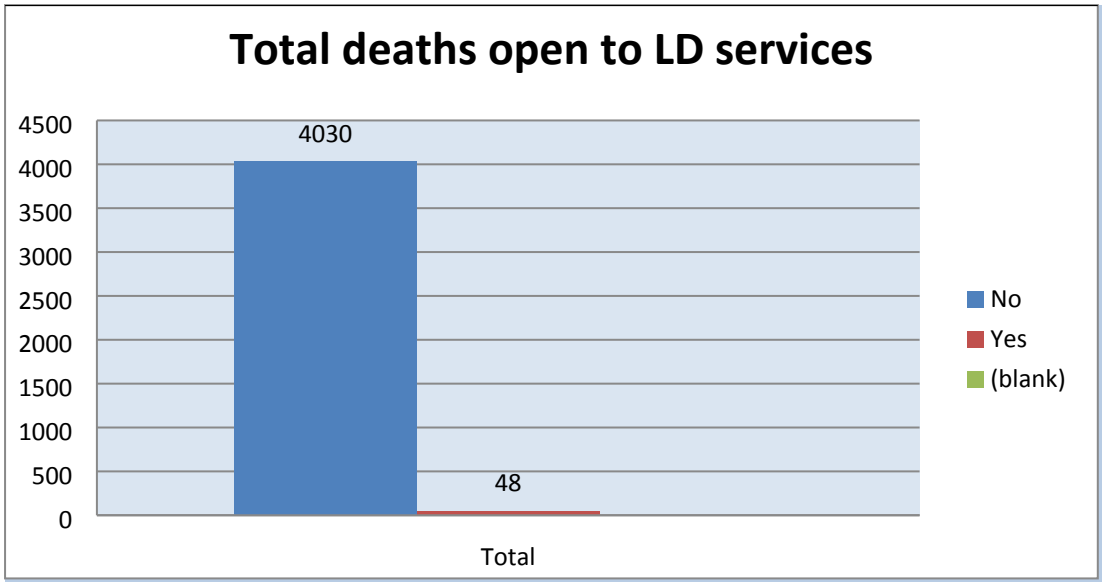
	Female	Male	Grand Total
Count of Gender	**2080**	**1998**	**4078**

6.3 Death by age group since 1 January 2017

The youngest age was classed as 0 and the oldest age was 107 years. Most deaths occur within the 85-89 age groups (indicated by the star), in the last report most deaths occurred between 82-87 age group.



6.4 Learning Disability Deaths since 1 January 2017



	No	Yes	Grand Total
Count of Known To LD	**4030**	**48**	**4078**

The Trust reviews all Learning Disability deaths. The Trust also currently sends all Learning Disability deaths that have been reported through the Datix system to the Learning Disabilities Mortality Review (LeDeR) Programme. However, we are unable to ascertain how many of these deaths have been reviewed through the LeDeR process as LeDeR only look at a sample of overall deaths. Currently the Lead Professional for Patient Safety and Experience is working closely with LeDeR so that the Trust can be involving moving forward in the review process.

6.5 Death by Ethnicity since 1 January 2017

White British is the highest recorded group with 3275 recorded deaths, 483 deaths had no recorded ethnicity assigned and 54 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Row Labels	Count of Ethnicity
White - British	3275
Not Known	483
White - Any other White background	95
Not stated	54
Other Ethnic Groups - Any other ethnic group	54
Indian	25
White - Irish	25
Caribbean	22
Mixed - Any other mixed background	9
Pakistani	9

Row Labels	Count of Ethnicity
Asian or Asian British - Pakistani	7
Asian or Asian British - Any other Asian background	7
Mixed - White and Black Caribbean	7
Other Ethnic Groups - Chinese	2
Asian or Asian British - Bangladeshi	2
Asian or Asian British - Indian	1
Mixed - White and Asian	1
Grand Total	**4078**

7. Recommendations and learning

Below are examples of the recommendations that have been undertaken following the review of deaths either through the *Untoward Incident Reporting and Investigation Policy and Procedure* or *Learning from Deaths Procedure.* These recommendations are monitored by the Patient Safety Team and are allocated to specific team and individuals to be completed. This is not an exhaustive list.

7.1 Learning / action log

- To clarify in the seclusion policy the reasons why all seclusions are to be detailed as moderate harm

- To consider developing new / incorporating within training already provided a module about the Mental Health Act paperwork linked to seclusion, including seclusion exception reporting and the seclusion policy

- To share with commissioners, the impact and access of community based psychological therapy for interfamilial child trauma

- Where there are co morbid complex physical health issues in someone with a severe mental illness, their care plan safety plan must reflect any concerns or risk related to the management of that physical health need. This includes any concerns around medication.

- To identify the threshold for Forensic Service input and method of referral and dissemination of information

- To gain an understanding of the issues related to being a veteran and our responsibilities with regard to the Armed Forces Covenant.

- Development of a Safeguarding Protocol which would include details regarding how to access safeguarding advice and support which would complement information already available via the Safeguarding Connect web page.

- The process for managing Front Door Presentations to Psychiatric Units needs to be clarified and reviewed.

- An offer of psychiatric advice around complex medication issues should form part of the discharge information sent to primary care for patient who have Severe Mental illness

- There is a waiting list for psychological therapy, for EMDR (Eye movement desensitization and reprocessing (EMDR) is a type of psychotherapy that was developed to help people deal with and heal from experiences that have caused emotional trauma). Review with commissioners solutions to reduce the waiting time

- A team awareness raising session regarding the frequent revisiting of a service user's decision to withhold information from family and carers using the 'Advanced Planning for People with Bipolar Disorder Guide' from the East Midlands Academic Health Science Network and also the 'Sharing information with family and carers' booklet and the 'Advance Statement about information sharing and involvement of family carers'.

- To review the MDT (Multi-Disciplinary team) documentation processes with regard to the decision making actions when there are patient safety concerns. This should take into account the immediate action taken by the medics, care co-ordinators and supervisors.

- For DHCFT staff who work in out of hours services (mental health triage hub, Crisis team) to have access to IAPTUS (patient management system for Improving Access to Psychological Therapy) notes as read only.

- Trust to ensure development of clinical standards for personality disorder and a robust Personality Disorders Pathway and appropriate training for staff and teams

- For the Mental Health Office to develop a system of escalation for confirmation that sections are invalid. With only B5 or B7 (or escalation to RK in their absence) with final authority

- Ensure family are involved in assessments and decision making process wherever possible in line with Think Family and Triangle of Care approach, and also making sure that support is offered to carers and children

- Review of the CPA (Care Programme Approach) policy in terms of transfer between secondary services to provide clarity. Transition policy to be updated in include process in the event of a dispute between services in transition Clarity required for services regarding dispute resolution in transition

- If it is considered that withholding a script is in the interest of safety for a service user, then prior to this decision being made, it is imperative that this is discussed with a consultant, senior practitioner or manager; all options need exploring before coming to this decision.

Derbyshire Healthcare NHS Foundation Trust
Report to the Trust Board of Directors – 2 October 2018

Emergency Preparedness, Resilience and Response (EPRR) self-assessment and annual report

Purpose of Report

The Trust is required to self-assess against EPRR Core Standards every year. This report provides Trust Board with this year's assessment.

The Trust has been required to submit this to commissioners in draft form (the deadline has been brought forward without notice) ready for our annual confirm and challenge session in October.

Executive Summary

This paper provides an assessment against EPPR Core Standards in order to meet the requirements of the Civil Contingencies Act 2004 (CCA 2004) and NHS Commissioning Board, Emergency Preparedness Framework 2015.

The Civil Contingencies Act 2004 outlines a single framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparedness and response at the local level. As a Category 2 responder, the Trust is subject to the following civil protection duties:

- Assess the risk of emergencies occurring and use this to inform contingency planning;
- Put in place emergency plans;
- Put in place business continuity management arrangements;
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;
- Share information with other local responders to enhance co-ordination; and
- Co-operate with other local responders to enhance co-ordination and efficiency.

We have undertaken the self-assessment process for 2018 and reviewed evidence which supports full compliance. This is subject to the yearly confirm and challenge session with the CCG on 12 October 2018. The self-assessment has been attached at the end of this report.

It is worth noting that the 2018 self-assessment includes more core standards for mental health providers than in previous years.

Progress against the Core Standards

Duty to assess risk

The main focus of activity has been with the General Mangers supported by the EPRR Lead to carry out refreshed Business Impact Assessments and develop

Business Continuity Plans as outlined in the Trust's overarching Business Continuity Management System Plan.

All are making good progress and a level of real-time testing has taken place responding to planned and unplanned events relating to power outage and water supply at the Radbourne Unit in August 2018.

Governance
All EPRR related policies are reviewed and updated in a timely manner in accordance with Trust standards and national requirements. The EPRR Steering Group meets on a 2 monthly basis.

Training and Exercising
Our training plan is reviewed at each EPRR Steering Group meeting. Gold and silver command training was provided in June and July 2018. All courses were well attended bringing compliance up to 90% for Gold, 74% for Silver and 78% for Bronze.

We contribute as appropriate to NHSE instigated exercises and are aware that there will be exercises over the next twelve months.

Learning has been shared from the Radbourne Unit Fire Systems major incident and from the water and power incidents.

NHS England EPRR lead has offered to support the Trust with table top exercises for flood and terrorist scenarios. We are meeting in September and hope to run the exercises in late 2018 / early 2019.

Significant learning from the Manchester Arena bombing and the Salisbury attacks is being rolled out across the country. Information is being released quite slowly but there will be some specific actions related to Manchester that may impact our Human Aspects Major Incident Response Team [MIST] support.

Security clearance is also an issue arising from Ebola and Salisbury and there will be learning shared from this also.

Duty to Maintain Plans
Our work plan is reviewed and updated at each Steering Group meeting to ensure that we maintain current compliance for EPRR related plans and assurance.

Preparedness
Our learning from the Radbourne Unit Fire System incident demonstrated a state of readiness to deal with unforeseen events but has prompted us to think about how we would cope in the event of a sustained major incident occurring at the start of a weekend for example.

Readiness for incidents is essential and, whilst we have good examples as a Trust, some concerns are expressed at the end of this report relating to CCGs.

Information Sharing
The Trust continues to adhere to Local Resilience Forums information sharing protocols. Consistent attendance at meetings ensures that we are kept in information sharing communication loops and this will be vital going forward as

the intention of NHS England is to regard all NHS Trusts as Category 1 responders to a major incident although, for now, at least, we remain a Category 2 responder in terms of our human aspects [humanitarian assistance] role.

Maintain and Improve Links with Partner Organisations and Improve Co-operation with Partners
We continue to work hard to maintain our good standing in the EPRR community.

A good example of this is the work that we have undertaken with regard to Human Aspects and our role in Major Incident Support. With Psychology colleagues we have reviewed and updated our screening process, letters and guidance and submitted these to the local Human Aspects group.

Overall:

1. The Trust has maintained a position of full compliance against the national standards throughout the year and, we believe, that this will be sustained going into this year's self-assessment bearing in mind changes that have been introduced.

2. The Trust has declared one Major Incident in the last 12 months relating to a Fire System fault impacting the Radbourne Unit.

3. The Trust has coped with significant disruption incidents impacting the Radbourne Unit relating to power and water supplies.

4. The Trust continues to be fully engaged with relevant groups and work streams as required by our local commissioners and by leads at NHS England.

5. We are continuing to enlist the help of colleagues and EPRR leads in partner organisations as required to maintain our compliance and to further develop specific pieces of work e.g. NHS England support with planning exercises.

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.	

Assurances

Regular meeting of the EPRR group, alongside examples of real scenario emergency planning throughout the year and high training compliance rates

Consultation

- The Trust is adequately represented at local and regional EPRR forums.
- The Trust's EPRR Steering Group meets on a 2-monthly basis.

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).

There are no adverse effects on people with protected characteristics (REGARDS).	X
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential gaps/inequalities are outlined below, with the appropriate action to mitigate or minimise those risks.	

Actions to Mitigate/Minimise Identified Risks

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:

1) Receive and accept the core standards self-assessment (pending CCG confirm and challenge process)
2) Confirm and challenge as appropriate
3) Be assured of a sustained level of improvement in compliance with EPRR core standards.

Report presented by: **Mark Powell**
Chief Operating Officer

Report prepared by: **Karen Billyeald**
Assistant Director Safeguarding Adults

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below
1	**Governance**	**Appointed AEO**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for making sure the policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.
3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • business continuity, critical incidents and major incidents • the organisation's position in relation to the NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by lessons identified from: • incidents and exercises • identified risks • outcomes from assurance processes.	Y	• Process explicitly described within the EPRR policy statement • Annual work plan
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document
Domain 3 - Duty to maintain plans					
9	Duty to maintain plans	Collaborative planning	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Y	Partners consulted with as part of the planning process are demonstrable in planning arrangements
	Duty to maintain plans	Planning arrangements	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the following risks / capabilities:		
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as per the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heat wave on the population the organisation serves and its staff.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
15	Duty to maintain plans	Pandemic influenza	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
16	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
17	Duty to maintain plans	Mass Countermeasures	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, eg mass prophylaxis or mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependant on the incident, and as such requested at the time. CCGs may be required to commission new services dependant on the incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
18	Duty to maintain plans	Mass Casualty - surge	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to increase capacity by 10% in 6 hours and 20% in 12 hours.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in emergency/mass casualty incident. Ideally this system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.		Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage 'protected individuals'; including VIPs, high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
23	Duty to maintain plans	Excess death planning	Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
Domain 4 - Command and control					

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below
24	Command and control	On call mechanism	A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.
25	Command and control	Trained on call staff	On call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf on the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Y	• Process explicitly described within the EPRR policy statement
Domain 5 - Training and exercising					
26	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Y	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff
27	Training and exercising	EPRR exercising and testing programme	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	Y	• Exercising Schedule • Evidence of post exercise reports and embedding learning
28	Training and exercising	Strategic and tactical responder training	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Y	• Training records • Evidence of personal training and exercising portfolios for key staff
29	Training and exercising	Computer Aided Dispatch	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems have been tested annually		• Exercising Schedule • Evidence of post exercise reports and embedding learning
Domain 6 - Response					

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below
30	Response	Incident Co-ordination Centre (ICC)	The organisation has a preidentified an Incident Co-ordination Centre (ICC) and alternative fall-back location. Both locations should be tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Y	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards
31	Response	Access to planning arrangements	Version controlled, hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and hard copies
32	Response	Management of business continuity incidents	The organisations incident response arrangements encompass the management of business continuity incidents.	Y	• Business Continuity Response plans
33	Response	Loggist	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for accessing and utilising loggists • Training records
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising
35	Response	Access to 'Clinical Guidance for Major Incidents'	Emergency Department staff have access to the NHSE 'Clinical Guidance for Major Incidents' handbook.		Guidance is available to appropriate staff either electronically or hard copies
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.		Guidance is available to appropriate staff either electronically or hard copies
Domain 7 - Warning and informing					
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below
39	Warning and informing	Media strategy	The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'
Domain 8 - Cooperation					
40	Cooperation	LRHP attendance	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	Y	• Minutes of meetings
41	Cooperation	LRF / BRF attendance	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with other responders.	Y	• Minutes of meetings • Governance agreement if the organisation is represented
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource eg staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA).	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate
43	Cooperation	Arrangements for multi-region response	Arrangements outlining the process for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.		• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs
44	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and Public Health England will communicate and work together, including how information relating to national emergencies will be cascaded.		• Detailed documentation on the process for managing the national health aspects of an emergency
45	Cooperation	LHRP	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) meets at least once every 6 months.		• LHRP terms of reference • Meeting minutes • Meeting agendas
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.
Domain 9 - Business Continuity					
47	Business Continuity	BC policy statement	The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS).	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders
49	Business Continuity	Business Impact Assessment	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Y	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support.
50	Business Continuity	Data Protection and Security Toolkit	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation
52	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against the Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements

Derbyshire Healthcare NHS Foundation Trust
Report to Trust Board – 2 October 2018

Safeguarding Children and Adults Integrated Annual Report 2017/18
The Looked After Children report as required by the
NHS Contract and Section 11 statutory duties

Purpose of Report

This Annual report summarises the Annual report for the year 2017 to 2018 and includes the Safeguarding Children's Board Strategic plans

Executive Summary

These Annual reports were presented to the Trust's Safeguarding Committee on 11 September 2018 and were reviewed, information was scrutinised feedback was received on style, content and adjustments were made to the descriptive content, language, assurance and SMART actions were adjusted based upon feedback.

The purpose of this report is to:

- Provide the Trust Board with an overview of the issues, initiatives and themes within Safeguarding and to provide assurance on the quality of the services and the quality governance systems, processes to ensure the Trust has robust quality management of the Safeguarding required to provide safe services for Children and Adults.

- Safeguarding is a critical piece of governance and a key element of our safe clinical practice and operating standards in our provision of Children and Adult services. In particular individuals who are looked after children, have communication difficulties to their disability and a mental illness are more likely to have existing or subsequent harm.

- This report provides details of the safeguarding service requirements in line with our community population needs. The report details the community needs for our Children and families and the significant increase in the needs of Children and Adults in our services in the safeguarding arena and some of the escalated concerns that have occurred throughout the year and their mitigating action.

- This report was reviewed by the Safeguarding Committee on specific areas of concerns historically such as training compliance, which is improved performance with the need for continued scrutiny and prioritisation of training.

- The Committee was provided with information on the very high profile cases where child abuse has continued over the past year, especially regarding neglect, modern slavery, radicalisation, sexual exploitation, (FGM (Female Genital Mutilation)) and non-recent sexual abuse.

- The report provides significant assurance on the Trust's performance and how we are linking our work to system approaches with the Safeguarding Boards. This report provides assurance on our attendance, commitment and audits

that have occurred whilst working in partnership with our safeguarding partners.

- The report articulates and provides comprehensive detail on the themes and areas of safeguarding concerns, which demonstrate a good spread across the organisation. This is a positive indicator and assurances that our systems and training are impacting upon staff.

- The report details the statutory requirements and evidences that our organisation undertakes multi-agency audit activity and single agency audit work, encompassing recommendations and actions resulting from the audit activity to provide assurance to the Safeguarding Committee and the Board on the Trust's connectivity to the safeguarding systems.

- The report outlines and demonstrates effective systems and processes to implement the learning from serious case reviews, homicide reviews, police operations and learning reviews covered over the report's timeframe and show how the Trust has implemented this learning. These are statutory duties, and the executive lead can confirm full compliance with agencies in this reporting period.

- The Safeguarding Committee reviewed and was fully briefed upon the Safeguarding Unit's achievements and challenges over the year. The Committee scrutinised and confirmed oversight of the outline of the Safeguarding Unit's work plan for 2018-19. The Committee confirmed the Trust's safeguarding objectives for next year.

- The Looked after Children report is a key quality indicator of children who are both vulnerable and have experienced varying levels of harm or distress in their life experiences.

- These life experiences add additional risks to the young person's life outcomes, and physical, dental and psychological health outcomes. This report details the service provision, healthcare standards, compliance and quality governance of this specialist Children's team. Overall the Safeguarding Committee was significantly assured on the quality of the care this team provides and endorsed all recommendations and mitigating actions for this service.

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.	

Assurances

- The organisation will assure measures are put into place in accordance of the service specification
- Continue to capture the voice of the child/young person during each health assessment to contribute towards the health care plan, to evaluate and improve the service using a newly designed child friendly feedback form
- The statutory timescales for health assessments will be monitored and evidence is provided and scrutinised in order to achieve and improve health outcomes
- Review pathways to ensure an efficient robust system is in place and implemented within the Looked after Children team
- To provide a comprehensive administrative support service, to ensure that the administrative processes and procedures run smoothly
- To redesign the health passport for care leavers to provide a comprehensive health history from their childhood and key health information for transition to adulthood
- To strengthen working relationships with the Local Authority and key partners to ensure the Trust supports the Derby City Local Offer for Special Education Needs/Disability

Consultation

This report has been reviewed by members of the Safeguarding team, Safeguarding Committee and others acknowledged within the report.

Governance or Legal Issues

Section 11 of the Children's Act 2004 places duties on a range of organisations, agencies and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

The Trust's commissioners and Safeguarding Committee set as one of their formal standards under their review of Section 11, which the Safeguarding Children's report will be made public. The provider of care will ensure they have an executive lead who will brief the Trust Board on their governance arrangements and performance against agree objectives. This report connects the Safeguarding bodies and Children in care formal report and discharges that duty.

The Care Act 2014 requires statutory agencies to protect vulnerable adults from mistreatment and improve their quality of life. Caregivers must follow the principles of the Care Act 2014. The principles aim to emphasise that everyone in care is a human being with wants and needs.

The Trust's commissioners and Safeguarding Committee set as one of their formal standards to ensure that providers discharge their statutory duties and this is measured through required standards as outlined in this annual report and the formal scrutiny of this work through the Safeguarding Adults Assurance Framework (SAAF). One of the core requirements is for the production of an annual report and scrutiny of

the governance arrangements in this area of practice. This is detailed in the Mental Health Contract and Quality Schedule.

There are no other legal issues identified within this report that require consideration outside of our compliance with NHS executive standards for healthcare provision.

This paper provides an update on governance and regulatory aspects around Safeguarding Children standards which may form part of a CQC inspection or enquiry. These would be around Safeguarding Children practice, clinical standards, patient safety, leadership, responsiveness and effectiveness. Standards are set in the Derby City and Derbyshire within existing Safeguarding Children procedures and standards.

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).

There are no adverse effects on people with protected characteristics (REGARDS).	X
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	X

Actions to Mitigate/Minimise Identified Risks

Specific details of our community population and adaptations that we need to take into account in economic disadvantage and social deprivation are included and how this impacts upon life expectancy

Children who are looked after children or who experience adverse childhood events are at significant risk and this evidence and research is considered

The report details the potential needs of the new and emerging community in Derby city and the specific community adjustments that may be required to meet our Roma communities needs effectively and provide an inclusive and adapted service within the safeguarding procedures of the city and county

Children are identified in the report as under significant pressure with regard to their needs to be protected from abuse

Women and Children are identified at being at risk of Female genital mutilation and the services are adapted to identify and meet the needs of women and girls
Religious aspects and extremism are noted in the report for specific groups this is both for children and adults the protection of the community and the rights to religious observance are delicately explored in working in partnership with other safeguarding organisations and groups in channel process, in line with the statutory obligations of the PREVENT duty.

Recommendations

The Board of Directors is requested to:

1) Receive this formal set of annual reports in the Public Board
2) Note the Trust Safeguarding Committee's scrutiny, level of assurance and recommendations
3) Give constructive feedback on the annual report and note that two other mental health trust annual reports have been published this year have been included in the knowledge section on Board Pack that give a comparator of the level and standard of governance that they provide for Children's services to allow fair comparison of quality and completeness
4) To agree this annual report and its recommendations in the public domain and endorse its formal acceptance.

Report presented by:	**Carolyn Green** **Director of Nursing & Patient Experience**
Report prepared by:	**Tina Ndili, Head of Safeguarding Children** **Karen Billyeald, Head of Safeguarding Adults** **Dr Joanne Kennedy, Named Doctor for Safeguarding Children**
With input from:	**Wendy Brown, Consultant Psychiatrist and Clinical Director (Named Doctor Safeguarding Adults)** **Kelly Sims, CQC & Governance Co-ordinator** **Tracey Shaw, Training Manager** **Janette Beard, Safeguarding Children Trainer** **Zoe Rudderforth, MASH Health Advisor** **Louise Haywood, MASH Health Advisor** **Susan Earnshaw, Service Line Manager 0-19 Service** **Liz Harman, Health Visitor** **Wendy Slater, Core Care Standards and CPA Manager** **Ruth Thomason, Safeguarding Unit Coordinator**

Derbyshire Healthcare NHS Foundation Trust

SAFEGUARDING CHILDREN AND ADULTS AT RISK

ANNUAL REPORT

2017/18

CONTENTS

A. INTRODUCTION

The safeguarding of all our patients, both adults and children remains a high priority for DHCFT. Safeguarding and 'Think Family' is a fundamental component of the care provided. The purpose of this report is to provide a review and analysis of the year's Safeguarding activity and an update of Safeguarding developments across the Trust.

This report sets out the work of DHCFT in relation to safeguarding and the necessary frameworks in place to continue to develop the service. The Trust continues to work in partnership with statutory and voluntary partners across Derbyshire and bordering localities to discharge its responsibilities in relation to safeguarding children and adults at risk - The last 12 months have again been very busy and the complexity and breadth of responsibilities and assurances required continue to increase but we have been successful in many areas of development and implementation.

B. SAFEGUARDING UNIT REPORTING STRUCTURE

In 2016 the Safeguarding Unit governance was moved to the corporate sector of the Trust under the Executive Director of Nursing and Patient Experience This has been reviewed at year end and agreed to continue. The Safeguarding Vulnerable Adults & Children Committee became board level and this quarterly meeting reports directly to the Trust Board.

Both safeguarding adults and children have a bi-monthly operational meeting. During this meeting update reports are taken from all internal and external meetings attended by representatives.

DHCFT are committed and continue to work in partnership with Derby City & Derbyshire Safeguarding Children Boards. There is Trust representation and attendance has improved - This will be monitored and assured by the Safeguarding Children Operational Group. Safeguarding depends on strong partnerships within and with other agencies and the Safeguarding Board and a culture of consistent, respectful cooperation and representation to the Board and its sub-groups across the Derby city and Derbyshire is essential.

The Safeguarding Unit sends strategic/operational reps to all the following meetings to multi agency meetings and attendance can be confirmed.

Interagency meeting	Attendance
Derby City & Derbyshire Safeguarding Children Board Policies and Procedures	100%
Derby City & Derbyshire Safeguarding Children Board SCR Panel	100%
Derby City & Derbyshire Safeguarding Children Board CDOP	100%
Derby City & Derbyshire Safeguarding Children Board Named and	100%

Designated	
Derby City & Derbyshire Safeguarding Children Board Workforce and Development	100%
DSAB Board Meetings	75%
DSAB Operational and Leadership Group	50%
DSAB Customer Inclusion Groups (Derbyshire & City)	50%
DSCB Quality Assurance	75%
DSAB Safeguarding Improvement Group (Derbyshire & City)	50%
DSAB SAR Group	75%
DHCFT Liaison Meetings	100%
DHCFT COAT	90%

The Safeguarding Unit sends operational representatives to the following meetings:

Interagency meeting	Attendance	
MAPPA	100%	
MARAC	Children	100%
	Adults	75%
PREVENT / CHANNEL	100%	
CSE Tasking Group (multi-agency) – (Children)	100%	
Vulnerable Young People (multi-agency) – Joint City and County	100%	

The operational meetings hear reports from members that attend team and multi professional meetings across the Trust from the following sectors:

0-19 Service	Divisional Nurses – Campus, Neighbourhood, Central	Training
CAMHs	Children In Care	Workforce and OD
Perinatal	Learning Disability Service	Adults Link Workers
Paediatric Liaison Nurse	Specialist Childrens Service	

The Safeguarding Unit prepare a monthly report that is issued to all Clinical Operational Assurance Team (COAT) meetings for the Trust which includes Specialist, Childrens, Neighbourhood and Campus – This includes points for action for attendees as well as points for information.

Both the adults and children's operational meetings have standing agenda items 'Escalation for Committee' which details issues which have been fed into the operational meeting and require the fast attention of the committee. Escalation is for good news stories as well as concerns.

The developments and innovations contributed, designed and developed by these groups include:

Changes and Improvements 2017-2018

- COAT reports highlight the safeguarding & Think Family agenda and ensures the whole organisation are aware of safeguarding issues both locally and nationally
- COAT reports reinforce the cascading system of information sharing and making safeguarding everybody's business
- Changes to the operational meeting agendas means that the committee can be strategic and operational be operational whilst improving quality assurance within the organisation
- The MASH now provide monthly data and also quarterly data and narrative to provide insight for the committee

B.2. SAFEGUARDING UNIT STRUCTURE

The period covered by this report saw the following changes to the Safeguarding Unit structure and responsibilities:

- Named Nurse returned from secondment to the Complex Case Team in November 2017 – They continue to engage with Adult Mental Health and Substance Misuse Services
- Reduction and then cessation of the Complex Case Team (Aston Hall)
- Agreement and appointment of two WTE MASH Health Advisors (based at the Derby City Council House) fixed term by the CCG, recruited permanently to the Trust
- Safeguarding Advisor now fully embedded in the role as Safeguarding Children Advisor
- In January 2018 the admin team welcomed a 12 month secondment in the unit to continue full time cover of the child protection medicals and other duties

KEY

SILR	Serious Incident Learning Review	MAPPA	Multi-Agency Public Protection Arrangements
FNP	Family Nurse Partnership	SCR	Serious Case Review
LADO	Local Authority Designated Officer		

D.1. CHILDREN'S DASHBOARD

Item Number	Dashboard Requirements		Qtr 1 2017-2018	Qtr 2 2017-2018	Qtr3 2017-2018	Qtr4 2017-2018
1	Number of advice calls received and reported to off TPP and PARIS (specific and themes).		132	114	85	153
2	Number of supervision sessions, group supervision.		113	134	139	165
3	Number of attendance at MDMs, team meetings and ward rounds.		-	-	-	-
4	Number of MASH sessions covered by the safeguarding children team		1	15	12	14
5	Number of strategy discussions / meetings.-staff activity Sub sets: Section 47 Discussions by Named Nurses Case Conferences by 0-19 & Named Nurses Strategy Discussions by 0-19 & Named Nurses	S47 Strats Attended	122 4	119 9	120 11	82 6
6	Number of safeguarding meetings attended by the safeguarding team		8	9	15	15
7	Number of safeguarding children training/workshops delivered		11	10	9	3
8	Number of child protection medical :	Physical Sexual Neglect	31 5 1	29 4 1	47 9 2	31 7 1
9	Number of LADO referrals		0	0	0	1
10	Number of CHANNEL referrals		0	0	6	4
11	Number of MARAC cases with children discussed at MARAC:		72	49	58	103
12	Number of DV incidents processed				1004	959
13	Number of referrals to CSC		5	6	3	7
14	Number of : SCRs – Serious case reviews /SILRs/ Homicide reviews		7	8	8	12
15	Number of children in private foster care					
16	Number of LAC	Born In Born In Born Out **Total**	180 256 1 **437**	150 242 1 **393**	139 231 1 **371**	128 216 1 **345**
17	Number of children reported missing					
18	Number of child deaths:	CAMHS Children' Total	2 20 22	7 34 41	2 18 20	1 21 22
19	Number of children on a child protection plan : physical / sexual /emotional /neglect					
20	Number of children referred for risk of FGM		0	0	0	0
21	Number of children on a child in need plan		900	852	848	791
22	Number of children in an adult bed		0	1	1	1
23	Number of young carers		7	7	7	7
24	Number of audits		13	13	19	20
25	Number of adults accessing substance misuse services who are parents					
26	Number of adults accessing adult mental health services that are parents		2789	2827	2806	2737

(= still under development)

The above dashboard shows the current position and the areas still receiving development are highlighted.

