Derbyshire Healthcare NHS
NHS Foundation Trust

NOTICE OF BOARD MEETING
WEDNESDAY 27 JANUARY 2016
TO COMMENCE AT 1.00 PM IN THE CONFERENCE ROOMS A & B,
RESEARCH & DEVELOPMENT CENTRE, KINGSWAY, DERBY DE22 3LZ

Item	Time	AGENDA	Enc Ref	Discussion led by
1.	1:00	Chairman's Welcome and Opening Remarks	-	Richard Gregory
2.	1:05	Service Receiver Story – Substance Misuse	-	
3.	1:30	Apologies for Absence Declarations of Interest	-	Richard Gregory
4.	1:30	Minutes of Board of Directors meeting held on 25 November 2015	**A**	Richard Gregory
5.	1:35	Matters arising – Actions Matrix	**B**	Richard Gregory
6.	1:40	Chairman's Report	-	Richard Gregory
7.	1:55	Acting Chief Executive's Report	**C**	Ifti Majid
PATIENTS, QUALITY AND SAFETY				
8.	2:05	Position Statement on Quality	**D**	Carolyn Green/ John Sykes
OPERATIONAL PERFORMANCE REVIEW				
9.	2:20	Integrated Performance and Activity Report	**E**	Carolyn Gilby
FINANCE, STRATEGY AND GOVERNANCE				
10.	2:35	Finance Director's Report Month 9	**F**	Claire Wright
11.	2:45	Strategy Development Update	**G**	Mark Powell
B R E A K 3:00				
12.	3:15	People and Culture Committee Terms of Reference	**H**	Jayne Storey
13.	3:25	Remuneration Committee Terms of Reference	**I**	Jenna Davies
14.	3:35	Board Committee Minutes: - Audit Committee – Ratified minutes of meeting held 15 December 2015 - Quality Committee – Ratified minutes of meeting held 10 December - Safeguarding Committee – Draft minutes of meeting held 23 October - Mental Health Act Committee – Draft minutes of meeting held 27 November	**J**	Committee Chairs
FOR INFORMATION ONLY				
15.	3:45	I. Board Forward Plan II. Identification of any issues arising from the meeting for inclusion or updating of the Board Assurance Framework III. Discussion on future deep dives IV. Comments from observers on Board performance and content of meeting	**K**	Richard Gregory

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

The next meeting is to be held on 24 February 2016, at 1.00 pm in Conference Rooms A & B,
Centre for Research and Development, Kingsway, Derby DE22 3LZ
Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.
Participation in meetings is at the Chairman's discretion.

Enc A

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Wednesday, 25 November 2015

MEETING HELD IN PUBLIC

Commenced: 1:00 pm Closed: 4:50pm

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

PRESENT:	Mark Todd	Chairman
	Ifti Majid	Acting Chief Executive
	Caroline Maley	Senior Independent Director
	Maura Teager	Non-Executive Director
	Phil Harris	Non-Executive Director
	Tony Smith	Non-Executive Director
	Claire Wright	Executive Director of Finance
	Dr John Sykes	Executive Medical Director
	Carolyn Gilby	Acting Director of Operations
	Carolyn Green	Executive Director of Nursing and Patient Experience
	Mark Powell	Director of Business Development and Marketing
	Kate Majid	Head of Transformation and Patient Involvement
IN ATTENDANCE:	Anna Shaw	
	Sue Turner	Executive Administrator and Minute Taker
For item DHCFT 2015/160	Kirsty	Service Receiver
For item DHCFT 2015/160	Kate Heardman	Community Psychiatric Nurse
VISITORS:	Carole Riley	Derbyshire Voice Representative
	John Morrissey	Public Governor, Amber Valley South
	David Waldram	Member of the Public
	Winston Samuels	Member of the Public
APOLOGIES:	Jayne Storey	Director of Transformation
	Jenna Davies	Interim Director of Corporate & Legal Affairs
	Jim Dixon	Non-Executive Director

DHCFT 2015/159	**CHAIRMAN'S OPENING REMARKS, APOLOGIES, DECLARATIONS OF INTEREST** The Chairman opened the meeting by welcoming all present and declared that there was no conflict of interest in today's agenda.

DHCFT 2015/160	**SERVICE RECEIVER STORY** The service receiver visitor today was Kirsty who first came under the Trust's mental health care at the age of 18 within the adolescent service. She had been diagnosed with borderline personality disorder and she also had a history of self-harm. Kirsty had experience with various mental health teams within the Trust and had been admitted as an inpatient both as a volunteer and after being sectioned. Kirsty gave her impression of life as an inpatient and felt strongly that wards were very under staffed, although her last admission to the Trust' service was nearly five years ago. She felt nurses have so much to do it makes it difficult to talk to them in the wards if you were experiencing a crisis. Kirsty acknowledged that every effort is made to make the wards as comfortable as possible and t more activities carried out now, but she found it depressing being an inpatient and not having enough to do. Getting outside to have a walk and have some fresh air was difficult because of the lack of staff and was always seen as a "risk management" issue. Being outside and having a change of scenery helps with people's moods and calms them down and Kirsty was so desperate to get out of the ward that she started smoking and 10 years on she is still a smoker, now. Kirsty described the food on the ward as terrible. She believes having food that is stimulating and attractive would really help people on the wards who have a poor appetite or an eating disorder. Having a hot breakfast a few times a week would give service receivers something to look forward to. She suggested that fruit, dips and crudities would be a good addition. Kirsty listed other factors that would improve life on the wards. Having a quiet space where you can sit quietly, read a book or listen to music. Having a named nurse who is approachable who you can form a relationship with is important as well as being able to change your named nurse if needed. Kirsty had a lot of praise for the health care assistants who she felt were the back bone on the wards and the ones who take you for a smoke and sit and hold your hand and she didn't think they received the credit they deserved. The Chairman remarked that part of Kirsty's story was about testing whether the Trust had improved since she was last in hospital as an inpatient some four and a half years ago and the Board was keen to know how the Trust could work with people like Kirsty in the community to implement the improvements she would like to see. Maura Teager felt Kirsty gave a good account of being an inpatient and wondered if she ever saw things happening on the wards that didn't make sense Kirsty replied that she couldn't understand why nurses congregate and sit at the nurses' station. Rather than have them sitting around they should be walking round the wards and seeing if patients have what they need. She appreciated that sometimes they are completing paperwork but she thought they should be more active around the wards and check on patients behind curtains or sat and watched television with people. She also felt intimidated approaching the nurses' station and that it would be less intimidating if just one nurse was sitting there that you could approach if you needed to talk to someone. Getting to the activities hub was important and engaging in group scrabble games or word searches and doing things as a group helped conversation start to grow.

	Ifti Majid asked Kirsty what things have changed over the years? Kirsty replied that the Trust had become extremely "risk conscious". Everything was seen as a risk, even simple things like having a bath. Having more talking therapies would really help. Carolyn Green thanked Kirsty for telling her story. She could recognise the historical themes and would like to ensure continuous improvement on every point she raised. She confirmed she was in full agreement on therapeutic activity, quiet time, having a therapeutic and caring environment. She assured Kirsty that the Trust will continue to improve and provide patients with fresh air, such as evening or weekend walking groups, which could really help. The Trust had rolled out Safe wards which stimulates group activity and provides calming spaces. Ten research interventions have been introduced in Derby and these aspects would be extended throughout in-patient services. Calm down boxes which are used for massage sessions and relaxation groups and community groups have been replaced with mutual expectation meetings and one to one discussions are carried out to discover what is working and what isn't working in the drive to create improvements. Self-care and shared care are being introduced to the neighbourhoods which are all models in keeping with Kirsty's feedback on the Trust's services. There is still a lot of work to do and Carolyn Green would like to ask Kirsty to help as there is still a lot of work to be done. The Chairman thanked Kirsty for sharing her experience with the Board and thanked Kate Heardman for accompanying her. The Board would carry out a reflection of Kirsty's observations and will write to her setting out some recommendations for improvement. **RESOLVED: The Board of Directors expressed thanks to Kirsty for sharing her story and for her observations of the Trust's services.**
DHCFT 2015/161	**MINUTES OF DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST BOARD MEETING, HELD ON 28 OCTOBER 2015** The minutes of the Derbyshire Healthcare NHS Foundation Trust Board meeting, held on 28 October were accepted and approved.
DHCFT 2015/162	**MATTERS ARISING** **Actions Matrix:** All green completed items were removed and all other updates were noted directly on the matrix.
DHCFT 2015/163	**CHAIRMAN'S REPORT** The Chairman's report summarised his meetings and visits during the month and was noted by the Board. The Chairman pointed out he was very impressed with clinical leadership reporting arrangements. He highlighted the importance of building robust governor involvement into the strategy review and he hoped that governors would have a substantial input into this process at an initial point within the timeframe. Caroline Maley stressed the need to clarify the terms of reference and quorum arrangements of the governor working groups. She called for a clearer

	understanding of how these meetings should be held and asked that Jenna Davies work with governors to define the governor working group terms of reference and quorum arrangements. **ACTION: Jenna Davies to define the governor working group terms of reference and quorum arrangements.** **RESOLVED: The Board received and noted the Chairman's report.**
DHCF 2015/164	**<u>ACTING CHIEF EXECUTIVE'S REPORT</u>** Ifti Majid's report provided the Board of Directors with some of the key national policy changes or announcements over the last month. The report also provided an update on work within the Derbyshire Health and Social Care Community as well as covering key issues internal to the Trust. The report also drew attention to matters that were creating added pressure on the Trust such as the key issues raised by the acute sector that emerged from the feedback to Monitor and NHS England consultation on national tariff payment system for 2016/17. Ifti Majid drew attention to the fact that junior doctors had voted to take strike action on 1 December. This would be a challenge to the NHS and it was hoped the situation would improve once contract negotiations have recommenced. The Trust had prepared contingency plans to minimise disruption to people who use the Trust's services in the event of any strike action and Dr John Sykes had lead this initiative and provided an update on the Trust's action plan. He explained that consultants and senior doctors would provide emergency cover only. The Trust's plans had been put to NHS England and Dr John Sykes, Dr Wendy Brown, Dr Deepak Sirur and HR will be operating a mobile command centre and will be responsible for any issues that might arise on these days. Strength of feeling with junior doctors was high. Local relationships are good currently and will be maintained and there is a warm appreciation of support from the Trust for the determination to maintain patient safety and care that will not be compromised. Ifti Majid attended a session of the Trust Medical Advisory Committee which generated much discussion about the culture needed to create a climate where staff feels able to raise concerns. Attached to his report was a list of items that would support a culture where staff feel able to raise concerns that was received at the TMAC (Trust Medical Advisory Committee) meeting held on 11 November. Ifti Majid felt this provided a very helpful line of sight of what doctors and staff are saying and this will now be fitted into the Trust's work. The Staff Awards Ceremony took place on 16 November. Ifti Majid felt this was a tremendous event that provided an opportunity to celebrate the commitment of the Trust's staff in delivering care to residents of Derbyshire. He congratulated the Communications Team who performed an impressive job organising this event with very little funds. **RESOLVED: The Board of Directors received and noted the Acting Chief Executive's Report.**
DHCFT 2015/165	**<u>FINANCE DIRECTORS REPORT MONTH 7</u>**

	This report provided the Board with an update on financial performance against the Trust's operational financial plan as at the end of October 2015. Summarising, Claire Wright reported that the Trust was in a good position at the end of October and ahead of plan, although there would continue to be cost and income pressures within the financial forecast for the coming months. Ifti Majid and Claire Wright had updated Monitor on key issues relating to quarter 2 and informed the Board that Monitor would be looking at the sickness trends within the organisation. Monitor will also take an interest in IAPT (Improving Access to Psychological Therapies) performance and the associated re-procurement exercise The Board noted the Trust had breached both the qualified nursing agency expenditure ceiling of 3% and the framework rule for October. This has formally been reported to Monitor and signed off by Carolyn Green and Carolyn Gilby and this matter had also been escalated to the Board from the Finance & Performance Committee. Claire Wright informed the Board that systems and processes are in development for the level to reduce to within the appropriate ceiling. Carolyn Green has assessed the risks for the engagement of agency nursing staff in the community, CAMHS, IAPT. Carolyn Green wished to point out that due to the risks of clinical disengagement of children and families in therapy, associated safeguarding risks, community caseloads for vulnerable people who will struggle with a cessation of a case manager without a safe transition, this was a measured justifiable breach at this time. All agency workers will be phased out to full compliance but in these cases and taking into account the financial risk exposure the transition and phasing plan, is to maintain safe practice and enable a safe transition. Claire Wright drew the Board's attention to the new pay rate caps that have now come into force affecting all agency staff which will be monitored through the Finance & Performance Committee and the Executive Leadership Team. Claire Wright also informed the Board that she was forecasting a slight underspend in capital expenditure at the end of year which was due to the effect of clinical priorities having been prioritised within the capital progamme. **RESOLVED: The Board of Directors considered the content of the paper and was assured on the current and forecast financial performance for 2015/16.**
DHCFT 2015/166	**BOARD TO CONSIDER DELEGATION OF SIGN OFF TO AUDIT COMMITTEE OF ANNUAL ACCOUNTS, QUALITY REPORT, ANNUAL REPORT AND ANNUAL GOVERNANCE STATEMENT.** Claire Wright's paper requested that the Board confirm continued delegation from the Trust Board to Audit Committee for 2015/16 Annual Accounts and Report process, onwards. The Trust Board first delegated approval of Annual Report and Accounts last year for the 2014/15 year. The process went very well; concluding in sign-off of report and accounts a week ahead of deadline. There were no adverse governance or statutory impacts. The Board formally confirmed continued delegation of all aspects of the

	2015-16 Annual Accounts to the Audit Committee and that delegation to the Audit Committee would continue in perpetuity. **RESOLVED: The Board of Directors:** **1) Confirmed delegation to the Audit Committee for approval of annual report and accounts for 2015/16.** **2) Considered and confirmed delegation to the Audit Committee would continue each year, indefinitely.**
DHCFT 2015/167	**<u>STRATEGIC REVIEW/QUARTERLY PROGRESS</u>** This paper provided the Trust Board with assurance of progress against the strategic outcomes. The strategy set out the Trust's plans for 2013 to 2016 and had been refreshed for its final year. The progress report provided a reflection on current key issues, whilst continuing the vision outlined in the 2013-16 strategy. The report also reflects the current position across the organisation with regard to the achievement of the refreshed strategic outcomes and pillars of delivery. The Trust's current position is "All 21 goals are 'on plan' (green)". The report also provided examples of evidence of progress. Ifti Majid felt a couple of standards related to targets around staff culture and leadership and he proposed to discuss this further with the Director of Transformation, Jayne Storey. Discussions took place on how the strategy would be built into other frameworks and how it would be reviewed and measured and it was agreed that this would be considered within the Executive Leadership Team (ELT) meetings by Ifti Majid. Members of the Board agreed this was an opportunity to improve the strategy substantially and in preparation for the next version, appropriate tools will be put in place for monitoring delivery. **ACTION: Strategy to be further reviewed and measured by ELT.** **RESOLVED: The Board of Directors noted the content of the report and received assurance on progress to date.**
DHCFT 2015/168	**<u>INTEGRATED SERVICE DELIVERY</u>** Kate Majid's paper provided the Trust Board with assurance of progress against the strategic outcomes with respect to integrated service delivery and gave an update against several key advances in the development of neighbourhood working and campus developments. It was noted that in response to staff feedback, the implementation date of the Neighbourhoods had been delayed to 1 April 2016. The implementation date referenced within the Strategy report will be adjusted to reflect this position. John Sykes pointed out there was a significant CIP (Cost Improvement Programme) for medical provision within the neighbourhood model, and he asked whether there was an indication that medical and nursing workforce and was coming together. Kate Majid replied that this was an opportunity to bring this together. Work is being carried out on neighbourhood teams and pathways will be adapted to the WorkPro Tool. This will cover all levels of intervention across all medical areas and once it is defined for a medical

	workforce it is a small step to combine the two against the medical pathway. Carolyn Green felt it would be necessary to measure the impact of this challenge. The patient story heard earlier showed gaps in community access and specific measures of accessibility. Waiting lists will be looked into within the planned community skill mix review she had recently instigated with the Assistant Director of Clinical professional practice and this should enable a baseline of current pressures prior to transformation. Discussions centred around quality impacts relating to proposed changes to the neighbourhood and campus model and the inevitable financial challenges this would create. Tony Smith asked to what extent could Non-Executive Directors be aware of quality impacts over the last year. In response, Kate Majid explained that the Programme Assurance Board reviewed quality impacts on a monthly basis and this was reported to each meeting of the Finance & Performance Committee. If the Finance & Performance Committee has any CIP quality issues, this would be escalated horizontally to the Quality Committee. **RESOLVED: The Board of Directors received assurance from the paper in respect to the achievement of and alignment to the Trust's Strategic Outcomes as outlined above regarding the development of a Model of Integrated Service Delivery.**
DHCFT 2015/169	**<u>BOARD COMMITTEE MINUTES</u>** The ratified minutes of the meeting of the Quality Committee held on 15 October and the draft minutes of the meeting of the Safeguarding Committee held on 23 October were reviewed by the Board. It was agreed that the Board received more assurance from minutes than summary reports of the committee meetings. **RESOLVED: The Board of Directors noted the contents of the ratified Quality Committee Minutes and the draft Safeguarding Committee Minutes.**
DHCFT 2015/170	**<u>CHANGING FACE OF THE WORKFORCE – PEOPLE STRATEGY UPDATE METRICS</u>** This paper provided the Trust Board with an overview of organisational transformation that will have an impact on the shape of the workforce for 2016 17. The paper also gave a brief overview of the changing shape of the workforce (retrospective) and focused on changes to the workforce aligned with organisational transformation plans. Caroline Maley did not feel that the report set out the skills the Trust has at the moment and wanted to know at what point would this be evident. In response, Ifti Majid replied that there was a real need to work this through the People Strategy as the transformational change programme had moved on significantly in the last 12 months and the list of developments contained in the previous paper could provide this. The programme is due to go live on 1 April and will continue to develop. This will be documented more clearly and show a more structured and planned approach to the workforce and will identify the skills and training needed.