This Safeguarding Children dashboard was originally presented to the Safeguarding Adults at Risk & Children Committee in February 2018 for challenges and amendments.

The concept was well received by the committee and the unit have continued to work with the Trust IM&T department to develop a workable template and format.

A working group meet regularly to consider the data collected and refine the quality and use of the data. This has proved a complex job for the IM&T team and they anticipate it will take some time to complete.

Analysis of the main features within the safeguarding children dashboard:

- There is an increase in the number of advice calls received into the 'advice system'. This highlights the increased awareness of staff within the organisation of the safeguarding team since the team are attending more meetings, professional and multi-disciplinary. Internal safeguarding training also clarifies that staff can receive help and support on issues that they are concerned about. Word of mouth also promotes the advice system and how helpful the team can be
- There has been a strong emphasis on safeguarding supervision within the trust despite the increased amount of activity around SCRs. A recent internal safeguarding supervision audit highlights the quality of supervision delivered by the team
- The number of neglect medicals remain low compared to national figures. This appears to be down to agreement on policy and procedure. This is being addressed by the Designated Doctors for Safeguarding Children and the Community Paediatricians
- There is a significant increase in the number of cases discussed at MARAC, this growth is a national picture which sadly reflects the increase in the number of reported cases of domestic abuse. However, on the more positive note it also reflects the vast amount of commitment that is given in this area by all agencies

D.2. ADULTS DASHBOARD

The safeguarding adults dashboard has become established over the past year and, whilst, ambitious in some of the data it seeks to capture that may not currently be achievable, it reflects the expected performance requirements of commissioners and some aspirational targets for data in the future.

	Duty / Requirement	Metric	Definition of Metric	Target Group	Target	Qtr1	Qtr2	Qtr3	Qtr4
1	Data received from Tracy Shaw	**Adult Safeguarding Level 1 Training (3 yearly update)**	Adult Protection training allows staff to be able to identify early any safeguarding risks and to know what actions to take	Q1: 641 Q2: 615 Q3: 654 Q4: 659	85%	90.28%	91.42%	89.34%	87.50%
2	Data received from Tracy Shaw	**Safeguarding Adults Level 1 + 2 (2 yearly)**	Adult Protection training allows staff to be able to identify early any safeguarding risks and to know what actions to take	Q1: 1719 Q2: 1747 Q3: 1771 Q4: 1817	85%	83%	83.56%	83.45%	85.13%
3	Data received from Tracy Shaw	**Safeguarding Level 3 (2 yearly)**	Enquirers training in order to be compliant with Care Act and Derbyshire Adult Safeguarding Policy and Procedures	Q1: 149 Q2: 140 Q3: 122 Q4: 135	85%	29.24%	35.8%	47.38%	53.95%
4	Data received from Chris Elkin	**Number of urgent DoLS authorised** - Urgent DoLS are authorised by the Trust on the day we request an assessment (as we are the managing authority)	Accurate recording of number of DoLS applications ensures compliance and appropriate application of legislation	N/A	N/A	2	0	0	0
5	Data received from Chris Elkin	**Number of standard DoLS applied for to the LA**	Accurate recording of number of DoLS applications ensures compliance and appropriate application of legislation	N/A	N/A	1	20	15	14
6	Data received from Chris Elkin – To be included in quarterly total report only	**Number of people with an authorised DoLS granted by Supervisory body as at end of quarter**	Accurate records and monitoring of numbers ensures good governance and compliance with legislation	N/A	N/A	5	2	2	1
7	Data received from Chris Elkin – To be included in quarterly total report only	**Number of referrals to coroner for people who have passed away and have an authorised DoLS granted by Supervisory body as at end of quarter**	Accurate records and monitoring of numbers ensures good governance and compliance with legislation	N/A	N/A	0	0	0	0

Duty / Requirement		Metric	Definition of Metric	Target Group	Target	Qtr1	Qtr2	Qtr3	Qtr4
8	Data received from Hannah659 Cook/Tracy Shaw	**DoLS training for frontline / clinical staff**	DoLS awareness ensures compliance with legislation in relation to people who lack capacity to make decisions at appropriate time	Q1: 1132 Q2: 1169 Q3: 1116 Q4: 1148	85%	86.57%	86.34%	87.93%	86.15%
9	Kelly Sims to provide data on breaches reported by CQC (through inspection reports), based on inspection dates	**Compliance with CQC requirements, Regulation 13, (Safeguarding people who use services from abuse)**	All providers are required to reach compliance with CQC Essential Standards of Quality and Safety in all Areas of the Service		0	0	0	0	See notes
10	See notes from KB – Will be filed separately	**The provider will complete SSASPB Safeguarding Adults Self-Assessment and share actions with the CCGs**	To support Health Services to meet Safeguarding Adult responsibilities and to demonstrate improved outcomes in preventing harm	N/A	N/A	N/A	N/A	N/A	N/A
11	See notes from KB	**Number of adult safeguarding referrals made where allegation is within their own service**	Numbers of referrals from health staff to Social Care. Some providers beginning to collect this. Reliable source data is LA. However this is not currently broken down into health providers	N/A	N/A	N/A	N/A	N/A	N/A
12	See notes from KB	**Number of adult safeguarding referrals made by staff where allegation relates to other care providers**	Numbers of referral from health staff to Social Care. Some providers beginning to collect this. Reliable source data is LA. However this is not currently broken down into health providers	N/A	N/A	N/A	N/A	N/A	N/A
13	Data received from Carolyn Green	**Numbers of staff referred to their professional body due to safeguarding concerns**	Total number staff referred due to concerns about their ability to practice safely	N/A	N/A	0	0	0	See notes
14	Data received from Hannah Cook/Tracy Shaw	**Total training compliance**	Total average of lines 15, 16, 17	Q1: 478 Q2: 458 Q3: 472 Q4: 495	85%	69.79%	77.46%	77.18%	73.73%
15	Data received from Hannah Cook/Tracy Shaw	**Triangle of Care – Training compliance / numbers trained in quarter**	Compliance with the Carer's Trust accreditation scheme	N/A	N/A	N/A	N/A	N/A	N/A
16	Data received from Hannah Cook/Tracy Shaw	**Triangle of Care - % of teams with completed self-assessments**		N/A	N/A	N/A	N/A	N/A	N/A
17	Data received from Hannah Cook/Tracy Shaw	**Positive and Safe – Training compliance for PACE & SCIP and Positive and Safe**		Q1: 478 Q2: 458 Q3: 472 Q4: 495	85%	69.79%	77.46%	77.18%	73.73%

Duty / Requirement		Metric	Definition of Metric	Target Group	Target	Qtr1	Qtr2	Qtr3	Qtr4
18		**Provider has a fully resourced and authorised PREVENT Lead**	Provider identify name of lead	N/A	N/A	KB	KB	KB	KB
19	Data received from Tracy Shaw - All new staff attending induction	**Number of staff who have received induction / basic awareness in Prevent**	All staff should have a basic awareness of Prevent	Q1: 66 Q2: 635 Q3: 682 Q4: 668	See Notes	100%	45.47%	63.49%	90.23%
20	Data received from Tracy Shaw	**Prevent Wrap Training to be delivered to all front-line staff (3 yearly update)**	Number of identified staff group who require WRAP training from an accredited WRAP facilitator	Q1: 781 Q2: 1727 Q3: 1756 Q4: 1806	85%	39.09%	81.28%	84.57%	90.86%
21	Data received from Hannah Cook/Tracy Shaw	**EPRR Silver Command Training – compliance in quarter**	EPPR requirements for compliance with national core standards	N/A	N/A	N/A	N/A	N/A	N/A
22	Data received from Hannah Cook/Tracy Shaw	**EPRR Gold Command Training – compliance in quarter**		N/A	N/A	N/A	N/A	N/A	N/A
23	Data received from KB	**Full attendance at MARAC meetings (fortnightly)**	Fulfilling our Public Protection responsibilities alongside partner agencies.	N/A	100%	City: 100%	City: 100%	City: 100%	Exception reported
24	Data received from KB	**Full attendance at MAPPA 3 meetings (monthly)**	Fulfilling our Public Protection responsibilities alongside partner agencies	N/A	100%	100%	100%	100%	100%
25	Data received from KB	**Full attendance at DSAB, City and County**	Fulfilling our responsibilities as full and equal members	N/A	100%	See relevant section	See relevant section	See relevant section	See relevant section
26	MASH KPIs - Children and Young People Performance Data MASH provide data81.28%	**The number of Adult Safeguarding information sharing requests for Health received**	Evidence to be gathered to ascertain demand for and effectiveness of this partnership initiative to present to Commissioners	N/A	N/A	157	118	135	271
27		Monitor the number and type of requests for information coming through to the Derby City MASH Health team from Children Social Care	Record of number of request for information for children and young people	N/A	N/A	77	81	67	72
28		Time to conduct research (mins)	Record of the time taken to gather information / analysis	N/A	N/A	6417	3150	3715	4350
29		Monitor the number of strategy discussions for safeguarding	Record of the number of strategy discussions pertaining to children and young people	N/A	N/A	22	26	9	72

	Duty / Requirement	Metric	Definition of Metric	Target Group	Target	Qtr1	Qtr2	Qtr3	Qtr4
		children							
30		How many children, young people, parents/ carers were discussed	Record of the number of children, young people and parents discussed	N/A	N/A	524	317	381	391
31		Time in strategy meetings (mins)	Record of time in strategy meetings	N/A	N/A	3362	2152	2755	2960
32		Number of professionals liaised with	Record of the number of professionals liaised with for the strategy discussions / meetings	N/A	N/A	30	3	24	16
33	**MASH KPIs – Adult Performance Data**	Time to conduct research (mins)	Record of the time taken to gather information / analysis	N/A	N/A	2981	2078	3730	4800
34	MASH provide data	Monitor the number of strategy discussions for adults at risk	Record of the number of strategy discussions pertaining to adults at risk	N/A	N/A	27	22	16	28
35		How many adults were discussed	Record of the number of adults at risk discussed	N/A	N/A	140	102	71	101
36		Time in strategy discussion/ meetings (mins)	Record of time in strategy discussion /meetings	N/A	N/A	2346	1098	1100	1350
37		Number of professionals liaised with	Record of the number of professionals liaised with for the strategy discussions / meetings	N/A	N/A	60	27	53	50
38	**MASH KPIs - Domestic Violence Performance Data**	Number of domestic violence standard cases discussed at triage	Record of the number of *standard* domestic violence discussed	N/A	N/A	447	442	443	385
39	MASH provide data	Number of domestic violence medium cases discussed at triage	Record of the number of *medium* domestic violence discussed	N/A	N/A	226	226	250	279
40		Number of hours spent in domestic violence triage meetings	Record of time spent in domestic violence triage meetings	N/A	N/A	51.5	52.5	58	70.25
41		Time taken to conduct research for domestic violence cases (mins)	Record of the time taken to gather information / analysis for domestic violence cases	N/A	N/A	2258	1310	1410	2940
42	**MASH KPIs – Other Performance Data**	Training, shadowing, supervision (hours)	Number of hours for training, shadowing and supervision	N/A	N/A	54.5	28	50	66
43	MASH provide data	Tasks received from DHCFT safeguarding service	Number of hours for processing tasks from DHCFT	N/A	N/A	13	9	15	5
44		Number of times when the Safeguarding Health advisor /	Number of hours that the MASH service did not have face to face presence in the MASH Service	N/A	0	See notes	See notes	See notes	See notes

Duty / Requirement		Metric	Definition of Metric	Target Group	Target	Qtr1	Qtr2	Qtr3	Qtr4
		Named Nurse was not available within the MASH Service (hours)							
45	Data received from Hannah Cook/Tracy Shaw	**All training compliance – Safe, Well-led**	Same data as line 17	Q1: 478 Q2: 458 Q3: 472 Q4: 495	85%	69.79%	77.46%	77.18%	73.73%
46	Data received from Katie Jordan Qtr4 data requested	**Number of DBS risk assessments carried out**	Target group includes all new starters/routine checks each month Data to include all DBS checks for new staff and (separately recorded) all DBS checks for existing staff. Exceptions reporting required if any non-standard checks are made	Q1: 81 Q2: 98 Q3: 87 Q4: 74	100%	96%	95%	100%	100%
47	See notes from KB	**Stories, feedback, early indicators of potential abuse, trends, application of best practice, good news stories**		N/A	N/A	See notes	See notes	See notes	See notes

Over time this data will have further analysis and will be continually developed so benchmarking with other organisation can be explored to further consider trends and patterns to enable the trust to plan and predict levels of care needed.

Analysis

- Activity in adult safeguarding has continued to be high across the Trust and MASH Health Advisors
- The trend has been for adult safeguarding activity to increase, particularly relating to requests for adult related information made to the MASH Health Advisors, whereas child related requests have remained fairly constant. Time spent in strategy meetings for adults has also increased over the year. Activity for children peaks in terms time then tends to fall over the school holidays
- County activity has also continued to be significant and close partnership working across agencies is particularly important due to the different configuration of dedicated safeguarding services

- The dashboard will continue to be refined and the intention is to have a final version agreed at the Safeguarding Committee by the end of quarter two in the year 2018/19
- DoLS activity is well managed within the organisation and we have representation at the MCA DoLS sub group of the Safeguarding Adults Boards

E.1. TRAINING - ADULTS AND CHILDREN

Healthcare workers can be in an important position in helping to recognise child maltreatment and adults at risk of harm or neglect. Therefore they need to be alert to signs and symptoms of maltreatment, harm or neglect. They have a vital role in ensuring effective recording, communication and sharing of information to help improve identification and ensure appropriate support for children, young people and adults in need or at risk of harm. Healthcare organisations need to ensure that all staff that might be in contact with children or their carers have a clear awareness and understanding of safeguarding issues.

E.2. ADULTS – TRAINING POSITION

This provides an update to the safeguarding adults training provision, compliance and action plan in the Trust as at **31 March 2018**

Current training provision

Level 1 - Taught programme
- This is delivered on the monthly induction programme for ALL new starters
- Available as e-learning for updates

Level 2 taught programme
- This is delivered on the bi-monthly clinical induction block training
- Regular update courses are available

Level 3 training
- This is an external course provided by various trainers from different agencies on behalf of the Safeguarding Board 'Making Enquiries under s42 of the care Act (2014)'. A large amount of training was provided in 2017. Fewer courses are scheduled in 2018 (six courses)

PREVENT awareness
- Included on corporate induction for all new starters
- Additional taught sessions (WRAP and awareness) have been put on for the last quarter to increase compliance in line with Home Office requirements

PREVENT WRAP
- Included in level 2 safeguarding adults training
- Additional PREVENT WRAP / awareness sessions have been put on for the last remaining three months of this financial year to increase compliance

E.3. DHCFT TRAINING FRAMEWORK

Training Name	Target Group	Compliant	Non-Compliant	Compliant %
Safeguarding - Adults Level 1 3 Yearly	664	574	90	86.45%
Safeguarding - Adults Level 1+2 3 yearly	1828	1594	234	87.20%
Safeguarding - PREVENTing Radicalisation - Level 1 3 yearly	665	600	65	90.23%
Safeguarding - PREVENTing Radicalisation/WRAP Level 3 3 yearly	1828	1661	167	90.86%
Safeguarding - Adults Level 3 2 Yearly	138	75	63	54.35%

Training Comparison

Training Name	10.10.16	31.1.17	31.3.17	30.6.17	30.9.17	31.12.17	31.3.18	
	Compliance %	Compliance %	Compliance %	Compliance %	Compliance %	Compliance %	Compliance %	Previous comparison
Safeguarding Adults Level 1 3 Yearly	89.43%	87.04%	90.15%	89.47%	92.12%	89.71%	86.45%	↓
Safeguarding Adults Level 1+2 3 yearly	83.71%	77.27%	83.12%	83.83%	83.06%	83.92%	87.20%	↑
**Safeguarding Adults Level 3 2 Yearly	44.07%	33.72%	22.52%	29.66%	43.41%	58.54%	54.35%	↓
Safeguarding - PREVENT Awareness Training 3 yearly			22.52%	43.85%	53.36%	67.98%	90.23%	↑
Safeguarding - WRAP 3 Training 3 yearly	47.82%	64.04%	76.17%	79.66%	81.42%	85.48%	90.86%	↑

	Below 82%
	82%-84.99%
	85%

General trends
Most training competencies are increasing due to additional courses put on in the last quarter. We managed to meet our targets as set out by the Home Office for March 2018 of 85% compliance.

Level 1 requires some promotion around this.

Level 3 is currently the external Safeguarding Adults Board s42 Making Enquiries under the Care Act is still low uptake. This is in spite of the courses being promoted via email to relevant staff. 2017 provided a considerable amount of courses. 2018 is offering 6 (3 of which have already taken place). Staff leave their roles and new staff come into roles hence the reason for some of the decline in compliance for level 3.

Analysis: Risks and Mitigation

- The risks of having elements of non-compliant staff in the workforce increase the risk where safe and effective provision of care is concerned
- Naturally, we continue to put strategies in place to address our compliance concerns and, going forward, a wider review of our compliance will be taken as part of a mapping exercise against the newly released Inter-Collegiate Adult Safeguarding document. In the meantime, we aim to mitigate risk by our continued investment in the Adult Safeguarding Link Worker network and positively targeting non-compliant staff members and offer some work-based alternative training at level 3

E.4. DHCFT SAFEGUARDING CHILDREN TRAINING PROVISION

Safeguarding Children training provision

- Level 1 Internal E-Learning with a 'face to face' taught programme for staff that do not wish/cannot access E-Learning
- Level 2 Internal 'face to face' taught programme
- Level 3 Internal 'face to face' taught programme
- Level 4 Attendance at external DSCB providers

Current and future course provision continues to be forward planned against anticipated trajectory of month on month compliance levels.

Success

- Training compliance was achieved within 'all' internal training levels at end of year for this reporting period
- An external training event at Level 4 was planned for completion in April 2018, ensuring compliance at this level would also be achieved and was received positively

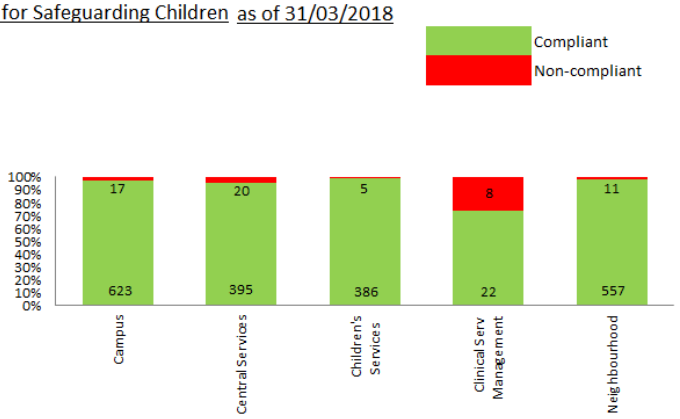
Challenges

- A challenge within training compliance and provision is fluctuating attendance figures due in part to local and national recruitment difficulties. To attempt to offset this, future Safeguarding Children training provision is always forward planned against anticipated Trajectory of month on month compliance level figures. This ensures the training provision remains flexible with this approach helps ensures compliance levels are maintained
- The risks associated with these recruitment deficits are mitigated with the People services, as much as they can be controlled

Compliance Report for Safeguarding Children as of 31/03/2018

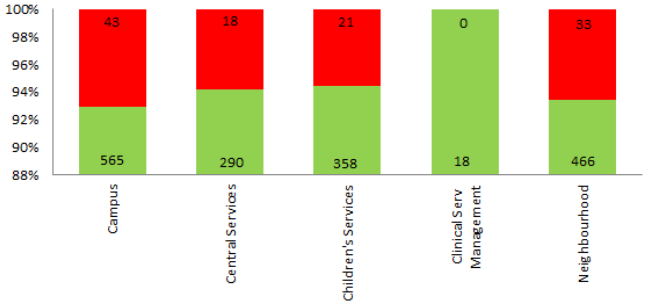
Safeguarding Children Level 1 - Operational Services Compliance

Training Name	Target Group	Compliant	Non Compliant	Compliant %
Campus	640	623	17	97.34%
Central Services	415	395	20	95.18%
Children's Services	391	386	5	98.72%
Clinical Serv Management	30	22	8	73.33%
Neighbourhood	568	557	11	98.06%



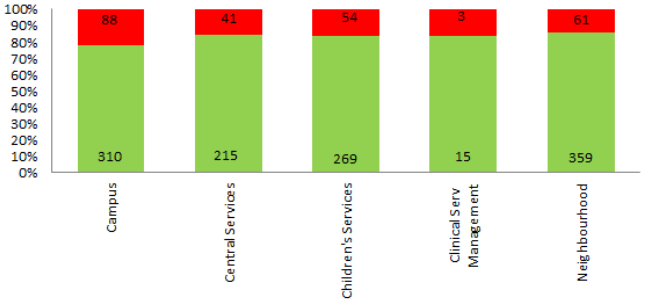
Safeguarding Children Level 2 - Operational Services Compliance

Training Name	Target Group	Compliant	Non Compliant	Compliant %
Campus	608	565	43	92.93%
Central Services	308	290	18	94.16%
Children's Services	379	358	21	94.46%
Clinical Serv Management	18	18	0	100.00%
Neighbourhood	499	466	33	93.39%



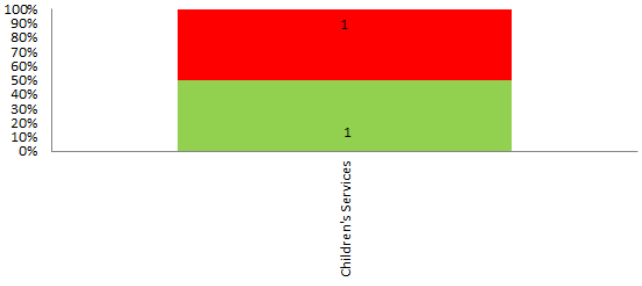
Safeguarding Children Level 3 - Operational Services Compliance

Training Name	Target Group	Compliant	Non Compliant	Compliant %
Campus	398	310	88	77.89%
Central Services	256	215	41	83.98%
Children's Services	323	269	54	83.28%
Clinical Serv Management	18	15	3	83.33%
Neighbourhood	420	359	61	85.48%



Safeguarding Children Level 4 - Operational Services Compliance

Training Name	Target Group	Compliant	Non Compliant	Compliant %
Children's Services	2	1	1	50.00%



F. SECTION 11 AUDIT

Section 11 of the Children Act 2004 places duties on a range of organisations, agencies and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. The CCG discharges its duties through the Section 11 audit.

Updated Section 11 self-assessment
Work has taken place with Derbyshire Safeguarding Children Board to update the Section 11 self-assessment tool for 2018. The new self-assessment has taken into account key learning points from serious case reviews and recommendations from recent audits in order to gain assurance from partners on how these have been embedded into practice. Discussions will be taking place to agree with Derbyshire Safeguarding Children Board the time frame to roll out of the new assurance tool and plan Section 11 safeguarding quality visits with partner agencies The 2017 S11 audit took place in time to be included within the annual report, however this year's S11 report will be out of the timescale for this annual report.

The key learning points to be included in the audit are:

- Complete/update their S11 Audit tool for 2017 – 2018

- Assurance visits will be carried out to discuss findings of the updated audits and explore evidence of how DHCFT captures an understanding of its own effectiveness

The following areas for assurance are linked to the S11 standards and will be the subject of discussion at the assurance visits for 2018 (in addition to the commentary for each section alongside the statutory S11 audit tool).

STANDARD 1 – Accountability structure
Illustrates how Executive Board (or equivalent) has plans to ensure that safeguarding assurance will continue during the transition from LSCBs to Safeguarding Partnership Arrangements.

To illustrate this the Trust needs to ensure progress against DSCB Key Priorities by:

Referral processes that comply with existing procedures:
- What evidence is available to ensure referrals to CSC are followed in writing?
- What evidence is available that feedback is being provided to referring agencies in writing about what action is being taken by CSC?

The use of the escalation processes:
- What evidence is available to demonstrate that follow up action is being taken in cases where feedback has not been provided in writing about what action is being taken by CSC?

- What evidence is available to demonstrate that follow up action is being taken in cases where there is a difference of professional opinion that has not been resolved by frontline practitioners?
- Strategy discussions and meetings to inform multi-agency decision making - What evidence is available to demonstrate that your agency is being invited to participate in strategy discussions and meetings?
- The quality of assessment (including multi-agency involvement) to inform decision making
- How does your agency know that appropriate assessment tools are being used and there is effective management oversight of their quality?

STANDARD 2 – A culture of listening to children, young people, carers and to staff
Please provide evidence of how your agency knows that children and young people are aware of how to raise concerns within your agency that may be linked to any safeguarding issues.

STANDARD 3 – Information sharing
What evidence is there within your agency that front line managers have checked that frontline staff are clear on their increased responsibilities around information sharing arising from the change to the Data Protection Act (DPA) which will be replaced by GDPR (General Data Protection Regulation) on 25 May 2018?

This will affect all teams and services and the Board wishes to obtain assurance that effective information sharing will continue to safeguard children.

STANDARD 4 – Safe recruitment and dealing with allegations against people working with children
Please show how senior management in your agency are updated and monitor the levels of staffing required to carry out work to keep children safe.

In particular are there concerns about workface capacity in respect of relevant front line job roles?

STANDARD 5 – Effective appropriate supervision and support for staff, including safeguarding training
Please show how senior management in your agency are updated about the monitoring of the quality of supervision and support for staff, including safeguarding training.

In particular how effective is the supervision and training for relevant front line job roles in your agency?

These areas will be included in Safeguarding Children Trust reports and a summary of evidence will be submitted to the Safeguarding Committee to confirm evidence, assurance and where any deficits are founded, what the mitigating actions plans are.

G. TRIANGLE OF CARE ACCREDITATION

The Triangle of Care membership for the Trust has been awarded two stars. Our responsibility is to provide an update to the Carers Trust every six months, and to renew the award every 18 months. The six key standards state that:

1. Carers and the essential role they play are identified at first contact or as soon as possible thereafter
2. Staff are 'carer aware' and trained in carer engagement strategies.
3. Policy and practice protocols re: confidentiality and sharing information, are in place
4. Defined post(s) responsible for carers are in place
5. A carer introduction to the service and staff is available, with a relevant range of information across the care pathway
6. A range of carer support services

The Triangle of Care Operational Group is led by the Assistant Director for Safeguarding Adults and the Carer's Lead for the Trust. The group is working on the elements of the Triangle of Care, and managing the membership process, working to the Carers Engagement Group.as an oversight group.

Actions taken
Work undertaken to support carers includes:

Carers champions

- Have had the opportunity to attend two Carers Champions Days, in Chesterfield and Derby. The agenda was about IT opportunities and development of the Carers Champions self-assessment, County Council Carers website and the new Infolink resource
- The Carers Champions list has been updated and new Carers Champions have been identified in the in-patient service at the Radbourne Unit

Carers and families support gaps
Work with carers has continued to identify the gaps in support. Using example of gaps reported by the Carers Forums, we have identified the need for:

- A 'waiting well' leaflet and resource on the website - A Head of Nursing is working on a policy for this

- A 'Carers Journey' booklet that has information about the service available for carers and service receivers depending on the needs they have. A small group has been working on this

- Carers' involvement in monitoring and reviewing services. Carers have started this work in our inpatients services

- The 4E's Carers Subgroup has been amended to be the Trust Carers Engagement Group, which better describes its function. The Group has had speakers such as the Chief Executive of the Trust, Healthwatch and Mental Health Together, and DWP Partnership and Benefits services. The Trust Carers Engagement Group is the Oversight Group for the Triangle of Care

- Triangle of Care self-assessment IT system. We started work on this last year, and it has been completed with some excellent joint working with the Trust's IT department. A system has been built that works independently of Connect, the Trust's intranet site but will have a link to it. The system has been populated by a Trust Volunteer so that our Carers Champions can work on the team's self-assessment and action plan. It will also have the opportunity to have an analysable reporting system which can be monitored at any point

- Infolink health resource booklet has been redone on a web based database. There are over 850 resources to support staff, service receivers and carers. The data was input from scratch by a Trust Volunteer, is being reviewed prior to publishing, and a printed booklet produced as well as having it the Trust website in a couple of months

- County Council Carers website 'Carers in Derbyshire' on http://www.carersinderbyshire.org.uk/ has revised its young carer's information. Derby City Council has applied to be part of the website, and this is likely to be implemented by the end of the year. The site has 190 carers resources for the county

- Paris: This is one of the Trust's Electronic Patient Record systems and work is being done on Paris to expand the options for recording Carers, as this is very limited at the moment. Further work is being undertaken to rationalise the system

- County Group: The services working in the county area have got together to take a combined view of the needs of carers. The first actions relate to Carers Week, and involve producing a leaflet about services available, which will be sent out with the next Who Carers? Carer's newsletter

- The Trust's Core Care Standards website section on Families and Carers has had 3934 hits so far this year, and 6,067 hits last year. It is the third most popular section on the site after Search and Care Planning. The Recovery Centre section on Carers and Families has had 795 hits so far this year, and 1,134 hits last year


NHS Derbyshire Healthcare NHS Foundation Trust

who cares?

Quarterly newsletter for carers — Issue 42 - February 2018

Triangle of Care – Second Gold Star awarded

We are pleased to announce that Derbyshire Healthcare Foundation Trust has been awarded its Triangle of Care second gold star by the Carers Trust for its work to offer better support to Carers and Families. This means that we have been given recognition for the work we have already done and it also means we will be continuing to make improvements in the future. Contact Wendy Slater on wendy.slater@derbyscft.nhs.uk for more information about the award.

We understand that looking after someone who is unwell, or has problems, can have an impact on the lives of families, friends and carers, and we want to help identify any needs you have, and to support your wellbeing wherever we can. Our Core Care Standards set out how we will work with families, friends and carers to support them and the person they care for.

Triangle of Care MEMBER

This will include:

- Identifying what you need to provide support to the person you care for in areas such as day to day living, medication, parenting, or emotional support.
- Making sure that you have the **right information**, including key people to contact and what to do if you need urgent help
- Thinking about **information sharing**, and working out with the person what information should and should not be shared, and what has to be kept confidential

Forum for mental health carers

There are two forums for carers of people with mental health problems offering help, support and information. New members welcome.

Derby City and South Derbyshire Mental Health Carers Forum

When and where:

Meetings Third Friday of each month 11.30am – 2pm, The [illegible] Hall, 32 Charnwood Street, Derby DE1 2GE

Tel: Vivien: 07921 162 740
Pam: 07891 456 119

- Who Cares? The newsletter is produced and sent out every quarter to carers listed on Paris. The last one was in February 2018, and there will be one in time for Carers Week. This is sent to about 1800 carers, as well as our services and partners

- Carers training: We have about 200 staff trained in the Triangle of Care, and we are now including Triangle of Care training in our block training programme for community staff from April 2018. Inpatient staff will be trained next year

- Analysis of Carers Complaints: These are now collected and analysed every quarter and submitted to the Trust's Patient and Carer Experience Committee

Actions planned for 2018/19

- Carers Complaints analysis to be taken to the Carers Engagement Group for comment
- Who Carers? newsletter to be sent out ahead of Carers Week and to include the 'Healthy and Connected' leaflet
- Carers Week actions to be carried out
- Work to take place with the county group on Carers Rights Day
- Video to be recorded and publicised for Carers Week
- Planning for Carers Rights Day with partner organisations

H. QUALITY VISIT

In July 2017 the Safeguarding Children Nurses and Admin Team received the Season 8 Quality Visit. The panel was the Chief Executive, the Head of Clinical & Operational Care Currencies & Outcomes and a Trust Governor.

We presented on the following areas of excellence, focusing on 'Inclusivity in Practice' which was the Season 8 main theme:

- Child Death Overview Panel – Admin Processes
- Supporting Staff Through Serious Case Reviews
- Safeguarding Children and Adult Mental Health Services

The presentation was very well received and resulted in a **Gold Award**. The Unit were then put forward as nominees for the Promoting Safety Award at the Trust's Delivering Excellence Awards 2017. Representatives from the unit attended the event and while we did not win our category we all felt honoured to be nominated amongst such worthy colleagues.

I. SAFEGUARDING ADULTS ASSURANCE FRAMEWORK (SAAF)

In September 2017 the Unit were happy to welcome a panel from the Derby Safeguarding Adults Board, chaired by the Head of Adult Safeguarding - NHS Erewash, Hardwick, North Derbyshire & Southern Derbyshire Clinical Commissioning Groups for the SAAF Visit.

Ahead of the meeting we provided the panel with an evidence file which contained evidence to demonstrate our commitment to the priorities identified in the 2016-17 SAAF.

We began our meeting by providing an overview detailing how the Operational Safeguarding Group has developed and the governance arrangements ensure that the business of this group is reported directly to your Trusts internal Safeguarding Committee. Communication from this group is also fed back to operational staff via your Clinical Operational Assurance Teams.

We showcased the inaugural Trust Joint Adults and Children Safeguarding Annual Report including both sets of data and activity. We detailed how we had contributed a section from our services to both the Derbyshire and Derby Safeguarding Adults Boards Annual Reports. We also acknowledged how important our Trust is represented at Channel and MAPPA meetings, without our presence and input these meetings would be significantly compromised.

During the visit we were able to show how the Trust plays a significant role in supporting multi-agency work streams and support networks. We work hard to ensure that your Trust is represented at a wide and varied range of public safety initiatives and your experience, knowledge, and expertise contribute toward positive outcomes for adults at risk.

We demonstrated our response and service provision for the Prevent agenda particularly in regard to the significant number of people being referred to Channel who have a mental health profile. We discussed the staffing requirement for this and the Training Manager was able to assure the panel that her planned training trajectory would have the end result of bringing the Trust training figures fully into compliance.

We shared with the Panel our experiences of the Multi Agency Safeguarding Hub (MASH) in Derby, and how this has helped to feedback to staff on referrals they have made into safeguarding. We outlined communication issues with colleagues in Social Care at Derbyshire County Council caused by differing processes.

We were able to demonstrate good examples of the Trust evidencing the Care Act (2014) Making Safeguarding Personal agenda. We shared some innovative practice and positive outcomes for adults at risk. We also discussed how the Trust manages allegations of abuse against staff. We told the panel that about the current review of this policy and that the LADO is made aware of any concerns relating to staff as appropriate.

We had a valuable discussion about the issues raised by CQC in relation to compliance with the Mental Capacity Act 2005. We were able to remind the Panel that the CQC inspectors had stated that staff knowledge was good but that the formal recording of capacity assessments required attention. As a result of this we have additional staff recruited to look at this area of work and that you have an MCA working group which feeds into our Operational Safeguarding Group. We have implemented an audit program which includes MCA compliance and staff use safety plans to record assessments and best interest decisions rather than the FACE document.

We shared with the panel our ASIST screening tool which has been developed to aid communication with those patients who have difficulties with verbal communication; we shared our plans to roll out training on the ASIST tool with small groups of staff initially.

We received a formal letter of acknowledgement from the Head of Adult Safeguarding - NHS Erewash, Hardwick, North Derbyshire & Southern Derbyshire Clinical Commissioning Groups congratulating the team on a successful SAAF visit, in the letter the significant and excellent progress that we have made was noted and the unit was complimented their commitment to continue to deliver excellence, gratitude to the team that they had prepared the SAAF with such diligence was also expressed.

J. 2016 CQC COMPREHENSIVE INSPECTION – OUTSTANDING ACTIONS

In response to the 2016/17 CQC actions and recommendations we have continued to work with partner agencies, i.e. social care and the police to address the specific matters as identified.

In addition to this the Assistant Director and Named Doctor for Safeguarding Adults continue to review all loss and theft related Datix incidents across the whole Trust on a monthly basis as a proactive measure to pick up on more significant incidents, identify where measures are not effective to identify themes and trends. This would include advisory acting and action plans should any patterns occur. This year has seen the implementation of safeguarding reviews, mitigating actions and an extended pilot of CCTV in an area of risk.

K. AREAS OF CONCERN/CHALLENGE

Public health nursing for school age children
This year has seen considerable increase in numbers of Children and young people on child protection plans from approximately 440 to 650. This is both in Derby city and mirrored nationally.

The public health commissioners significantly disinvested in school nursing and reduced capacity, and reduction to staffing levels. This has resulted in not all schools having a school nurse and substantially reduced capacity and targeted capacity only.

Recent Serious Case Reviews have also highlighted significant learning and potential missed opportunities. From meetings held with practitioners it is apparent that the main reasons are around capacity, morale is also extremely low and of this, leading to staff moving onto new jobs and/or a high level of sickness. This is being explored and included in learning reviews.

The impact on safeguarding, particularly child protection and practice standards, therefore children, young people and their families, were significant and concerning. The specifics

will be highlighted within the completed current SCR once completed and recommendations will be made.

Additional escalations have been expressed to the safeguarding children team have been increasing and discussions were held to escalate the concerns over a period of time. The staffing concerns have been placed onto the Trust's risk register, and action being taken by managers to mitigate the risks. Due to the impact on the teams, which is significant, resilience training was arranged for February 2018 in an attempt to support staff with this service pressure. The safeguarding children concerns escalated to a level that a meeting took place between Assistant Director of Safeguarding Children, the Operational Manager for 0-19 services, the Designated Nurse for Safeguarding Children and Public Health Commissioners.

The mitigation to the risks raised and indicated were operationally revisited with advice from the Safeguarding team. A rationalisation of current and/or future posts was undertaken. This resulted in a further re-modelling of the 0-19 service within the current financial envelope to improve outcomes and safeguarding practice by creating different/more resource. This was managed by operations and safeguarding jointly.

As a result of the plan staffing levels within the 0-19 services are improving with interview dates set to recruit into the vacant posts. There has been a redesign of the skill mix within the school health teams. The one health worker project is to be resurrected. The new single point of access for school health is being expanded over the next six months to help with referrals and domestic violence work. Resilience training was delivered and whilst there is still a significant increase in safeguarding work the situation to-date has improved considerably. This theme will be monitored and reviewed in the forthcoming year to monitor resilience and implementation of the unpublished serious case review.

CAMHS waiting lists

CAMHS services locally and nationally have been undertaking a transformation programme since 2012. The Trust has recently completed an organisational change programme in support of some of the developments. Following an extensive period of consultation the CAMHS transformation programme started on 01 October 2017.

The primary change was around the shift away from locality based teams to a specialist pathway (by primary need/disorder/behaviour). The risk strategy outlines issues identified and concerns raised as part of the change programme. This was mainly around staff shortages and difficulty in recruitment, therefore increased waiting lists, causing concern from a safeguarding perspective. Staff have been aligned to vacant positions as a result of the transformation, which offered both clinical and operational carer progression opportunities.

Assurance has been given based on a clear understanding of the strengths and difficulties in the delivery of current services, including a clear picture of current patient pathways, numbers of people in treatment, waiting times/lengths of stay, unmet need and current spend as there is no specified budget for this piece of work and the budget is that of the CAMHS Service Line.

All outputs had to be delivered within current resources, and as part of current workload. Mitigation plans are in place which consists of a revision of current waiting referral and response protocol. Internal waiting allocation of case coordinator to be addressed. A duty waiting list initiative has been developed to contact patients waiting and follow up appointments to be offered if needed urgently:

- Consideration to develop groups for parents of those young people waiting
- Identify overtime budget to support additional evening and/or weekend clinics

Work has also been undertaken with the performance team and the CAMHS Operational Team to identify current waits and the proposed impact and to foresee waiting time targets. The potential risks to effective care and therefore safeguarding are monitored.

Bank staff
In 2016/17 we had a number of challenges that related specifically to bank staff and the Trust's shared service provided by the Royal Derby Hospital were a concern. The Safeguarding Unit concerns were not fully implemented and concerns were raised with regard to the consistency and quality of safeguarding training.

We are pleased to report that, from the start of the current reporting year the Trust has taken responsibility for its own bank staff and is working with colleagues from Derbyshire Community Healthcare Services to mirror established best practice. From a safeguarding perspective the Assistant Director for adults has made recommendations for the training and supervision offer to bank staff and these will be implemented in year. To date recommendations that have been made have all been implemented.

Admin staffing levels
This year has been a challenging year for the admin team. We have said goodbye to two team members as a Safeguarding Administrator retired and another team member moved to a new job. As a result we were able to create a secondment post and we have welcomed a Senior Safeguarding Administrator to the Unit. Change and remodelling has increased immediate pressure to the team and service; a full team will be in place by August 2018.

MARAC/MAPPA
The year has seen a high level of MARAC and Domestic Abuse activity across City and County. The MASH Health Advisors make reference to this and, in response, Derbyshire Police have instigated a change to MARAC meeting arrangements in an endeavour to achieve greater parity across City and County. The Trust has struggled to achieve 100% attendance at MARAC meetings and, whilst the involvement of mental health and substance misuse services is essential, there are on-going co-ordination challenges to achieve our target attendance. This will be monitored through the operational group in partnership with operational leads.

MAPPA Level 3 has 100% attendance throughout the year and the Trust has Director attendance at MAPPA Strategic Board. MAPPA Level 2 remains challenging which relies

heavily on the neighbourhood teams to facilitate representation. Again, the Assistant Director for safeguarding adults continues to meet with clinical and operation leads to support a higher level of compliance to ensure safe practices.

L. INNOVATIONS

1. Learning disability service
Learning Disability services have produced two resources for people with learning disabilities to access the internet more safely.

Resources are specific to males and females and have been developed to reduce the risks that people with learning disabilities are exposed to when they are on-line.

The safeguarding adults Link Worker Network has grown over the last year to 30 in number. Quarterly meetings are held and have a strong educational and support emphasis.

There has been on-going development of ASIST (Accessible Safeguarding Initial Screening Tool) in terms of training two more cohorts of staff to use the tool. This includes a group of three people with learning disabilities who are employed as assistants by the Trust as assistants in the learning disabilities service to assist the work of the Strategic Health Facilitation Team. Safeguarding Adults Link Workers have also taken part in the training.

2. Amalgamation of children and adults safeguarding teams to work collaboratively and creatively where safeguarding concerns are across families with complex needs

Historically the two teams have been worked completely separately. With the 'Think Family' CQUIN commencing and 'Think Family' being a golden thread throughout the Trust, it seemed a natural progression to work more closely together.

In order to achieve there has been a number of successful initiatives:

- The two Assistant Directors working more closely together and providing cover when necessary
- A joint Safeguarding Committee
- Safeguarding Coordinator working across the teams
- Joint annual report
- Representation at the respective operational meetings
- The offices are now aligned to accommodate closer working relationships
- Management and supervision of the MASH Advisors across children's and adults safeguarding teams
- 'Think Family' thread in both adult and children training
- Joint team meetings
- Joint workshops and team building day

Next steps:

- Joint quality visit
- Joint advice system
- Shadowing opportunities across for staff
- To jointly submit an option paper for extra resources for Safeguarding Adults
- To deliver a family inclusive conference to a multi-agency audience in September 2018
- To deliver an interagency Trauma Conference in 2018

3. Trauma conference

In October 2017 DHCFT, in partnership with Derbyshire Police, organised and hosted the first Team Derbyshire Trauma Conference. Attendance approached 100 participants and was a huge success. A variety of speakers, including nationally recognised experts and experts by experience gave informative, inspirational and moving presentations. We recognise that there is much more work to be done but reflect on the conference as a landmark event that has established a wide network of partners who continue to share articles of interest and news updates.

4. Consanguinity training - Cousin marriage and genetic disorders in diverse communities - One day seminars

Research shows there are many assumptions and much controversy about cousin marriage and child health among professionals, families and the public. Due to the rate of incidences within Derby City, the Trust and the Chair of CDOP secured some funding via Public Health and we commissioned Dr Amra Darr (Senior Research Fellow (Hon) at the School of Health Studies, University of Bradford), an expert in this topic to deliver four 1 day training sessions.

This training used a mix of presentations, discussion and activities to demystify medical facts about cousin marriage and genetic disorders. The main issues covered were:

- Infant mortality
- Genetic risk
- Informed choice
- Service delivery to multi-ethnic populations
- Professional responsibility
- Dealing with diversity
- Equity in service delivery

This training was to empower professionals with accurate information and resources to promote understanding and enable effective communication between professionals and families.

We particularly targeted the multi-agency arena for staff who work with relevant communities and who will be able to offer support around this issue to their clients and colleagues.

5. Resilience training – to support staff first and with increased safeguarding pressures

The Universal Children's 0-19 service has commissioned four emotional resilience workshops for staff to attend recently. The decision to commission the workshops was following feedback from staff on how they had been feeling over the recent couple of years. The service had gone through a 'tender process' in 2016 and also for the last couple of years, recruitment of Public Health Nurses (PHNs) into the service had been an on-going issue, mainly due to the fact that less PHN's are now being trained compared to ten previous years. The safeguarding element within the role had increased due to the increased number of children on a child protection plan within Derby City and this combination was leaving staff very tired and emotionally drained.

The service decided to invest in emotional resilience workshops to support staff during this difficult period, to deliver the workshops to staff.

This was the second round of training commissioned in this area, the last being around five years previously.

After an initial meeting to plan and confirm the agenda there was a delay, the workshops, a total of four, were delivered during May and June 2018 and offered to all staff within the 0-19 Universal Service.

84 staff in total from the service completed the Emotional Resilience workshops. The feedback from the staff was very positive, it gave them space away from the work environment to reflect on the demands of their role and how it affected them personally and allowed then to explore coping strategies to help their emotional wellbeing.

6. Supervision training

In response to both evaluations from Serious Case Reviews and Clinical Record and Supervision Audits within the Derby City Children's Service and the cascade model of supervision within the Trust, it became evident that further support and training for supervisors and structure was needed to ensure effective analysis and supervision were further embedded within the service.

Training was designed with these key outcomes for the Derby City Children Service. The training went through a validation process facilitated by the DSCB and was accredited at level four.

The training was to explore what effective supervision and analysis was. Learning was shared from the Family Nurse Partnership, NSPCC and recent level four safeguarding training from an independent trainer.

To ensure quality and best outcomes for families it is essential that there is a consistent approach with approved resources and tools. All new supervision tools and paperwork have gone through the Trust's governance process and have been ratified prior to training being delivered. These new resources will be embedded in the Trust Supervision Policy.

The tools have been shown to support effective supervision by acting as an enabler and structure to complete the full reflective cycle. The quality of analysis and understanding of complex cases has been demonstrated through both anecdotal evidence and successful outcomes for escalation/de-escalation of cases.

Training has been offered to all senior managers within the Children Services and safeguarding teams (Band 8 and 7) 100 % uptake within the 0 -19 service further training dates have been arranged for band 6 practitioners. Training will be developed for those who do not have the accountability of cases but still with the same outcomes matching the roles needs.

Administrative staff have all received training within the 0-19 service on effective supervision and containment. Appropriate tools such as supervision contracts and new supervision recording documents have been introduced.

The evaluation of training delivered has been 100% positive. It had been feedback that previous training was useful however the need to consolidate learning and have a more practical approach was essential to embed new approaches to supervision.

Feedback from staff

- "Deeper understanding of cases and I feel a more meaningful and effective action plan can be drawn up"
- "Supported the escalation process by a detailed and robust analysis demonstrated through new tools, enabled me to articulate the risk of significant harm and that thresholds were met"
- "The focus on supervision is much more on reflection and analysis rather than a list of actions. It is effective and of high quality not just a tick box activity. I come out of supervision feeling contained rather than stressed and anxious about cases"
- To ensure the sustainability of changes and quality to supervision and analysis certain adjustments have been made within the service
- New record audit tool exploring analysis within record keeping being facilitated in both 1-1 supervision and within teams to support peer learning
- Supervision training and peer reflection to be on-going. Timescales to be set
- Shadowing of supervision to support shared learning
- Annual audits on quality of supervision
- Supervision contracts to be revisited annually
- Supervision policy to be updated with new tools and paperwork

7. Link workers

The safeguarding link workers was developed in the autumn of 2017 as part of an educational and support network to meet four times per year with an agenda that reflects current priorities, quality improvements and offer advice and support in the world of adult safeguarding from the Assistant Director for Safeguarding Adults and the lead trainer for safeguarding adults. The aim is to have a link worker in all clinical areas to develop knowledge and expertise to form the first point of contact for teams seeking advice and

guidance on issues regarding safeguarding with the support of their line manager and safeguarding leads.

Key functions of the link worker:

- To be a local source of information for their service area, bringing recent development session information, news, initiatives to the attention of staff
- To be an effective communicator – Ensuring safeguarding remains high on the local agenda
- To be proactive in identifying problems, sourcing help and information as required by teams
- To be able to give advice, regarding the care of patients/ carers and families, which would be recorded as appropriate
- To ensure that issues of concern are referred appropriately following safeguarding policies and procedures
- To support the development of good practice guidance to be used within the Trust
- To ensure that safeguarding practice is based on compliance with the Derby and Derbyshire policies and procedures and Trust policies and procedures

M. SAFEGUARDING POLICIES & PROCEDURES

Safeguarding adults
Trust staff are directed to the 'Safer Derbyshire' and Safeguarding Adults Board websites for all current Safeguarding Adults policies, procedures and professional guidance. For specific areas, the Trust develops its own policies and procedures, for example, 'Protecting Those Vulnerable to Extremism (Contest, Prevent and Channel) Policy and Procedures'.

Safeguarding children
Multi-agency, Derby City and Derbyshire, safeguarding children procedures are available on the Trust intranet (Connect) and also on the Safeguarding Children Boards' websites.

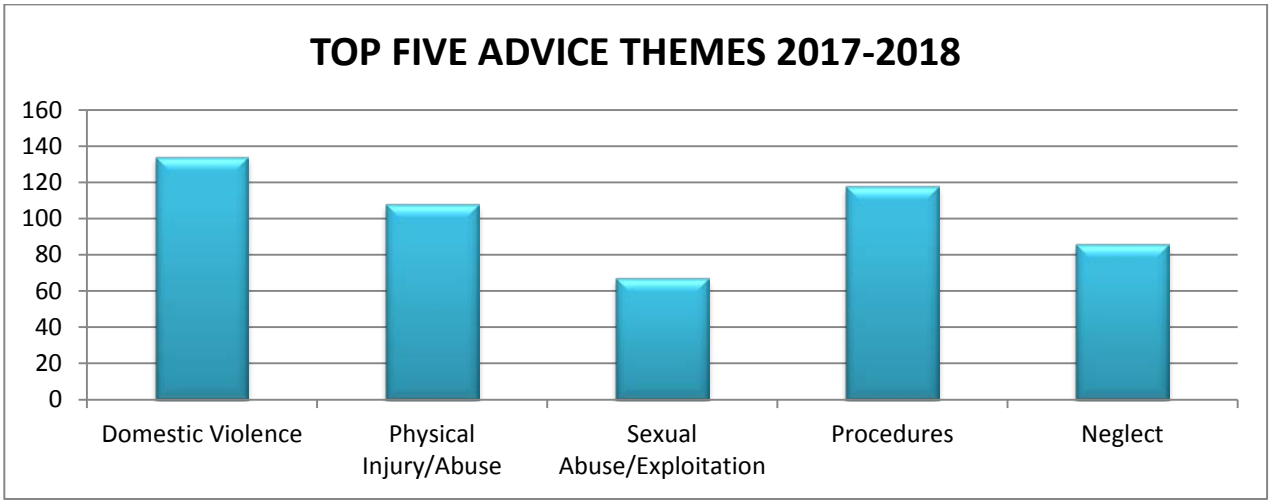
All policies and procedures go through the DSCB Policy and Procedures sub-group for review and ratification and all policies are also updated by the national system (TRI-X).

N.1. SAFEGUARDING CHILDREN ADVICE THEMES

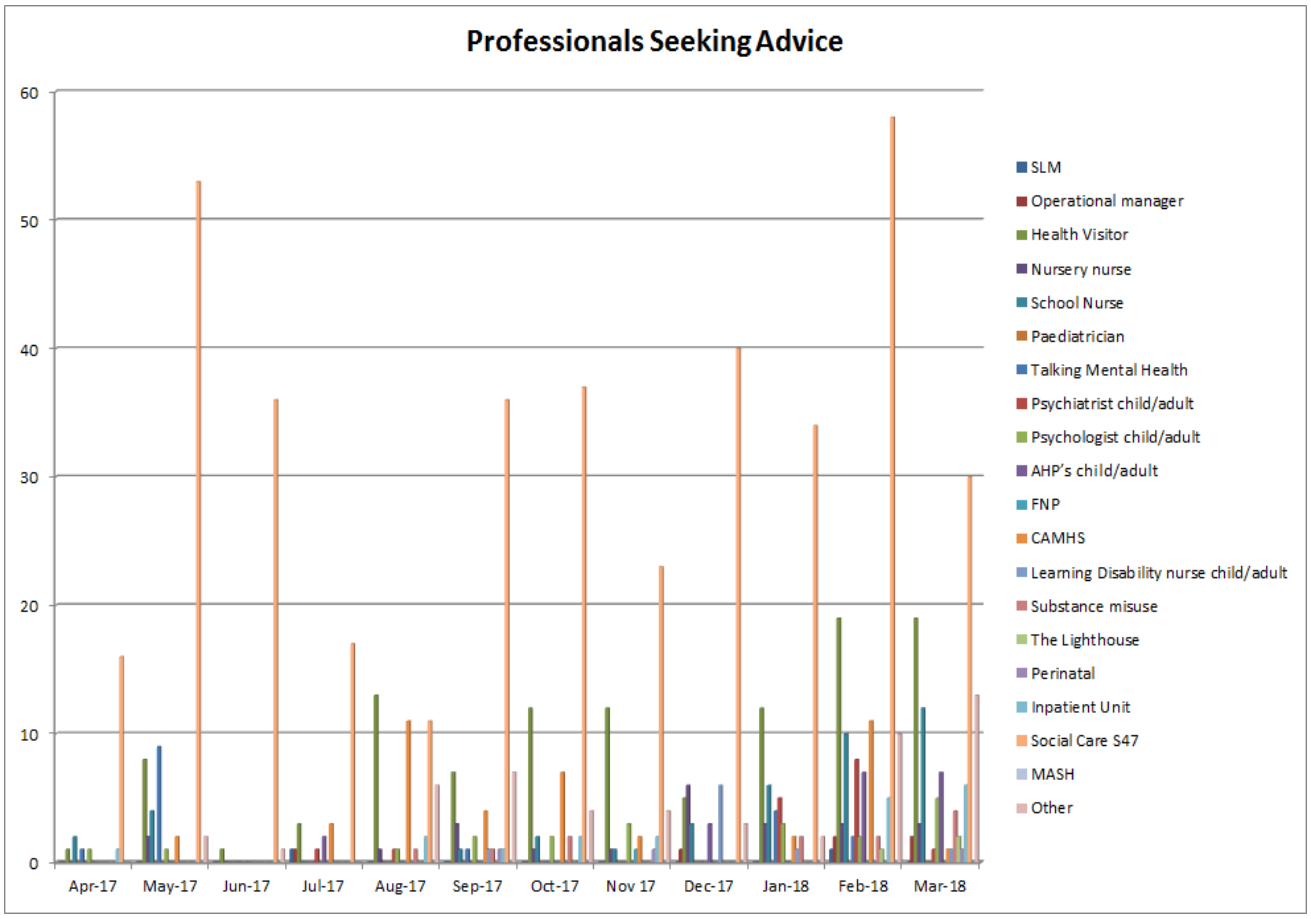
As part of our departmental data collection, we have collated information around the kind of advice that is being sought via the Safeguarding Unit – This information gives us strong indicators on future training needs and rising trends and concerns among professionals. Our figures also include S47 discussions with Social Care as within our clinical advice themes.

We discussed in last year's report how our emphasis over 2017-18 has been to disseminate learning in two key areas – Those of neglect and child sexual exploitation. We

have focussed on these areas due to learning from Serious Case Reviews and Learning Reviews. As a result of this we have seen an increase in calls to the unit around sexual abuse and neglect – This is encouraging as this show professionals are considering these aspects to cases more strongly than they may have had before. While domestic violence continues to be the largest area of concern for advice calls and Section 47 we can see from the chart below that neglect and sexual abuse / exploitation advice calls have risen to outstrip concerns around parental mental health and parenting capacity. While we recognise that many of these issues become intertwined particularly in cases of neglect these figures demonstrate a shift in how the child has become more central to the assessment of need. There has also been an interesting rise in professionals asking for support around processes and procedures. We believe this is also due to learning from serious case reviews that the unit has disseminated this year, particularly encouraging professionals to more consider policy and procedure for such processes as case conferences, referrals to Social Care and the non-recent sexual abuse policy.



The below graph shows the groups of professionals seeking advice:



As would be expected the Named Nurses dedicate a lot of their duty afternoons to give advice to Social Care on Section 47 enquiries. After this group our main groups asking for support and advice are 0-19 Public Health Nurses. It is encouraging to see a rise in the amount of Adult Mental Health Service Teams accessing the advice system for support; this would indicate the efforts to reach Adult Mental Health teams more effectively over the last year are working.