	Discussions took place on organisational development and gaps in leadership. Areas of weakness would be defined to ensure leaders are in place to address the gaps required, bring teams together and secure the workforce of the future. This was a matter of concern for the Board and it was agreed this would be addressed and developed through ELT and other key priority areas discussed today will be followed up and monitored in the Finance & Performance Committee. The Board noted that a more detailed action plan of the outcomes from the last deep dive in sickness absence was received at the November meeting of the Finance & Performance Committee. However, the committee was not assured by the action plan and an improved version will be submitted to the next meeting of the committee in January and will be reported back to the Board and/or other committees if the committee is not fully assured. Claire Wright wished to point out an inaccuracy contained in the report in the third paragraph on page 12, that stated suicide was the leading cause of death in the UK across the majority of age groups, and clarified that her understanding was that this was in certain age groups for men and a fairer measure would be significant. **ACTION: Organisational development and gaps in leadership and creation of workforce for the future will be addressed and developed through ELT and monitored through the Finance & Performance Committee.** **RESOLVED: The Board of Directors:** **1) Considered the proposed workforce and wider organisational implications of transformation** **2) Obtained partial assurance from the report as noted above.**
DHCFT 2015/171	**<u>ANNUAL PATIENT SURVEY</u>** Carolyn Green's high level summary showed the Trust had not slipped in performance. The national community mental health teams had seen a weakening of performance but the Trust had been rated as average or had improved performance. Carolyn Green pointed out that she felt the leadership of the Chief Pharmacist had made a big impact on the performance of medication knowledge through the pharmacy strategy implementation which showed a good average overall. The summary contained the safeguarding children inspection report. However, the full report did not contain the original attachment and Carolyn Green requested that the Safeguarding Systems Report and associated action plan be received at the next meeting of the Board in January. The Board noted that the Trust had performed well given cost constraints. Learning would be gained from points of success and improvement would be sought in specific targeted areas for next year. Challenges were received from Non-Executive Directors around the fact that although this was a solid performance, the organisation should be striving for higher levels of sustained improvement. Carolyn Green responded to state that with significant cost efficiency programmes she felt this was a sound performance, although she would be looking at areas of significant

	improvement to consider what were the key factors for improvement and metaphorically bottle them and use the learning from these areas into more stagnant areas of clinical performance. **ACTION: CQC Safeguarding report has been received by Board in the confidential session and the full report and action plan will be submitted to the January Board meeting by Carolyn Green.** **RESOLVED: The Board of Directors noted the recently published information.**
DHCFT 2015/172	**<u>POSITION STATEMENT ON QUALITY & QUALITY DASHBOARD</u>** Carolyn Green's report provided the Board of Directors with an update on the Trust's continuing work to improve the quality of services provided in line with the Trust's Strategy, Quality Strategy and Framework and strategic objectives. Carolyn Green drew attention to the Rapid Assessment Interface and Discharge (RAID) model of liaison mental health care. This new model of liaison team, based in Chesterfield Royal Hospital was commissioned in April 2014 and provides a rapid 24/7 response. The service has a one hour target for becoming involved in the care of patients with mental health or substance misuse care needs presented to the Emergency Department and the report demonstrated very strong performance in this clinical target area. Another area of the report specifically highlighted was the results of the Annual Inpatient Survey in the Quality Dashboard. Carolyn Green pointed out that 49% of patients said they did not feel safe on the Trust's inpatient wards and she assured the Board that she was aware of this result and this was being looked into. The Quality Committee had previously been briefed on this point and this was being considered within the seclusion and proactive and safe work streams, with improvement work through Safewards. The Board scrutinised the Quality Dashboard which highlighted various areas that would be focussed on in detail and would be monitored by the Quality Committee and Finance & Performance Committee and People Forum. **RESOLVED: The Board of Directors:** **1) Received the Quality Position Statement and Dashboard and noted areas of improvement** **2) Felt enough care had been taken of physical health and purposes of medications explained "Completely" 2012 (Q24).** **3) Noted the key areas to develop a greater understanding of performance, which each committee will have oversight of with a named improvement plan:** **a) Safety on our wards and patient experience (Quality Committee and Positive and Safe work plan)** **b) "When you arrived on the ward, or soon afterwards, did a member of staff tell you about the daily routine of the ward, such as times of meals and visitors times?" (Quality Committee and Patient Experience work plan) (QA3),** **c) "Were you able to get the specific diet that you needed from the hospital?" (Quality committee and Positive and Physical Healthcare Committee) (Q8),**

	d) Percentage of staff having well-structured appraisals in last 12 months (Q8) (Finance & Performance committee / People Forum)
DHCFT 2015/173	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT AND SAFER STAFFING** This report defined the Trust's performance against its Key Performance Indicators plus any actions in place to ensure performance is maintained. Compliance with the Trust's performance indicators is being actively monitored and corrective actions are put in place where appropriate. Areas covered in this report include, the Main Performance Indicators, Health Visitors, IAPT and Ward Safer Staffing. Carolyn Gilby drew attention to the low number of service users who have opted in to receive text message reminders for consultant outpatient appointments and suggested that the Trust operates an "opt out" arrangement for text messaging. However, a wider range of options to address DNAs (Did Not Attends) is now being explored. It was noted that 28 day readmissions had increased and that further work is being carried out to understand this, although initial analysis has suggested this does not relate to the older adult population. The Board was aware that EPR (Electronic Patient Records) and clustering had been discussed in detail at the November meeting of the Finance & Performance Committee. John Sykes explained the course of action when applying clustering, how this is recorded in EPR and how it was risk assessed. The Board was pleased to note that an action plan to address the inconsistency in cluster recording will be followed up and closely monitored by the Finance & Performance Committee. Ifti Majid was pleased to note an improvement in the position of safer staffing which demonstrated that the recruitment strategies recently put in place were working Trust wide. **ACTION: Carolyn Green will carry out quality checks in partnership with Carolyn Gilby on areas that have been highlighted.** **ACTION: Inconsistency in cluster recording will be followed up and closely monitored by the Finance & Performance Committee.** **RESOLVED: The Board of Directors:** **1) Acknowledged the current performance of the Trust** **2) Noted the actions in place to ensure sustained performance**
DHCFT 2015/174	**ITEMS ESCALATED TO THE BOARD FROM THE FINANCE & PERFORMANCE COMMITTEE** Items escalated to the Board and listed on the agenda were worked into today's discussions and were noted in the following items above: • DHCFT 2015/165: The breaches of the agency nurse ceiling and framework cost

	• DHCFT 2015/173: Lack of assurance and need for an action plan to address inconsistency in cluster recording and the potential quality and financial implications • DHCFT 2015/173: Need to improve assurance around securing formal clinical confidence, buy-in and medical clinical leadership in the PARIS EPR system.
DHCFT 2015/175	**FOR INFORMATION** **I. Board Forward Plan:** The Forward Plan is to be redeveloped for 2016/17 by Executives with the Board Secretary. **II. Board Assurance Framework:** Risk 3a Financial Plan will be brought to the Audit Committee in December. Narrative of medical EPR evidence within Risk 2b will be developed. **III. Future deep dives:** It was agreed that the Quality Dashboard would be the focus of the deep dive to be held at the next meeting in January. **IV.** Comments were received from members of the public. Winston Samuels asked how checks were carried out to ensure information is correct for each individual patient within the clinical records system. Carolyn Green explained the concept of interpreting clinical records with him outside of the meeting. David Waldram was pleased to see that RAID had been discussed at the meeting. He was also sorry that this would be last meeting that Mark Todd would be attending as Trust Chair.
DHCFT 2015/176	**CLOSE OF THE MEETING** The Chairman thanked all of those present for their attention and comments and closed the public meeting at 4:50 pm. This was the last meeting of Mark Todd's Chairmanship and thanks were given for his excellent leadership and service to the Trust.

DATE OF NEXT MEETING

There will be no meeting in December. The meeting of the board in public session is scheduled to take place on Wednesday, 27 January 2016 at 1.00 pm. in Conference Rooms A & B, R&D Centre, Kingsway Site, Derby, DE22 3LZ (confidential session to commence earlier at 10.30 am).

BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - JANUARY 2016						
Date	**Minute Ref**	**Action**	**Lead**	**Status of Action**	**Current Position**	**Enc B**
24.6.2015	DHCFT 2015/099	Staff Health Check	Jayne Storey	Jayne Storey to lead the Cultural Change Programme	This is identfied within the governance well-led action plan. Initially discussions have taken place with an external provider. A tender proposal will be submited to the People and Culture committee in February 2016.	Yellow
29.7.2015	DHCFT 2015/119	Verbal Workforce Strategy Update	Jayne Storey	Jayne Storey to provide an interim report to the Board outside of the meeting prior to a full update to the Board in September	Circulated post board in July. ACTION COMPLETE	Green
29.7.2015	DHCFT 2015/126	AOB - Board Development Programme	Jenna Davies	Jayne Storey to provide a clearer definition of the Board Development Programme at the next meeting of the Board in September	The Forward Plan for Board Development together with a clearer definitiion of the constraints and purpose of the Board Development framework is required from Jenna Davies and will be provided at the March meeting.	Yellow
30.9.2015	DHCFT 2015/134	Committee Summary Reports	Jenna Davies	Revised draft of the Raising Concerns at Work (Whistleblowing) Policy and Procedures to be submitted to the Board at the October meeting. Committee minutes to be submitted to the Board in future rather than summary reports.	Revised draft of the Raising Concerns at Work (Whistleblowing) Policy and Procedures deferred to March meeting in line with the outcome of the creation of a national policy.	Yellow
30.9.2015	DHCFT 2015/137	Deep Dive in Managing Sickness and Absenteeism	Jayne Storey	The results of the deep dive in sickness absence will be reported to the People Forum at the next meeting on 13 October. The Finance & Performance Committee will receive a report from the People Forum at its next meeting in November and an update report on the action plan and results from these actions will be provided to the Board at its meeting in November. Monitor to receive an update report by the end of October.	A more detailed action plan was presented to F&P in January. Continued monitoring of progress will be through the People and Culture Committee.	Yellow
28.10.2015	DHCFT 2015/148	Acting Chief Executive's Report	Ifti Majid/ Jayne Storey	People Strategy to be reviewed in line with the Trust Strategy and considered within the People Forum	People Strategy is being reviewed in line with the Trust Strategy and will be monitored through the new People and Culture Committee. This is a key action on the governance and well-led action plan.	Yellow
28.10.2015	DHCFT 2015/148	BAF Update	Jenna Davies	Discussions on elements of risk 2c will take place outside of the meeting with Jenna	Discussions completed and will be update will be provided to January Audit Committee. ACTION COMPLETE	Green
28.10.2015	DHCFT 2015/153	Deep Dive into Suicide Prevention	John Sykes	Trajectory of improved suicide prevention training compliance and update on performance to be received by the Quality Committee. Suicide strategy to be submitted to the Quality Committee, together with confirmation of when the draft will be received.	Suicide Strategy has been reviewed by the Quality Committee. Waiting confirmation from Quality Committee that an update on suicide training this has been received. 27.1.2016 Suicide Prevention strategy will be received by QC at February meeting and will include an update on training and trajectory.	Green

28.10.2015	DHCFT 2015/155	Integrated H&S Governance Annual Report	Carolyn Green	Improvements in the work programme on workplace stress to be addressed at the Health and Safety Committee and reported to the Quality Committee to give the Board assurance that workplace stress is being attended to and with appropriate action plans.	Received by Quality Committee in December 2015.The report will be escalated to the People and Culture Committee and to Jayne Storey to align this support alongside sickness trends and be triangulated with the health check and staff survey to identify causal factors and any required service improvements. The People and Culture Committee and Jayne Storey are requested to provide a written report back to the Quality Committee on their progress by March 2016	Green
25.11.2015	DHCFT 2015/161	Service Receiver Story	Carolyn Green	Carry out a reflection of Kirsty's observations and write to her setting out recommendations for improvement	Carolyn Green has written to Kirsty regarding her observations. ACTION COMPLETE	Green
25.11.2015	DHCFT 2015/163	Chairman's Report	Jenna Davies	Jenna Davies to define the governor working group terms of reference and quorum	The Trust is reviewing the governance of COG as part of the governance action plan.	Green
25.11.2015	DHCFT 2015/170	Changing Face of the Workforce - People Strategy Update	Ifti Majid/ Carolyn Gilby	Organisational development and gaps in leadership and creation of workforce for the future will be addressed and developed through ELT and monitored through the Finance & Performance Committee.	This action has been superseded. Following the receipt of the 'Yates' report and completion of our wel led self-assessment the Board is set to approve a new Board committee (People and Culture Committe) that will oversee development and delivery of our revised people strategy. This committee as can be seen by the ToR in today's Board will be responsible for overseeing this action via a dynamic workforce plan.	Green
25.11.2015	DHCFT 2015/171	Annual Patient Survey	Carolyn Green	CQC Safeguarding report has been received by the Board in confidential session. Full report and action plan wil be submitted to the February Board meeting by Carolyn Green	Item for February Board agenda.	Yellow
25.11.2015	DHCFT 2015/173	Integrated Performance & Activity Report & Safer Staffing	Carolyn Green/ Carolyn Gilby	Carolyn Green will carry out quality checks in partnership with Carolyn Gilby on areas that have been highlighted.	Carolyn Green and Carolyn Gilby have been assessing the staffing issues in service area triggering staffing concerns are in active Liasion with the SLM in solutions and ideas generation in staff deployment. Carolyn Green and Carolyn Gilby are scheduling a site visit in January to talk to staff directly in addition to this action to date. ACTION COMPLETE	Green
25.11.2015	DHCFT 2015/173	Integrated Performance & Activity Report &	Carolyn Gilby	Inconsistency in cluster recording will be followed up and closely monitored by the Finance & Performance Committee.	Will be addressed at Finance & Performance Committee on 25 January. ACTION COMPLETE	Green

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

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 27th January 2016

Acting Chief Executive's Report

1. Introduction

This report provides the Board of Directors with some of the key national policy changes or announcements over the last month that we should consider and use to inform strategic discussions within the Board meeting. The report also provides an update on work within the Derbyshire Health and Social Care Community as well as covering key issues internal to the Trust.

2. National Context

2.1 22 December saw the NHS planning guidance published by NHS England, in partnership with the five arm's length bodies (NHS Improvement (Monitor and TDA), Health Education England, the National Institute for Clinical Excellence, Public Health England and the Care Quality Commission).

This year's guidance has been published in the context of the recent spending review announcements, and is explicitly positioned to set out how the sector is expected to deliver the Five Year Forward View by 2020, 'restore and maintain financial balance' and 'deliver core access and quality standards for patients'.

This year, organisations within the NHS will be required to produce two plans:

1. All local health and care systems will be required to develop a five year sustainability and transformation plan (STP), covering the period October 2016 to March 2021 subject to a formal assessment in July 2016 following submission in June 2016

2. All NHS foundation trusts and trusts are required to develop and submit one year operational plans for 2016/17. These plans will need to be 'consistent with the emerging STP' and in time to enable contract sign off by end of March 2016

Mark Powell will deliver a more detailed appraisal to the Board later in the Agenda

2.2 In December 2015 The Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015 was published. This report detailed a significant number of omissions, errors and poor practice around the leadership, investigations and governance procedures relating to unexpected deaths. I would strongly urge all Board members to read the full report available at

https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-rep.pdf

Carolyn Green has led a process reporting through Quality Committee and being discussed later at Board today looking at the outcomes and recommendations and reviewing our compliance within the Trust.

2.3 Monitor has released two guides that support planning for mental health contracting:

- Developing a capitated payment approach for mental health
- Developing an episodic payment approach for mental health

As part of our contracting process this year we are engaging with our commissioners around plans for using these models. At its simplest capitated payment approaches will enable a single provider to co-ordinate/deliver/contract for mental health care for a specific capitated group so for example Erewash. This is in line with negotiations thus far with our commissioners and has strong links to the direction of travel for non-mental health services within Derbyshire. Episodic payment methods are where a provider is payed a fixed fee for a single episode of care, this method relies more heavily on tools such as care clustering, where we perform well but where there are many concerns about variation in clustering nationally. For next year we are able to adopt a local approach, possibly some hybrid and we will keep the Board updated through Finance and Performance Committee.