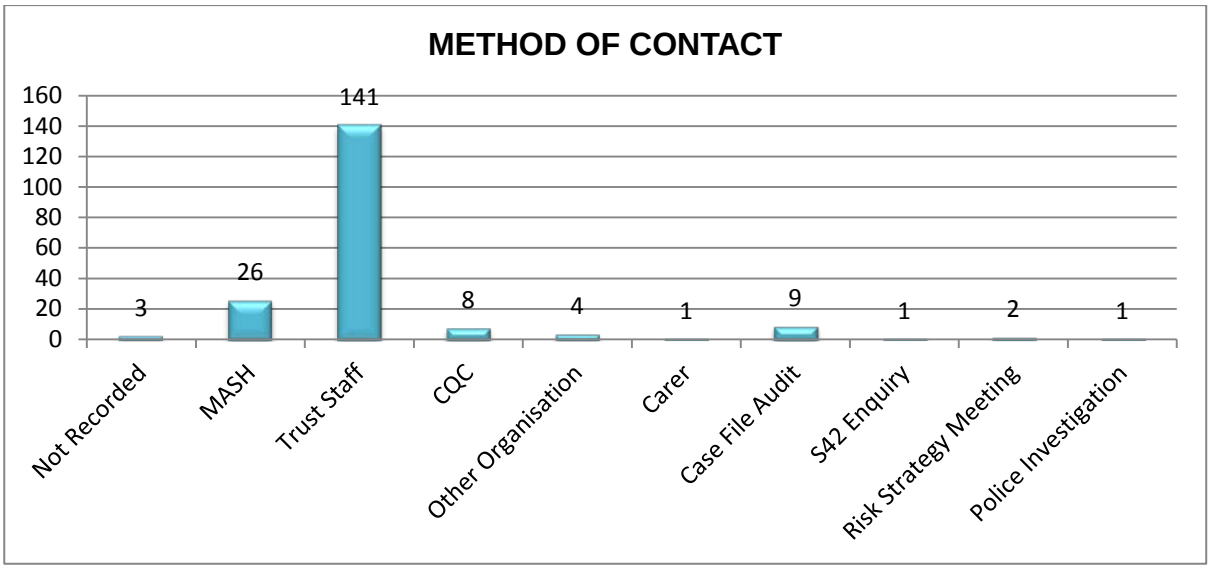
N.2. SAFEGUARDING ADULTS ADVICE THEMES

The Safeguarding team at Derbyshire Healthcare Foundation Trust receive requests for advice regarding safeguarding concerns, referrals and on-going cases. Requests are received in several different ways and from various sources. All of the adult related requests are logged and remain open to the Safeguarding advisor/s until resolved. The Assistant Director for Safeguarding Adults takes the lead on this.

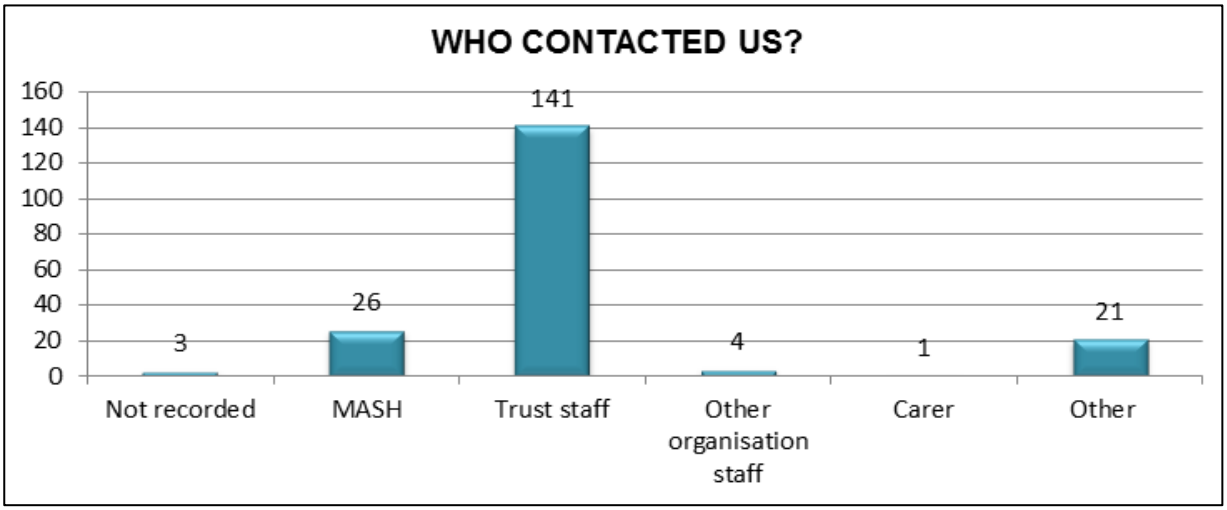
From 01.04.17 to 31.03.18, 178 requests were logged. There are also another 18 requests recorded without specific dates but as '2017'. Data analysis has been completed on the 178 requests alone, on the 18 requests alone, and also as a combined total of 196 requests. The raw data for each analysis can be seen in the appendix. The statistics included in this report are from the combined analysis, i.e. all 196 requests.

This does not include specific work streams that have been developed in response to particular phenomena, e.g. pre-referral screening for non-recent abuse disclosures received in IAPT services or requests for agency information from the Prevent Counter-Terrorism Team.

How are requests received?
The method of contact for requests is usually via Trust staff. Third parties may approach staff who then log the request, or staff themselves often request advice for service users, carers and family members that they are working with and have concerns for.

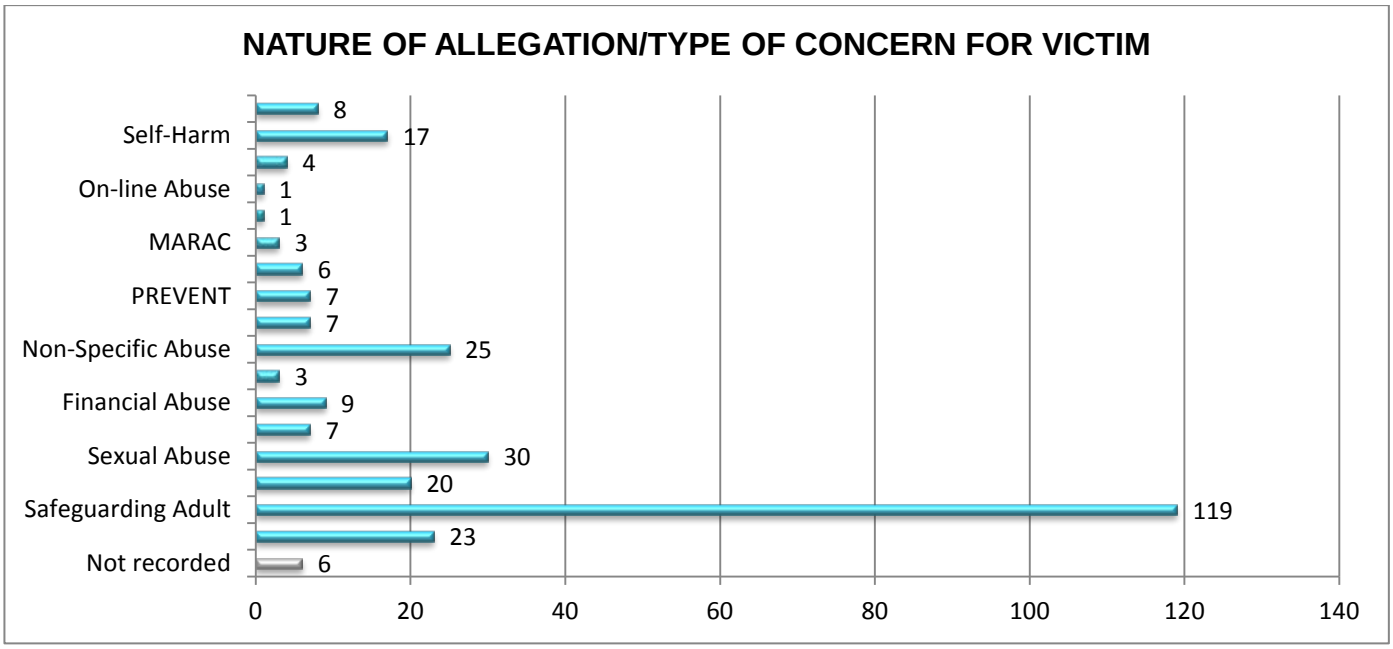


Requests are also received from sources external to the Trust such as other organisations, for example care homes, Social Services or the Care Quality Commission (CQC). The breakdown of these can be seen in the chart below:



What are the requests about?
Advice is sought on all aspects of safeguarding. The chart below indicates the nature of the concerns raised for all 196 requests.

There may be more than one reason for concern in each request. For example, one requests for advice might be made for one client, but that client might be experiencing domestic violence, sexual abuse and financial abuse, so all three of these issues would be logged – One request, three types of concern. So, the total number in the chart below exceeds the total number of cases within the analysis period.

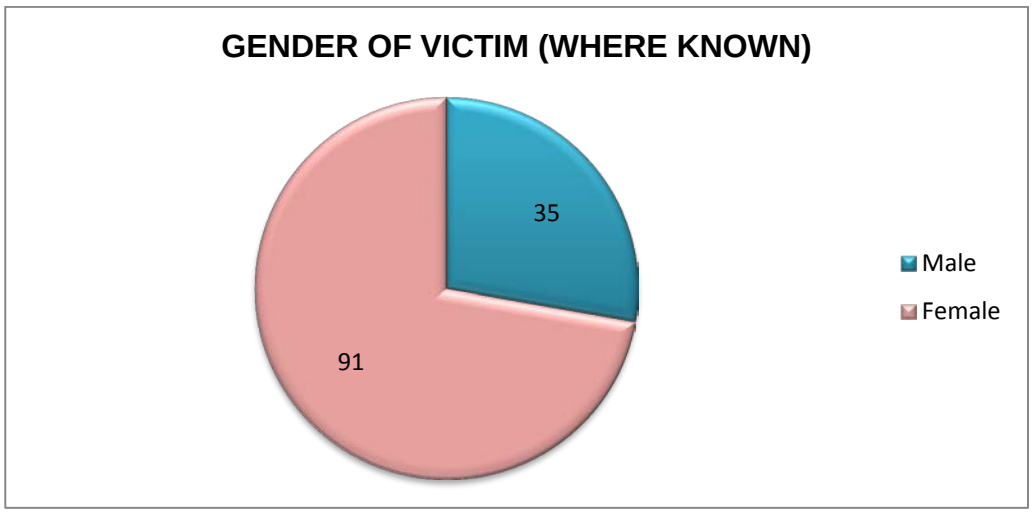


Safeguarding Adult/Children categories
These are only recorded in the chart above if details of the concern indicate clearly which category the victim is within. Ages of victims have not always been recorded in advice requests so the data in the chart for the adult/children categories is not a true statistical indicator.

Who are the requests about?
Information is recorded about those that concerns are about, referred to here as 'victims', and also those that are of risk to others, referred to here as 'perpetrators'.

Who are the victims?
The victims are most commonly family members or partners of the perpetrators. Trust staff, staff from other organisations, and carers have also been recorded as being alleged perpetrators.

The gender of victims isn't always recorded in advice requests, but where the records have deemed it obvious, which was in 96 of the requests, then the data has been included in the chart below.

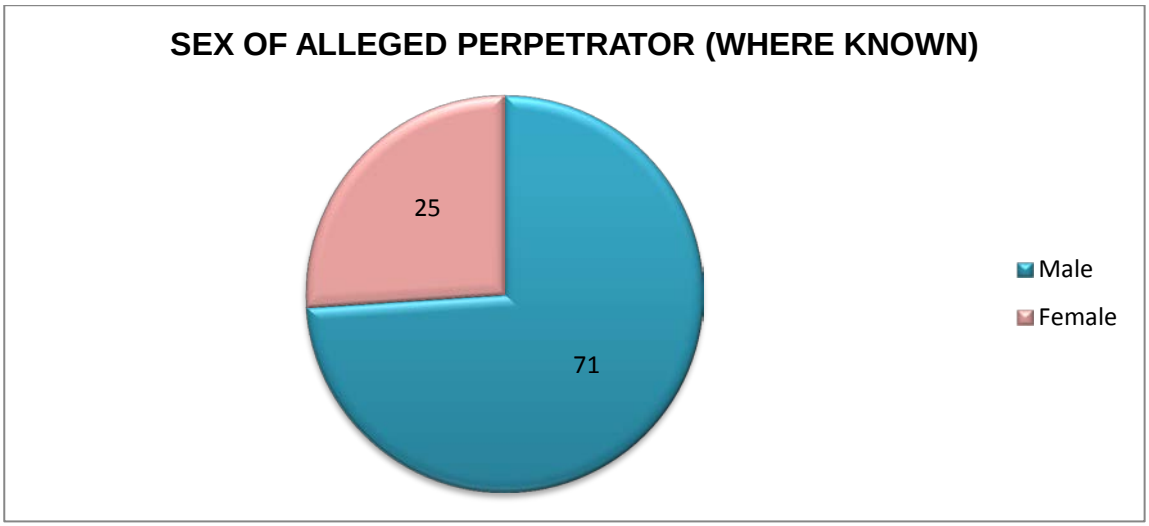


Who are the perpetrators?
Where recorded, the data shows that the majority of the alleged perpetrators are family members or partners of the victims. In many (but not all) of the 'other – male' and 'other – female' cases the alleged perpetrators were known to the families, for example friends of direct family members..

In total 58 alleged perpetrators were either Trust staff or staff from other organisations.

We provide assurance that all investigations into allegations have been managed in partnership with external agencies. This includes Police, Social Care and in relation to other organisations may include the health regulator. The Safeguarding leads can offer assurance that all incidents logged are reported, internally and externally and all investigations are followed thought to completion. At the time of reporting not all allegations were fully completed. Please note these allegations may be non recent abuse, interfamilial abuse, symptoms of post-traumatic stress disorder and reliving previous experiences and new incidences. The individual breakdowns are not provided to ensure protection of the information and identity.

In 126 of the requests the gender of the alleged perpetrator was recorded.



Note: Both genders include people of opposite gender by birth choosing to identify as other at the time of the request for advice.

Analysis of findings
This first 12 months of data demonstrates activity in all areas of safeguarding including Public Protection and Counter-Terrorism.

One would anticipate some changes in the next 12 months due to the increased stability of support offered by the MASH Health Advisors, greater integration across children and adult safeguarding in the Trust and further development of the Link Worker network.

Recommendations
- It is recommended that this become an annual process of data collection and analysis using 2017/18 as a baseline
- To benchmark, each quarter, against City and County-wide data that is submitted to and reviewed by the Performance Improvement Sub-groups of the Safeguarding Adult Boards

O. SAFEGUARDING – PREVENT AND CHANNEL

Derbyshire Healthcare continues to be a valued contributor to the Counter-Terrorism agenda in the County. Both Assistant Directors attend monthly Channel Panel meetings alongside colleagues from a wide range of criminal justice, health and social care colleagues. Activity over the year 2016/17 increased by 300% following attacks in London and Manchester and the Trust has struggled with the pressure of the increased demands for agency information sharing but continues to recognise its vital role in this area of work. We have had some particularly rewarding examples of joint working over the last year that are testament to the value of the interventions that can be offered and the success that can be achieved. These can be briefed in confidential section if required by Non-Executive Directors.

P. DHCFT SAFEGUARDING CHILDREN PRIORITIES

P.1 JOINT TARGETED AGENCY INSPECTION (JTAI) DERBY CITY

The Multi Agency Quality Assurance subgroup of DSCB have had the opportunity to review the JTAI guidance document and the JTAI analysis document that has been produced by Ofsted to gain an overview of what themes have been identified from other JTAI inspections that have taken place across the country. As the JTAI theme is going to be focussing on Intra familial child sexual abuse a child sexual abuse strategic action overview document has been compiled from a multiagency perspective.

The multi-agency Quality Assurance subgroup will be working together to prepare for the JTAI inspection and pulling together relevant information that will enable Derby City to be Inspection ready.

P.2 NEGLECT

Neglect remains a priority area for both Derby City and Derbyshire County Safeguarding Children Boards 2018.

Derby Safeguarding Children Board neglect audit - DHCFT position statement on action plan from 2017:

Agencies involved in the neglect audit were asked to provide evidence demonstrating the progress made to implement the Neglect Strategy and address actions arising from the cases reviewed during the audit. This report will contribute to the overall action plan arising from the multi-agency neglect audit and be reviewed by the Quality Assurance Group.

The following commentary illustrates the progress made by DHCFT against the following questions:

1. How do you know that the Neglect Strategy has been implemented in your agency and is understood by key managers and frontline practitioners?

    - The strategy and action plan has been discussed at various meetings throughout the organisation with front line staff and managers by the Safeguarding Children Team
    - Staff have also been advised and encouraged to attend the workshops and neglect training. Neglect also features within the internal training. Cases are also discussed within supervision and a recent team meeting was organised within a team to discuss a particular case

2. How is the Neglect Strategy influencing improved practice?

- More cases being discussed at supervision. Thresholds discussed in meetings throughout the organisation
- Appears to be a better understanding of the accumulative effect of neglect and how neglect can be a hidden factor within other areas

3. Recommendations from the audits:

- Parental capacity / capability can be effectively identified and assessed: This is formally discussed in supervision and training by the safeguarding team, parenting capacity is commonly an action to be instigated
- Use of the pre-birth assessment is formally discussed in supervision and training by the safeguarding team: DHCFT will work with the multi-agency teams in order to ensure pre-birth assessments are completed and any action to form part of the care plan as necessary. DHCFT will attend any pre-birth case conferences and core groups
- Historical information that is indicative of trauma and is discussed in supervision and training and the importance of history is highlighted: The safeguarding children team will recommend that case file are read at allocation meetings and prior to taking on the families and developing the care plan. This is also required with parents and carers in view of the impact of trauma and abuse on parenting capacity
- Management oversight, to improve planning and increased reviewing of cases to reduce drift and the effectiveness of planning is addressed in supervision and training re drift and escalation and thresholds: Case examples are used also. The graded care profile and EHA are tools that are promoted. These have been discussed as part of the neglect action plan at team/professional meetings and in training by the safeguarding children team
- Robust scrutiny of inconsistent explanations of injuries to children is discussed within training and supervision: Staff has access to the safeguarding advice system and the safeguarding team have direct access to the consultant paediatricians
- Policy is followed. DHCFT have provided clarification to help staff be clear about their responsibilities to inform the safeguarding team of complex cases to help recognise increasing seriousness of individual circumstances
- All Trust staff receive induction training from the safeguarding team that highlights the roles of the safeguarding children team. The safeguarding children supervision protocol highlights suggested cases to be bought to supervision for discussion. The management supervision policy also highlights the cases/issues/themes that should be discussed within management supervision
- The safeguarding children team attend professional meetings/team and MDT meetings to discuss the above. Learning from SCR and Learning reviews and incidents is cascaded. The safeguarding children team read all case conference minutes and follow up as necessary
- DHCFT ensure interconnectivity between their services and that they effectively work together to ensure concerns are shared

- There has been reflection on how supervision can challenge staff to recognise factors that may require escalation and ensure they are discussed and help staff identify when they need to seek advice

Derbyshire County joint targeted area inspection 2017:
Derbyshire County Council's commissioned Children's Services to undertake a 'deep dive' the theme: Children living with neglect. Approximately 27 cases were audited by the multi-agency wide teams from April 2017 to include young people aged between 7 and 15 years old who have been or who were being neglected. This was followed by a panel convened to discuss the cases.

Findings relevant to DHCFT:

Childs voice	Many agencies across the partnership understand the importance of hearing the voice of the child in families where there is neglect, and it is a strength that children's views, especially those of older children, are evident across many records seen
Multi-agency working	Good evidence of multi-agency working across the files audited; evidencing timely and effective communication between agencies to appropriately share information about children at risk, or potential risk, of neglect. In the cases seen, this was contributing to protecting children from harm

Key Learning Points relevant to DHCFT:

What's Working Well	Evidence examples
Multi-Agency working	• Where outcomes for older children were improving, there was evidence of skilled partnership work across agencies, including the police, health, Probation services the YOS, schools and social workers to support parents to develop a safe nurturing environment for their children • The audit findings identified that schools played a crucial role in working with partners and parents to understand the specific needs of older children. They then tailored additional support in schools to children to enable them to access education and begin to achieve their potential
Managing risk	• Core groups and Conferences were found to be outcome focused, addressing the needs of each individual child • Risks, needs and strengths are clear in the majority of assessment, with good evidence of the Social Worker consistently reviewing the concerns during

	stat visits, core group and at conference • When professionals provided a safe, supportive network for parents and worked with children directly to address their experience of neglect, this was mirrored in the more positive relationships that were developing between parent and child • Parents own childhood experience has been assessed, considered and fully taken into account. • Theme of parent's that require additional support and help have been signposted to enable this

Areas for Development	Actions Required
Multi-Agency working	• Health assessments and/or reviews had not always been completed in a timely manner which is essential when identifying and addressing issues of neglect. Staff need to be reminded of the importance of timely initial and review health assessments • A key area for improvement is the timeliness and rigour of evaluating the progress of multi-agency work to reduce risk and the impact of neglect on children. In a small number of cases, there was drift and delay in ensuring that the plans to reduce neglect were making sufficient progress and meeting children's needs. In addition, there is a need for more focus on the ability and motivation of parents to make and sustain improvements in parenting to reduce neglect and to improve the lives of children
Managing risk	• Chronologies are not regularly and routinely updated • Records of strategy discussions do not always include clear safety plans to address immediate concerns and reduce risks while waiting for a child protection conference and multi-agency plan • Staff in adult services do not always identify and respond appropriately to children at risk of neglect. Risks to children of neglect due to parental substance misuse is not always identified by adult substance misuse services, and in adult mental health services there is insufficient focus on the impact of parental mental health on children • Assessments identify the main areas of risk, but do not always offer good analysis of the impact of on-

	going and historic neglect on children. In some cases, the impact of parents' behaviour on children is considered but not thoroughly analysed. In some cases, this could be articulated by workers but was not recorded well on case files

The Neglect Action Plan is monitored through the DSCB Policies and Procedures Sub Group. DHCFT planned activities against the multi-agency action plan are as follows:

- Neglect gap analysis against NICE guidance and DHCFT action plan is complete
- Training at level 3, on neglect, including graded care profile on training programme
- Knowledge and discussion around Neglect and Graded Care Profile and its application by Clinical Health Practitioners and CYPD within cases of neglect is discussed during all level 3 Safeguarding Children training
- Learning from SCRs is cascaded throughout the organisation in various ways
- Neglect is high on the agenda for supervision and actively escalate difference in professional opinion
- Training includes disguised compliance, was not brought, accumulative effect and drift, resistant families
- Was not bought audit completed in DHCFT CAMHS. The audit showed documentation of risk and safe guarding issues documentation however, direct contact with the parents/ carers/ referrers about the consequences of not attending and the reasons for not attending can be yet improved. In addition capacity assessment documentation could be improved and documentation for setting timelines for the action plans and following them can also be improved
- Issues/ risks posed as a result of the audit
- Neglect CP medicals remain an issue. This has been raised with the designated doctors and discussed at DSCBs. A solution is being concluded

P.3 ONLINE ABUSE

Online safety continues to be a priority at both a National and local level. The latest annual report from the NSPCC – 'How Safe are our Children' - highlights our emerging understanding of technology-facilitated abuse and exploitation in addition to continued concerns regarding online bullying. There were over 3,000 police-recorded offences for sexual communication with a child in England and Wales and of the offence of communicating indecently with a child in England and Wales. In more than half of cases where the data was recorded (53%), offences took place on Facebook and the apps it owns. The Online Safety Lead reports on recent online issues via the Safeguarding Operational Group and the monthly Safeguarding Report to all the Clinical Operational Assurance Team (COAT) to disseminate information. The Safeguarding Trainer incorporates information on technology-facilitated abuse and exploitation updated on a regular basis. The Trust now has a bespoke 60 minute Safeguarding training on the 'The Digital World and Safeguarding', which is offered to Trust staff and has been presented externally at the Derbyshire Safeguarding Children Board Multi-Agency Learning and

Development event. The training has been well received. A Trust online Safety Strategy is in progress.

Q. CITY MULTI AGENCY SAFEGUARDING HUB (MASH)

The MASH team has significantly developed since the Health Advisors commenced their posts in December 2016.

MASH adult
MASH adults undoubtedly take a large amount of the health advisor resource due to the volume of referrals received on a daily basis. Due to this demand, there is now a larger duty team and a permanent senior practitioner has been appointed (awaiting a start date).

A total of 655 Information Exchange Request Forms (IERF) have been received; of these, health advisors were invited to 107 Strategy meetings. On a few occasions our attendance was not required as health professionals already involved in the care attended and health advisors had no further information to share.

The 'backlog' of interagency referrals prior to MASH being established continued to be cleared; the number has reduced considerably and is now under half from the previous year. This task will hopefully be complete over the next year to ensure new safeguarding referrals return too interagency requirements.

The categories of physical and domestic abuse are the most prevalent cases requiring information exchange from the health advisors.

IERF's for trafficking / modern day slavery remain low due to specific pathways for these cases. Referrals for forced marriage also remain low possibly by the nature and cultural elements of the concerns. This will be monitored in the Safeguarding operational group.

MASH children
MASH children strategy meeting remains at a pressured level. A total of 324 strategy meetings were held in MASH during the year. Unsurprisingly, the lowest month for referrals was August (16 in total). This is to be expected as children perhaps do not have as many opportunities to disclose abuse and teachers do not physically see them to monitor signs of abuse during the summer holiday.

Interestingly, the highest number of referrals was in June (54 in total) which is almost double the level of activity for other months This spike in activity may have been influenced by staff making more referrals as an anticipatory action around children not being monitored in school over the upcoming summer holidays.

Health information remains an invaluable resource in the MASH and at times is the sole agency in the strategy meetings to provide research.

Health advisors have built good working relationships with the First Contact Team (FCT) since commencement. Although MASH work is always prioritised, quick checks have proved invaluable for safeguarding children and providing an early intervention service.

A case vignette to articulate the safeguarding impacts was a mother stated she had taken a child to the GP for an injury; a quick check of the child records proved this was not the case; the risk therefore increased and subsequently a strategy meeting was held, a CP medical booked and the child was assessed under section 47. Without these relationships there could have been a delay in the child receiving the assessments and care they required.

Physical, sexual and domestic abuse are the most prevalent categories of abuse referred to MASH.

Themes for adults and children MASH (Think Family approach)
To provide a more effective safeguarding journey for vulnerable adults / children and their families, MASH are keen to ensure all agencies adopt a think family approach and children and adults are not segregated; this is recommended as best practice from serious case reviews and has proven to work well within our team.

MASH have held several complex strategy meetings involving adults and children services and as the MASH continues to develop, the team endeavours to continue to adopt this philosophy to ensure the best service to our ability is provided.

Physical abuse is the predominant category of abuse reported to MASH for both children and adults; domestic abuse is also prevalent for both. This may be explained by physical abuse is being more commonly reported as injuries are visible and it is sometimes easier for a child / vulnerable adult to explain if they are prompted to discuss how a physical injury has occurred compared to abuse that is not physically obvious.

A great deal of work has been undertaken in the year to engage more effectively with GPs. We have a greater understanding of the specific pressures that impact good working relationships.

Health advisors were invited to attend the GP's meeting to attempt to resolve issues relating specifically to how information is presented to GPs and developing assurance that processes are robust. A potential resolution has been suggested for all GP surgeries to have a 'safeguarding group' to 'task' through TPP, the electronic records system, to alert to safeguarding concerns, Health advisors agreed to continue to email or phone GPs if any action is required and will continue to do as above as it is felt this is best practice, the safest and most effective way to communicate information.

Domestic abuse (DA) triage (previously domestic violence)
Standard triage continues with some restrictions due to Police resources, all standard referrals are now sent to the Triage Social Worker to screen alongside health.

This process appears to be working well and has saved significant amounts of time following triage.

Health advisors remain concerned that the safeguarding of adults at risk is still not achieving parity with safeguarding children in relation to domestic abuse. To attempt to eliminate some of this inequality, health advisors have agreed for DA notifications to be sent to the Health Advisor's inbox if there is any mention of mental ill-health or substance misuse. Although this is time consuming, this process has proven invaluable. Since October 2017, health advisors have collected data for these 'follow ups' and subsequently information has been shared for approximately 143 vulnerable adults with other health professionals, i.e. GPs, CPNs, substance misuse services.

Advice calls
There has been a significant increase in the frequency of advice calls; in the six month report health advisors received seven calls; since March 2017, 76 calls for advice have been received. The vast majority for these have been in relation to vulnerable adults or complex families; the safeguarding nurses continue to take advice calls for children as per policies.

Data collection
Due to having a comprehensive understanding of activity levels from the initial year, data collection is now reduced whilst still capturing the main elements of the MASH work. The team will revise data recording to include a think family approach and monitoring for increases in complex family cases

Professional development
Health advisors are committed to develop their knowledge and skills and to continuously improve their Nursing portfolio and professional development. Skills development in the team has included a complex chronology for a serious case review and the shadowing a domestic homicide review. This is to develop the team knowledge and develop our future talent.

Health advisors have attended locality and CPN meetings to inform Trust colleagues about the MASH and the health advisor role; this has been successful and since the meetings several colleagues have shadowed the team and feedback has been very positive. In addition, students have visited who have also given positive feedback. One student informed our safeguarding admin that 'it was one of the most informative, interesting visits ever done' – He was really enthusiastic about it all so thanks for being such great hosts.

The MASH team continues to develop and efforts are made for team socials to ensure therapeutic relationships are formed and maintained; these have been successful and have proven to break some of the barriers to multi-agency working. Colleagues are open to discuss any case and debriefs / supervision can be held at any point to support each other. The above has proven important to the teams' wellbeing and morale given the nature of the referrals and the emotional impact this can potentially have on individuals.