Derbyshire Health and Social Care Community

2.4 Senior leaders across both Units of Planning and the MCP Vanguard in Erewash have been discussing the 'Sustainability and Planning Footprint' within Derbyshire that would best meet needs of local residents. Our Board is asked to discuss this using the paper attached in appendix 1 and share the outcome of our discussions with the CEO and Chief Officer Meeting in February.

2.5 Derbyshire and Nottinghamshire's devolution bid is now available in full on Derbyshire County Councils website. The Board will remember previous discussions around this under the name of Devolution D2N2. The name of the Devolution bid has now been changed to Devolution North Midlands. The bid has altered little from the iteration seen by the Board however I have attached the final summary version as appendix 2 as this should inform an important part of the Boards strategy development discussions.

Inside Our Trust

2.6 I was fortunate to be able to visit every one of our wards and both Crisis Teams over the Christmas period and would like to thank the staff and patients for the welcome they gave me. A key theme that came out of my discussions with staff was around the use of temporary staff in our in-patient areas. Staff expressed frustration at the current arrangements linked to the temporary staffing office –

often having more success in finding staff themselves. This is something I have given assurance will be reviewed. I also received feedback around the number of vacancies on the Radbourne Unit and a request to use the rolling recruitment process again.

One lady who is using our services at the Radbourne Unit was telling me how grateful to the staff she was because she recognised that when she was very poorly they worked hard to keep her on the ward and not send her to a PICU (Psychiatric Intensive Care Unit).

2.7 I attended the Trust Medical Advisory Committee on Thursday, 14 January. Amongst the organisational and clinical matters discussed I was very impressed with an innovative development championed by Dr David Walker, Consultant Psychiatrist High Peak called the 'safety box'. This is an interface between PARIS and consultant letters to enable the population of a box at the top of all Consultant letters that briefly details risk history, current risk and diagnosis with a hope to also include medication. This will be welcomed by our colleagues in primary care as an aid to safely managing the primary/secondary care interface.

I am also delighted to announce to the Board that Dr Subodh Dave, Consultant Psychiatrist has put himself forward for nominations as Dean of the Royal College of Psychiatrists. Subodh has worked as Associate Dean for a number of years and has shown great commitment to medical education, international psychiatric aid and continuous quality improvement. I will update the Board once voting is complete later in the year.

2.8 Tuesday, 12 January was the first 24 hour Junior Doctor strike. Clinically the Trusts contingency plans worked well with around 18 appointments showing as being cancelled on the day and no serious incidents being reported. Situation reporting to NHS England was more problematic with the first sitrep giving an erroneous number of doctors at work, this was updated as soon as it was spotted however the upload from NHS England to the Department of Health had already occurred. Dr John Sykes is working on a clear action plan for the next phases of the strike which will include robust plans for sitrep reporting.

Legal Issues

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

Equality Delivery System

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

Consultation

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

Recommendation

The Board of Directors are requested:

1) To note and discuss the paper using its content to inform strategic discussion.

Report Prepared by: **Ifti Majid**
Acting Chief Executive

Delivering the 5 year Forward View:

NHS planning guidance

Sustainability and Transformational Planning Footprint

Purpose:

This paper acts as an aid for Chief Executives and senior leaders in their discussions with Boards and Governing Bodies of health and care organisations in Derbyshire and Derby City, when considering the appropriate footprint for the 5 year Sustainability and Transformation Plan (STP).

Boards/Governing Bodies are asked to consider the most appropriate footprint in light of the full guidance and the brief points contained in this document including the latest thinking from system leaders.

Context

In previous NHS planning rounds, footprints have largely been determined by commissioners in dialogue with partners, as we move locally and nationally towards placed based models of care and begin to scope out sustainable service solutions for health and care, it is right that health and care partners agree the footprint on which we transform and sustain services for our population.

There isn't a perfect footprint that covers all services for any population but we do need to make sure that the footprint we collectively agree largely supports the scale of the task and the requirements of the Sustainability and Transformation Plan (STP).

The Focus of the STP

The STP will cover the period October 2016 to 2021 and will need to set out what we will do to ;

- support our population to have better health, (How will we close the health and wellbeing gap?)
- transform the quality of care delivery – new models of care
- ensure we have sustainable finances and close the finance and efficiency gap
- deliver the Governments mandate to NHS England
- The STP also allows for system wide financial control totals

The credibility of the STP footprint and plan will also be key in accessing transformational funds to accelerate new models of care delivery and other key priorities. The planning guidance recommends paying regard to Transforming Care and Digital Roadmap footprints in considering the scale required for a STP footprint. For both of these priority areas we are already working on Derbyshire County and Derby City footprint.

Partner Discussions to date:

Derbyshire Health and Well Being Board, on 7.1.16, discussed the Sustainability and Transformational footprint and members expressed a preference for a countywide footprint including Derby City. The logic for the footprint being the strong focus of the STP being on; place, prevention, health and wellbeing and resilient communities and the need for scale to support sustainable health and care in the future. There was also recognition of the need to retain existing engagement and influence in sustainability and transformation programmes over the county borders that could impact on our population e.g *Working Together in South Yorkshire*

On 8.1.16 Derbyshire Chief Executives discussed the requirements of the plan and based on the requirements of the plan above considered the most appropriate footprint to be that of Derbyshire county and Derby city. The group recognised the joint Derbyshire and Derby City health and care vision for joined up care which was agreed by all partner organisations in 2015 as a strong starting point for the development of the STP. There was agreement that good work in both south and north units of planning would need to maintain pace and momentum, opportunities to optimise use of leadership capacity was also recognised.

Regulator views

Boards and Governing Bodies may also find it useful to refer to the Monitor discussion document 'Considerations for determining local health and care economies' . Pages 37 and 38 are the Derbyshire specific pages.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/489862/Considerations_for_determining_local_health_and_care_economies_selective_branding_.pdf

Initial views from NHS England indicate a preference for larger footprints and Derbyshire and Derby City is viewed as a logical footprint.

Consideration - Reaching agreement

Whilst recognising the need to maintain the existing strong links with transformation programmes over borders, there is logic and a proposed view from system leaders across Derbyshire and Derby City health and care organisations for a single Derbyshire and Derby City footprint.

Boards and Governing Bodies are asked to share their views on the proposed footprint by 26 January at the latest. Should there be a preference for another footprint it will be necessary to share a convincing rationale for the footprint to allow expedited discussions ahead of 29 January deadline.

Provisional next steps:

There is a clear need to understand how we optimise the benefit from working at a larger scale and maintain momentum on local transformation.

Derbyshire and Derby City health and care leaders have consider the next steps in progressing the development of a STP and are planning a workshop to schedule Workshop w/c 22 February of senior managerial and clinical leaders to:

- Agree the scope of the STP
- Understand the degree of alignment of priorities across North and South units of planning and with Health and Well Being strategies
- Understand the health and wellbeing gap and the actions we need to take address it
- Agree the population levels at which we plan a range of specific services and priorities
- Consider the implications of acute sustainability both and outside of the footprint
- Scope opportunities for shared leadership and programme resource
- Development of a Roadmap to deliver a credible and compelling STP

NORTH MIDLANDS
NOTTINGHAMSHIRE DERBYSHIRE

SUMMARY: Draft North Midlands Devolution Agreement

This is a summary of the draft North Midlands Devolution Agreement submitted to the government by all 19 Nottinghamshire and Derbyshire local authorities and the local enterprise partnership D2N2 in December 2015.

Following months of positive discussion with the government, the North Midlands Devolution Agreement sets out the final negotiating position agreed by all Nottinghamshire and Derbyshire council leaders for the proposed transfer of powers and funding from London.

The full draft document can be read at www.derbyshire.gov.uk/devolution

How Devolution Would Work

The proposed governance arrangements for the powers and funding transferred from central government to local councils are:

- **A single combined authority for Nottinghamshire and Derbyshire** would be created comprising all 19 city, county, district and borough councils. A combined authority is a formal, legal body that enables councils to work more closely together in a structured way but it is not a merger or take-over of councils or a unitary council.
- **A single elected Mayor** for Nottinghamshire and Derbyshire would be directly accountable to local electors for the area covered by the new combined authority. The Mayor would chair the combined authority, provide overall leadership, be responsible for any devolved powers and would eventually take on the role of the two existing Police and Crime Commissioners for Nottinghamshire and Derbyshire.
- **The Mayor would be required to consult the combined authority** (made up of one elected member from each of the 19 authorities) on his/her policies including budget proposals and key plans and strategies. A constitution will be developed for the combined authority which will set out the voting arrangements. The Mayor and the combined authority would be held to account by an independent Overview and Scrutiny Committee.
- The proposals for a Mayor and a combined authority are subject to **public consultation, final consent of each of the 19 councils, and parliamentary approval.** If the proposal goes ahead the first election for a Mayor will be held in May 2017.

The Proposed Devolved Powers

The key areas where local councils are proposing that control and funding is transferred from central government to the new Mayor and combined authority are:

- **Skills, apprenticeships and employment:** it is proposed to take local control of the 19+ adult skills budget, business support funding, apprenticeship grants and employment schemes currently administered by central government. This will create access to more apprenticeships, qualifications and training and careers advice that are relevant and responsive to the local jobs market. It is also proposed to consider how rural growth programmes could be devolved locally in the future, to develop a case for a 'free trade' or 'accelerated trade' zone linked to East Midlands airport with more efficient customs

procedures for goods manufactured within the zone, and to take joint control with the government for the export advice service locally.

- **Housing and planning:** it is proposed to maximise the use of surplus and brownfield land to build 77,000 more houses and create new employment opportunities through control of a £200m housing investment fund and by tighter coordination, streamlining and joint planning between the new combined authority and the Government. It is also proposed to set up publically owned and controlled local development corporations to ensure economic benefits are reinvested within the area.

- **Transport:** it is proposed that the Mayor of the new combined authority will have control of a single local transport budget and new powers devolved from central government. These powers would include influencing bus services to create a better coordinated transport system that provides access to employment opportunities and implementing an 'Oyster'-style smart ticketing system across the whole combined authority area. It is proposed the combined authority would work closely with the government to reduce the journey time by train to London to under 90 minutes and to maximise the benefits of the HS2 high speed rail line.

The Key Benefits of Devolved Powers

- At least £900m in an investment fund over 30 years that is locally controlled and spent
- 55,000 new private sector jobs
- 77,000 extra homes
- Control over £150m annual adult skills budgets
- £137m a year in consolidated transport funding
- £200m housing investment fund to support new housing and affordable homes
- Control of the regulation of bus services
- Single Oyster-style card ticketing
- Responsibility for support to help businesses grow and create more jobs
- Control of grants to deliver 110,000 more apprenticeships
- Control over government programmes to help people back into meaningful employment
- Midland Mainline Electrification – Nottingham and Derby in 90 minutes to London
- A major HS2 station and engineering depot and regeneration of the surrounding areas.

The 19 Councils

The North Midlands devolution bid includes all 19 local authorities in Derbyshire and Nottinghamshire: Amber Valley Borough Council, Ashfield District Council, Bassetlaw District Council, Bolsover District Council, Broxtowe Borough Council, Chesterfield Borough Council, Derby City Council, Derbyshire County Council, Derbyshire Dales District Council, Erewash Borough Council, Gedling Borough Council, High Peak Borough Council, Mansfield District Council, Newark and Sherwood District Council, North East Derbyshire District Council, Nottingham City Council, Nottinghamshire County Council, Rushcliffe Borough Council and South Derbyshire District Council.

D2N2 Local Enterprise Partnership (promoting economic growth in Derby, Derbyshire, Nottingham and Nottinghamshire) is a partner in the bid.

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 27 January 2016

Quality Position Statement

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

Executive Summary

1. SAFE SERVICES

1.1 Improving Physical Health of those with a Serious Mental Illness (SMI) a s one of our Trust Quality priorities

We have undertaken the national audit, led by the Royal College of Psychiatrists for the second year, to assess against national standards of screening for physical illness and side effects. This involves an audit of 100 sets of casenotes, across the organisation, in a sample selected and generated by the Royal College team, within a one month period. The audit is to ascertain routine screening for cholesterol, blood pressure, smoking and weight gain, and to assess interventions implemented as part of our care. We will await the national report, as yet we have no timescale for its delivery.

1.2 Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015

This report as published by Mazars is an integrated, international audit, tax and advisory firm who worked with an expert reference group set up by NHS England to review all deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015. 540 individual reports of deaths of service users were reviewed and a number of key findings which resulted in recommendations for the trust and its commissioners. One of the purposes of reviewing the deaths was to 'to establish if there is any learning for the Trust, the wider NHS and its partners around the circumstances of the death and the care provided leading up to a death'. The report sets out what best practice looks like as set out below:

National reports and research indicates to us that best practice would be that: (taken directly from the report)

- there are thorough and challenging reviews undertaken when the death of a service user
- happens unexpectedly – regardless of the location of the death;
- these are not necessarily serious incident investigations but occur in a

range of ways
- including clinically led mortality reviews;
- the learning from national reports is applied when making decisions about local
- investigations;
- there is an open, transparent and independent approach to investigations with the intention
- of securing all the evidence needed;
- families and carers are involved where at all possible;
- reviewers are trained and investigations are of a high standard;
- lessons are shared widely between providers, commissioners and other agencies; and
- that organisations investigate incidents of unexpected deaths jointly where appropriate.

We have:

Considered the report and its findings and recommendations. A review of how we report deaths and a review of all deaths in the last 12 months was presented to the Quality Committee on 14th January 2016 with detailed analysis and recommendations on the Trust procedures and learning from other organisations areas for improvement.

2. CARING SERVICES

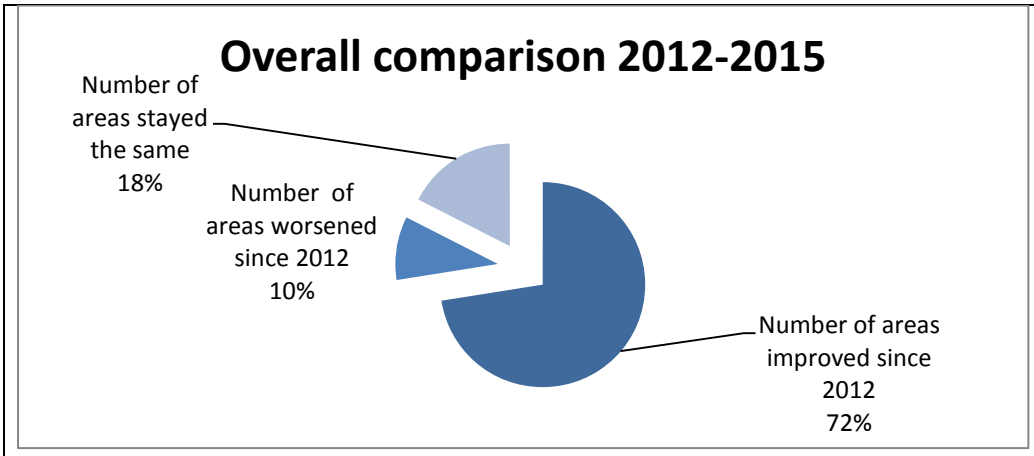
2.1 Inpatient Survey results 2015

This survey is conducted voluntarily by Derbyshire Healthcare NHS Foundation Trust (DCHFT) in addition to the Community Survey which is conducted and published by the CQC annually. The survey is conducted by an external provider called Quality Health who conduct surveys on behalf of Trusts in England. As the inpatient survey is voluntary not all Trusts continue to conduct it and consequently the benchmarking number of responses is lower (18 Trusts) than for the Community Survey. The number of respondents to the 2015 survey was 83 people.

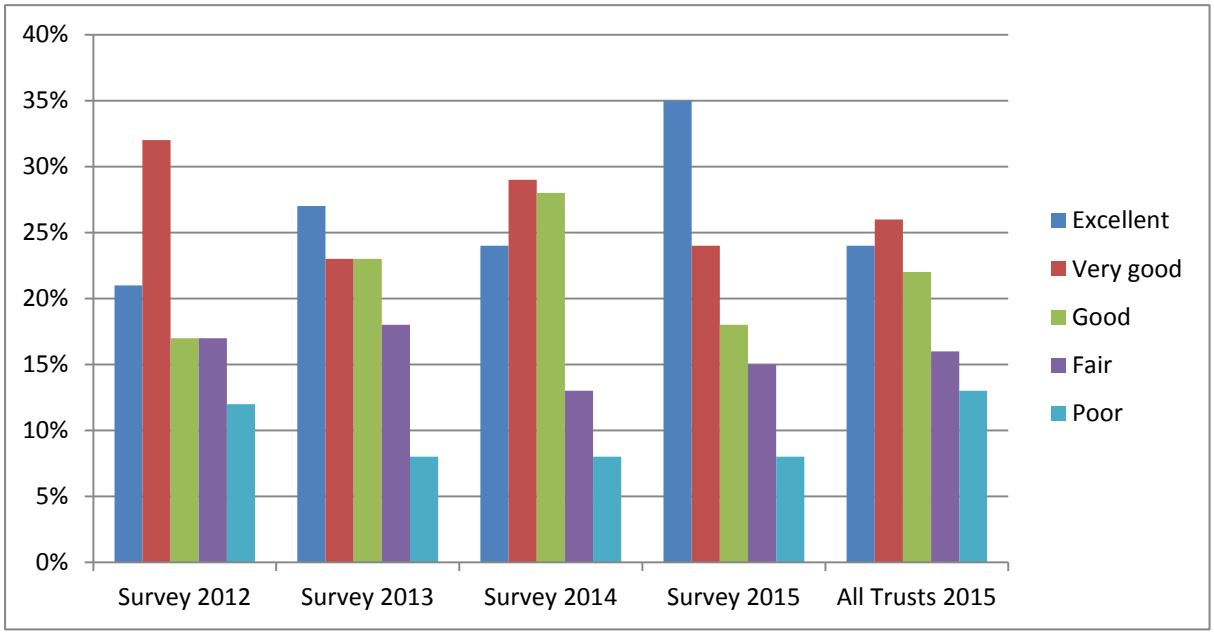
We received the results of our inpatient survey 2015. An analysis of the data since 2012 is attached at appendix one. A summary is set out below:

The final response was 26%. Respondents were split male (41%) and female (59%). Ages of respondents ranged from 16-over 65 but the number of respondents over 65 was only 2 people. 87% of respondents stated their ethnic background as “British”. Where questions have been omitted from this report they can be found in the overall survey results from Quality Health.

Of the 40 questions analysed in this report 29 (72%) have improved results compared to the 2012 Inpatient Survey, 4 (10%) have worse results, 7 (18%) have remained static to within 1%, and 5(16%) are not applicable to measure.



The chart below shows the results for overall care year on year



Areas of positive feedback

- Overall over the period patients have felt welcomed onto the ward. Their views on how good hospital food has been increasing to above the benchmarks of other trusts by 9% in 2015. This confirms out PLACE assessment results for 2015 where the Hartington unit scored 92.01% for food and the Radbourne unit 95.05%. More patients required help with their home situation and received this help from staff.

- Overall over the period patients have felt satisfied with our staff. For both psychiatrists and nurses in 2015 all the scores are higher than for our comparable trusts. All the areas have either improved or stayed the same when compared to 2012; no area has worsened in terms of patient satisfaction. The area with the biggest improvement since 2012 was nurses listening to patients and patients having confidence in the nursing staff.

- There has been a big improvement in explanations about medicines with a 19% increase on patient satisfaction but there is more work to do on

explaining the side effects. The availability of activities in the evening and weekends has improved by 11%. Physical healthcare shows an improvement since 2012 but a decrease of 6% since the 2014 survey. This survey may be slightly early for the effects of the commissioning for quality and innovation agreements to be fully realised.

- Good progress has been made in this area with patients feeling positive about the notice they were given and less patients are being delayed from leaving hospital.

Areas of priority for action planning are:

- Noise on the ward at night and ensuring patients feel safe on the ward. Although above the benchmark for other trusts by 7% it is 2% lower than in 2012.
- Physical healthcare
- Explaining the side effects of medications.
- Having the number of someone from our services that patients can phone out of office hours although has improved since 2012 but is 10% below our comparators.

3. EFFECTIVE SERVICES

3.1 Nutrition and Dietetics

As a result of the increased funding secured from our Commissioners, we now have 3 Mental Health Dietitians in place (in addition to our two Specialist Dietitians already in post) , and will recruit to the final Dietetics Assistant post soon. The team will then be at full strength, and are working on planning the delivery of training for relevant staff, assisting our catering team with menu review and targeted interventions in the Campus settings. This has been a significant development in 2015, as we feedback to commissioners that we were concerned about capacity of dietician support for our service receivers.

3.2 SmokeFree services

The project team working on the development and implementation of the SmokeFree Trust status are finalising plans and seeing many aspects of support coming together. This includes enhanced training for staff, provision of Nicotine Replacement Therapy (NRT) for inpatients, signage and information and better links with Community Stop Smoking services. We have had concerns raised from some voluntary and mental health groups about what this means for in-patients and how will they be supported effectively. Our project team are responding directly to Mental Health Action Group (MHAG) to listen to their concerns and work together on solutions.

3 RESPONSIVE SERVICES

4.1 'The Parents Say'

'The Parents Say' is a new toolkit launched on 2 December 2015 aimed at improving mental health services for children and their families**.** The toolkit was developed by NHS England and mental health charity YoungMinds. The toolkit It consists of a series of online modules, downloadable guides for commissioners and parents as well as 14 case studies to help clinicians understand the experiences of families. More than 900 parents were involved in the consultation work and 5 short films have also been developed, where parents talk about how they need to be better informed about their child's treatment.

Our response

Our Children's and CAMHS services will consider the use of the toolkit in their future work.

4 WELL LED

5.1 **Providing a safe and effective learning environment.**

Every 3 years Health Education England complete a review of the quality of services provided through Education contracts with Higher Education Institutes. The review is in addition to the normal contracting reviews which are held throughout the year. The areas covered in the review are:

- Improving Practice Learning
- Improving Retention in the East Midlands
- Innovating the Curriculum

The review of the contract with the University of Derby took place in May 2015. A stakeholder event was held on 22 May where students, service users, representatives from the University of Derby and staff from our organisation had the opportunity to contribute to the review. An action plan from this event was then developed based on the day's feedback. The action plan will then be implemented, monitored and evaluated through a number of professional groups and forums which meet throughout the year. The action plan includes improving the support and communication with supervisors and mentors. To develop more community placements, to prepare students for employability, to use more 'cross professional' modules, and to look at how patient feedback during placement can be recorded and utilised in a meaningful way as part of the healthcare programmes. The full action plan and supporting letter can be obtained from our Director of Nursing or our Head of Education.

5.2. You said, we listened, we responded, we did

Executive Director of Nursing and Patient Experience, Carolyn Green and our acting Director of Operations, Carolyn Gilby have re-started open drop in sessions in the North and the South of the county for staff to come along and talk. This is for ideas, to talk about experiences or raise issues and solutions.

The first session was held on the morning of 21 December, at Kingsway, and Chesterfield in January a number of staff attended. A feedback template is completed with consent and visits or discussions can also happen anonymously, as requested by our staff or individuals. More sessions are planned for the future with a rolling programme for the next 12 months.

Themes are:

1. Can the trust senior team be more explicit about issues and pressures in the community services and what they are doing to deal with commissioning gaps and capacity?
2. How does the trust really value staff if it is undertaking restructures that result in Band 4 staff being down banded to Band 3? Is that compassion?
3. Feedback on the approach to patient centred care being positive, ideas an solutions about doing it well.
4. Feedback that in-patient wards still continue to be medically dominated and MDM meetings still feel medically led not person centred.
5. Feedback on how all managers need to have conversations about performance, what am I getting right, what am I getting wrong and talking to me if I am not meeting your expectations
6. Ideas about waste and things that the senior team could consider. To be emailed

5.3 Inspiring innovation/ creating green shoots

A key quality for the Trust is the development of clinical leadership, personalised care which is evidence through personalised and effective care planning, role modelling of using research into practice and developing our future leaders.

We held one of our nursing strategy and educational events on 16 December 2015 these events are promoting contemporary clinical nursing practice, developing staff engagement, developing accessibility of the nursing and quality team to a wide range of staff, promoting knowledge of the Nursing and Quality strategy and enabling staff to see their wider contribution to the Trust goals.

The events are linked directly to the component parts of the nursing strategy and it is an enabling event to ensure revalidation is rolled out effectively, gain and continual role modelling of the nursing and quality team as approachable and accessible to a nursing workforce that has feedback that in early 2014, if felt disconnected and no concept of the nursing and quality team and how they supported the clinical services specifically nurses to flourish.

There are evaluations of these events both in learning, attendance, reflection and in what have these events done to make you think differently and embedding a learning reflective record, a keep component part of preparing the skills of self-reflection for informed clinical practice and revalidation.

This is an extract from an Older Adults nurse reflecting on practice of personalised care and the role of families and carers after having a presentation on the Kings Fund evaluations of patient activation, one page profiles for patient care, reflecting upon power dynamics in the caring relationship.

"Thank you for replying to my email so quickly, I had some further thoughts today post night shift so I hope you don't mind me sharing. I have devised a quick modified rating scale (see revised tool) which I took from the 13 item scale and reduced it to 10 items, with a rating scale leading to a total score out of 50. I then defined the levels of activation based upon that. My reasoning partially being that I feel that carers in the community are more likely to be more engaged with the care and I think that some of the barriers I mentioned previously would be removed there so it would be a good place to pilot. I would also like to try and pilot it on the wards as well though. I think that if we got some figures of our current activation levels in the day hospitals and inpatient wards it would then be good to compare, and I think it may be a starting point to try and improve engagement with carers and increase activation. I think activation levels will be higher in community services than inpatients (I may be wrong) and my personal thoughts would be that we may unintentionally partially reduce activation levels in hospitals by not communicating or engaging effectively with carers and this is something that we need to improve on. The findings would be the start of the discussion process around how we can educate and engage carers regarding their relatives health needs and work more collaboratively. There maybe then the opportunity to re-assess activation levels amongst carers maybe 6-12 months down the line to see if any actions we have devised have had a beneficial effect?"

We will:

Our Assistant Director of Clinical Professional Practice will present the Kings fund paper on Patient activation at the Quality Leadership Team meetings to commence embedding this work in practice. We will also be exploring the use of PARIS in this work in developing a set of clinically focused outcome measures.

We will continue to hold our Nursing Conferences to promote clinical nursing practice, develop staff engagement, and increase accessibility of the nursing and quality team. These events are part of the implementation of the Nursing strategy, Nursing in our Trust, which is overseen by the Nurse Leadership group.

5.4 Inspiring innovation/ the occupational therapy professional strategy and enable self-care developments and vocational and occupational recovery

In December 2015 the Quality committee received and agreed the Mental Health Occupational Therapy professional strategy. Karen Wheeler and the Occupational therapists were thanked for their developments and their key focus on professional issues and clinical standards and their acknowledgement and contribution to the current Trust Strategy and how their work will fit and or be adapted in line with the soon to be redesigned Trust strategy. We look forward to receiving the final draft of the Allied Health professional's strategy for 2016, which is nearing completion.

Strategic considerations

- To ensure the results of the inpatient survey are considered in our future work and planning.
- To continue to learn from national publications and their findings.
- To continue to listen, respond and take action when our staff share their ideas and talk about their experience of working in the trust.

(Board) Assurances

- The high level of assurance from the comparison between the 2012 inpatient survey and the 2015 results.
- Developing systems and ring fencing time to enable staff feel able to talk and share their ideas and concerns and know that we will respond, listen and take action where we are able. This will include responding positively where we can but also giving clarity on things that senior staff may not be able to find an immediate solution.

Consultation

This paper has not been previously presented.

Governance or Legal issues

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

Equality Delivery System

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

Recommendations

The Board of Directors is requested to:

- Note the quality position statement and attached dashboard and trends.
- Give direction or further scrutiny on our current position, work plan or a steer from the Board on additional information to provide Board level assurance.
- To receive the results of our inpatient survey, and note areas of improvement.

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

Report prepared by: **Clare Grainger**
Head of Quality and Performance

Inpatient Service Users Survey 2012-2015 Comparison Report

3.QUESTIONS ABOUT THE WARD

Q1 When you arrived on the ward, did staff make you feel welcome? %age stating "Yes"

Survey 2012	Survey 2013	Survey 2014	Survey 2015	All Trusts 2015	Better/ Worse than 2012.
73%	65%	90%	87%	85%	 +14%

Q2 When you arrived on the ward, did you feel that the staff knew about you and any previous care you had received? %age stating "Yes, definitely"

20%	24%	30%	33%	27%	 + 13%

Q3 When you arrived on the ward, or soon afterwards, did a member of staff tell you about the daily routine of the ward, such as times of meals and visitors times? %age stating "Yes, certainly"

37%	38%	33%	43%	37%	 +6%

Q4 During your most recent stay, did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex? %age stating "Yes

10%	8%	10%	17%	9%	 +7%

Q5 During your most recent stay, were you ever bothered by noise at night from hospital staff? %age stating "Yes"

24%	17%	28%	22%	25%	 -2%

Q6 During your most recent stay, did you feel safe? %age stating "Yes, always"?

49%	54%	39%	47%	40%	 -2%

Q7 How would you rate the hospital food? %age stating "Very Good"

Survey 2012	Survey 2013	Survey 2014	Survey 2015	All Trusts 2015	Better/ Worse than 2012.
24%	23%	26%	37%	28%	 +13%

Q8 Do you have a specific diet, for example because of your cultural or religious beliefs, because you have a particular health condition, or through personal choice? %age stating "Yes"

19%	21%	24%	11%	19%	N/A

Q9 Were you able to get the specific diet that you needed from the hospital? %age who stated "Yes, always"

25%	57%	30%	45%	38%	 + +20% (very small response rate)

Q10 In your opinion, how clean was the hospital room or ward that you were in? %age stating "Very clean"					
59%	64%	64%	60%	55%	 +01%
Q11 How clean were the toilets and bathrooms that you used in hospital? %age stating "Very clean"					
44%	50%	49%	44%	45%	
Q12 Do you feel the hospital helped you to keep in touch with family or friends? %age stating "Yes definitely"					
44%	47%	40%	53%	45%	 +09%
Q13 During your most recent stay, did you need any help from hospital staff with organising your home situation? %age stating "Yes"					
14%	53%	31%	21%	23%	 +07%
Q14 Did you receive the help you needed from hospital staff with organising your home situation? %age stating "I received all the help I needed"					
20%	27%	44%	60%	45%	 +20%

3.1 Summary of responses about the ward

Number of areas in 2015 better than in 2012 	Number of areas in 2015 worse than in 2012 	Number of areas in 2015 about the same as in 2012 	Areas not applicable
9	**3**	**1**	**1**

3.2 Positive views

Overall over the period patients have felt welcomed onto the ward. Their views on how good hospital food has been increasing to above the benchmarks of other trusts by 9% in 2015. This confirms out PLACE assessment results for 2015 where the Hartington unit scored 92.01% for food and the Radbourne unit 95.05%. More patients required help with their home situation and received this help from staff.

3.3 Areas for improvement

Areas of priority for action planning are noise on the ward at night and ensuring patients feel safe on the ward. Although above the benchmark for other trusts by 7% it is 2% lower than in 2012.

4. QUESTIONS ABOUT OUR HOSPITAL STAFF

Q15 Did the psychiatrist(s) listen carefully to you? %age stating "Yes, always"					
Survey 2012	**Survey 2013**	**Survey 2014**	**Survey 2015**	**All Trusts 2015**	**Better/ Worse than 2012.**
59%	66%	49%	58%	52%	 -1%
Q16 Were you given enough time to discuss your condition and treatment with the psychiatrist(s)? %age stating "Yes, always"					
57%	64%	46%	59%	47%	 +2%
Q17 Did you have confidence and trust in the psychiatrist? %age stating "Yes, always"					
48%	41%	41%	47%	43%	 -01%
Q18 Did the psychiatrist(s) treat you with respect and dignity? %age stating "Yes, always"					
65%	79%	58%	72%	66%	 +7%
Q19 Did the nurses listen carefully to you? %age stating "Yes, always"					
40%	52%	53%	56%	48%	 +16%
Q20 Were you given enough time to discuss your condition and treatment with the nurses? %age stating "Yes, always"					
38%	40%	38%	43%	39%	 +5%
Q21 Did you have confidence and trust in the nurses? %age stating "Yes, always"					
44%	49%	43%	56%	47%	 +12%
Q22 Did the nurses treat you with respect and dignity? %age stating "Yes, always"					

Survey 2012	**Survey 2013**	**Survey 2014**	**Survey 2015**	**All Trusts 2015**	**Better/ Worse than 2012.**
55%	66%	63%	55%	48%	

4.1 Summary of responses about hospital staff

Number of areas in 2015 better than in 2012	Number of areas in 2015 worse than in 2012	Number of areas in 2015 about the same as in 2012	Areas not applicable
5	**0**	**3**	**0**

4.2 Positive views

Overall over the period patients have felt satisfied with our staff. For both psychiatrists and nurses in 2015 all the scores are higher than for our comparable trusts. All the areas have either improved or stayed the same when compared to 2012; no area has worsened in terms of patient views. The area with the biggest improvement since 2012 was nurses listening to patients and patients having confidence in the nursing staff.