Testimonies

"I have worked in the Derby MASH team for the past 11 months. Prior to this I had no experience of working in safeguarding. As a result I did not know what to expect in terms of daily information sharing with other agencies – obviously one of which is Health.
I have no issues with any of the Health advisors to date, I have found their research concise and relevant and they are not afraid to robustly challenge other agencies when they have a point to raise. They are a credit to the NHS."
City Referral Unit, Derbyshire Police

"I am a Team Manager for Children's Social Care reception team. I often have to cover MASH which means chairing strategy meetings which you attend as the MASH health advisor. My experience of working with you has been very positive and invaluable.
The research you complete in relation to the children and families we discuss is always clear, relevant and concise and helps to contribute to safety planning. Your contributions are always thoughtful and help to develop clear safety plans for the children we work with."
Thank you.
Team Manager - Reception Team Central

"Just to say, it is a joy to work alongside the MASH Health Advisors who bring an invaluable dimension to the multi-agency approach to safeguarding adults that MASH endeavours to deliver. The Health Advisors have the facility to access health records and share relevant information in a timely manner (sometimes this is required immediately) to inform our decision-making as to how to progress with our safeguarding enquiries. The Advisors are very professional, knowledgeable and always approachable. They provide a critical contribution to the multi-agency case discussions that are convened within MASH; the objective of which are to share relevant information about the more complex referrals, to inform the risk assessment process and formulate immediate safety plans.

I can recall how, as a Social Worker, I could spend many hours (sometimes over several days) trying to identify and liaise with Health professionals whom I believed may have been supporting or have relevant information about a patient/customer whom I was concerned about, the MASH Health Advisors can furnish me with relevant information within minutes, which in turn, enables me to provide a more person-centred, informed response."

In conclusion, the MASH team and health advisors continue to progress to meet the needs and demands of the service. Having health within the multi-agency team has proved invaluable to both vulnerable adults and children and the role of the health advisors has significantly developed and will continue to expand.

R. LEARNING FROM REVIEWS

Serious case reviews, serious incident learning reviews, homicide reviews and Police operations:
The Local Safeguarding Children Board (LSCB) commission a Serious Case Review (SCR) when a child dies or is seriously harmed when abuse or neglect is known or suspected to be a factor in the death (or serious harm), and after suspected suicide. Serious Incident Learning Reviews (SILRs) are commissioned for cases that do not meet the threshold for a SCR, but from which significant interagency learning can be drawn.

Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act, 2004. This provision came into force in April 2011. The purpose of a DHR is to establish what lessons can be learned from the domestic homicide regarding the way in which professionals and organisations work individually and together to safeguard victims. It should identify clearly what those lessons are both within and between agencies in the context of an action plan with clear timescales for completion. At the end of 2017/18 the Trust was actively involved in ten homicide/domestic homicide review processes.

A Police operation is when there are specific police operations a multi-agency approach is required. A Strategic Gold Group is formed and has explicit responsibility to ensure that arrangements are put in place to safeguard any children and witnesses that are subjects of the unique complex investigation and that these arrangements are clearly understood and acted upon by those working at an operational level.

The Trust Safeguarding Adults at Risk and Children Committee and the DSCBs receive and monitor progress against the developed action plan as a result of any recommendation made as a result of the multi-agency review. There have been ten reviews in total that the Safeguarding Children team have been working on covering 2017 and 2018 and three Police operations which the Safeguarding Children team have had significant involvement.

As part of the SCR processes the team has also contributed detailed information on a number of other cases being reviewed by Safeguarding Boards ahead of a decision on possible review.

All safeguarding research encourages a culture that supports openness, enquiry and an appropriate level of challenge where learning, including learning from Serious Incidents, is welcomed. Ensuring the workforce takes ownership for continuous learning and self-development is essential. Staff need a clear understanding of their roles and responsibilities within ‘Safeguarding Families’ ensuring that everyone who works with adults at risk, children, young people and their families understands how safeguarding links to their everyday practice .There have been a number of successful multi-disciplinary internal workshops delivered as a result of Serious Case Reviews, learning and homicide reviews with excellent learning outcomes for professionals to support the change of culture and practice. These continue with each completed review. Learning from both local

and national reviews is also cascaded throughout the organisation to ensure lessons learnt are captured.

The following Serious Case Reviews and Learning Reviews are complete and have been published. Below are summaries of the cases and the learning gained from them:

County – SCR to look into the death of a 19 month old child – Pronounced dead on arrival at A&E. The post mortem revealed a number of injuries which were considered to be non-accidental at first assessment. Exploration and analysis of maternal history of substance misuse, parental mental health and any concerning behaviour will be reviewed in this specific case

City – SCR to look into the circumstances were a nine year old Slovakian boy, with a level of learning needs, suffered serious scalds to his legs whilst living in the family home with both parents and four siblings. There were issues of neglect and the children had previously been subject to a child protection plan. Parents failed to seek medical attention and as a consequence the boy suffered a serious infection. This has been completed and published

County – Single agency review by children's social care to look into a case of an incident where a young man slaughtered a number of chickens, was arrested and due to his current mental health state was assessed under the Mental Health Act 1983 and was detained under section 2 and placed in secure accommodation for eight months due to considerable multi-agency communication breakdown. Whilst the case was a single agency review and DHCFT was not involved the named Doctor for Safeguarding Children gave expert advice to the review and the recommendations were taken on board as the learning was transferable to DHCFT CAMHS service.

The themes of the learning identified from these reviews are placed on the DHCFT amalgamated action plan which is managed via the safeguarding children operational meeting and assurance of progress/completion of actions against recommendations given to both the DSCB and the Trust Safeguarding Committee.

When there are specific police operations a multi-agency approach is required. A Strategic Gold Group is formed and has explicit responsibility to ensure that the arrangements put in place to safeguard the children and witnesses subject of the unique complex investigation are clearly understood and acted upon by those working at an operational level.

There have been three operations DHCFT have been involved with throughout the period covered within the annual report. Each operation is coded. Once the victims are identified compliance with safeguarding procedures and protective measures are addressed for each victim and the offending group needs to be identified. There is continuous learning to promote best practice, including learning from previous investigations and reviews.

Homicide Reviews

This year saw the Trust contributing to a Domestic Homicide Review (DHR) into the death in 2015 of a 34 year old woman. Her male partner was subsequently charged with manslaughter.

Domestic abuse, mental ill-health and alcohol and substance misuse featured in the profiles of both adults. The final review report was published in March 2018.

The findings of this DHR made reference to organisations having developed comprehensive domestic abuse policies over the period covered by the review:

- Highlighted a lack of 'professional curiosity' beyond the basic policy and procedures There were junctures identified where further exploration by professionals rather than an acceptance at face value of events may have led to an escalation of concerns and subsequent multi agency involvement and action
- There was an absence of referrals to domestic abuse support, despite repeated disclosures and reports to agencies by the victim, often because she would later retract the allegation she had made. This was not seen in the context of the level of coercion and control that was being exerted by perpetrator. There were aspects of good communication between involved agencies but each had its own information and no one agency had the complete picture and, it seemed that, each incident of domestic abuse was addressed individually rather than collaterally
- Agencies were largely aware of the volatile and chaotic nature of the couple's relationship and their alcohol and mental health issues were recognised

One agency reported that "the insidious tolerance to the behaviour of people who are known to misuse substances warrants further investigation by provider services".

Some of the learning from this tragic case had already been integrated into staff training and practice prior to the release of the final report. The specific actions for DHCFT were:

- To share the learning from the DHR and remind staff of the importance of responding to disclosures of domestic abuse by referral to the appropriate person within the organisation and to domestic abuse services

- To remind staff of the importance of looking at patterns of behaviour and the accumulative picture rather than focusing on the presenting problem as a 'one-off' incident

In response, training in domestic abuse now reflects the learning from this and other serious incidents, mental health teams demonstrate learning through the referrals that they make to domestic abuse services and partnership working with police and the safeguarding community. Activity levels in this area of abuse have risen significantly in the past three years and this is evidenced in data from the Safeguarding Children and Adult Boards.

As a Trust, we have incorporated the learning from this and other serious incidents regarding collateral risk into a review of the Care Programme Approach (CPA) Policy and Procedures, with Phase 1 completed at the end of March 2018.

Calls for advice to the Safeguarding Unit demonstrate an increased knowledge and awareness and an improved level of competence in the Trust workforce with regard to domestic abuse and the relationship between this, substance misuse and mental ill-health.

S. RECOMMENDATIONS SUMMARIZED FROM SERIOUS CASE REVIEWS

RAG Rating	
	Recommendation Not Started
	Recommendation Started
	Recommendation In Process
	Recommendation Completed

Recommendation	RAG
When sharing information with agencies, staff to ensure that they are providing up to date information including whether the child is registered with a GP	
All GP practices to enable a share with the Integrated Family Health teams where there are safeguarding concerns about families	
Staff to provide details of local dentists and opticians to families and to follow up that they have registered	
Staff to challenge whether a CP plan should end if all actions are not completed	
To raise awareness around procedures to ensure quality of referrals and follow up in writing. DHCFT should satisfy itself that all staff follow up verbal referrals in writing and if no response is received, have escalated this to the relevant manager in Children's Social Care in accordance with the Derby Safeguarding Children Board escalation policy	
Senior staff to ensure that regular supervision of Band 3/4 staff takes place and is recorded in the child's records	
Staff to complete graded care profile and consider impact of drift and accumulative effects of neglect as appropriate. Graded care profile paperwork needs recirculating to the teams and staff to attend neglect training. The completed single agency GCP to be shared with social care to inform the formal GCP when being submitted to VCM	
Derby Safeguarding Children Board should assure itself that single assessments are always shared with other agencies and the family. They should always include checks and previous local authorities in the UK and with authorities abroad. DHCFT to ensure that they request a copy for information and upload this to the child's record	
All agencies should ensure that their staff understand the impact of culture, race and heritage, when identifying neglect and significant harm and ensure that assumptions are not made about the practice and beliefs of newly emerging communities, nor should they condone these if they are not in accordance with practice in England	

To recommend to the Commissioners the recommissioning of the New & Emerging Communities health team or an alternative model which includes cultural adaptation Recommendation to DSCB: Derby Safeguarding Children Board should ensure that a strategic multi agency needs assessment in relation to Slovak families and families from new, emerging communities in Derby City is undertaken to ensure there is a sufficient range of services to meet identified need. This should include consideration of the reinstatement of the complex case meetings for Roma and new emerging communities and other previous arrangements	
To recommend a review of the interpreting services languages and request the commissioning of Roma interpreters	
Derbyshire LSCB should ensure that this report is made available to local practitioners to inform practice and widen learning. (Intended outcome: To share the learning obtained from undertaking this review with the overall aim to improve service delivery and service development)	
CAMHS service should produce and share widely guidance for other professionals that highlights	
Referral criteria for CAMHS and pro-forma which includes threshold guidance and response times for urgent, soon and routine referrals	
Guidance for parents, young people and professionals on how to access advice from CAMHS service	
Availability of alternative sources of mental health, emotional and behavioural support for young people and parents to access if CAMHS threshold is not met. (Intended outcome: To guide professionals in their decision making, help them to determine the level)	
Children and young people who display complex and/or dangerous behaviour need to have a clear assessment process with pathways and services available to ensure they receive the interventions required and not constantly be faced with 'not our remit': (Intended outcome: For the Young Person to be at the centre with a Team Around the Family process to be enacted to resolve service deficiency. We need to ensure that the right people are involved at the right time to take responsibility and take action for the Young Person	
Review of the potential for the commissioning of additional provision for children and young people who require CAMHS inpatient at a local level or as close to home as possible. (Intended outcome: To reduce stress and anxiety for young people and their families who are already going through a very difficult time without the further issues of having to travel unrealistic distances to visit. To ensure that professionals can attend meetings easier without the constraints of excessive travel and time)	
Children's Services to ensure Threshold models are used consistently around Step up discussions and procedures and staff should be aware of how to escalate concern in cases where there is a difference of opinion in line with the LSCB Escalation Policy	
CAMHS Tier 4 to ensure that all records and reports are suitably stored and available on request as appropriate	

Children Services and CAMHS to look at bringing processes in line to minimise the amount of meetings and assessments, to share systems and processes to ensure that the system error/failure to prompt professionals to commence an assessment and work with a family once a case has been allocated has been resolved	
DHCFT should ensure that this report is made available to local practitioners and cross border LSCBs to inform practice and widen learning	
It is good practice that professionals who are working with young people who are presenting with early signs of vulnerability complete an early help assessment and that team around the family (TAF) meetings take place. The DSCB should undertake an audit of early help processes/ arrangements to ensure the use of early help intervention is making a positive difference to children, young people and families	
CAMHS service should produce and share widely guidance for other professionals that highlights: 1) Referral criteria and proforma which includes threshold guidance and response times for urgent, soon and routine referrals. 2) Guidance for parents, young people and professionals on how to access advice from CAMHS service 3). Alternative sources of mental health support for young people and parents to access	
The GP and school nurse should receive a copy of the appointment confirmation and discharge letter from the CAMHS service	
When a professional knows a young person and /or family outside their professional role then an alternative worker should be explored in order to offer the service to the young person	
As part of the assessment of the young person all professionals should ascertain the young person's internet use and clarify with them the types of sites being accessed and the frequency of use especially when there are concerns around self-harm and suicidal ideation	
Organisations that directly employ family support workers/ pastoral support workers should ensure that they have robust governance arrangements in place, such as supervision arrangements, management oversight, record keeping and information sharing processes	
The DSCB to consider working together with Public Health and partners in developing a self-harm and suicide prevention strategy and action plan	

Lessons learned since April 2017

Safeguarding Adults

Improvement plan in response to recommendations outlined in the independent investigation into the care and treatment of Ms Z (24 July 2017)

In 2013 a very serious incident occurred in Derbyshire, which involved an individual in receipt of mental health services (Ms Z). Immediately following these tragic events, Derbyshire Healthcare NHS Foundation Trust undertook an internal investigation, in order to explore the care and treatment provided to Ms Z and identify any learning to ensure a

similar incident was prevented from occurring again. An action plan was developed in response to this internal investigation, which has now been completed in full.

Separate to the Trust's internal investigation, NHS England commissioned an external review of the care and treatment provided to Ms Z. This report was published on 24 July 2017 we continue to make good progress against the actions. The action plans are regularly reviewed and updated and can be viewed on the Trust website.

Improvement plan in response to recommendations outlined in the independent investigation into the care and treatment of Mr S 22 September 2017
In 2010 a very serious incident occurred in Derbyshire, which involved an individual in receipt of mental health services (Mr S). Immediately after this tragic event, Derbyshire Healthcare NHS Foundation Trust undertook an internal investigation, in order to explore the care and treatment provided to Mr S and to identify any learning. An action plan was developed in response to this internal investigation, which has now been completed in full.

Separate to the Trust's internal investigation, NHS England commissioned an independent investigation into the care and treatment provided to Mr S. This report was published on 22 September 2017. It is usual procedure for NHS England to commission an external report following a serious incident of this type, which involved a patient in receipt of mental health services. The report and its associated recommendations come from a non-NHS organisation. The action plans are regularly reviewed and updated and can be viewed on the Trust website.

A further review of these cases has been commissioned and at time of report publication remains not completed and will be published and reviewed in the 2018/19 Annual report period.

T. AUDITS

Audit on practice standard around domestic violence and recording utilising System One (January 2018 – Safeguarding Children Team)
The aim of the audit is to ensure that domestic violence is documented appropriately on System One and alerts are in place to highlight significant history/events to inform analysis and action. In total 130 cases were looked at and four questions were devised and used via an audit tool. It was necessary to assess the following:

1. Is there a copy of all domestic violence notifications on the child's health record?
2. Is the incident being recorded in 'Safeguarding Concerns – Child Domestic Abuse Template' on System One?
3. Is the incident being recorded in the 'Safeguarding Information' node template on System One?
4. Has an analysis and action plan been completed as part of the 'Safeguarding Concerns' template?
5. If yes… what was the quality of the entry?

Conclusion
The audit found good compliance on the whole, with the exception of question 3. The audit found that 100% of notifications were attached to the record. 82% of the cases had a complete 'Safeguarding Concerns' template. With regard to the 'Safeguarding Information' node completion this showed at only 8% and it was felt that this was due to a knowledge gap on process – This step of the process is needed as it creates a list on the record that can be viewed by TPP/ system One users users from other organisations who will not be able to see the detail of the 'Concerns' pages. The quality of the entries varied. Four areas were considered, date, detail, analysis of the incident and an action plan. Only 39% of records audited showed that all four areas had been completed.

As a result of the audit the following recommendations were made:

Recommendation	Action
Children's and CAMHS COAT has the responsible committee to review the results of this audit and assess the adequacy of the action plan to address risks arising from any shortfalls in compliance	COAT to approve this action plan to indicate that action plan adequately addresses risks arising from any non-compliance to standards and/or suggest further actions if required e.g. if a risk assessment is deemed necessary
Dissemination of results to the Services that participated in the audit to involve in the solutions for improving practice	E-mail/present report and action plan to members of the 0-19 Integrated Family Health Teams
Review the current process of recording on two nodes of TPP and the necessity for this	Discussion with TPP- System One /IT Leads around the implementation of process guidance development and adding to TPP. Information to then be shared with members of the 0-19 Integrated Family Health Teams
Provide guidance to teams on criteria required when reviewing PPN and to be made available on TPP	Guidance to be developed and to be added to TPP. System One Discussion with TPP/IT leads
To re-audit in order to establish recommendations have been implemented and are established as best practice	Submit project plan for re-audit to the Children's and CAMHS COAT

NHS Safeguarding Children's supervision / advice audit (March 2018, Safeguarding Children Unit)
An audit took place to assure quality of the safeguarding children supervision offered by the Named Nurses. The standard to be tested was that Supervision is an essential component of sound governance and is central to the Trust's governance processes – operational governance, clinical governance and professional governance.

22 Members of the 0-19 SCPHN teams completed questionnaire on Safeguarding Children's Supervision and Advice. They were required to answer 15 questions based on the frequency, content and quality of their supervision sessions.

Conclusion
The audit highlighted the need for a consistent approach towards the delivery and recording of safeguarding supervision. This had been identified through CQC inspection and feedback from staff. Level Four Training is being delivered to Managers on Effective Supervision & analysis to address this. Standard supervision tools have now been ratified through CRG and are on System One. There has been positive anecdotal feedback from staff on use of new Supervision Tools. Tools need to be used consistently by supervisors and support the process of analysis.

The new record audit tool has been ratified which was redesigned to support with process of analysis. A lack of analysis / action planning demonstrated in this audit and in Serious Case Reviews.

Analysis is imperative to the positive outcomes and safeguarding for children and families, therefore plans have been made to deliver further support on analysis skills to all staff.

The proposed new supervision recording document and clinical audit tool will promote standardised record keeping and identify areas of growth for practitioners. The use of Supervision Contracts will formalise responsibilities for recording and focus on areas based on supervisees specific needs/strengths, assets and areas of improvement. The development of new tools into the service i.e. outcome tools and supervision tools, has only been recent, therefore time is needed to embed into practice. With the planned reconsolidation of learning with managers and promotion of tools to staff at relevant meetings this will support an increase in use.

The following recommendations were made:

Recommendation	Action
The Children's COAT and CRG Meeting as the responsible committee to review the results of this audit and assess the adequacy of the action plan to address risks arising from any shortfalls in compliance	The Children's COAT and CRG Meeting to approve this action plan to indicate that action plan adequately addresses risks arising from any non-compliance to standards and/or suggest further actions if required e.g. if a risk assessment is deemed necessary
Annual completion of Trust supervision contracts	Managers to ensure all staff have a supervision contract completed as stated in the Trust Supervision Policy and Procedure document
Presentation of results at the operational	As per recommendation

team meeting	
To be clear on process of recording action plans from supervision and sharing information with managers	Ensure recording and sharing process and responsibility is negotiated in the supervision contract. (Please refer to supervision policy and procedure point 7)
Consistent tools to use in safeguarding supervision, accessible on System One	Supervisors to promote and use ratified supervision tools
Support staff with action planning through use of analyse	Supervisors to Audit clinical records with practitioners in supervision
Re-design recording of supervision document. to give more guidance around clinical/safeguarding supervision as well as managerial. Ensuring priority topics are covered	Approved at CRG April 2018. To share with authors of Trust policy and procedure
Band 7 & 8 0 -19 Staff/Managers Attend level four training on effective clinical supervision and analyse outcomes	As recommendation (ensure consistent approach to supervision within service)
Group / team supervision Sharing best practise, themes, challenges	Refer to supervision policy point 10. To explore with supervisors group supervision model

Communications audit
The Trust has undertaken a snap shot audit over a three-month period to identify some of the challenges that have been raised by 0-19 front line staff in communicating with Social Care. The findings of this report are:

The result of the audit highlighted that there are issues with communication between social care staff and 0-19 integrated health staff, particularly with telephone communication.

Health staff are calling social workers and either no one is answering the phone or if someone does answer the phone and they leave a message, calls are not being returned.

This is a particular issue in Locality 3 and 1.
Of the issues where ‘any other reason was stated’ a number of these were due to case conferences being cancelled on the day of conference and health staff not being informed. Also, conference dates had been changed at short notice.

Conclusion
Health teams are spending a great deal of time attempting to call social workers to discuss care of children, these calls are often going unanswered. On occasions when they have left messages these have not been returned.

The majority of the calls that health teams are making are in relation to single assessments, where health staff are attempting to contact social workers to establish the outcome of a single assessment that is being completed.

Emails have be used on occasions, however most social workers do not have secure email addresses therefore personal data cannot be shared.

Recommendations
It is a recommendation from a SCR that social care share copies of completed single assessments with all agencies. Once the process for this has been established health teams will not need to contact social workers for outcomes, however they may still want to discuss the case.

Wider recommendations on improvement with communication include updated social care staff lists, including telephone numbers and emails to be provided to the 0-19 integrated health teams on a regular basis, access to mobile telephone numbers to health staff, if they have them.

This was shared with the interagency at QA subgroup and it was agreed that the audit and the findings are shared with Children Social Care in order to address the findings from the audit.

Pre-birth audit
A very thorough and comprehensive multi agency pre-birth audit has been undertaken of which DHCFT took part in. This is now the second pre-birth audit. Although there have been some improvements made from the original audit, unfortunately, the interagency QA subgroup cannot be assured that processes in place are robust and being adhered to. The audit and the key themes and findings have been shared with both Health and Children Social Care.

Recommendations/findings
The following key themes/recommendations can be drawn from the multiagency audit:

- Referrals – Cases need written referrals in order to track, and evidence reasons for concerns and threshold
- Where there has been a delay in referral, or a delay in the response to a referral, this should be documented within the case file to ensure that there is a recorded rationale for this. This needs to be consistent across all agencies
- Communication between all partners needs to be more succinct, with expectations laid out from each agency, particularly before closure. In cases where there is not agreement to the plan, this should be explicitly communicated and recorded for

consideration. The escalation policy should be evidenced in those cases where this has not been resolved
- Lack of children being registered in the children's centre - Reminders to be sent to all agencies and prompts to be used in social care assessment
- Clarity is required by other agencies to understand the systems used in MASH/DV triage to ensure that information shared with midwifery is clear within assessments - There has been an assumption in some cases that social care will receive the same information as health, via the police in cases of domestic violence and therefore this has not always been recorded at referral
- Appropriate safeguarding information needs to be shared between partners, in accordance with information governance procedure, to ensure that assessments are thorough and relevant
- Outcomes of assessments need to be shared, as appropriate, with relevant partners to ensure consistent planning and intervention
- There is a little variability in threshold of the 'grey area' cases

The following are particularly poignant, though not exclusive, to sibling groups:

- All teams are to routinely create the unborn baby at notification, not waiting until the pre-birth assessment has been completed for those cases where the family may already be known to services
- Pre-birth assessments need to standalone, and not be a single assessment with minimal pre-birth information, particularly in case of families already known. Quality of assessments is variable with a requirement to be more sophisticated and thought through in terms of analysis, and consideration of all risks
- Sibling groups – There is a need to consider how the unborn baby is identified as a new case - Not getting 'lost in the system' whilst other safeguards are in place for children who share the same home
- Midwifery liaison group to ensure that they undertake robust risk assessments and analysis with parents and escalate concerns to children social care in a timely way

A Task and Finish group been set up to update the pre-birth protocol, as there some areas within the protocol that need to be reviewed to help professionals be clearer on what is required of them, and ensure that the action plan is implemented. The view of the QA subgroup is that this audit will need to be repeated in the New Year and that this issue remains on the Derby Safeguarding Children Board risk log. The Safeguarding operational group will oversee DHCFT-specific recommendations and any transferable learning.

Multi-agency quality assurance visit completed to Derby MASH: 12 December 2017

Methodology

On 12 December 2017 a multi-agency quality assurance visit to the MASH was carried out to check application of safeguarding procedures and threshold and whether the anticipated outcomes had been met. Representatives from the police, children's services and health formed the quality assurance team. The visit included:
- Observation of the domestic violence triage
- Focus group of the dv triage staff in the MASH

- Case file audits to check compliance with the quality assurance framework
- Observation of a strategy discussion meeting
- Observation of a social worker conducting a section 47 investigation

Findings from the observation of the domestic violence triage meeting
The MASH Auditors were extremely impressed with the triage meeting and how the meeting was managed, facilitated, the discussions that took place and the level of actions agreed.

Of the 27 standard domestic violence cases that the MASH Auditors listened to we were able to feedback that we were in full agreement with the decisions that were reached by the Triage team that the correct threshold had been adhered to. That the plan to look further into the 18 cases in order to determine what level of intervention was required was very appropriate.

Observation of the strategy meeting was undertaken and minor learnings on consideration of diversity

Overall findings

Strengths
All partners involved in the MASH audit found adherence to safeguarding policy and procedures and that thresholds were applied correctly. There was prompt and detailed information sharing. Additionally, it was pleasing to see the high level of cooperation and multi-agency working across partners, with evidence of respectful challenge and a think family approach.

Areas for improvement
Since the Quality Assurance visit the issue of circulation of strategy minutes has been discussed at the MASH strategic board and agreement reached about what should be shared with the Trust as the minutes often contain substantial sensitive information. It is now agreed that the MASH manager will send the strategy minutes to Trust staff in the Safeguarding Unit.

Improvement plan

#	Action	Desired Outcome
1	To review additional pathways within LCS to strengthen management information	Improved management information
2	To work jointly across FCT and MASH to give confidence on threshold application	Consistent threshold application
3	To consider working environment of MASH team specifically to ensure FCT manager has sight of all workers to assist with flow of work	Improved working environment
4	The process of sending out strategy	To ensure minutes sent have been

	meeting minutes to agencies to be reviewed	received
5	The process of requesting health information to be reviewed	To ensure all health services are receiving requests and responses are consistently recorded on health systems
6	Consideration of a strategy meeting action template for all attendees to be completed at meeting and taken away	To ensure everyone is clear on actions when they leave the meeting.

U. MAKING IT HAPPEN

The Trust made a strong commitment to safeguarding by reviewing its safeguarding governance structures in line with the 'Safeguarding Children: Roles & Competences for Healthcare Staff, Intercollegiate Document 2014'. Safeguarding Leads, Named Nurses and Doctors directly reports to the Executive Lead for Safeguarding Children. The Safeguarding Adults at Risk and Children Committee now directly reports to the Trust Board. This has been a very constructive move and has resulted in improved scrutiny, quality and assurance that safeguarding is and remains a Trust priority.

V. SAFEGUARDING CHILDREN WORK PLAN

The Safeguarding Children Work Plan has remained on target and updated on a monthly basis throughout the period covered by the annual report. All actions are either complete or complete to date but on-going.

The following two actions remain outside of the safeguarding team's control:

- Due to the increased challenges of a safeguarding nature the DSCB made Emerging and New Communities a priority and agencies worked together to look at systems and processes. The local authority are to fund and develop a 'New Team' from their Migrant Impact Fund to establish a targeted early help team to provide early help to Slovakian and New and Emerging Communities in Derby City. The team are to be bi-lingual workers and should be in post from May 2018

- To further develop specialist roles within 0-19 services to enable staff development/competencies, create opportunities and specialities within the workforce and aid retention of staff. The work plan is a standing agenda item on the Safeguarding Children Operational meeting and is working progress

There was some interest expressed to join the safeguarding team for secondments and development opportunities, however this hasn't progressed due to resource and capacity issues within the workforce.

W. NEW INITIATIVES/OBJECTIVES 2018/2019

Objective / Initiative	Timescale
To continue to develop and integrate the Children's and Adults Safeguarding team within the Trust	Complete by end of Quarter 4 2018-19
To ensure the new 'applicable quality requirements' (KPIs) are collated and submitted to the Designated Nurse for monitoring on a quarterly basis	Submitted quarterly
To fully develop dashboards for Adults and Children in order to provide progress reports on a quarterly basis	Complete by end of Quarter 4 2018-19
To ensure that succession planning, develop expertise within the workforce and consider talent management	Beginning Quarter 1 2019-20
To continue to build resilience in the workforce and support staff around complex work.	Complete by end of Quarter 4 2018-19
To provide chronologies and reports for SCRs, SILRs, internal incidents, homicide reviews and police operations . To then implement the learning, future developments and/or recommendations	Ongoing
To collate data, review and evaluate the DHCFT involvement within the MASH and to ensure current funding remains	Quarterly
To develop and submit an option paper for extra resource around Safeguarding Adults and Complex Case Team	Complete by end of Quarter 4 2018-19
DHCFT to be a full and active partner in work towards Derby City becoming a 'Modern Slavery Free City'.	End of Quarter 3 2018-19
Further development of the Safeguarding Unit within SystemOne	Ongoing
To work in partnership with all agencies around the challenges of working with emerging and new communities.	Ongoing
For safeguarding representatives to provide a report and attend monthly COAT meetings.	Monthly
To cascade safeguarding learning throughout the Trust and to work with People's Services to ensure safe and effective training	Ongoing
To ensure the Think Family remains a key clinical safeguarding standard.	Ongoing
To be fully involved in the Derby City JTAI on interfamilial sexual abuse 2018-19	Complete by end of Quarter 4 2018-19
To undertake a joint City / County Section 11 and provide effective evidence of the Trust compliance	End of Quarter 3 2018-19
To ensure that the changes in Working Together 2018 are fully	Complete by

implemented within the Trust	Quarter 2 2019-2020
To engage full in the Care Programme Approach agenda within the Trust	Ongoing
To review and further develop the Trust Safeguarding Strategies	Complete by end of Quarter 4 2019
To further develop the Link Worker Network	Ongoing
To continue thematic reviews of advice calls received into the Safeguarding Advice System on a yearly basis	Ongoing
To continue to work in partnership with the Ann Craft Trust to improve the accessible safeguarding screening tool (ASIST), led by the Assistant Director of Safeguarding Adults	Ongoing
To work in partnership on the development of Trauma Informed Approaches (TIA) and update the Survivor Strategy to reflect lessons learnt from the Complex Case Team	Complete by end of Quarter 4 2019
To provide assurance that the Trust fulfils its public protection duties for MAPPA and/or s.41 of the Mental Health Act	Complete by end of Quarter 4 2019
To work towards our third and final "Carer's Trust Triangle of Care" star.	Complete Quarter 2 2019-2020
To review the incident reporting processes within the Trust specifically around referrals into Social Care	Complete Quarter 3 2018-19

REPORT PREPARED BY:

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ANNUAL REPORT FOR DERBY CITY LOOKED AFTER CHILDREN PROVISION

Year: 2017/18

Contributors:

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This annual report has been compiled through collaboration between Derbyshire Healthcare Foundation Trust and Southern Derbyshire Clinical Commissioning Group key staff members.