5. QUESTIONS ABOUT 'YOUR CARE AND TREATMENT'

Q23 During your most recent stay, were you given any medication (including tablets, medicines and injections) as part of the treatment for your mental health? %age stating "Yes"					
Survey 2012	**Survey 2013**	**Survey 2014**	**Survey 2015**	**All Trusts 2015**	**Better/ Worse than 2012.**
95%	97%	94%	94%	96%	N/A
Q24 Did the hospital staff explain the purpose of this medication in a way you could understand? %age stating "Yes, completely"					
34%	37%	50%	53%	42%	+19%
Q25 Did the hospital staff explain the possible side effects of this medication in a way you could understand? %age stating "Yes, completely"					
17%	23%	22%	23%	26%	+06%
Q26 Were you given enough privacy when discussing your condition or treatment with the hospital staff? %age stating "Yes, always"					
66%	70%	60%	64%	57%	-02%
Q27 Were you involved as much as you wanted to be in decisions about your care and treatment? %age stating "Yes, definitely"					
Survey 2012	**Survey 2013**	**Survey 2014**	**Survey 2015**	**All Trusts 2015**	**Better/ Worse than 2012.**
34%	35%	36%	36%	32%	+02%

Q28 During your stay in hospital, did you ever want talking therapy? %age stating "Yes"					
47%	29%	46%	43%	50%	N/A
Q29 During your stay in hospital, did you have talking therapy? %age stating "Yes"					
14%	17%	26%	24%	28%	 +10%
Q30 If you had talking therapy during your stay in hospital, did you find it helpful? %age stating "Yes, definitely"					
43%	40%	57%	59%	52%	 +16% Small number of respondents
Q31 During your most recent stay, were there enough activities available for you to do during the day on weekdays? %age stating "Yes, all of the time"					
28%	32%	28%	28%	27%	
Q32 During your most recent stay, were there enough activities available for you to do during evenings and/or weekends? %age stating "Yes, all of the time"					
14%	12%	18%	25%	16%	 +11%
Q33 During your most recent stay, did you have any medical tests about your physical health? %age stating "Yes"					
89%	87%	96%	94%	91%	 +05%
Q34 During your most recent stay, do you feel that enough care was taken of any physical health problems you had (e.g. diabetes, asthma, heart disease)? %age stating "Yes, definitely".					
47%	55%	56%	50%	46%	 +3%

5.1 Summary of responses about our care and treatment

Number of areas in 2015 better than in 2012 	Number of areas in 2015 worse than in 2012 	Number of areas in 2015 about the same as in 2012 	Areas not applicable
8	**1**	**1**	**2**

5.2 Positive views

There has been a big improvement in explanations about medicines with a 19% increase on patient satisfaction but there is more work to do on explaining the side effects. The availability of activities in the evening and weekends has improved by 11%. Physical healthcare shows an improvement since 2012 but a decrease of 6%

since the 2014 survey. This survey may be slightly early for the effects of the commissioning for quality and innovation agreements to be fully realised.

5.3 Areas for improvement
Areas of priority for action planning are physical healthcare and to continue our work on explaining the side effects of medications.

6. QUESTIONS ABOUT 'YOUR RIGHTS'

Q35 At any time during your most recent admission were you detained (sectioned) under the Mental Health Act? %age stating "Yes"					
Survey 2012	**Survey 2013**	**Survey 2014**	**Survey 2015**	**All Trusts 2015**	**Better/ Worse than 2012.**
45%	46%	40%	52%	59%	N/A
Q36 When you were detained (sectioned), or soon after, were your rights explained to you in a way that you could understand? %age stating "Yes, completely"					
37%	44%	39%	46%	39%	 +09%
Q37 During your most recent stay, were you made aware of how you could make a complaint if you had one? %age stating "Yes"					
41%	41%	52%	47%	53%	 +06%

6.1 Summary of responses about your rights

Number of areas in 2015 better than in 2012 	Number of areas in 2015 worse than in 2012 	Number of areas in 2015 about the same as in 2012 	Areas not applicable
2	**0**	**0**	**1**

6.2 Areas for improvement
Areas of priority for action planning are ensuring patients on the wards know how they could make a complaint.

7. QUESTIONS ABOUT LEAVING HOSPITAL

Survey 2012	Survey 2013	Survey 2014	Survey 2015	All Trusts 2015	Better/ Worse than 2012.
Q39 Do you think you were you given enough notice of your discharge from hospital? %age who stated "Yes"					
74%	83%	78%	82%	75%	 +8%
Q40 Once you were due to leave hospital, was your discharge delayed for any reason? %age stating "Yes"					
27%	29%	27%	20%	21%	 -7%
Q42 As far as you know, did hospital staff take your family or home situation into account when planning your discharge from hospital? %age stating "Yes, completely"					
44%	60%	49%	53%	51%	 +09%
Q43 Do you have the number of someone from your local NHS mental health service that you can phone out of office hours? %age stating "Yes"					
54%	62%	69%	63%	73%	 +09%
Q44 Before you left hospital, were you given information about how to get help in a crisis, or when urgent help is needed? %age stating "Yes"					
68%	67%	79%	73%	75%	 +05%
Q45 Have you been contacted by a member of the mental health team since you left hospital? %age stating "Yes"					
90%	93%	89%	89%	84%	 -01%
Q46 About how long after you left hospital were you contacted? %age stating 1 week or less"					
69%	72%	77%	69%	76%	 -

7.1 Summary of responses about leaving hospital

Number of areas in 2015 better than in 2012 	Number of areas in 2015 worse than in 2012 	Number of areas in 2015 about the same as in 2012 	Areas not applicable
5	**0**	**2**	**0**

7.2 Positive responses

Good progress has been made in this area with patients feeling positive about the notice they were given and less patients are being delayed.

7.3 Areas for improvement

Having the number of someone from our services that patients can phone out of office hours although has improved since 2012 but is 10% below our comparators.

Q47 Overall, how would you rate the care you received during your recent stay in hospital?

	Survey 2012	Survey 2013	Survey 2014	Survey 2015	All Trusts 2015
Excellent	21%	27%	24%	35%	24%
Very good	32%	23%	29%	24%	26%
Good	17%	23%	28%	18%	22%
Fair	17%	18%	13%	15%	16%
Poor	12%	8%	08%	08%	13%

Clare Grainger on behalf of:

Carolyn Green
Executive Director of Nursing and Patient Experience
January 2016

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 27 January 2016

Trust Performance Report
Key Performance Indicators Compliance

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

Executive Summary

- The Trust continues to be compliant with all Monitor regulatory indicators
- The recording of Payment by Result Clusters and Health of the Nation Outcome Scores 12 month reviews continue to be challenging however there have been recent improvements and new targets agreed with Commissioners
- The rate of outpatients who did not attend is still causing concern
- Health Visitor performance remains strong
- IAPT recovery rates have gone below target in December
- The Trust continues to have qualified staffing vacancies in the Hartington Unit that impact on staffing fill rates, Tansley is most adversely effected
- This report includes a 6 month review of staffing levels by ward

Strategic considerations

- This report supports the achievement of the following strategic outcomes:
  - People receive the best quality care
  - The public have confidence in our healthcare and developments

(Board) Assurances

- This report provides full assurance for;
  - Monitor Targets (CPA 7 Day follow up measured Quarterly)
  - Performance related elements of schedule 6
  - Health Visitors
  - Fixed Submitted Returns
- The report provides partial assurance for ;
  - Locally Agreed Targets
  - Performance related elements of schedule 4
  - IAPT Performance (recovery rates only)
  - Ward Staffing

Consultation

- Performance is managed at an operational level through the Trust performance and Contract Overview group

Governance or Legal issues

Failure to comply with key performance indicators could lead to regulatory action being taken by Monitor for breach of licence conditions. In addition these core indicators contribute to the Trusts compliance with the CQC Quality domains

Equality Delivery System

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

Recommendations

The Board of Directors is requested to:

1) To acknowledge the current performance of the Trust
2) To note the actions in place to ensure sustained performance

Report presented by: **Carolyn Gilby**
Acting Director of Operations

Report prepared by: **Peter Charlton and Vicky Williamson**
Information Management and Technology

Performance Summary Dashboard January 2016

Performance Dashboard (Monitor & Exceptions)

15-16 Performance Dashboard	Target	Nov	Dec
- Monitor Targets			
- CPA 7 Day Follow Up	95.00%	96.05%	93.94%
- CPA Review in last 12 Months (on CPA > 12 Months)	95.00%	94.95%	95.21%
- Delayed Transfers of Care	7.50%	1.59%	2.18%
- Data Completeness: Identifiers	97.00%	99.34%	99.35%
- Data Completeness: Outcomes	50.00%	94.97%	95.01%
- Community Care Data - Activity Information Completeness	50.00%	91.25%	91.31%
- Community Care Data - RTT Information Completeness	50.00%	92.31%	92.31%
- Community Care Data - Referral Information Completeness	50.00%	72.18%	71.56%
- 18 Week RTT Less Than 18 Weeks - Incomplete	92.00%	96.89%	96.44%
- Early Interventions New Caseloads	95.00%	100.00%	102.90%
- Clostridium Difficile Incidents	7	0	0
- Crisis GateKeeping	95.00%	100.00%	100.00%
- IAPT Referral to Treatment within 18 weeks	95.00%	99.38%	99.61%
- IAPT Referral to Treatment within 6 weeks	75.00%	93.69%	94.51%
- Locally Agreed			
- Patients Clustered Regardless of Review Dates	96.00%	94.80%	94.67%
- CPA HoNOS Assessment in last 12 Months	90.00%	87.21%	88.05%
- Schedule 4 Contract			
- Consultant Outpatient Appointments DNAs	15.00%	16.18%	16.93%
- Outpatient Letters Sent in 10 Working Days	90.00%	86.09%	76.35%
- Outpatient Letters Sent in 15 Working Days	100.00%	92.44%	91.58%

Safer Staffing(December 2015)

Ward name	Day		Night	
	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)
Audrey House Residential Rehabilitation	100.0%	100.0%	100.0%	100.0%
Child Bearing / Perinatal Inpatient	119.3%	134.7%	110.3%	148.6%
CTC Residential Rehabilitation	100.8%	97.8%	100.0%	101.6%
Enhanced Care Ward	104.8%	85.5%	78.3%	123.2%
Hartington Unit Morton Ward Adult	97.8%	108.6%	82.8%	136.4%
Hartington Unit Pleasley Ward Adult	102.7%	105.6%	104.8%	95.3%
Hartington Unit Tansley Ward Adult	88.0%	117.4%	70.0%	148.9%
Kedleston Unit - Curzon Ward	86.2%	106.8%	100.0%	100.0%
Kedleston Unit - Scarsdale Ward	97.5%	100.0%	100.0%	100.0%
KW Cubley Court Female	101.9%	97.5%	90.0%	100.8%
KW Cubley Court Male	99.4%	98.1%	90.0%	110.5%
LRCH Ward 1 OP	98.8%	97.4%	95.7%	100.0%
LRCH Ward 2 OP	103.5%	94.6%	95.7%	101.4%
RDH Ward 33 Adult Acute Inpatient	99.5%	98.7%	104.9%	105.7%
RDH Ward 34 Adult Acute Inpatient	101.6%	106.5%	51.6%	231.3%
RDH Ward 35 Adult Acute Inpatient	121.9%	114.4%	90.9%	131.8%
RDH Ward 36 Adult Acute Inpatient	101.1%	107.5%	77.3%	155.6%

IAPT Recovery Rates

Indicator name	Nov-15	Dec-15
Recovery Rates KPI 6 / (KPI 5 - KPI 6b)	50.00%	46.97%
Partial and Full Recovery Rates	67.97%	66.23%

Health Visitors

15-16 Health Visitor Dashboard	Target	Nov-15	Dec-15
% 10-14 Day Breastfeeding coverage	95.00%	96.90%	98.30%
% 6-8 Week Breastfeeding coverage	95.00%	99.70%	96.50%
% Still Breastfeeding at 6-8 Weeks	65.00%	66.10%	73.80%

Variance Commentary

Indicator	Target	Over/under Performance	Rationale for Variance	Actions	Confidence in Actions
CPA 7 Day Follow up	95%	Under	Unable to make contact with patients	Inpatient-specific dashboard to be developed by performance team by mid-February 2016 to enable closer monitoring of this issue and alternative solutions to making contact to be considered	Medium
Patients clustered regardless of Review Dates	96%	Under	Patients not cluster and clusters not reviewed to required timescale	Working with teams to address under-performance and increasing training.	Low
Consultant Outpatient did not attends	15%	Under	Patients missing appointments without giving prior notice	SMS Text opt out approach has recently been implemented.	Medium
Outpatient Letters	100% in 15 days and 90% in 10 days	Under	Letters not completed to agreed timescales	To implement and monitor the agreed action plan against recovery trajectory	Medium
Safer Staffing	Between 90% and 125 % of planned roster	Under	Staff vacancies and increased observations	Recruitment currently underway. Ongoing work to migrate the source from Safer Staffing solution to eRostering.	Medium

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

Introduction

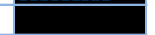
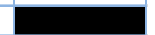
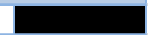
The following Performance Compliance report is organised into the following sections;

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

1 Trust Performance Dashboard

Key to colour coding	
Compliant with target	
Target exception	

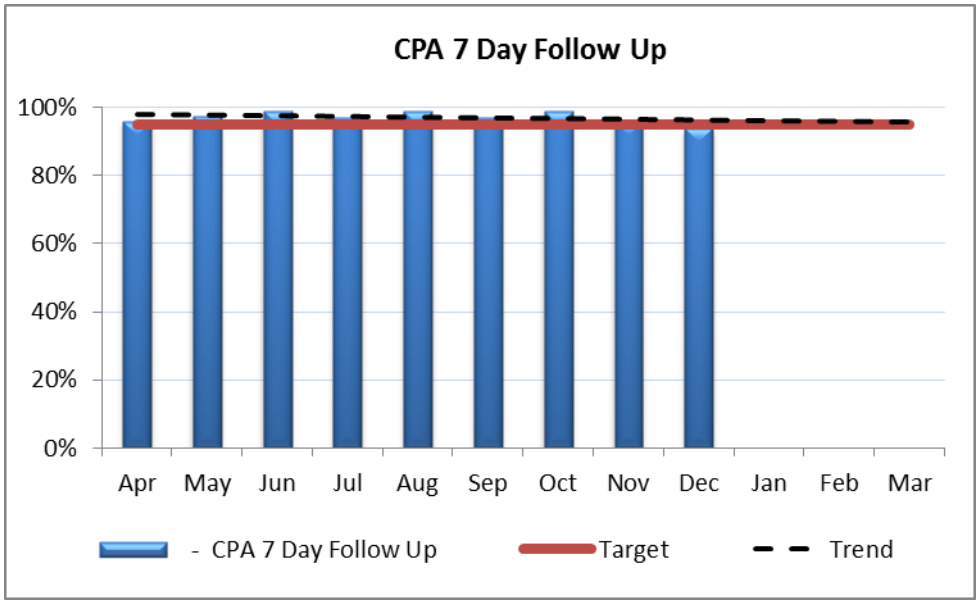
15-16 Performance Dashboard	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Trend
- Monitor Targets														
- CPA 7 Day Follow Up	95.00%	96.15%	97.59%	99.16%	97.22%	98.96%	97.24%	99.13%	96.05%	93.94%				
- CPA Review in last 12 Months (on CPA > 12 Months)	95.00%	96.84%	96.39%	96.41%	96.34%	96.68%	96.26%	95.73%	94.95%	95.21%				
- Delayed Transfers of Care	7.50%	0.75%	0.67%	0.68%	0.69%	0.41%	0.35%	0.79%	1.59%	2.18%				
- Data Completeness: Identifiers	97.00%	99.29%	99.27%	99.36%	99.38%	99.39%	99.42%	99.36%	99.34%	99.35%				
- Data Completeness: Outcomes	50.00%	94.21%	93.74%	93.49%	93.57%	93.73%	94.04%	94.90%	94.97%	95.01%				
- Community Care Data - Activity Information Completeness	50.00%	91.48%	91.34%	91.05%	90.95%	90.87%	90.88%	91.41%	91.25%	91.31%				
- Community Care Data - RTT Information Completeness	50.00%	92.31%	92.31%	92.31%	92.31%	92.31%	92.31%	92.31%	92.31%	92.31%				
- Community Care Data - Referral Information Completeness	50.00%	73.12%	72.78%	72.74%	73.03%	72.68%	72.17%	72.40%	72.18%	71.56%				
- 18 Week RTT Less Than 18 Weeks - Incomplete	92.00%	95.65%	95.12%	96.47%	95.84%	96.30%	94.41%	96.26%	96.89%	96.44%				
- Early Interventions New Caseloads	95.00%	163.60%	130.40%	126.50%	119.60%	115.80%	108.70%	107.80%	100.00%	102.90%				
- Clostridium Difficile Incidents	7	0	0	0	0	0	0	0	0	0				
- Crisis GateKeeping	95.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				
- IAPT Referral to Treatment within 18 weeks	95.00%	99.44%	99.41%	99.48%	99.05%	98.98%	99.01%	99.51%	99.38%	99.61%				
- IAPT Referral to Treatment within 6 weeks	75.00%	89.22%	86.67%	85.84%	87.96%	91.22%	89.62%	91.79%	93.69%	94.51%				
- Locally Agreed														
- CPA Settled Accommodation	90.00%	99.28%	99.14%	98.95%	98.91%	98.87%	98.54%	98.18%	97.97%	97.56%				
- CPA Employment Status	90.00%	99.44%	99.30%	99.26%	99.23%	99.12%	98.89%	98.67%	98.49%	98.33%				
- Data Completeness: Identifiers	99.00%	99.29%	99.27%	99.36%	99.38%	99.39%	99.42%	99.36%	99.34%	99.35%				
- Data Completeness: Outcomes	90.00%	94.21%	93.74%	93.49%	93.57%	93.73%	94.04%	94.90%	94.97%	95.01%				
- Patients Clustered not Breaching Today	80.00%	74.74%	75.11%	75.48%	75.60%	76.07%	76.86%	78.48%	80.54%	80.70%				
- Patients Clustered Regardless of Review Dates	96.00%	95.55%	95.43%	95.04%	94.82%	94.75%	94.56%	94.75%	94.80%	94.67%				
- CPA HoNOS Assessment in last 12 Months	90.00%	81.84%	80.59%	80.01%	80.38%	81.09%	82.84%	86.51%	87.21%	88.05%				
- 7 Day Follow Up – All Inpatients	95.00%	95.90%	97.80%	98.55%	97.76%	97.35%	96.97%	98.43%	93.26%	94.50%				
- Ethnicity Coding	90.00%	94.48%	95.50%	95.96%	95.52%	95.21%	94.62%	93.72%	92.80%	91.34%				
- NHS Number	99.00%	99.86%	99.93%	99.95%	99.96%	99.97%	99.97%	99.98%	99.98%	99.98%				

15-16 Performance Dashboard	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Trend
- Schedule 4 Contract														
- Consultant Outpatient Appointments Trust Cancellations (Within 6 Weeks)	5.00%	3.25%	2.74%	4.45%	3.56%	5.95%	5.14%	6.05%	3.56%	3.41%				
- Consultant Outpatient Appointments DNAs	15.00%	16.07%	15.79%	17.22%	17.67%	15.79%	16.61%	15.08%	16.18%	16.93%				
- Under 18 Admissions To Adult Inpatient Facilities	0	0	0	0	0	0	0	0	0	0				
- Outpatient Letters Sent in 10 Working Days	90.00%	78.12%	69.23%	72.35%	65.98%	58.39%	57.10%	73.69%	86.09%	76.35%				
- Outpatient Letters Sent in 15 Working Days	100.00%	88.38%	85.65%	87.26%	85.70%	85.11%	83.51%	89.26%	92.44%	91.58%				
- Average Community Team Waiting Times (Weeks)	N/A	6.27	6.18	5.79	5.49	5.65	5.45	4.86	4.86	4.91				
- Inpatient 28 Day Readmissions	10.00%	11.97%	5.88%	5.44%	11.84%	10.40%	10.34%	16.44%	7.75%	7.14%				
- MRSA - Blood Stream Infection	0	0	0	0	0	0	0	0	0	0				
- Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0				
- 18 Week RTT Greater Than 52 weeks	0	0	0	0	0	0	0	0	0	0				
- Discharge Fax Sent in 2 Working Days	98.00%	98.52%	98.96%	97.04%	98.67%	100.00%	98.68%	99.17%	100.00%	100.00%				
- Fixed Submitted Returns														
18 Week RTT Greater Than 52 weeks	0	0	0	0	0	0	0	0	0	0				
18 Week RTT Less Than 18 weeks - Incomplete	92.00%	93.66%	92.94%	94.48%	94.35%	95.00%	94.48%	96.90%	98.18%	96.74%				
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0				
Completion of IAPT Data Outcomes	90.00%	98.33%	97.65%	96.35%	96.66%	98.36%	97.36%	98.36%	94.47%	95.68%				
Ethnicity Coding	90.00%	93.62%	94.75%	95.64%	95.26%	95.10%	94.67%	94.05%	93.54%	91.85%				
NHS Number	99.00%	100.00%	100.00%	99.99%	99.99%	99.99%	99.77%	99.99%	100.00%	99.99%				

1.1 Exception Items and Specific Areas of Interest

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

1.1.1 Monitor – CPA 7 Day Follow Up



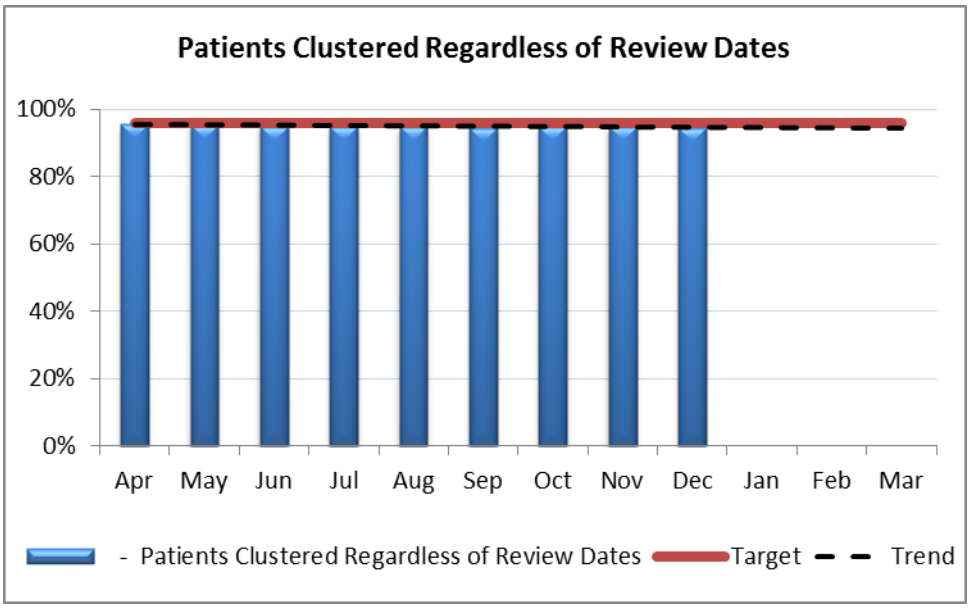
A number of exceptional circumstances have arisen over the course of December, specifically;

- Patient arrested on day of discharge and remanded to Prison
- Advised by probation that patient was now of no fixed address and that due to risk history it would not be appropriate to follow up in community. Probation advised they had seen him and had no major concerns regarding his current safety
- Patient admitted for a period of assessment and during admission period no evidence of mental illness
- Patient returned to Poland after discharge to continue his recovery

Action planned:

- Inpatient-specific dashboard to be developed by the performance team by mid-February 2016 to enable closer monitoring of this issue
- Initial Service Management Review (ISMR) is being done for those where no contact has been made and alternative solutions to be considered for other exceptions such as:
    - telephone call to father in Poland to confirm patient ok
    - telephone call to Prison to ascertain patient safety or our prison in reach team to liaise with prison in reach team to ascertain patient safety
    - do joint visit with probation to minimise risk and assure patient safety

1.1.2 Locally Agreed – Patients clustered regardless of Review Dates



The Payment by Results Advisor continues to work with teams and individuals offering training, support and advice. We are taking the opportunity of the WorkPro road-test to emphasise the importance of timely and accurate clustering. We highlight the importance of Clusters for understanding demand and in the commissioning of relevant training.

We now have an added driver to improve compliance in that monitor are pressing for outcomes-based payment systems to be introduced. In light of this we are implementing performance management for cluster compliance

Medical Director's Bulletin December 2015 briefed the medical staff regarding these new Monitor clustering requirements and has resulted in the Payment by Results Advisor receiving more requests for help and support with clustering

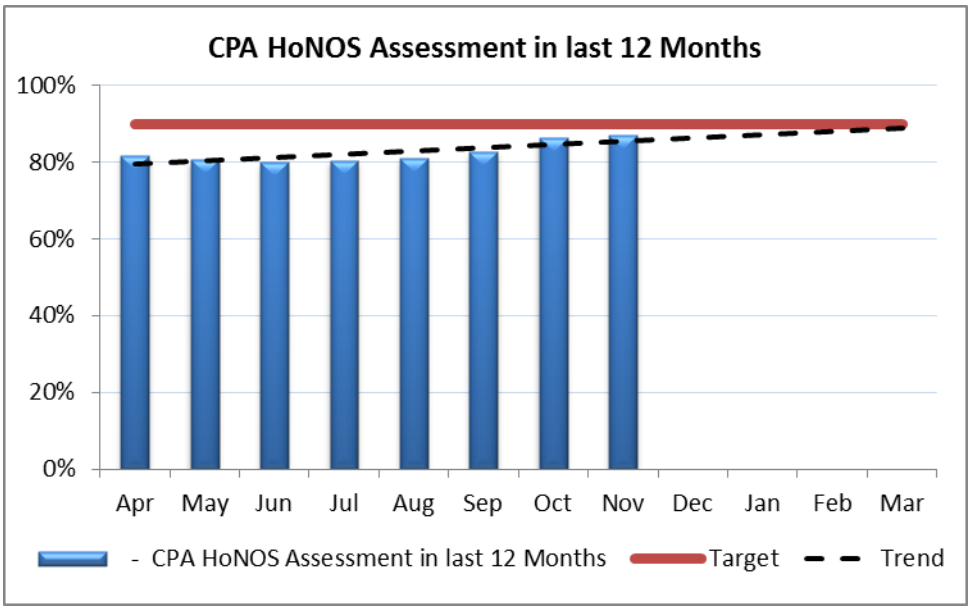
An e-learning package on mental health currencies and payment was recently developed and went live on 12th January 2016.

The position continues to improve.

Action planned: There are solutions being deployed on an ongoing basis:

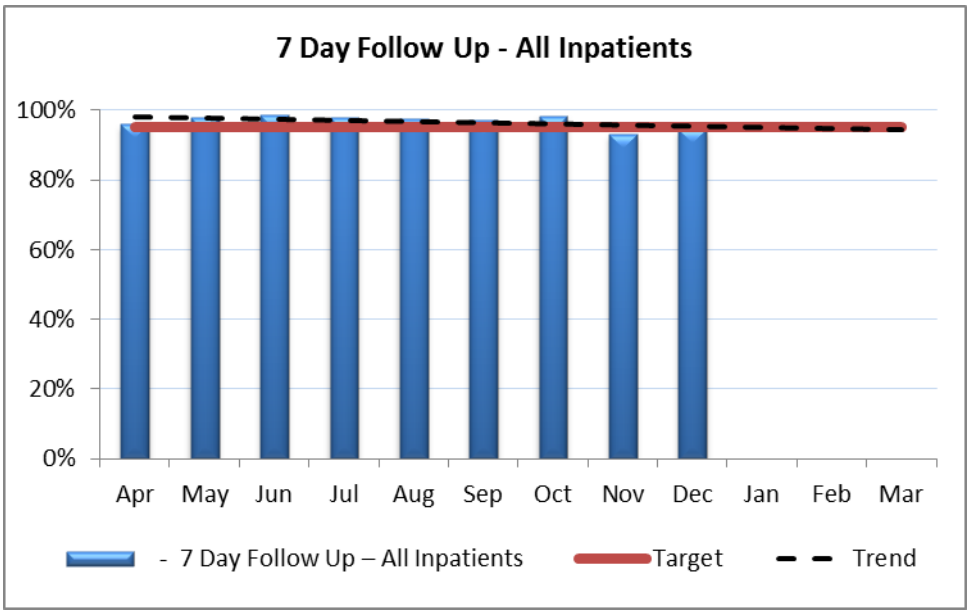
- To data cleanse
- Make improvements in practitioner clustering
- Highlight to staff responsible for clustering the issues needing to be resolved
- Monitoring performance
- Team based training

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



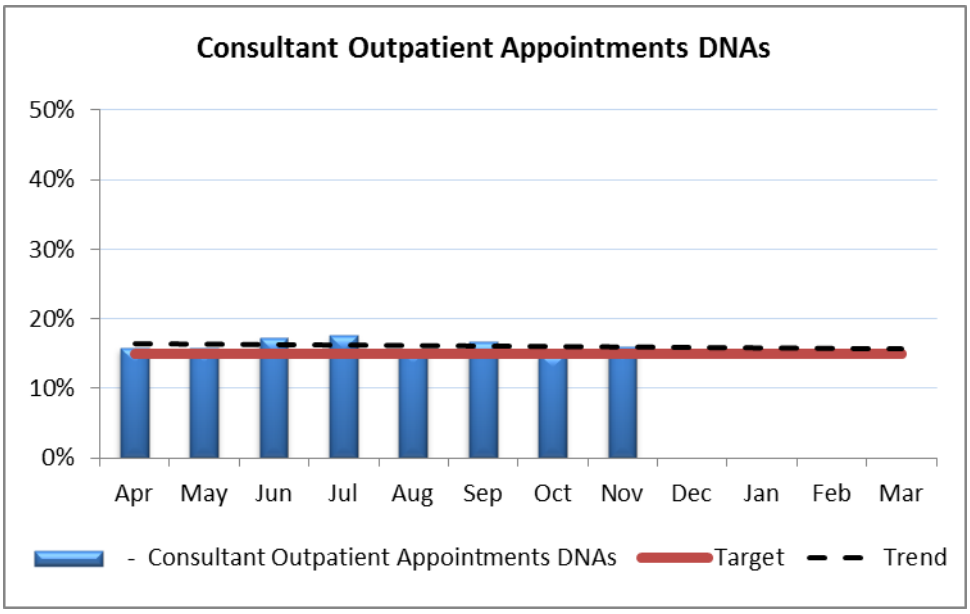
Health of the Nation Outcome Score assessments are part of clustering so by improving the clustering position we will improve the Health of the Nation Outcome Score assessments position by default. Please see comments and action plan in section 1.1.2

1.1.4 Locally Agreed – 7 Day Follow up All Inpatients



Please see comments and action plan in CPA 7 Day Follow Up section 1.1.1

1.1.5 Schedule 4 – Consultant Outpatient Did Not Attends

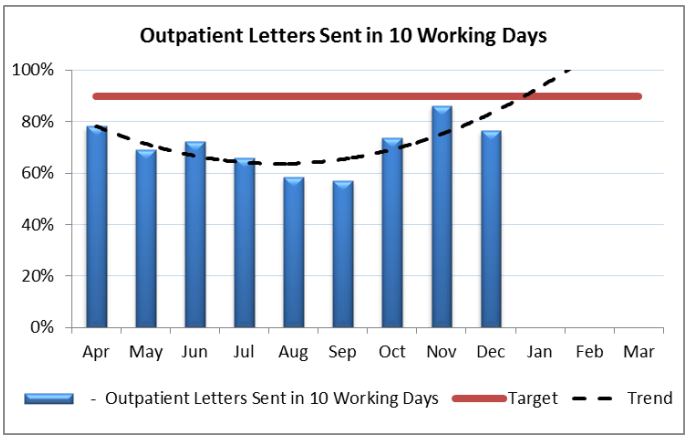


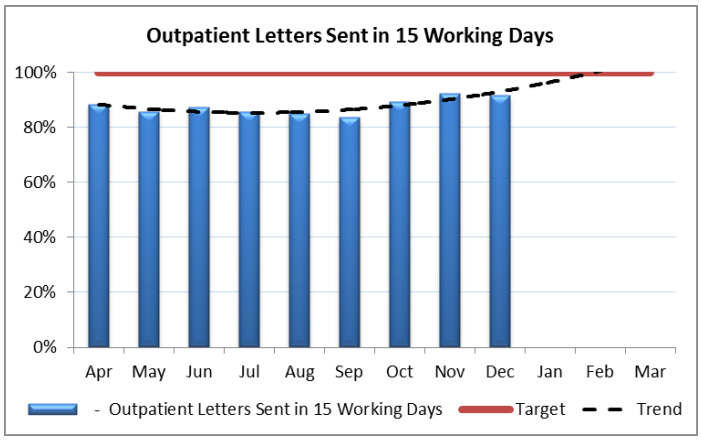
The recent transition from opt-out to opt-in text message reminders should gradually start to have an impact over the coming months

Action Planned:

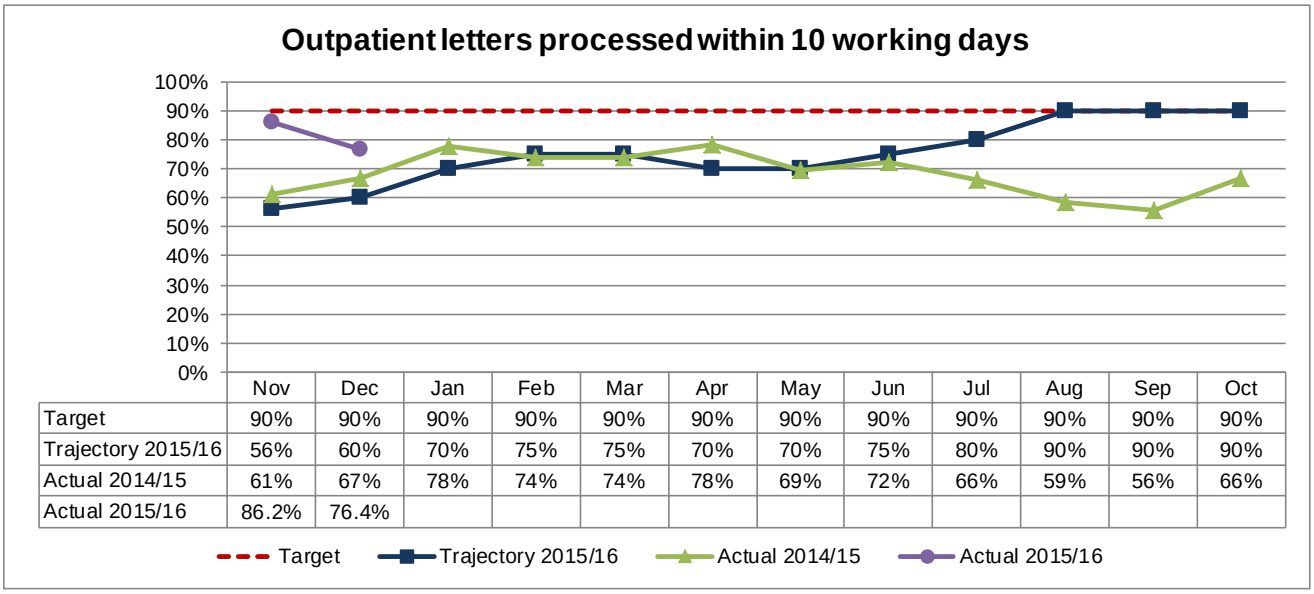
- Text message reminders to be sent to everyone who has not opted out.
- To continue to encourage admin staff in outpatients and clinical staff on community visits to collect and record mobile phone numbers and to check that the mobile number we have is still correct.
- To add a paragraph to the computer-generated appointment letters which asks the patient to call us fi the mobile number we hold is no longer current.
- Add information in the Medical Director's Bulletin to ask Doctors to telephone clients who do not attend so patient safety/wellbeing is established and a contact is recorded

1.1.6 Schedule 4 –Outpatient Letters





The action plan is being implemented. We continue to perform above trajectory, although there was a dip in December as expected owing to Christmas.