Section 1: Introduction and context

Introduction

1.1 The purpose of this report is to provide Southern Derbyshire Clinical Commissioning Group (SDCCG) and Derbyshire Healthcare NHS Foundation Trust (DHcFT) an overview of the progress, challenges, opportunities and future plans to support and improve the health and wellbeing of looked after children in Derby City. This includes all cohorts of looked after children that Derby City Local Authority are responsible for, no matter where they live (see appendix 1 for explanation of the differing cohorts). The report will also outline how DHcFT support looked after children who are placed in Derby City from other Local Authorities.

1.2 The report will outline how Commissioners, Designated Professionals, Local Authority and health providers have worked together in partnership to meet the health needs of children in care in Derby City; in line with the statutory guidance 'Promoting the health and wellbeing of looked after children' (DH, 2015).
It will summarise key improvements, service performance; along with setting out the objectives and priorities for the next financial year (2018/19) for looked after children in Derby City.

1.3 This report has been compiled in partnership with the Named Nurse for looked after children, Designated Nurse & Designated Doctor for looked after children and the Medical Advisors supporting looked after children.

1.4 The report contains and analyses the compliance to the statutory framework in respect of timeliness and quality of health assessments and is obtained by the use of snapshot audits. Another key objective of this report is to reflect the progress DHcFT have made in relation to obtaining the voice of the child and carer at health assessments and mechanisms to further improve the service delivery and scope to this most vulnerable group of children and young people.

1.5 Within all national and local policies and guidance the service is known as Looked after Children, however within Derbyshire Healthcare NHS Foundation Trust the service is known as Children in Care. This was a result of the previous Designated Nurse for looked after children asking the young people at the Children in Care Council in 2015/2016 their preference and the majority preferred to be called Children in Care.

Context

1.6 Definition of a looked after child/ child in care

A child that is being looked after by the Local Authority, they might be living with:

- foster parents
- at home with their parents under the supervision of Children's Social Care
- in residential children's homes
- other residential settings like schools or secure units.

They might have been placed in care voluntarily by parents struggling to cope, or Children's Social Care may have intervened because a child was at significant risk of harm.

Health and wellbeing of looked after children

1.7 It is well recognised that children's early experiences have a significant impact on their development and future life chances. As a result of their experiences and blended effects of poverty, poor parenting, chaotic lifestyles, abuse and neglect, looked after children often are at greater risk and have poorer health than their peers (DfE, DH, 2015).

Ref: Promoting the health and well-being of looked-after children, March 2015, Department for Education and Department of Health

1.8 The Royal College of Paediatrics and Child Health (2015) states that looked after children and young people have greater mental health problems, along with developmental and physical health concerns such as speech and language problems, bedwetting, coordination difficulties and sight problems. Furthermore the Department for Education and Department of Health (2015) argue that almost half of children in care have a diagnosable mental health disorder and two thirds have special educational needs. When there are delays in identifying or meeting the emotional and mental health needs this can have a detrimental effect on all aspects of their lives leading to unhappy unhealthy lives as adults.

Ref: Promoting the health and well-being of looked-after children, March 2015, Department for Education and Department of Health

Ref: Looked after children: Knowledge, skills and competencies of health care staff, Intercollegiate Role Framework, March 2015, Royal College of Paediatrics and Child Health

Section 2: Statutory Framework, Legislation and Guidance

The statutory guidance focused around Looked after Children is in abundance; the key documents and legislation are outlined as follows:

2.1 **Children Act (1989)**

Under this Act a child is defined as being 'looked after' by the local authority if the child or young person is in their care for a continuous period of more than 24 hours by the authority.

There are four main groups:

- **Section 20** children who are accommodated under a voluntary agreement with their parents
- **Section 31 and 38** children who are subject to an interim care order or care order
- **Section 44 and 46** children are subject to emergency orders
- **Section 21** children who are compulsory accommodated including children remanded to the care of the local authority or subject to criminal justice supervision with a residence requirement.

2.2 Adoption and Children Act (2002)

This Act modernised the law regarding adoptive parenting in the UK and international adoption. It also enabled more people to be considered by the adoption agency as prospective adoptive parents. This Act also places the needs of the child being adopted above all else.

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2.3 Children and Young People's Act (2008)

The purpose of the Act is to extend the statutory framework for children in care in England and Wales and to ensure that such young people receive high quality care and services which are focused on and tailored to their needs.

2.4 Children and Families Act (2014)

This Act strengthens the timeliness of processes in place to ensure children are adopted sooner. Due regard is given to the greater protection of vulnerable children including those with additional needs

2.5 Promoting the health and wellbeing of looked after children (March 2015)

This guidance was issued by the Department of health and Education. It is published for Local Authorities, Clinical Commissioning Groups, Service Providers and NHS England.

2.6 Looked after children: Knowledge, skills and competences of health care staff intercollegiate role framework (March 2015)

This document sets out specific knowledge skills and competencies for professionals working in dedicated roles for looked after children

2.7 The Children and Social Work Act (2017) New legislation which received Royal Assent in April 2017 aims to:

- Improve decision making and support for looked after and previously looked after children in England and Wales
- Improve joint work at local level to safeguard children and enabling enhanced learning to improve practice in child protection
- Enabling the establishment of new regulatory regime for the social work profession
- Improve the provision of relationship and sex education in schools

The guidance documents for the finer detail have been published in June 2018 and are currently being implemented.

Section 3: Looked after children data and profile

National and local data

3.1 The number of looked after children has increased steadily over the past eight years. There were 72,670 looked after children on 31 March 2017, an increase of 3%, compared to 31 March 2016 and an increase of 6% compared to 31 March 2013. The most up to date national figures for 2017/18 are not yet available from the Department for Education (Stats: Looked after Children, Department for Education, 2018), the usual publication date being December 2018.

3.2 Number of children looked after in England at 31 March 2013 to 2017

2013	**68,080**
2014	**68,800**
2015	**69,540**
2016	**70,440**
2017	**72,670**

Ref: Data made available from Derby City Local Authority Informatics Department

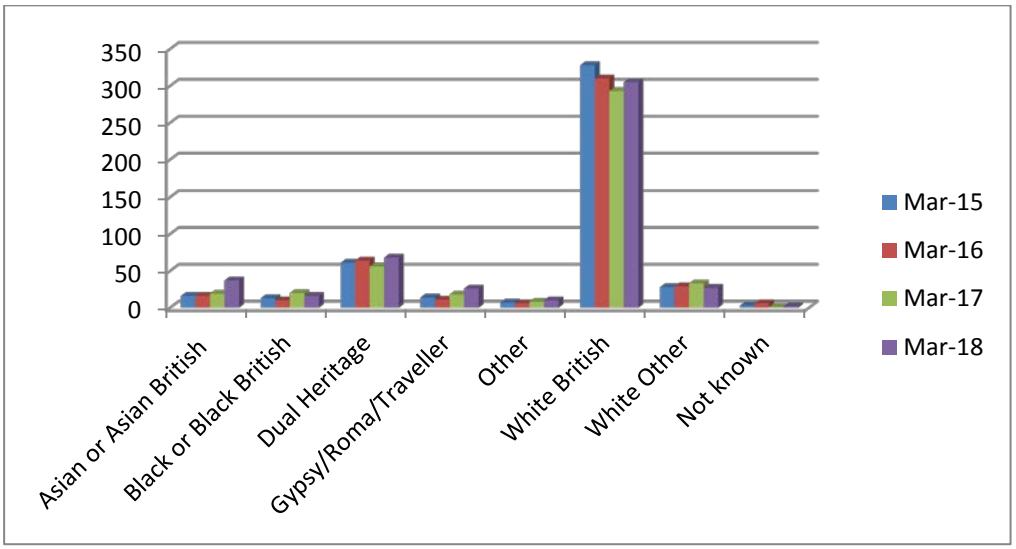
3.3 Number of children looked after in Derby at 31 March 2013 to 31 March 2018

2013	**465**
2014	445
2015	470
2016	452
2017	448
2018	491

Ref: Data made available from Derby City Local Authority Informatics Department

Profile of looked after children in Derby City

3.4 Ethnicity comparisons over the last four years:



Ref: Data made available from Derby City Local Authority Informatics Department

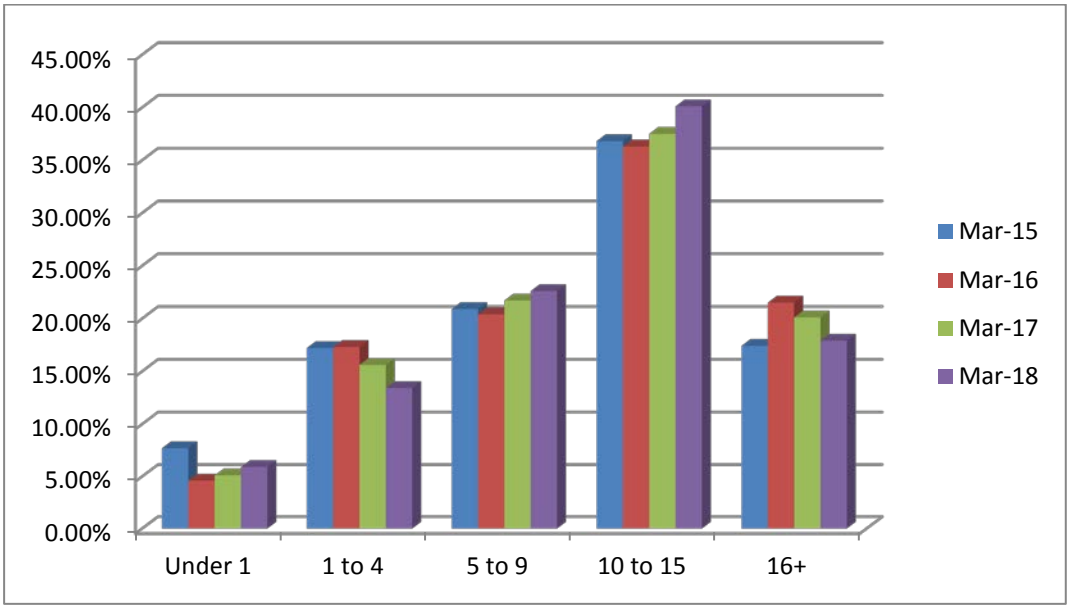
On analysing the data, it is clear that there is an increase of looked after children from the Gypsy/Roma/Traveller, Asian/Asian British and Dual Heritage ethnic group; this reflects the Derby City picture of a recent influx of new emerging communities. There have been significant cultural differences found in the new emerging communities, in relation to childcare, parenting, disciple and safety aspects. This has resulted in an increase of cases being referred to Children's Social Care and involvement at all levels of intervention; in some cases children/young people taken into care. The number of White British children coming into care has increased, after a fall over the past three years; this may be reflection of the overall increased population changes within Derby City.

3.5 Gender of looked after children in March 2018

Gender	
Male	57.4%
Female	42.4%

Ref: Data made available from Derby City Local Authority Informatics Department

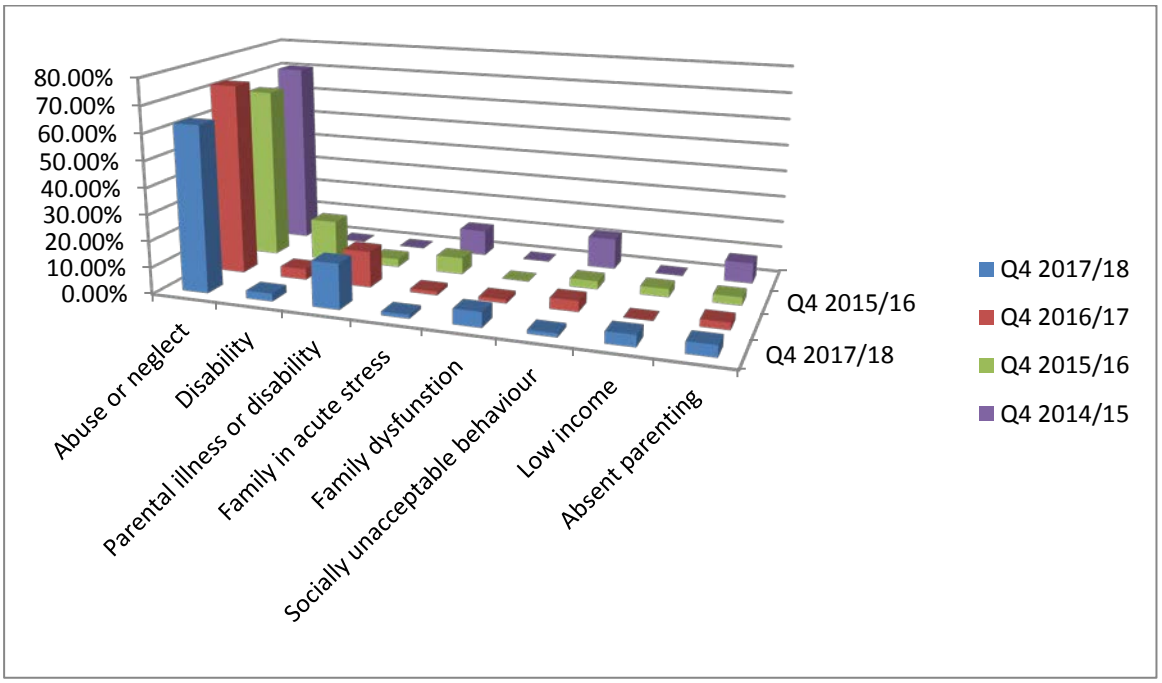
3.6 Age comparisons over the last four years:



Ref: Data made available from Derby City Local Authority Informatics Department

In comparing the data for the past four years, the 10 to 15 year old age group consistently remain the highest number of children/young people coming into care. It is difficult to determine the definitive reasons for this but it may be linked to the increase in socially unacceptable behaviour, abuse/neglect, acute stress within the family home vocalised by children/young people and family dysfunction identified as a reason for coming into care.

3.7 Reasons for children coming into care – comparison in quarter 4 data over last four years



Ref: Data made available from Derby City Local Authority Informatics Department

Abuse or neglect remains the most dominant reason for children/young people coming into care, with the percentages remaining relatively stable in reason categories reflected in the

above data. When making comparisons of a quarter by quarter basis over the past four years, there is a change in the overall trend with more children being taken into care due to homelessness (Local Authority category - low income), parental illness/disability and family in acute stress. This may in some circumstances be associated to the financial climate within England, changes in benefit systems which is then reflected in family pressures; this is difficult to confirm.

3.8 Distribution of Looked after Children placed In and Out of Derby City

	March 2018	March 2017	March 2016	March 2015
Within Derby City	36.3%	38.6%	42%	46.2%
Outside of Derby City	63.7%	61.4%	58%	53.8%

Ref: Data made available from Derby City Local Authority Informatics Department

3.9 The Local Authority has acknowledged that the shift of Looked after Children placed out of Derby City is increasing; this is not always in the best interests of the child. Children placed out of Derby City can potentially not receive a timely service or have access to timely specialist services this is due to the child having to be referred to services in the area they are residing in; this clearly needs addressing and resolving as all looked after children should wherever they reside receive services they need in order to meet their individual identified needs. Derby City Local Authority are proactively working in partnership with Derby City Foster Carers and Independent Fostering Agencies, implementing a comprehensive strategy, in order to increase the level of Foster Carers /placements within the City or placements close to Derby City. Within Quarter 2 in 2017/18 the Local Authority held an Independent Sector engagement event, with a vision to increase foster placement capacity within the City and the Looked after Children health team were actively involved in this event.

3.10 The Local Authority has made some progress in placements within a 20/40 mile radius of Derby City and indeed has approximately 75% of Derby City Looked after Children placed within that parameter. This is in line with the development of the Children in Care health team now undertaking health assessments at a 20 mile radius of Derby City, which has had a positive impact on improved quality and timely health assessments for those living within an approximate 30 mile radius.

Section 4: Summary of achievements in year 2017/18

4.1 During the period of 2017/18 the Children in Care health team have continued to experience significant change and it has been acknowledged despite this the Specialist Nurses and Medical Advisors have shown innovation and marked improvements within their service delivery. All the priority actions within the annual report 2016/17 have been achieved.

The following are an indication of the progress made and not an exhaustive list of achievements:

4.2 Several health pathways have been developed and successfully implemented, for example: health assessment refusals, was not brought to appointment, Specialist Nurse in-put for

those children with special educational needs. These changes have resulted in more efficient working, improved compliance with statutory timescales and improved service delivery across administration and clinical

4.3 Peer record keeping audit template developed and implemented, with a vision to improve the standards, quality of documentation, completion of the coramBAAF forms and to share learning as a team. This will be further evaluated within the year 2018/19

4.4 Completion of the CCG 'Markers of Good Practice' assurance framework and the implementation of an improvement plan in collaboration with Designated Professionals (detailed in section 11, pages 14-15)

4.5 Implementation of the service specification and submission of key performance indicators as agreed

4.6 Redeveloped the training programme for Foster Carers and Residential Care Workers and this commenced in March 2018 and will continue within the year 2018/19

4.7 Action learning sets facilitated by the Designated and Named Nurse have been introduced within the service. Sessions have focussed on: Social Media and the impact on children and young people, smoking cessation, staff well-being and developing a compassionate team and has been demonstrated to increase the skills/knowledge of the team. This also acts as an assurance that the Children in Care health team undertake required specialist training and maintain their skills and knowledge

4.8 Development of a Specialist and Named Nurse 'biography' continues to be in working progress. The 'biography' is planned to be given to all looked after children new to care and to Derby City children's homes. Following consultation with the Children in Care Council the initial ideas and format was agreed and is due to be completed within 2018/19

4.9 Designated Nurse, Designated Doctor and Named Nurse have strengthened existing relationships and networks with key professional, local partners and agencies locally and regionally, which has facilitated information sharing, health outcomes and the voice of the child (including those out of area)

4.10 Health access to Liquid Logic Child Social Care system has been established, which has been proven to improve information sharing between agencies (in the best interest of looked after children) and had a positive impact on the accuracy and validity of health data reportable to Department for Education

4.11 Health history booklet and process has been improved in partnership with the Provider, Local Authority, leaving care teams (recommended in Ofsted inspection)

4.12 Reporting and assurance into the SDCCG Quality Assurance Committee has been strengthened via quarterly reporting of performance and quality of the Children in Care service

Section 5: Provider and Partnership Working

5.1 Partnership working between DHcFT and SDCCG has further developed and become well established in Derby City over the year 2017/18. This has been as a result of the increased capacity (Designated Nurse), motivation and dedication of the Designated Nurse,

Designated Doctor, Named Nurse, CiCA Nurses and the administration team. Collaboration and co-operation between the Provider and the Designated Nurse has proved essential in the ability to improve the health and well-being of Looked after Children in Derby City and those placed out of county.

5.2 DHcFT and SDCCG have liaised on a regular basis with the Local Authority, attended the relevant Looked after Children focussed meetings and always strive to achieve the best outcomes for looked after children.

Section 6: DHcFT service provision for Looked after Children

Named and Specialist Professional roles

6.1 The DHcFT Children in Care health team have core competencies, specialist skills, knowledge and attitudes to act as advocates, undertake health assessments, identify and manage health needs and provide support/training to Foster Carers and Children's homes (in line with the Intercollegiate Role Framework, RCN, RCGP, 2015). The team also contribute to health care plans for all looked after children including children with special educational needs and/or disabilities.

6.2 The team have improved their offer for Looked after Children by including; the delivery of health promotion to children and young people, support for care leavers, development of a robust system to collate health histories for care leavers, improved identification of risk of child sexual exploitation (including boys/young men) and provision for children who have special needs and/or disability (revised service specification during 2017/18).

6.3 The staffing levels for the health team at the end of the financial year (March 2018) were as follows:

Designation	Hours	WTE
Designated Doctor	4 hours (1 session)	
Designated Nurse (SDCCG)	37.5 hours	1 (From May 2017)
Named Nurse	30 hours	0.8
Specialist Nurse	14 hours	0.37
Specialist Nurse	22.5 hours	0.6
Specialist Nurse	32 hours	0.85
Specialist Nurse	26 hours	0.7

6.4 The staffing provision at the end of the financial year 2017/18 was WTE 3.3, which is almost in line with the recommendations within the Intercollegiate Document (March 2015). This is concluded as a result of approximately 75% of the Looked after Children cohort being placed within 40 miles of Derby City (equating to approx. 368), therefore the advised level of Specialist Nurse staffing would equate to WTE 3.6, consequently being short of only WTE 0.3.

However, it has to be acknowledged this document is deemed to be 'gold standard' and one for services to aspire and fulfil as much as possible; to ensure that looked after children receive the healthcare services they require by skilled competent staff and in a timely manner.

6.5 In 2017/18 the newly agreed service specification for the Children in Care health team was implemented to reflect current statutory requirements and completion of health assessments within a 20 mile radius. The Children Commissioners, Designated Nurse and the Provider have and continue to work collaboratively to monitor performance, in line with statutory guidance.

Administration Team

6.6 The Children in Care administrative team consists of an Administrator Coordinator (Band 4) and three Administrators (two at Band 3 and one at Band 2). Their hours equate to a total of 1.92 WTE, however from December 2017 to March 2018 the Children in Care administrative team had a Band 4 vacancy due to the previous Administrator Coordinator leaving the service. During this period the Health Provider and Named Nurse (with support from the Designated Nurse) completed the recruitment process. A successful candidate was appointed, however due to unforeseen circumstances declined the post prior to commencement. Unfortunately this resulted in the recruitment process having to be commenced again. In the interim period the administrative team were offered additional hours and an agency administrator was temporarily employed to support the team and cover the required work during this period.

6.7 The purpose of all four roles is to provide a comprehensive administrative support service to the Children in Care Health team, ensuring that all administration needs are fully met and that the administrative processes and procedures run smoothly. Responding and making decisions where necessary and follow up any actions from health professionals from local and external areas with confidentiality, discretion and diplomacy due to the sensitive information being shared regarding these vulnerable children.

6.8 Improvements have been made over the last year 2017/2018 to ensure robust administration systems are in place. The Designated Nurse and Named Nurse have worked in conjunction to update and develop all administrative processes, some of which are discussed within this annual report.

6.9 The timeliness for requesting the out of area (at a distance) health assessments have significantly improved towards the end of the year. This was due to the agency administrator focusing on ensuring the requests were sent out at least eight weeks prior to the due date (following the newly implemented out of area at a distance flowchart) and being more proactive around chasing outstanding review health assessments completed by outside providers. This needs to be sustained moving forwards into 2018/19.

6.10 In October 2017 it was agreed between the Local Authority, SDCCG and the Provider that a list would be provided from the Local Authority on a weekly basis: to include new children placed in care, children and young people discharged from care and any placement changes. This has helped improve timeliness within the Children in Care Team in opening referrals, ending care and changing address details which has replaced relying on the CA6 change of circumstance form for this notification.

Section 7: Strength and Difficulties Questionnaire (SDQ)

7.1 During quarter two of year 2017/18, a new strengths and difficulties questionnaire (SDQ) process was developed and implemented, in order to increase the completion rate of the questionnaire (Appendix 2). This process ensures that the SDQ score provided by the Local Authority was in line with the review health assessment and supported the Specialist Nurse identifying any emotional or behavioural difficulties of the child/young person and assessing the impact of support provided (or if required).

7.2 If the score is not available at the time of the review health assessment the Specialist Nurse ensures the carer receives a blank copy of the SDQ form, provided by the Local Authority and requests it's submission via a stamped addressed envelope. Once the SDQ score is received by the Children in Care Health team, post review health assessment, the administration team follow a defined process, alerting the Specialist Nurses to high score SDQs. This allows the Children in Care Nurse to make a decision as to whether a referral on to another service is required or any other action is needed. This process is due to be reviewed in July 2018 (in conjunction with the Local Authority); in order to ascertain progress and to further develop the meaning/impact of the SDQ score for the child/young person.

7.3 Table showing number of SDQ's completed (eligible ages):

Year	SDQ received	Percentage of completion rate	Average score (higher the score = higher need)
2015-2016	183	70%	16.4
2016-2017	189	79%	16.3
2017-2018	236	93.6%	16.2

Ref: Data made available from Derby City Local Authority Informatics Department

7.4 The completion rate of SDQs is significantly higher within year 2017/18 than previous years and this is a direct result of the newly implemented process and joint efforts from the Children in Care team and Local Authority Business Support Services.

7.5 As already identified, the meaningfulness of the score and impact for the child/young person and the vision to (reduce the scores of SDQ) improve the emotional health and well-being of Looked after Children will be a focused area of work for the forthcoming year/s.

Section 8: Missing Episodes/Incidents Notifications for Looked after Children

8.1 The Local Authority team responsible for monitoring and supporting children/young people who go missing from home, care or education, have worked in partnership with the Children in Care health team to improve the health input and relevant health interventions following incidents/episodes of missing of Children in Care.

8.2 The Local Authority have a responsibility to complete a 'return interview' (upon their return) with children/young people within 72 hours of any missing episode or incident. The compliance and standard of the interviews are monitored within the Local Authority, to ensure the timeliness, quality and significance of the missing episode is analysed in relation to risks and safety for the child/young person.

8.3 During quarter three an innovative process was agreed between SDCCG, the Provider and the Local Authority that a copy of all 'return interviews' for missing children and young people (Looked After) were sent to the Children in Care Health Team. The Designated Nurse and the Named Nurse developed a pathway for missing Looked after Children/Young People to support this process. A template has been developed within SystmOne to capture the information from the return interview in the child's electronic records using certain read codes to identify the following;

- Risk factors identified whilst missing
- Reasons for going missing
- Intervention offered
- Referrals on to any other services

8.4 The rationale for capturing this level of information enables the Children in Care Nurses to identify any health issues, risks potentially impacting on health and actions offered as appropriate. The Children in Care team have a named 'champion' for missing children and young people who attends the multi-agency 'Missing Children's Monitoring Group' in order to share information between agencies regarding patterns of missing, risks and impact of interventions. Having these processes in place has strengthened the links between the Children in Care Team and the Local Authority with regards to missing children and young people to work together in partnership to reduce any health and safety risks.

8.5 An example of the impact of this newly implemented process:

The Children in Care team received a return interview for a missing episode on a young person where it was identified that this young person disclosed they had unprotected sexual intercourse with a male. With consent from the young person a Children in Care Nurse visited the young person (at a venue that suited the young person) and it was disclosed that the unprotected sexual intercourse was with a high risk male therefore support was given to attend the sexual health clinic and subsequent support offered.

8.6 Implemented missing Looked after Child pathway can be found in Appendix 3.

Section 9: Analysis of Adoption and Medical Advisor activity

This section compiled by Dr A. Marudkar (Named Doctor for Adoption) and Dr V. Kapoor, (Named Doctor for Children in Care) CICA-Derby City

9.1 This section of the report has been prepared based upon the information available from DHcFT data and data provided by the Local Authority regarding adoption related work provided by DHcFT service. This includes the data for relevant Looked after Children activity and Initial Health Assessments.

9.2 Quality improvement activities:

9.2.1 Both Medical Advisors deliver bespoke training three times a year for prospective adopters and Foster carers. This training highlights the impact of maternal smoking, alcohol and drug

use during pregnancy on the unborn child, blood borne infections and indications for blood borne infection screening in high risk children. The feedback on training is collected and collated annually as part of appraisal paperwork and again evaluated positively within 2017/18.

9.2.2 As part of the annual GP vocational training course in Derby, a lecture was delivered on the Children in Care and Adoption service along with the Designated Nurse. This training evaluated by all attendees as showing increased learning and understanding about children in care and those adopted/being adopted.

9.2.3 Both Medical Advisors attend the Looked after Children Midland Regional Network meeting twice a year, which incorporates training on relevant topics and peer supervision of complex cases. This supports the Medical Advisors maintain and develop their specialist skills and competencies.

9.3 Analysis of Adoption Activity

9.3.1 The staffing for the adoption part of the service remains the same as previous years, with one medical advisor providing whole of the adoption service as the Named Doctor. The Named Doctor remains solely responsible for the completion of reports; for suitability for adoption and at matching stages of the adoption process

9.3.2 The adoption medical report is prepared for Agency Decision Maker (ADM) exploring the child's suitability for adoption, which incorporates information from Initial Health Assessment, any Review Health Assessments and Social Care document of Child Permanence report

53 ADM reports were prepared as compared to 29 last year (83% increase). 29 Children were matched, which was comparable to 31 from last year. This increase significantly impacted on the workload of the sole medical adviser. In light of the increased workload DHcFT plan to increase the Medical Advisor capacity to support the adoption process in year 2018/19

9.3.4 If individual consultations with prospective adopters were requested by Social Care, then a telephone or a face to face consultation was arranged with prospective adopters. A total of 14 consultations this year in comparison to 13 last year.