	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Trajectory 2015/16	56%	60%	70%	75%	75%	70%	70%	75%	80%	90%	90%	90%
Actual 2014/15	61%	67%	78%	74%	74%	78%	69%	72%	66%	59%	56%	66%
Actual 2015/16	86.2%	76.4%										

Action planned:

- To continue to implement and monitor the action plan against recovery trajectory

2 Health Visitor Dashboard

2.1 Key Performance Indicators

15-16 Health Visitor Dashboard	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Health Visitors (FTE) in Post ESR	N/A	69.85	68.72	67.65	67.36	67.36	71.07	71.88	70.21	71.21			
Health Visitors in Post (Headcount)	N/A	82	81	80	79	79	83	84	82	83			
Number of Student Placements (Headcount)	N/A	9	9	9	9	9	11	11	11	11			
Number of Student Placements (FTE)	N/A	9	9	9	9	9	11	11	11	11			
Number of mothers receiving antenatal check	N/A	195	152	204	226	167	197	189	172	122			
% Births that receive NBV within 10-14 days	N/A	88.00%	88.41%	92.00%	91.47%	92.84%	87.94%	91.50%	92.93%	90.94%			
% NBVs undertaken after 15 days	N/A	12.00%	10.20%	8.00%	6.10%	6.00%	9.90%	7.30%	6.10%	5.90%			
% Children who received a 3-4 month review	N/A	5.30%	11.40%	7.80%	9.60%	9.50%	6.90%	9.60%	11.70%	9.50%			
% Children who received a 12 month review	N/A	97.70%	98.40%	98.20%	97.60%	98.20%	98.00%	97.30%	96.60%	96.70%			
% Children who received a 12 month review at 15 months	N/A	97.50%	95.10%	97.30%	97.70%	98.40%	98.20%	98.80%	98.20%	97.70%			
% Children who received a 2 to 2.5 year review	N/A	94.90%	95.40%	97.60%	98.50%	97.70%	98.40%	97.60%	98.00%	93.90%			
% Staff who have received child protection training	N/A	63.40%	63.00%	62.50%	63.30%	63.30%	61.40%	60.70%	59.80%	60.20%			
% 10-14 Day Breastfeeding coverage	95.00%	99.00%	99.00%	98.50%	99.00%	99.40%	98.20%	95.90%	96.90%	98.30%			
% 6-8 Week Breastfeeding coverage	95.00%	100.00%	99.70%	100.00%	99.20%	97.40%	99.40%	99.30%	99.70%	96.50%			
% Still Breastfeeding at 6-8 Weeks	65.00%	65.10%	70.40%	71.70%	72.90%	62.70%	66.90%	69.90%	66.10%	73.80%			

2.1.1 Exception Comments

No exceptions

3 IAPT Services Dashboard

3.1 Dashboard

Total Derbyshire CCSs AQP KPI and Activity Data 2015/16

Indicator no.	Indicator name	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
3a	The number of people who have been referred for Psychological Therapies (during the reporting quarter)	997	936	966	1132	931	1200	1173	1177	855	0	0	0	9367
3b	The number of active referrals who have waited more than 28 days for treatment	427	384	352	266	251	274	336	499	570	0	0	0	
4	The number of people who have entered Psychological Therapies	817	733	855	861	753	882	762	890	716	0	0	0	7269
5	The number of people who have completed treatment (for any reason)	535	511	577	629	488	606	606	646	505	0	0	0	5103
6	The number of people who are "moving to recovery"	274	253	313	294	249	316	288	295	217	0	0	0	2499
6b	The number of people completing treatment who did not achieve caseness at the commencement of treatment	38	51	38	48	48	50	51	56	43	0	0	0	423
7	The number of people moving off sick pay and benefits	35	40	45	42	42	54	53	49	36	0	0	0	396

	Recovery Rates KPI 6 / (KPI 5 - KPI 6b)	**55.13%**	**55.00%**	**58.07%**	**50.60%**	**56.59%**	**56.83%**	**51.89%**	**50.00%**	**46.97%**				**53.40%**
	Partial and Full Recovery Rates	**75.45%**	**72.17%**	**75.32%**	**68.50%**	**72.05%**	**74.64%**	**68.83%**	**67.97%**	**66.23%**				**71.20%**

3.1.1 Exception Comments

Year to date we are exceeding target at 53.4% against a target of 50%. The December rate dropped below target at 46.97%. The reason for this is that we took a deliberate decision to do more single sessions of treatment at step 2 for people who were being moved to wit list or signposted out so as to boost the number of completed treatments at step 2 as a proportion of all treatments. This has a direct and anticipated negative impact on recovery rates. This step was taken to reduce the income reduction at step 2 that we would otherwise have seen in December.

Action planned to drive up improvement are focused on:

- Discontinued use of this strategy in the longer term
- Introduction of a severity cut off at step 2 with the new contract (April),

- Increasing the level of individual performance management of step 2 staff,
- Extension of step 2 computerised CBT service with a new sub-contractor being sought for the new contract.

4 Ward Safer Staffing

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

Key to colour coding	
Between 90% and 125%	
Under 90% or Over 125%	

Ward name	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
Audrey House Residential Rehabilitation	100.0%	100.0%	100.0%	100.0%	No	None required
Child Bearing / Perinatal Inpatient	119.3%	134.7%	110.3%	148.6%	Yes	We have broken the current fill rate tolerances for care staff due to cover for long term sickness absence, vacancy and patient/infant observation levels/activity.
CTC Residential Rehabilitation	100.8%	97.8%	100.0%	101.6%	No	None required
Enhanced Care Ward	104.8%	85.5%	78.3%	123.2%	Yes	NONE RECEIVED
Hartington Unit Morton Ward Adult	97.8%	108.6%	82.8%	136.4%	Yes	The reason for the shortfall of registered nurses on night duty is that we are still carrying 4.36 Band 5 vacancies on Morton ward, also x 1 Band 6 is redeployed to Pleasley ward to act up as a Band 7 and x 1 Band 6 is currently on maternity leave. I am also acting one of the band 5s into the band 6 role, hence not always able to put x2 qualified staff on the night shift.
Hartington Unit Pleasley Ward Adult	102.7%	105.6%	104.8%	95.3%	No	None required
Hartington Unit Tansley Ward Adult	88.0%	117.4%	70.0%	148.9%	Yes	Tansley continues to carry band 5 vacancies (5.6) of which 3.6 are currently appointable. Recruitment is on-going. As such the ward is unable place x2 registered nurses on nights and relies on backfilling with both bank registered and non registered staff, predominantly non registered. The ward has also had to increase staffing throughout much of December due to increased levels and general clinical activity.

Ward name	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
Kedleston Unit - Curzon Ward	86.2%	106.8%	100.0%	100.0%	Yes	NONE RECEIVED
Kedleston Unit - Scarsdale Ward	97.5%	100.0%	100.0%	100.0%	No	None required
KW Cubley Court Female	101.9%	97.5%	90.0%	100.8%	No	None required
KW Cubley Court Male	99.4%	98.1%	90.0%	110.5%	No	None required
LRCH Ward 1 OP	98.8%	97.4%	95.7%	100.0%	No	None required
LRCH Ward 2 OP	103.5%	94.6%	95.7%	101.4%	No	None required
RDH Ward 33 Adult Acute Inpatient	99.5%	98.7%	104.9%	105.7%	No	None required
RDH Ward 34 Adult Acute Inpatient	101.6%	106.5%	51.6%	231.3%	Yes	We continue to not meet safer staffing requirements due to ongoing vacancies for registered nurses
RDH Ward 35 Adult Acute Inpatient	121.9%	114.4%	90.9%	131.8%	Yes	Our ward broke the fill rates for care staff due to having high observation levels over a sustained period.
RDH Ward 36 Adult Acute Inpatient	101.1%	107.5%	77.3%	155.6%	Yes	Our ward broke the fill rates for care staff due to having high observation levels over a sustained period.

Action planned:

- Ongoing work to migrate the source from Safer Staffing solution to eRostering.

4.1.1 Safer Staffing Six months Review

Ward Staffing Monthly Fill Rates

> 125%

< 90%

Ward	Shift	Resource	Jul-2015 Complete	Aug-2015 Complete	Sep-2015 In Progress	Oct-2015 In Progress	Nov-2015 In Progress	Dec-2015 In Progress
AUDREY HOUSE RESIDENTIAL REHABILITATION	Day	Average fill rate - registered nurses/midwives (%)	98.85%	100%	96.47%	100%	100.95%	100%
		Average fill rate - care staff (%)	97.96%	100%	101.04%	100%	101.22%	100%
	Night	Average fill rate - registered nurses/midwives (%)	100%	100%	100%	100%	100%	100%
		Average fill rate - care staff (%)	108.33%	100%	100%	100%	110.34%	100%
CTC RESIDENTIAL REHABILITATION	Day	Average fill rate - registered nurses/midwives (%)	102.19%	97.74%	100%	98.45%	96.72%	100.78%
		Average fill rate - care staff (%)	99.43%	98.24%	97.16%	98.88%	101.14%	97.78%
	Night	Average fill rate - registered nurses/midwives (%)	100%	100%	100%	100%	103.33%	100%
		Average fill rate - care staff (%)	98.44%	101.64%	100%	100%	100%	101.59%
ENHANCED CARE WARD	Day	Average fill rate - registered nurses/midwives (%)	84.41%	77.17%	70.79%	74.19%	96.67%	104.84%
		Average fill rate - care staff (%)	105.38%	116.32%	110.93%	118.42%	90.86%	85.48%
	Night	Average fill rate - registered nurses/midwives (%)	90%	88.71%	88.14%	90%	87.27%	78.33%
		Average fill rate - care staff (%)	116.92%	123.44%	109.72%	104.48%	116.18%	123.19%
HARTINGTON UNIT - MORTON WARD ADULT	Day	Average fill rate - registered nurses/midwives (%)	93.99%	107.07%	100%	97.8%	95.35%	97.79%
		Average fill rate - care staff (%)	108.21%	89.92%	96.03%	104.84%	105.93%	108.63%
	Night	Average fill rate - registered nurses/midwives (%)	80.43%	71.15%	70.59%	78.57%	76.92%	82.76%
		Average fill rate - care staff (%)	129.41%	136.96%	148.65%	140.54%	120.83%	136.36%
HARTINGTON UNIT - PLEASLEY WARD ADULT	Day	Average fill rate - registered nurses/midwives (%)	92.43%	90.37%	101.66%	93.01%	108.89%	102.69%
		Average fill rate - care staff (%)	104.03%	112.31%	95.04%	103.91%	89.17%	105.65%
	Night	Average fill rate - registered nurses/midwives (%)	106.25%	109.38%	115.63%	122.58%	122.58%	104.76%
		Average fill rate - care staff (%)	98.36%	96.77%	91.53%	90.32%	90.48%	95.31%
HARTINGTON UNIT - TANSLEY WARD ADULT	Day	Average fill rate - registered nurses/midwives (%)	93.6%	93.41%	94.3%	90.75%	82.24%	87.97%
		Average fill rate - care staff (%)	94.33%	104.2%	108.63%	113.33%	113.19%	117.42%
	Night	Average fill rate - registered nurses/midwives (%)	72.88%	74%	66%	65.45%	61.54%	70%
		Average fill rate - care staff (%)	134.15%	128%	134.69%	146.34%	168.42%	148.94%
KEDLESTON UNIT - CURZON WARD	Day	Average fill rate - registered nurses/midwives (%)	99.19%	103.1%	101.68%	100%	95%	86.18%
		Average fill rate - care staff (%)	98.47%	98.46%	99.18%	100.79%	102.34%	106.77%
	Night	Average fill rate - registered nurses/midwives (%)	103.23%	100%	103.33%	100%	100%	100%
		Average fill rate - care staff (%)	101.64%	101.45%	98.25%	100%	100%	100%

Ward Staffing Monthly Fill Rates

> 125%

< 90%

Ward	Shift	Resource	Jul-2015 Complete	Aug-2015 Complete	Sep-2015 In Progress	Oct-2015 In Progress	Nov-2015 In Progress	Dec-2015 In Progress
KEDLESTON UNIT - SCARSDALE WARD	Day	Average fill rate - registered nurses/midwives (%)	99.2%	102.42%	97.5%	91.94%	96.64%	97.54%
		Average fill rate - care staff (%)	100%	95.24%	96.69%	103.91%	103.33%	100%
	Night	Average fill rate - registered nurses/midwives (%)	103.23%	103.33%	100%	100%	100%	100%
		Average fill rate - care staff (%)	96.61%	100%	100%	98.39%	100%	100%
KINGSWAY CUBLEY COURT - FEMALE	Day	Average fill rate - registered nurses/midwives (%)	104.76%	103.92%	107.69%	114.45%	103.62%	101.95%
		Average fill rate - care staff (%)	92.71%	95.07%	94.24%	90.91%	96.09%	97.54%
	Night	Average fill rate - registered nurses/midwives (%)	90.48%	97.62%	97.22%	90.74%	93.88%	90%
		Average fill rate - care staff (%)	107.21%	100.82%	99.24%	100%	101.9%	100.81%
KINGSWAY CUBLEY COURT - MALE	Day	Average fill rate - registered nurses/midwives (%)	100.68%	99.29%	97.84%	100%	100%	99.43%
		Average fill rate - care staff (%)	93.93%	95.36%	95.85%	99.25%	99.19%	98.15%
	Night	Average fill rate - registered nurses/midwives (%)	95.83%	96.08%	91.84%	89.83%	86.79%	90%
		Average fill rate - care staff (%)	101.65%	100%	103.92%	101.74%	105.1%	110.53%
KINGSWAY MELBOURNE HOUSE	Day	Average fill rate - registered nurses/midwives (%)	95.08%	88.62%	99.17%	92.68%	80.88%	N/A
		Average fill rate - care staff (%)	94.19%	99.44%	98.16%	98.8%	104.82%	N/A
	Night	Average fill rate - registered nurses/midwives (%)	88.33%	83.87%	78.33%	85.25%	71.88%	N/A
		Average fill rate - care staff (%)	106.1%	115.71%	117.91%	117.74%	124.24%	N/A
KINGSWAY TISSINGTON UNIT - OLDER PEOPLE	Day	Average fill rate - registered nurses/midwives (%)	96.15%	102.76%	98.43%	N/A	N/A	N/A
		Average fill rate - care staff (%)	92.74%	87.89%	91.28%	N/A	N/A	N/A
	Night	Average fill rate - registered nurses/midwives (%)	86.89%	91.94%	89.66%	N/A	N/A	N/A
		Average fill rate - care staff (%)	107.59%	97.83%	101.96%	N/A	N/A	N/A
LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP	Day	Average fill rate - registered nurses/midwives (%)	102.78%	101.79%	101.24%	103.09%	101.32%	98.78%
		Average fill rate - care staff (%)	96.64%	97.69%	96.24%	99.25%	100%	97.41%
	Night	Average fill rate - registered nurses/midwives (%)	88.46%	94.44%	91.67%	90.57%	92.45%	95.74%
		Average fill rate - care staff (%)	103.13%	100%	112.7%	105.26%	108%	100%
LONDON ROAD COMMUNITY HOSPITAL - WARD 2 OP	Day	Average fill rate - registered nurses/midwives (%)	98.52%	96.38%	100%	97.93%	100%	103.52%
		Average fill rate - care staff (%)	97.92%	100%	102.21%	100.68%	101.29%	94.56%
	Night	Average fill rate - registered nurses/midwives (%)	100%	94.74%	97.37%	94.59%	100%	95.65%
		Average fill rate - care staff (%)	109.09%	101.75%	100%	96.88%	100%	101.45%