9.4 Looked after Children activity:

9.4.1 The staffing has remained the same during this year with two medical advisors undertaking all the Initial Health Assessments, with some done by trainees under supervision

9.4.2 This year the Initial Health Assessment (IHA) activity has increased significantly to total 231 from 184 last year. The last year's figure was inaccurately reported as 133, showing a 10% reduction in numbers from the previous year, but in fact it was a rise of 25% over previous year. There is further rise of 26% this year.-, overall 5% rise in two years. This has in turn significantly affected the timeliness of Initial Health Assessments, breaching the statutory timescale of completion within 20 working days

9.4.3 The unattended appointment (children not brought or refusing to attend) rate reduced from 8.3% last year to 6.9% this year overall, however the out of area 'was not brought' rate was still high at 12.5%.

Section 10: Health Data and Performance for Year 2017/18

10.1 Health data and Local Authority performance is a mandated submission to the Department for Education on a yearly basis and the table below summarises the performance over the last three years:

Health Data Indicator	Year 2015/16	Year 2016/17	Year 2017/18
Annual health assessments	87.5%	91.2%	92.7%
Dental checks	80.0%	84.1%	87.6%
Immunisations up to date	100%	97.7%	93.9%
Development checks (two RHAs in the 12 months for under 5 years old)	83.3%	81.6%	87.5%

NB: the data is only mandatory for those children/young people in care for a period of 12 months or more

10.2 Overall performance of the Health Provider's provision continues to improve with the support of both the clinical and administration team and has been acknowledged within the Clinical Commissioning Group, DHcFT and Local Authority.

10.3 The immunisation uptake rate data is noted to have declined over the last three years, however it has been acknowledged that the data in 2015/16 and 2016/17 is likely to be inaccurate. The Local Authority informatics system had undergone a significant change just before 2015 and this may have had an impact on accuracy of the immunisation data. Since the Children in Care team have access and mechanism to update Liquid Logic (Local Authority IT system), the accuracy of heath data has significantly improved. The current immunisations uptake rate for 2017/18 is in line with the national immunisation uptake rates.

Section 11: Markers of Good Practice (MOGP)

11.1 In August 2017 the Children in Care Team submitted the Markers of Good Practice – self assessment tool for Children in Care within Derby City. The Markers of Good Practice tool, which is 'RAG' rated, provides the Children in Care Team with a productive opportunity to showcase their service to the Clinical Commissioning Group and Designated Professionals

11.2 With the submission of evidence and 'RAG' rating, the tool supports the Children in Care team highlight progress, any gaps or improvements that are required to assure the commissioners our service is working towards a 'gold standard' delivery and that the needs of the children in care are being met and identified in line with the statutory guidance.

11.3 Following on from the MOGP submission, representatives from the Clinical Commissioning Group and Designated Professionals completed a site visit to the Provider in October 2017. A discussion was held between key representatives from DHcFT and the commissioners both SDCCG and NDCCG. Each standard was discussed and it was confirmed whether or not the RAG rating provided by the Provider was in line with that of the commissioners' assessment.

11.4 During the MOGP process the following was identified by the provider:

- DHcFT found the MOGP self-assessment tool easy to understand and were clear around provision of relevant evidence to provide CCG assurance
- DHcFT felt that the tool aided them to be 'inspection ready' with regard to CQC
- DHcFT found the MOGP process to be an opportunity to reflect, evaluate progress and plan for future improvements
- DHcFT found the process to be fair, open, honest and a true reflection of the service.

11.5 Strengths and challenges were identified, agreed by both parties and an action plan developed for the organisation to work through within the year to achieve compliance in the areas that were not yet rated as green. The Markers of Good Practice action plan has been fedback to the Safeguarding Operational Meeting held by the organisation and is continually discussed with the Designated Nurse LAC.

11.6 The Clinical Commissioning Group have been assured that the Children in Care service provision is overall at a good standard and the Health Provider is working in partnership in all areas that have been identified as requiring further progression or improvement.

Section 12: Quality Assurance Processes

12.1 The Designated Professional role for Looked after Children has a statutory responsibility to promote the health and welfare of looked after children (Statutory Guidance: Promoting the health and well-being of looked after children, March 2015). This role is intended to be strategic at a Commissioning level (working in partnership with the Local Authority) and ensuring the voice of the child is heard and acted upon in the relevant arena.

12.2 The Designated Nurse is directly employed by SDCCG, which enables a level of independence to the Health Provider. A key element of the Designated Nurse and Doctor roles is one of quality assuring the service provision of health assessments within Derby City and out of area, to ensure the placement for the child in no way disadvantages them in healthcare provision and outcomes; in comparison to those Looked after Children living in Derby City and provide assurance to the SDCCG that the service that it commissions is of a high standard.

12.3 To inform this report, snap shot audits have been completed by the Designated Nurse (for Born In, Lives In and Born In, Lives Out – close to home) and are summarised within Appendix 4.

Data for Year 2017/2018

Quality of assessment	Unsatisfactory	Satisfactory	Good	Outstanding	Total Number
Number	0	6	22	7	**35** included in snap shot audits
Percentage	0%	17.1%	62.8%	20%	

12.4 Areas noted to have improved over the year 2017/18, in comparison to year 2016/17 are:

- Timeliness and quality of the review health assessments (particularly for those living out of Derby City within 30/40 miles)
- The use of the tool 'Ages and Stages Questionnaires', including the social and emotional tool
- Improved capture of the emotional well-being of the child / young person
- Documented wishes and feelings of the child / young person
- Capturing of the voice of the child

12.5 Areas identified for further improvement in Year 2018/19:

- Completing all areas of the coramBAAF forms (including number of placements, legal status, venue, likes to be known as)
- Robust health care plans with SMART objectives
- Further improve the capture of the 'voice of the child'; particularly non-verbal young children and those with special educational needs/disability
- Stronger analysis on the health implications for the child / young person

12.6 The findings of the quality audits are fed-back to the Named Nurse and a plan of action discussed in order to improve the quality overall, with an aim to ensure all of the Review Health Assessments are of outstanding quality. The Named Nurse will discuss quality standards with each individual Specialist Nurse within monthly one to ones, team meetings, collate peer record keeping audits and develop a pre-health assessment checklist to aid the completion of documentation. The Designated Nurse and Named Nurse are planning to deliver a team workshop in July 2018, with a focus on quality and outstanding quality Review Health Assessments. The quality audit will be repeated in the Autumn of 2018 to ascertain the impact of this workshop.

12.7 Born In, Lives Out – At a distance:

All review health assessments for those Looked after Children placed by Derby City at a distance are quality assured by the Designated Nurse.

Data for Year 2017/2018

Quality of assessment	Unsatisfactory	Satisfactory	Good	Outstanding	Total Number
Number	9	24	60	22	**115**
Percentage	7.8%	20.8%	52.1%	19.1%	

All unsatisfactory Review Health Assessments are returned to the completing Health Provider with a request for improvement (specifically stating reasons for return) and monies are not released until the Designated Nurse is in receipt of the improved quality health assessment documentation.

12.8 The Designated Professionals undertake an on-going audit programme throughout the year and findings are given as feedback to the Health Provider and Local Authority as appropriate. Any concerning issues found are escalated as appropriate via the contracting and quality routes within the relevant agency and within the Clinical Commissioning Group. The audit programme for the Designated Nurse can be found in Appendix 5.

12.9 Initial Health Assessment quality assurance process

The Designated Nurse has been working with the Children's Commissioner, Named Nurse, Designated Doctor and the Service Line Manager to improve the Looked after Children service specification key performance indicators submission and adherence to the statutory requirements in relation to Initial Health Assessments. Further improvements are required and have been identified as part of the Markers of Good Practice process and there is currently an outstanding action in regard to this matter. In the interim period the Designated Nurse has quality assured eight DHcFT Initial Health Assessments and has provided feedback to the Designated Doctor and Medical Advisors so remedial action can be taken and future improvements made. Quality assurance of the Initial Health Assessment is a requirement of the Designated Doctor and the provision of feedback as part of the service specification key performance indicators.

Section 13: Voice of the child

13.1 The voice of the child/young person should be embedded in all aspects of service development and delivery. It is essential that children and young people are listened to and their views responded to in order to promote and respect the rights of children.

13.2 The voice of the child is obtained through a variety of mechanisms (dependent on their age, capacity, levels of understanding, analysis of non-verbal cues and body language):

- The child/young person is offered the opportunity where age appropriate to be seen alone.
- At each appointment confidentiality is explained to the child or young person
- Identification in collaboration with the child/young person of their own strengths, wishes, feelings and their needs
- Use of the evaluation form after health assessments or any individual contact with a child or young person
- Clear documentation of the child's voice by using direct speech quotes or agreed summary of conversations

13.3 During the year 2017/18 the Named Nurse and Designated Nurse have attended the Children in Care Council by invitation, on a couple of occasions. The main purpose of the interactions was to:

- Explain the role of the Children in Care team, Named Nurse and Designated Nurse
- Provide the Council with some feedback of actions taken, following on from their previous input and suggestions (you said, we did)
- Introduce and gain comment on the staff biographies

13.4 Within the Corporate Parent Committee the Health Provider and Designated Nurse are held to account and asked to respond to any presentations, concerns raised or submissions to the Committee. There is always child representation at the Corporate Parent Committee meetings and any responses are given in a child's language. As a response to the annual report presentation last year, the Children in Care Council requested a child friendly version to be made available to cascade to Looked after Children and Young People.

13.5 The plan to re-evaluate the feedback questionnaire during 2017/18 in conjunction with the Children in Care Council has been completed. The aim was to ensure the form was in a child focused format, easy to understand and enables the child to express their thoughts and

feelings about their health assessment and if they feel any improvements can be made to improve their assessment experience. The new style feedback form can be found in Appendix 6. All feedback received is collated by the Named Nurse, fedback into the Health Provider Governance structure and to the Children in Care team.

13.6 The Named Nurse consulted the Children in Care Council in the development of the feedback form and further improvements are planned during year 2018/19, following their views and comments. Children in Care Council comments can be found in Appendix 7.

13.7 The Named Nurse and Designated Nurse have supported the development and delivery of a study day led by the Local Safeguarding Childrens Board, in conjunction with Independent Reviewing Officers, Education, Emotional Health and Well-being Service and the Local Authority representatives. The study day focuses specifically on the voice of the Looked after Child, how professionals can support, change their practice and have a greater understanding of the complexities of children / young people's lives whilst being looked after and the potential impact on adulthood.

Section 14: Special Educational Needs / Disability

14.1 The Health Provider and Designated Nurse have worked exceptionally hard, in partnership with the Local Authority to improve the service provision for Looked after Children with additional needs and/or disability.

Changes and achievements over the year 2017/18 are:

14.2 Newly improved feedback forms for children with additional needs (several versions). The opinion and voice of the child/ren with special education needs/disability was sought in its development and acted upon.

14.3 With the employment of a new Specialist Children in Care, the team had the capacity to provide a Link Nurse to the residential Local Authority home for children with complex needs. This has improved the continuity of the nurse completing the health assessments, knowing the child's method of communication and their individual needs.

14.4 Obtaining copies of Education, Health Care Plans (EHCPs) has been a historical issue and not been acted on previously. During the year there has been significant progress made, with the compliance of access to the EHCP within child's health record has gone up from 1% in August 2017 to 63% in February 2018. The Local Authority collaboration in ensuring compliance improves has been outstanding, even for those children living out of area and work continues to obtain 100% compliance.

14.5 Prior to a review health assessment the Specialist Nurse reviews the previous Review Health Assessment, letters from other health providers and EHCPs, to ensure the Review Health Assessment meets the needs of the child. An assessment of suitable methods of communication, obtaining appropriate resources, right venue for the child and who can support with relevant up to date information, also takes place prior to the health assessment.

14.6 Virtual School now send monthly reports to the Designated Nurse – indicating the support required for all school age looked after children. Any changes in between months have been noted and sent to the Named Nurse to amend the clinical child's health record accordingly.

14.7 Improved communication and clear pathways have been established between Special Educational Needs / Disability Co-Ordinator and the Children in Care health team. This has resulted in the Children in Care team being made aware of when there is a request for health

information to contribute to the Education Health Care Plan and liaison between professionals as appropriate.

Section 15: Children in Care Team Successes

On completion of the annual report the Children in Care team submitted feedback they had received during the year 2017/18 (via face to face, telephone, evaluation forms):

"The admin team were extremely helpful and efficient" – Social Worker that required an urgent report

"Named Nurse always keeps the child at the centre of all the team do" – Designated Nurse for LAC

"Nurse came to see me at the Childrens Home and she was far nicer than I thought….I'd definitely see her again" – Young person in care, aged 14yrs

"It was great to see the same nurse again for my review health assessment….I didn't have to retell my story" – Young person in care, aged 15yrs

"I enjoyed showing the nurse my new football and DVDs" – child in care, aged 8yrs. RHA undertaken at his placement

Foster carers who attended a focussed session on weaning / infant feeding gave feedback – "I like the informal delivery and that we can bring the children to the session". The foster carers also requested a community based venue which has been arranged for next planned session

Through collaboration with the CIC Nurse, Social Worker and foster carer, a young person (who had previous not engaged with local services) began to engage with services to support their emotional health and well-being

Section 16: Priorities for Year 2018/19

16.1 Designated Nurse key priorities for 2018/19:

- Support the Children in Care team to improve the quality of the Review Health Assessments undertaken for children Born In, Live In; Born In, Live Close to Home
- Continue to strive for improved quality for out of area health assessments, through standardised quality assurance processes and providing feedback as required
- Improve the quality, timeliness and quality assurance processes for Initial Health Assessments, in collaboration with the Designated Doctor and Medical Advisors
- Explore the possibilities of introducing 'My Health Passport' for Children in Care, in order for children to have a personal held health record and contribute to their healthcare and health assessments
- Review and renewal of the Children in Care service specification and support the Health Provider in meeting any improvements and changes

16.2 DHcFT Provider key priorities for 2018/19:

- Increase the compliance and completion of the Health History documentation for all Care Leavers prior to them turning 18 years old
- Improve the quality, timeliness and quality assurance processes for Initial Health Assessments, in collaboration with the Designated Nurse, Designated Doctor and Medical Advisors
- Enhance the use of information technology and the sharing of health information between Health and local Authority IT systems. With a vision to improve administration processes, resulting in efficiencies for the administration, clinical teams, Social Workers and Local Authority
- Embed the role of the newly appointed Administration Co-ordinator and facilitate any improvements, suggestions and innovation for the benefit of Looked after Children
- Greater focus on health promotion work to empower children and young people to make healthy life choices.

16.3 These key priorities are an overview of some of the on-going work and strong commitment to improving the health and welfare of looked after children. The vision is to ensure looked after children reach their natural potential through the interventions of competent, skilled, compassionate professionals and their drive to make a difference to this vulnerable group of children and young people.

The authors of the report request that DHCFT and SDCCG accept the annual report and agree on the key priorities set for 2018/19

References

Promoting the health and well-being of looked-after children, March 2015, Department of Health and Department of Education

Looked after children: Knowledge, skills and competencies of health care staff, Intercollegiate Role Framework, March 2015, Royal College of Paediatrics and Child Health

Stats: looked after children, Department for Education, 2017
https://www.gov.uk/government/collections/statistics-looked-after-children

APPENDICES

Appendix 1 – Looked after Children cohorts explanation

BORN IN, LIVES IN – Looked after Children born in Derby City and reside within the City.

BORN IN, LIVES OUT (placed near home) – Looked after Children that were born in Derby City but reside within approximately 20 miles away from Derby City in another Local Authority area.

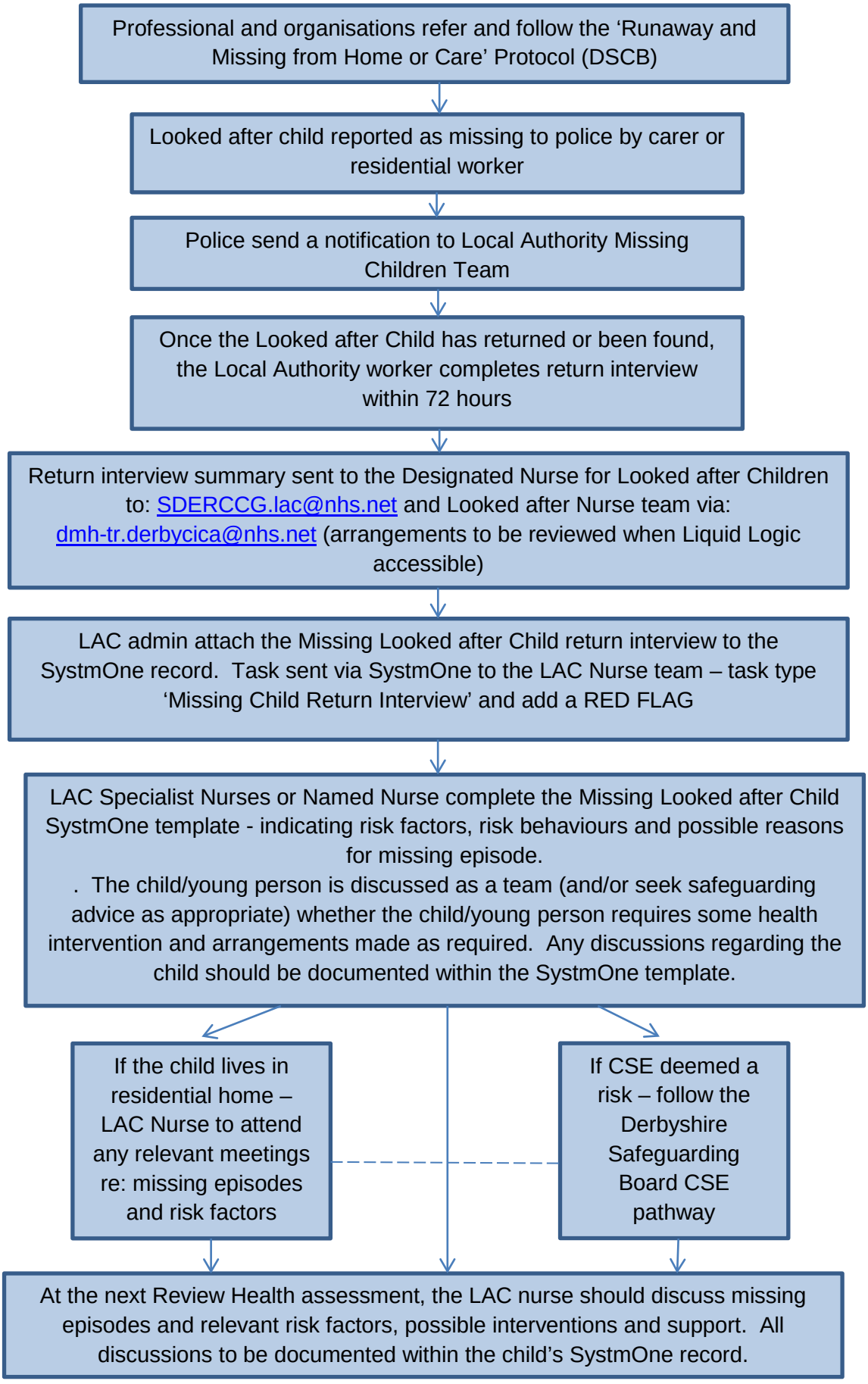
BORN IN, LIVES OUT (at a distance) – Looked after Children that were born in Derby City but reside in another Local Authority area over 20 miles away from Derby City.

BORN OUT, LIVES IN – Looked after Children that were born in another area outside of Derby City but reside in Derby City.

Appendix 2: Strengths and Difficulties Questionnaire Process

Appendix 3 – Missing Episodes / Incidents for Children in Care

Missing Looked after Child Pathway



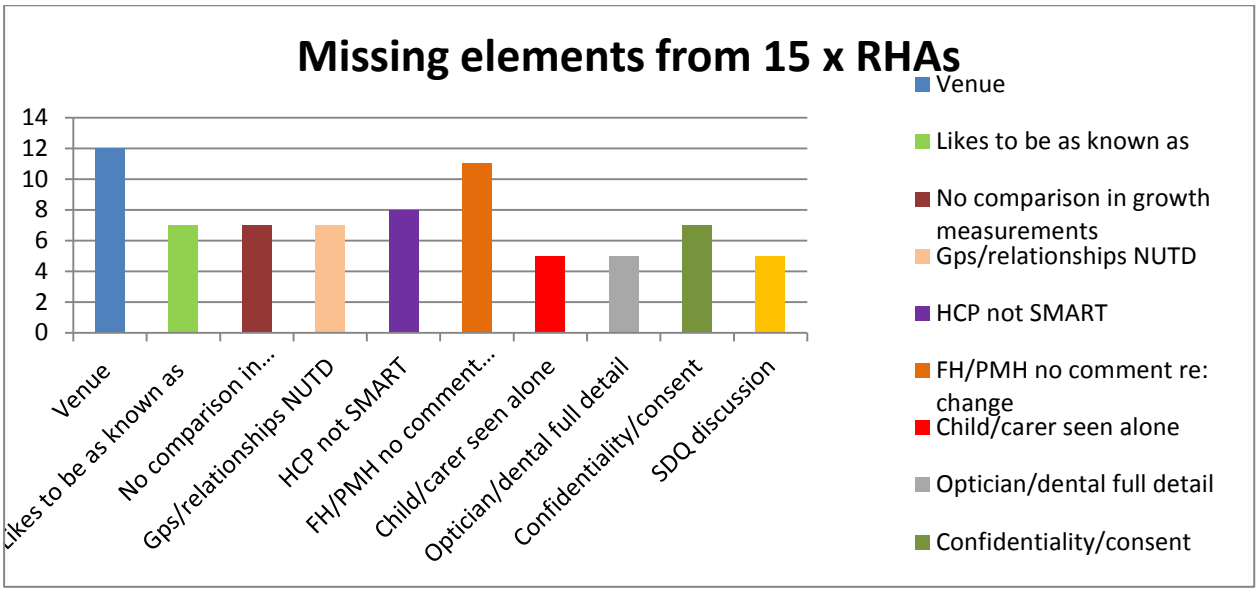
Appendix 4 – Quality assurance summary of audits

Timeliness: 80% of the review health assessments were within the statutory timescales; however there was a clear reason for the lateness within the clinical record. Reasons: previous was not brought, late cancellation of appointments by foster carers and appointment being rebooked and placement change.

Key missing elements or not documented within the review health assessments:

- Sections within the coramBAAF left blank (eg: 'likes to be called', dental dates, optician dates, family history, past medical history)
- Lack of voice of the child and carer
- Good analysis of implications for the future
- Poor SMART actions within the Health Care Plans
- Lack of analysis with SDQ scores and assessment of emotional health
- Impact of contact with birth family

Missing elements from a quality audit of 15 Review Health Assessments:



Excellence noted:

- Good analysis of SDQ and emotional health
- Impact of contact with birth family – and strategies given to foster carer to help the child cope
- Confidentiality and consent clearly documented
- Clear vision of the child's aspirations
- Analysis of routine and educational progress
- Voice of the child and carer
- Interactions noted with carer and LAC nurse
- Excellent description of child's appearance and body language at different points within the assessment

The quality of review health assessments should be at least of a 'good' standard as a minimum with a vision for 'outstanding' quality for all review health assessments that are within the remit of the Specialist Nurses at Derbyshire Healthcare NHS Foundation Trust.

Appendix 5 – Designated Nurse Audit Programme

Required to complete	
Establish a quality matrix to rank quality of health assessments in a standardised manner	Completed in June 2017
Quality assure all out of area review health assessments, escalate and/or return as necessary	On-going continual basis
Quality assure a snap shot of review health assessments completed by DHcFT LAC team	Completed in July 2017
Quality assure review health assessments carried out within the contract variation for completion within 20 mile radius and make comparison with the previous year/RHA	Completed in August 2017
Data quality for LAC who were on child protection plans – ensuring the read code for 'no longer on CP plan' has been applied to the SystmOne record	Completed in October 2017
Health representation and health report submission at LAC reviews	Completed in November 2017
Data quality for LAC who were child in need – ensuring the read code for 'no longer child in need' has been applied to the SystmOne record	Completed in December 2017
Visiting pattern of Health Visitor to LAC	Completed in December 2017
Data quality for LAC who have EHCP, Statement of Special Educational Need or require SEN support – clearly and correctly documented within SystmOne record	Completed in January 2018
Audit use of the peer record keeping audit, findings and resulted in any change in documentation quality	Completed in February 2018
Quality assure review health assessments carried out within the contract variation for completion within 20 mile radius and make comparison with the previous year/RHA	Completed in February 2018
Quality assure a snap shot of review health assessments completed by DHcFT LAC team	Completed in March 2018

APPENDIX 6

Derbyshire Healthcare NHS Foundation Trust

YOUR HEALTH ASSESSMENT VIEWS

Tell us a little bit about you:

1. **Are you:**

A girl? ☐ 

A boy? ☐ 

2. **How old are you?**

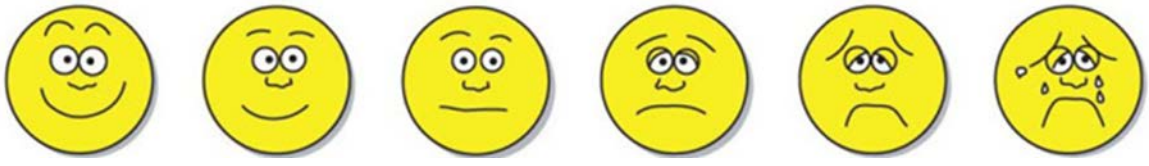
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19

Tell us about your visit today:

4. **Where did your health assessment take place?**

Hospital	☐	**Health Clinic**	☐
School	☐	**Home**	☐
Other	☐		

5. **Which smiley face best describes how you feel about your health assessment?**



6. What did you like and not like about your health assessment?

7. Were you seen by:

Doctor ☐ **Nurse** ☐

8. Did you feel you were listened to?

Yes ☐ **No** ☐

9. Did you have chance to ask questions?

Yes ☐ **No** ☐

10. Did you get an answer to your questions?

Yes ☐ **No** ☐

Appendix 7: Children In Care Council feedback

Liked

- The layout
- Not too long
- Simple and easy
- Smiley faces

Suggestions

- Tick boxes under the smiley faces
- Bigger writing
- Tick box for carer if completed by carer
- Question 4 tick boxes closer to the writing
- Question 7,8,9 and 10 'I don't know' option
- Comment box bigger
- Felt awkward if they had to give it back to the nurse if there was a negative comment

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 2 October 2018

Register of Trust Sealings 2018/19

Purpose of Report

This report provides the Trust Board with an update of the authorised use of the Foundation Trust Seal since 1 April 2018.

Executive Summary

In accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors the Foundation Trust Seal is affixed to legal transactions, including deeds, transfer and letting of contracts over £100,000.

All contract documents, up to the value of £100,000, shall be signed on behalf of the Trust by an Executive Director (voting or non-voting) or nominated officer. Every contract value which exceeds £100,000 shall be executed under the Common Seal of the Trust and be signed by the Trust Secretary and an Executive Director (voting or non-voting) duly authorised by the Chief Executive and not from the originating department (as set out in the Board's Standing Financial Instructions point 8.18).

These transactions will apply where the Board has previously approved the business through the Capital Expenditure Plan or the Estates and Agile Working Strategy. In accordance with the Standing Orders of the Board (section 12 point 6) a report of all sealing shall be made to the Trust Board twice a year. The report will contain details of the seal number, the description of the document and date of sealing. The register will be retained by the Trust Secretary.

Reporting on use of the seal for the 2017/18 financial year was made to the Board on 1 May 2018. Since the beginning of the 2018/19 financial year the Trust Seal was affixed as follows:

1. DHCFT55 Project No. 17006/K3117 additional parking at the Radbourne Unit
2. DHCFT56 Sale of 17 and 18 Vernon Street, Derby (Audrey House)
3. DHCFT57 Under lease of Coleman Street, Derby

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.	

4) We will **transform** services to achieve long-term financial sustainability.	X

Governance or Legal issues

The affixing of the seal is consistent with the Board's responsibilities outlined within the Standing Financial Instructions and Standing Orders of the Board of Directors.

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).

There are no adverse effects on people with protected characteristics (REGARDS).	x
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	

Actions to Mitigate/Minimise Identified Risks – no impact on those with protected characteristics has been identified.

Recommendations

The Board of Directors is requested to note the authorised use of the Foundation Trust Seal since April 2018 and receive full assurance that this has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.

Report presented by: **Sam Harrison**
Director of Corporate Affairs

Report prepared by: **Sue Turner**
Board Secretary

Derbyshire Healthcare NHS Foundation Trust

Board Committee Summary Report to Trust Board
Mental Health Act Committee (MHAC) - meeting held 7 September 2018

Key items discussed:

- **Matters arising MHAC Action Matrix**
  The roll out of the national Single Oversight Framework has been delayed

  To develop the Dashboard for the Quality Committee in the meantime – to include Rapid Tranquillisation, Seclusion, Prone Restraint, S62 data

  S12/CAMHS on call project rolls on (and on) – to report to next MHAC

- **Review of Policy Matrix**
  On track, S117 due for major rewrite

  Lead appointment for S136 – for Deep Dive March 2019, to add to Forward Plan

- **Minutes of MHAC Operational Group and Actions Matrix**
  MHA (Mental Health Act) Managers to investigate feasibility of automatic escalation of CTO (Community Treatment Order) non-compliance to Medical Managers in real time – for feedback at MHAC Operational Group

- **Review of BAF risks**
  Significant progress and satisfactory trajectory but no downgrading until targets achieved regarding capacity assessments in Community Teams (80%)

- **Deep Dive of BAF Risk 1b MHA/MCA (Mental Capacity Act) compliance**
  Issue of gender issues relating to detention discussed. Services for people diagnosed with 'Personality Disorder' have been chronically underfunded and underdeveloped for decades. They were often excluded from services until the 1990s and 80% of those diagnosed will be female. Recent Serious Incident reports have highlighted the poor service these women can experience and that clinicians often feel ill equipped to help them. The neighbourhood review is aiming to define our current offer but this is likely to fall short of what is required. No clear direction of travel has emerged from Joined Up Care Derbyshire.

  The Director of Nursing and Patient Experience will raise the issue with the Executive Leadership Team (ELT)/Quality Committee with a focus on psychological therapies/service for survivors of psychological trauma

- **MHA Manager's Quarterly Report**
  Variation in rates of rapid tranquillisation/seclusion noted across wards and inpatient units

  David Harrison, Professional Practice & Compliance Lead for Restrictive Practices, will align practice against NICE guideline NG10 "Violence and aggression: short-term management in mental health, health and community settings"

  There is a backlog of Hospital Managers' hearings and a plan is in place to resolve this

- **Dashboard of indicators in relation to MHA** – verbal update – see notes arising from MHAC Action Matrix

- **Update report on audit of CMHT assessment of capacity to consent in community services**
  Overall compliance improved from 49.7% to 68.27%
  Quality ratings up from 58% to 90%
  To re-audit in four to six months
  Bespoke training package for Children's services/CAMHS (Child and Adolescent Mental Health Service) ready for roll out
  To consider at what stage consent to admission should be required at Operational Group

- **Management of Associate Hospital managers (AHMs) – proposal for ratification**
  Issue of how peer appraisal would work is main issue to resolve

- **Hospital Managers' Update** – verbal update
  Three vacancies – to proceed to recruitment

- **Derby City and Derby County Local Authority reports**
  Detailed reports were received
  There has been a decrease in County activity and an increase in the City – particularly ED assessments in Derby Royal – further analysis is ongoing

- **Monitoring of compliance with MHA related CQC actions**
  New monitoring/reporting system agreed – to be updated as CQC actions accrue following visits

- **Training Compliance Report**
  People & Culture Committee has agreed a revised 85% target for training
  All training on trajectory to achieve this with exception of MHA – 80% by March 2019
  High (up to 40%) DNA (did not attend) rate noted

- **Seclusion Report**
  To develop report in context of Positive and Safe initiative monitored against NICE guidelines NG10
  To agree "top 3" actions to improve patient experience/safety

- **Reverse Commissioning Report**
  The premise is that people from ethnic minorities do not access services in a timely way and so present late and are more likely to be in crisis requiring detention. Once admitted black people are more likely to be secluded
  CEO leads Reverse Commissioning
  it was thought action needed to centre around access so the focus needed to be on Primary Care and Criminal Justice System
  May need to be taken up at Health and Wellbeing Board
  Governors could contribute to community/public health angle
  Positive and Safe reports to pick up seclusion issue

- **Policy Review**
  The following were ratified:
  - Section 5(2) Holding Powers
  - Section 5(4) Detention
  To include the importance of physical healthcare monitoring in MHA policies

- No additional issues were noted for BAF

- To include feedback from CQC 2018 visits at next Operational Group

- **Issues escalated to Board or transferred to other committees**
  The issue of Personality Disorder pathway will be raised at ELT and reported back to Quality Committee

- **Meeting effectiveness**
  Some papers did not prompt to ask for the level of assurance and so this was sometimes omitted!
  Having said that it was agreed steady progress is being made and is generally satisfactory

- No additional risks were identified

- **Decisions made:**
  - to develop items for Dashboard at Quality Committee
  - to automate CTO escalations to medical managers if possible
  - to monitor practice of seclusion against NG10
  - to agree management arrangements for AHMs
  - to recruit to AHM vacancies
  - monitoring arrangement for CQC actions agreed
  - papers to include prompt for assurance levels

- **Transfer to other committees**
  Gender issue to be discussed at ELT/reported back to Quality Committee

Committee Chair: Anne Wright	**Executive Lead: John Sykes, Medical Director**

Board Committee Summary Report to Trust Board
Safeguarding Committee – 11 September 2018

Key items discussed

- Minutes of the last meeting approved
- Action matrix – assurance received on progress and items completed
- Safeguarding Adults Position Statement
    - Significant assurance received on detail and governance and SMART objectives. Excellent work; congratulations fed back to the team for their excellent work. Report front sheets are to contain effective Executive Summary and synthesise
    - Quality Committee and on Unable to achieved objectives on CPA (Care Programme Approach) and improvement plans and will be referred to the Quality Committee and Executive Leadership Team (ELT).
    - Complex enquiry has been exemplary.
- Safeguarding Children Position Statement
    - Significant assurance received
    - Pressure related to joint targeted inspections and working together changes.
    - Significant assurance received on learning form case/obesity and recognition of neglect. Gap in Children's services for Bulimia and eating disorders. Exploration of cases and neglect with thresholds of Public Health.
- Looked after Children Annual Report
    - Significant assurance received
    - Included health outcomes and SMART actions to look and increase children who are brought. Increase of children over 20 miles radius and the risks of travel and placement.
- Forensic CAMHS (Child and Adolescent Mental Health Services)
    - Service is available, timely consultation. However no Derbyshire patients have been assessed by the regional service directly. Limited assurance received on monitoring, closed to Safeguarding Committee, monitoring by operations with engagement from the service. Action in February 2019 on Forensic pathways deep dive and service model in CAMHS and Adults
- Infant feeding policy and procedures (Quality priority area) ratified
- MAPPA (Multi-agency Public Protection Arrangements) Policy and Procedures – External review and comprehensive policy. Addendum to proportionate, sampling of this policy based upon risk based issues.
- Forward plan - revised timescales for strategy, work plan, changes to national policy, and revisions to ways of working.
- Meeting effectiveness - discussed improvement to papers and outcomes.
- Action for Executive lead on assurances for DBS and improvements.

Assurance/lack of assurance obtained

- Safeguarding Adults and Childrens Board – Significant Assurance. Revision to redact and ensure privileged information. Reduction of descriptive material to introduce service and model
- CPA policy and implementation and developing clinical model - significant assurance. Connectivity and roll out of clinical modelling and design is still in development and is behind schedule. Further support to ensure progress on required actions. Executive Director turnaround plan.
- The Committee was provided with how the Trust discharges the essential standards for safeguarding and received significant assurance across all domains.

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- Safeguarding MAPPA and Infant feeding policy reviewed and updated/agreed and ratified in line with strategy discussions
- Forward plan - revisions and agreements based upon BAF (Board Assurance Framework) and outcomes from Annual Report
- BAF risks – reviewed positively, following significant assurance.

Key risks identified

- Safeguarding training was reviewed. Continued improvement in compliance which will achieve compliance at year end, continues on trajectory.
- DBS checks and revisiting the current policy for improvements and revision with People services, with sign off by Safeguarding Adults and Children's Doctors, in line with professional issues; with lead Director Amanda Rawlings. Working with People and Culture Committee. To be prioritised for November Safeguarding Committee.

Decisions made

- Safeguarding Childrens and Adults reports, reviewed and scrutinised and accepted.
- Looked After Children Annual report scrutinised and accepted
- Improvement work identified and planned audit and improvements in the next quarter.
- Revisions to the forward plan were made in revising strategy, based upon national policy direction, learning from CQC and developing a revised strategy

Escalations to Board or other committee

- ELT to note issues re progress re CPA and potential options to ensure delivery

Committee Chair: Anne Wright	**Executive Lead: Carolyn Green. Executive Director of Nursing and Patient Experience**

Board Committee Summary Report to Trust Board
Quality Committee 11 September 2018

Key items discussed

- **Minutes of previous meeting held 14 August 2018:** Accepted
- **Matters Arising:** Summary of work to resolve pace of SI investigations discussed
- **Actions Matrix** reviewed and actions updated.
- **Policy Status Matrix** reviewed.
- **Summary of Board Assurance Framework (BAF) risks for Quality Committee:** Escalation update of CPA (Care Programme Approach) to be held to account. Discussion also took place on pharmacy governance and risk escalation
- **Quality Dashboard:** Performance/stability. New additions to the dashboard including physical healthcare, revamp of Patient Experience Group/Staffing and safety levels (breach/impact on quality), Observations/Pharmacy (assurance on plan and strategy/actions). High level indicator QIA (Quality Impact Assessment) and CIP (Cost Improvement Programme) model. Revise header/ Quality implications. Limited assurance.
- **Deep Dive BAF Risk 1c Physical Healthcare Compliance:** Presentation of CQUIN (Commissioning for Quality Innovation), and solution. Full information and achievements and ability to develop self-help to monitor/own physical healthcare trust. Confirmation of investment in physical healthcare. Risk levels included limited assurance and non-compliant with essential standard.
- **Physical Healthcare Strategy:** Transformation and implementation plan. Limited assurance with monthly updates, set core standards and outline for operational reporting for core essential standards and then CQUIN/sideway escalation to Executive Leadership Team.
- **Mortality report:** Appreciative enquiry to be reviewed into action into a positive outcome or achievement and potential thank you for good practice. Gaps in assurance included lack of medical availability. Risk appetite decision on investing further in this model at this time Trust has actively opted out of involving families in mortality and continues at current rate. Significant assurance received. External review of this model is good practice and the Trust is making good progress.
- **Q1 Patient Experience and Carer Report:** Revised reporting model received positively. Significant assurance. Very positive feedback to be given to the team. Themed report of actions, minutes of the meetings, improvement. High level of exception of actions.
- **Clinical Strategy for Autism:** This is in development in partnership with partners and colleagues. Verbal update provided on development of clinical strategies included the Autism strategy, chairing autism and commissioning and new solution to address in the strategy. Discussion with wider clinical strategy developments.
- **Medicines Optimisation Implementation:** Presentation of the medicine optimisation strategy and update against actions and improvements. Very clear and assurance and summary of medicines optimisation.

Challenge on limited attendance of CAMHS. Quarterly reports to include an overview of Pharmacy Strategy and Business plan and Medicines Optimisation.

- **Items for escalation to Board or other committees:** Executive Leadership Team to discuss Physical Healthcare monitoring and achievement of CQUIN

- **Consideration of any items affecting the BAF:** Review of mortality work and positive assurances

Assurance/Lack of Assurance Obtained

- Overall significant assurance in many areas

Meeting Effectiveness

- Meeting effectiveness - good use of time on physical healthcare, review of our delays in papers. The impact of a risk on how we deliver and how we support staff to deliver safely when an area of practice is under pressure.

Decisions made

- Forward plan and assurance reporting will be revised. August meeting will not be scheduled in 2019/20.

Escalations to Board or other committee

- Executive Leadership Team to discuss physical healthcare monitoring and achievement of CQUIN.

Committee Chair: Dr Julia Tabreham	**Executive Lead: Carolyn Green, Director of Nursing & Patient Experience**

Board Committee Summary Report to Trust Board
Finance & Performance Committee – Meeting held 18 Sep 2018

Key items discussed

- Minutes from meeting held July 2018 one typo to correct on 081 [had/have] – otherwise agreed
- Action Matrix and Matters arising – Confusing line – ref 002 is complete because there is no timeline for it so closed. Should not cross refer to action 071 – aside from that correction accepted as green
- Policy Matrix – no issues
- Board Assurance Framework – Finance & Performance Committee (F&P) risks for consideration. Timing lag differences for two of the three risks. Extracts do not match the deep dive and also the risk detail discussed yesterday at ELT (Executive Leadership Team) on flow risk but that is because it is a live document. Discussion points to note:
    - JUCD (Joined Up Care Derbyshire) and related governance of the system. Influence in JUCD and risk of transfer of risk in future. Risks/governance/horizon issues on structure sovereignty of requirements versus system. Timing on planning guidance timeline/ten year planning etc not yet known
    - Julia Tabreham flagged concern from Quality Committee to F&P about CQUIN (Commissioning for Quality Innovation) income loss – ref physical healthcare CQUIN. ELT discussions from 17/09/18 were discussed (i.e. from month 6 onwards related CQUIN income non-achievement will be forecast)
    - Progression on F&P risks (noting that Flow risk will go up in next iteration of full BAF (Board Assurance Framework). JUCD risk level reducing in likelihood (as per deep dive).
- Deep Dive Risk 3b – New format well received as clear and concise. Key points discussed:
    - Discussed NHSE (NHS England) / NHSI (NHS Improvement) coming together and whether that would have impact. Detriment of potential loss of key relationships through rationalisation but this dis-benefit should be offset by the perceived benefit that should happen when there will be improved consistency in messaging between NHSE and NHSI.
    - Differences in influence in mitigating reductions in this environment compared to being able to achieve large scale *enhancement* to all DHCFT service models. Agreed influencing and engaging well. MHIS (Mental Health Investment Standard) outcome successful but given Derbyshire can we ever achieve 'enhancement'. Reason for downgrade of risk is the achievement on QIPP (Quality, Innovation, Productivity Programme) outcome as opposed to achieving enhancements.
    - Deep dive accepted and rating agreed
- Commissioning Interface and Contract Update:
    - Paper accepted. CQUIN risk of physical healthcare as above. Low secure income risk discussed.
    - Future contracting assurance discussion: e.g. Second year of two year contract – what about new contract timeframes etc – risks to be ascertained.
    - Next meeting F&P have requested a focus on planning/contracts etc – eg update on

contracting and commissioning intentions and risk transfer e.g. PICU (Psychiatric Intensive Care Unit)/locked door rehab/national timeframes/implications etc

- Operational Performance and KPI Achievement interim including clustering:

    - Concern over ongoing delays to outpatient letters (will bring back action plan next time). Improvement in discharge emails is not improving at expected pace
    - ELT Clustering discussion held 17 September – discussion re diff approach to priority with a focussed support to areas that are currently engaged well. Review decisions pending planning guidance if clustering raised nationally.
    - DNAs (Did Not Attend). Neighbourhood review looking at service offer which may result in more flexible approach to outpatient model.
    - Three week notice pilot – possible that it could increase the risk of cancellations. Trial in two teams to assess impact
    - 'Safer' staffing – discussed ELT discussion on BAF risk for staffing

- CIP (Cost Improvement Programme) Delivery and Continuous (Quality) Improvement Delivery Programme:

    - Gaps in delivery against plan discussed. Areas of focus: Medics overspend, out of area and the 100 day plan, observation levels, low secure income
    - QI (Quality Indicator) process update. Some QIAs (Quality Impact Assessment) are red but can be cleared
    - Pipeline to develop in coming months (linking with plans on page)
    - CQI (Clinical Quality Indicator) development. More focus on cost pressure reduction
    - E rostering progress including roster cleanse

- IM&T (Information Management & Technology) strategy update (including cyber and equality monitoring):

    - Performance statistics versus staff perception and communication about what we heard/what we found etc
    - Responsive IM&T team and actively working on systems. Long term options and timeframe for system decisions. Next board meeting requires update/decision points
    - Good developments have happened eg hand held observations
    - Cyber – content with work done
    - Equalities recording- significant gaps in some recording - **Refer to ELT to discuss how to improve**

- Financial Performance and Planning Update:

    - Had discussed most key drivers of position within earlier agenda items
    - Run rates discussed comparing year to date and year to go
    - Non-operating PFI (private finance initiative) costs variance to budget additional information requested
    - Extreme risk on BAF is confirmed by the amount of risks in the forecast

- Draft Reference cost – draft position:

    - Noted draft position - ELT to review specific hot spot areas in light of clustering and commissioner discussions

- Revisit strategic direction of charitable funds:

    - Concern about only doing it 'low level'
    - Support the Executive view with reservations and revisit in future

- Deloitte phase 3 progress review:

- Annual planning - Agreed as complete. Discussed plans on page for next year with simplified approach and embedded approach, timeframes etc. Discussions at Performance reviews can be evidenced. Agreed as embedded
- Improvement methodology – Proposed as being amber now from red status to reflect work to date – challenge around content in paper being focussed on quality improvement as opposed to more broader sense of continuous improvement quality, cost and business improvement including leadership development. Noting continuous improvement never ends so need to clarify further what are we trying to achieve and why ie what green for us would look like: There are tools in pace, x numbers trained, leadership involvement, governance process assessing what is happening – ie our framework - etc. Joe Wileman/Gareth Harry to update. So F&P view this area as RED still until further definitions are applied
- Staff views on data – Proposal red to amber based on CRG (Clinical Reference Group) work to date – e.g. safety plan, risk plan functionality elements raised by staff are resolved. Ongoing feedback on EPR is often mixed as it will never be perfect, and resolve some issues but not all. Arguably limited scope to get this to 'green'. Future changes to system and taking different professions along. Links with CQC inspection findings and related action planning. ELT had discussed list of core requirements for system. Green will mean Mechanism in place to collect comments and set appropriate action planning for validated statements. IM&T report to this. Committee supports this amber assessment.

Assurance/lack of assurance obtained

- Deep Dive Risk 3b – rating change agreed
- Commissioning Interface and Contract Update – significant assurance
- Operational Performance and KPI Achievement interim mention Clustering – limited assurance
- CIP Delivery and Continuous (Quality) Improvement Delivery Programme – limited assurance
- IM&T strategy update (cyber and equality monitoring) – significant assurance
- Financial Performance and Planning Update – limited assurance
- Draft Reference cost – draft position – significant assurance
- Revisit strategic direction of charitable funds – agreed with reservations
- Deloitte phase 3 progress review
  - Annual planning – agreed complete
  - Improvement methodology – agreed amber
  - Staff views on data – not agreed as amber, reflected as red

Key risks identified

- Financial risks have increased mainly CQUIN income loss, Out of area costs
- Future planning timeframes, approach, commissioning/contracting intentions and frameworks unknown
- Staffing levels very high risk in some areas
- Flow BAF risk now extreme

Decisions made

- Shift in strategic direction of travel for Charitable funds to low level promotion

Escalations to Board or other committee IMT strategy delivery: Equalities recording to ELT for improvement plan	
Committee Chair: Richard Wright	**Executive Lead: Claire Wright, Deputy Chief Executive and Director of Finance**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 October 2018

Report from the Council of Governors Meeting
Held on Tuesday 4 September 2018

The Council of Governors met on Tuesday 4 September 2018 at the Ashbourne Centre, Kingsway, Derby. The meeting was attended by 19 governors.

Non-Executive Director Deep Dive
Anne Wright, Non-Executive Director and Chair of the Safeguarding and Mental Health Act Committees gave an update on the work she had undertaken in her committee chair role and gave an overview of the work of these Committees.

Integrated Performance Report Summary
Caroline Maley presented the Integrated Performance Report (IPR) to provide the governors with an overview of performance as at the end of July 2018. Each of the Non-Executive Director Board Committee Chairs present reported on how the report had been used to hold Executive Directors to account in their respective Board Committees for areas with regards to workforce, finance, operational delivery and quality performance. Geoff Lewins, member of the Finance and Performance Committee gave an update on the IPR issues as related to the work of the Finance and Performance Committee, in the absence of Richard Wright, Committee chair.

Escalation Items to the Council of Governors
Five items were escalated to the Council of Governors from the Governance Committee. Margaret Gildea responded to a question relating to the recently established People Services Team. Caroline Maley responded to a question on engagement activity by the Joined Up Care Board and governors agreed that the wider discussion on this issue satisfactorily covered the responses to two other related questions raised by governors. Geoff Lewins responded to a question relating to the recently announced commissioner decision to go out to consultation on the future of psychodynamic psychotherapy services. In responding to each question, clarity was provided and is reported in full in the public minutes of the meeting.

Governance Committee Report
Gillian Hough, Chair of the Governance Committee presented a report of the meeting held on 21 June 2018 and encouraged governors to consider the upcoming roles of Chair and Deputy Chair of the Governance Committee. Carole Riley has agreed to chair the Committee for three months.

Engagement Task and Finish Group
Angela Kerry provided an update on work of the task group and the action plan to be taken forwards was welcomed and agreed. Progress will be reviewed on a six monthly basis.

Membership of the Governors Nomination and Remuneration Committee
Kelly Sims and April Saunders were agreed as staff governor members of the Committee, and Gemma Stacey was agreed as appointed governor member, in addition to existing members. Work will continue to identify a further appointed governor member for the Committee.

Confidential Session
The Council met in confidential session to approve the appointment of the Trust's external auditor Grant Thornton, following a tender process. This followed the recommendation of the Bid Board, which included three governors who had been involved in the specification, procurement and selection process.

2018-19 Board Annual Forward Plan

Exec Lead	Item	1 May 18	5 Jun 18	3 Jul 18	4 Sep 18	2 Oct 18	6 Nov 18	4 Dec 18	5 Feb 19	5 Mar 19
		23 Apr	25 May	25 Jun	24 Aug	24 Sep	29 Oct	26 Nov	28 Jan	26 Feb
SH	Declaration of Interests	X	X	X	X	X	X	X	X	X
CM	Minutes/Matters arising/Action Matrix	X	X	X	X	X	X	X	X	X
CG	Actions and learnings from patient stories	X				X		X		X
CM	Board Forward Plan (for information)	X	X	X	X	X	X	X	X	X
CM	Board review of effectiveness of meeting	X	X	X	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE										
CM	Chair's Update	X	X	X	X	X	X	X	X	X
IM	Chief Executive's Update	X	X	X	X	X	X	X	X	X
MP/CW	NHSI Annual Plan - timing to be confirmed						X			
JS	Data Security and Protection - annual declaration									A
AR	Staff Survey Results and Action Plan									X
AR	Equality Delivery System2 (EDS2) & Workforce Race Equality Standard (WRES) Submission	A			X				X Benchmarking report	
AR	Pulse Check Results and Staff Survey Plan				X					
SH	Corporate Governance Framework						A			
SH	Trust Sealings	X				X				
SH	Annual Review of Register of Interests	A								
SH	Board Assurance Framework Update	X			X			X		
SH	Raising Concerns (whistleblowing) and Freedom to Speak Up Guardian Report			X					X	
SH	Committee Assurance Summaries (following every meeting) - Audit & Risk Committee - Finance & Performance - Confidential - Mental Health Act Committee - Quality Committee - Safeguarding Committee - People & Culture Committee	X	X	X	X	X	X	X	X	X

Exec Lead	Item	1 May 18	5 Jun 18	3 Jul 18	4 Sep 18	2 Oct 18	6 Nov 18	4 Dec 18	5 Feb 19	5 Mar 19
SH	Fit and Proper Person Declaration	X								X
MP	Emergency Planning Report (EPPR)					A				
SH	Board Effectiveness Survey									X
SH	Report from Council of Governors Meeting (for information)		X		X	X		X	X	
SH	Review of Policy for Engagement between the Board & COG									A
SH	Board Development Programme									X
GH	Business Plan 2017-18 Monitoring						X			X
GH	Measuring the Trust Strategy	X								
SH	Well Led Recommendations - update report on Phase 3 Deloitte recommendations to be received at the November 2018 Board meeting						x			
OPERATIONAL PERFORMANCE										
CG, CW, AR, MP	Integrated performance and activity report to include Finance, Workforce, performance and Quality Dashboard	X	X	X	X	X	X	X	X	x
QUALITY GOVERNANCE										
CG	Quality Report (Incorporates Strategy and assurance aspects of Quality management) Quarterly publication of specified information on death in Jan/Mar/Jul/Oct/Feb/Apr			X	X	X	X	X	X	x
CG/JS	Safeguarding Children & Adults at Risk Annual Report					A				
CG	Annual Looked After Children Report					A				
CG	Control of Infection Report			A						
JS	Annual report on Re-validation of Doctors including NHSE Returnon Medical Appraisals sign off by Trust Chair			A						
CG	Annual Review of Recovery Outcomes						A			

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST TERMS	
NHS Term / Abbreviation	**Terms in Full**
A	
A&E	Accident & Emergency
ACCT	Assessment, Care in Custody & Teamwork
ACE	Adverse Childhood Experiences
ACP	Accountable Care Partnership
ACS	Accountable Care System (now known as ICS)
ADHD	Attention Deficit Hyperactivity Disorder
AfC	Agenda for Change
AHP	Allied Health Professional
ALB	Arms-length body
AMHP	Approved Mental Health Professional
ASD	Autism Spectrum Disorder
ASM	Area Service Manager
B	
BAF	Board Assurance Framework
BMA	British Medical Association
BAME	Black, Asian & Minority Ethnic group
C	
CAMHS	Child and Adolescent Mental Health Services
CASSH	Care & Support Specialised Housing
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CCT	Community Care Team
CDMI	Clinical Digital Maturity Index
CEO	Chief Executive Officer
CGA	Comprehensive Geriatric Assessment
CHRT	Crisis Home Resolution Team
CIP	Cost Improvement Programme
CMDG	Contract Management Delivery Group
CMHT	Community Mental Health Team
CNST	Clinical Negligence Scheme for Trusts
COAT	Clinical Operational Assurance Team
COF	Commissioning Outcomes Framework
COG	Council of Governors
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPR	Child Protection Register
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQUIN	Commissioning for Quality Innovation
CRB	Criminal Records Bureau
CRG	Clinical Reference Group
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST TERMS	
NHS Term / Abbreviation	**Terms in Full**
CTO	Community Treatment Order
CTR	Care and Treatment Review
D	
DAT	Drug Action Team
DBS	Disclosure and Barring Service
DfE	Department for Education
DHCFT	Derbyshire Healthcare NHS Foundation Trust
DIT	Dynamic Interpersonal Therapy
DNA	Did Not Attend
DH	Department of Health
DoLS	Deprivation of Liberty Safeguards
DPA	Data Protection Act
DRRT	Dementia Rapid Response Team
DTOC	Delayed Transfer of Care
DVA	Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action)
DWP	Department for Work and Pensions
E	
ECT	Enhanced Care Team
ECW	Enhanced Care Ward
ED	Emergency Department
EDS2	Equality Delivery System 2
EHIC	European Health Insurance Card
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising & Reprocessing Therapy
EMR	Electronic Medical Record
EPR	Electronic Patient Record
ERIC	Estates Return Information Collection
ESR	Electronic Staff Record
EWTD	European Working Time Directive
F	
FBC	Full Business Case
FOI	Freedom of Information
FFT	Friends and Family Test
FSR	Full Service Record
FT	Foundation Trust
FTN	Foundation Trust Network
F&P	Finance and Performance
5YFV	Five Year Forward View
G	
GDPR	General Data Protection Regulation
GGI	Good Governance Institute
GMC	General Medical Council

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST TERMS	
NHS Term / Abbreviation	**Terms in Full**
GP	General Practitioner
GPFV	General Practice Forward View
H	
HEE	Health Education England
HES	Hospital Episode Statistics
HoNOS	Health of the Nation Outcome Scores
HSCIC	Health & Social Care Information Centre
HSE	Health and Safety Executive
HWB	Health and Wellbeing Board
I	
IAPT	Improving Access to Psychological Therapies
ICS	Integrated Care System (formerly ACS)
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDVAs	Independent Domestic Violence Advisors
IG	Information Governance
IM&T	Information Management and Technology
IPP	Imprisonment for Public Protection
IPR	Individual Performance Review
IPT	Interpersonal Psychotherapy
J	
JNCC	Joint Negotiating Consultative Committee
JTAI	Joint Targeted Area Inspections
JUCB	Joined Up Care Board
JUCD	Joined Up Care Derbyshire
K	
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework
L	
LA	Local Authority
LCFS	Local Counter Fraud Specialist
LD	Learning Disabilities
LHP	Local Health Plan
LHWB	Local Health and Wellbeing Board
LOS	Length of Stay
M	
MARS	Mutually Agreed Resignation Scheme
MAU	Medical Assessment Unit
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST TERMS	
NHS Term / Abbreviation	**Terms in Full**
MCA	Mental Capacity Act
MDA	Medical Device Alert
MDM	Multi-Disciplinary Meeting
MDT	Multi-Disciplinary Team
MFF	Market Forces Factor
MHA	Mental Health Act
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard
MHRT	Mental Health Review Tribunal
N	
NCRS	National Cancer Registration Service
NED	Non-Executive Director
NICE	National Institute for Health and Care Excellence
NHS	National Health Service
NHSI	National Health Service Improvement
O	
OBC	Outline Business Case
ODG	Operational Delivery Group
OP	Out Patient
OSC	Overview and Scrutiny Committee
P	
PAB	Programme Assurance Board
PAG	Programme Advisory Group
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PHE	Public Health England
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PLIC	Patient Level Information Costs
PMLD	Profound and Multiple Disability
PPT	Partnership and Pathway Team
PREM	Patient Reported Experience Measure
PROMS	Patient Reported Outcome Measure
Q	
QAG	Quality Assurance Group
QC	Quality Committee
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
R	
RAID	Rapid Assessment, Interface and Discharge
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST TERMS	
NHS Term / Abbreviation	**Terms in Full**
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
RTT	Referral to Treatment
S	
SAAF	Safeguarding Adults Assurance Framework
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SEND	Special Educational Needs and Disabilities
SI	Serious Incidents
SLA	Service Level Agreement
SLR	Service Line Reporting
SOC	Strategic Options Case
SOF	Single Operating Framework
SPOA	Single Point of Access
SPOE	Single Point of Entry
SPOR	Single Point of Referral
STEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Partnership
S(U)I	Serious (Untoward) Incident
T	
TARN	Trauma Audit and Research Network
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TMT	Trust Management Team
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
TMAC	Trust Medical Advisory Committee
W	
WTE	Whole Time Equivalent