Ward Staffing Monthly Fill Rates

> 125%

< 90%

Ward	Shift	Resource	Jul-2015 Complete	Aug-2015 Complete	Sep-2015 In Progress	Oct-2015 In Progress	Nov-2015 In Progress	Dec-2015 In Progress
PERINATAL PSYCHIATRY INPATIENT	Day	Average fill rate - registered nurses/midwives (%)	130.65%	118.75%	119.12%	106.15%	107.25%	119.3%
		Average fill rate - care staff (%)	158.23%	161.46%	136.36%	127.62%	127.66%	134.65%
	Night	Average fill rate - registered nurses/midwives (%)	110.71%	103.33%	107.14%	100%	103.33%	110.34%
		Average fill rate - care staff (%)	200%	234.48%	160%	127.5%	154.55%	148.65%
RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT	Day	Average fill rate - registered nurses/midwives (%)	98.33%	97.18%	97.01%	95.88%	101.89%	99.49%
		Average fill rate - care staff (%)	96%	103.33%	103.8%	104.76%	98.22%	98.66%
	Night	Average fill rate - registered nurses/midwives (%)	94.74%	93.48%	97.87%	97.56%	102.86%	104.88%
		Average fill rate - care staff (%)	102.82%	100%	103.13%	122.86%	100%	105.71%
RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT	Day	Average fill rate - registered nurses/midwives (%)	94.62%	100.54%	84.83%	90.32%	91.67%	101.61%
		Average fill rate - care staff (%)	111.28%	100.76%	122.48%	133.58%	116.06%	106.45%
	Night	Average fill rate - registered nurses/midwives (%)	55.74%	50%	50%	51.61%	58.33%	51.61%
		Average fill rate - care staff (%)	171.43%	221.88%	254.84%	247.62%	213.51%	231.25%
RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT	Day	Average fill rate - registered nurses/midwives (%)	95.21%	86.26%	105.96%	104.81%	111.64%	121.93%
		Average fill rate - care staff (%)	107.38%	121.88%	99.34%	75.46%	90.32%	114.39%
	Night	Average fill rate - registered nurses/midwives (%)	103.23%	86.05%	100%	121.88%	88%	90.91%
		Average fill rate - care staff (%)	98.39%	139.22%	134.33%	117.14%	113.75%	131.82%
RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT	Day	Average fill rate - registered nurses/midwives (%)	102.6%	107.18%	99.48%	103.09%	102.12%	101.06%
		Average fill rate - care staff (%)	100.71%	85.25%	91.94%	103.73%	97.52%	107.48%
	Night	Average fill rate - registered nurses/midwives (%)	108.82%	118.75%	79.55%	94%	80.43%	77.27%
		Average fill rate - care staff (%)	116.42%	98.33%	136.73%	122.92%	125%	155.56%

It can be clearly seen that some wards are having to compensate for gaps in registered staff with other care staff. Morton, Tansley, Perinatal, and Ward 34 consistently seem to require more staff than planned.

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 27 January 2016

Finance Director's Report Month 9

Purpose of Report

This paper provides the Trust Board with an update on financial performance against our operational financial plan as at the end of December 2015.

Recommendations

The Board of Directors is requested to:

1) Consider the content of the paper and consider their level of assurance on the current and forecast financial performance for 2015/16.
2) To note the Monitor agency rule overrides for December.

Executive Summary

- There is a favourable performance at the end of December, we are ahead of plan by £1.2m with a current surplus of £2m, and the forecast is to exceed the planned surplus of £1.3m by £0.5m. However there continue to be both cost and income pressures within the financial forecast for the coming months.

- The forecast necessarily includes a set of assumptions based on knowledge and expectations at this point in time. There remains a large performance range from worst-case to best-case outturn which is primarily dependant on the successful mitigation of emerging risks. The range is shown in the chart.

- The Financial Sustainability Risk Rating is a 4 year to date and forecast to achieve a 4 at the end of the year.

- The forecast assumes continued full achievement of all CIP efficiencies, albeit with largely non-recurrent schemes. Due to the phasing of the replacement schemes the year to date CIP is now ahead of plan.

- Cash is currently above plan and is forecast to be slightly better than plan due to lower capital expenditure and increased surplus (some components of which are non-cash items).

- Capital expenditure is forecast to be less than plan at the end of the financial year due to the reprioritisation of schemes and revised start dates.

Monitor agency requirements:

1. 3% ceiling: The Trust expenditure on qualified agency nursing was 3.7% in December (i.e. an override of the qualified nursing agency expenditure ceiling of 3%).
2. Framework and Pay caps: We have overridden the framework and pay caps rule during November and December, which has been reported to Monitor on a weekly basis.

- The Finance and Performance Committee received a report in January from the acting Director of Operations describing the changes to systems and processes that have been, and are being, put in place for temporary staffing in response to the additional requirements from Monitor. This included the opportunity for the committee to consider ongoing assurance levels around these systems; including rostering and the approach to longer term workforce planning to prevent future overrides.

Strategic considerations

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

Board Assurances

This report should be considered in relation to the financial risk contained in the Board Assurance Framework 2015/16:

- 3a Risks to delivery of 15/16 financial plan.
  If not delivered, this could result in regulatory action due to breach of Provider Licence with Monitor.

Consultation

- The Executive Leadership Team discuss and agree the key assumptions contained in the forecast financial position and agreed risk management actions to enable delivery of the planned financial surplus.

- Finance and Performance Committee challenges key strategic aspects of financial performance and financial risks and receives additional financial performance information to support its assessment of assurance in financial plan delivery.

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

- Capital Action Team oversees delivery of the capital programme.

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

Governance or Legal issues

Monitor aspects:
The information reported this report is consistent with the information contained in the quarter 3 compliance return which is included in the Confidential Board of the January meeting for sign off.

The Trust has exceeded the qualified nursing agency expenditure ceiling of 3% as well as the framework and price cap rules for both November and December which has been reported to Monitor through the weekly submissions.

There are no other governance or legal exceptions to note.

Equality Delivery System

This report has a neutral impact on REGARDS groups.

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

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

FINANCIAL OVERVIEW
DECEMBER 2015

1. Overall Financial Performance

Income & Expenditure – key statistics

We have achieved an underlying surplus of £150k in the month of December which is £60k better than plan. Operational profitability as measured by EBITDA[1] is better than plan by £114k in the month. This equates to 7.2% of income compared to a plan of 6.1%.

Year to date the surplus continues to be ahead of plan by £1.2m. EBITDA year to date is ahead of plan by £1.4m which equates to 7.6% of income compared to a plan of 6.1%.

The forecast position is an underlying surplus, excluding impairments, of £1.8m which is better than plan by £0.5m. EBITDA is forecast to be ahead of plan by £646k which equates to 6.8% compared to the plan of 6.2%. This improvement is consistent with recent correspondence from NHS Improvement asking providers to seek to improve their 15/16 outturns wherever possible.

The reported forecast position is deemed to be the most "likely" outcome assuming the successful mitigation of risks in financial performance. The Trust Board's attention is drawn to the forecast range of outturns which illustrates best case and worse case scenarios.

STATEMENT OF COMPREHENSIVE INCOME	DEC 2015								
	Current Month			Year to Date			Forecast		
	Plan	Actual	Variance Fav (+) / Adv (-)	Plan	Actual	Variance Fav (+) / Adv (-)	Plan	Actual	Variance Fav (+) / Adv (-)
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical Income	10,117	10,041	(75)	91,414	89,890	(1,524)	121,914	120,352	(1,562)
Non Clinical Income	832	814	(18)	7,753	7,574	(179)	10,248	9,966	(282)
Pay	(8,187)	(7,919)	268	(73,865)	(71,537)	2,327	(98,335)	(95,740)	2,595
Non Pay	(2,098)	(2,158)	(60)	(19,294)	(18,538)	757	(25,646)	(25,752)	(105)
EBITDA	**663**	**778**	**114**	**6,008**	**7,389**	**1,381**	**8,181**	**8,827**	**646**
Depreciation	(283)	(299)	(15)	(2,550)	(2,656)	(106)	(3,389)	(3,393)	(5)
Impairment	(100)	0	100	(100)	(0)	100	(300)	(300)	(0)
Profit (loss) on asset disposals	0	0	0	0	31	31	0	31	31
Interest/Financing	(181)	(177)	4	(1,678)	(1,614)	64	(2,221)	(2,136)	85
Dividend	(108)	(152)	(43)	(975)	(1,105)	(130)	(1,300)	(1,559)	(259)
Net Surplus / (Deficit)	**(9)**	**150**	**160**	**705**	**2,045**	**1,340**	**971**	**1,469**	**499**
Technical adj - Impairment	(100)	0	100	(100)	(0)	100	(300)	(300)	(0)
UnderlyingSurplus / (Deficit)	**91**	**150**	**60**	**805**	**2,045**	**1,240**	**1,271**	**1,770**	**499**

- Clinical income was behind plan in the month by £75k increasing the year to date under achievement to £1.5m due to the continuation of two main drivers:
    - cost per case income is lower than planned due to lower activity levels and lower occupancy levels

[1] EBITDA = **E**arnings **B**efore **I**nterest, **T**ax, **D**epreciation and **A**mortisation. This is a measure of operational profitability

- service developments that were planned to start from the beginning of the year have started later on in the year, these have corresponding expenditure reductions.

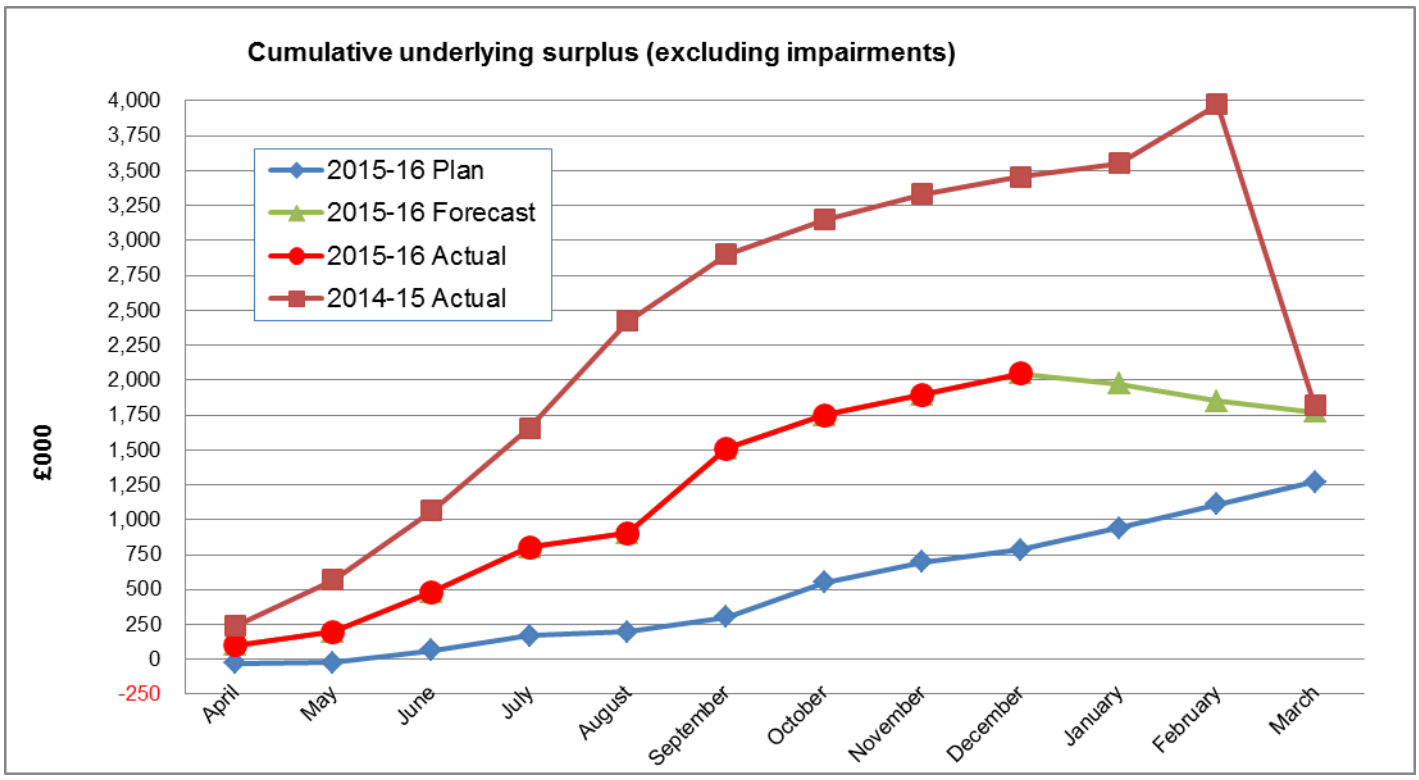
With the assumed levels of activity and occupancy, along with the start dates of service developments, clinical income is forecast to remain behind plan by £1.6m at the end of the financial year. This is an adverse movement of £0.3m on last month's forecast. The key risks to clinical income are achieving forecast cost per case income in light of updated transformation planning requirements and staffing levels.

- Non-clinical income is on plan in the month keeping the year to date adverse variance to £179k and is forecast to be behind plan by £282k. This is a slight improvement compared to last month. The underachievement of the forecast income relates to miscellaneous other income.

- Pay expenditure is underspent by £268k in the month which has increased the year to date underspend to £2.3m. The forecast of £2.6m is an adverse movement on last month's forecast of £0.2m. The main drivers within the forecast underspend are changes to staffing levels as a result of activity levels (offset by less income in some places), the later assumed start dates for service developments (less cost but also less income as above), unspent contingency reserves along with the balance of the budgeted pay-award funding now that all awards have been actioned.
  The key risks to pay expenditure performance are successfully containing the cost of temporary (particularly agency) staffing and capping the use of contingency reserves.

- Non pay expenditure is overspent in the month by £60k reducing the year to date underspend to £757k. This is mainly driven by the phasing of some of the replacement efficiency schemes which has a different phasing to the original plan. The forecast year end position is an adverse variance to plan of £105k which is an improvement of £0.3m. The forecast underspend is driven by additional expenditure forecast in the later part of the financial year and changes in CIP schemes between pay and non-pay. The main non pay risks are PICU cost-pressure containment and managing the use of contingency reserves.

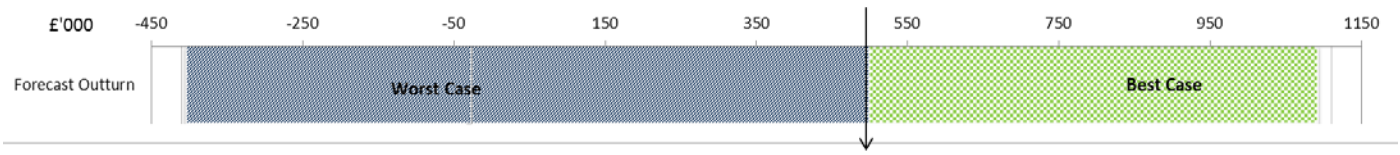
The graph below shows the cumulative underlying surplus for both actual and forecast compared to the plan, along with a comparison of the previous year's performance.



The forecast includes deficits for the next 3 months due to additional expenditure for one off requirements, which will reduce the current surplus down to £1.8m which remains ahead of the plan.

Forecast Range

Best Case	Likely Case	Worst Case
£1.1m favourable variance to plan	£0.5m favourable to plan	£0.4m adverse variance to plan



NB: Position of arrow shows current likely case forecast outturn

The best case of £1.1m better-than-plan assumes clinical income could improve, staff cost savings being reduced by different recruitment timings and current cost pressures improve sooner than in the likely case.

The worst case forecast includes an assumption that clinical income could worsen by £0.25m due to reductions in activity levels and delays in service developments. Other factors include increases in PICU out of area placement cost pressures and further continuation of other cost pressures for which improvements are assumed in the likely case.

It is important to note that the forecast range is based on an accumulation of either *all* the worst case or *all* best case scenarios happening together rather than a combination of a small group of scenarios.

What transpires in terms of actual financial performance will be a mixture of outcomes depending on risk crystallisation, the timing and success of the effect of management action, success of cost improvement delivery and any as-yet unforeseen events or pressures.

2. Regulatory Compliance

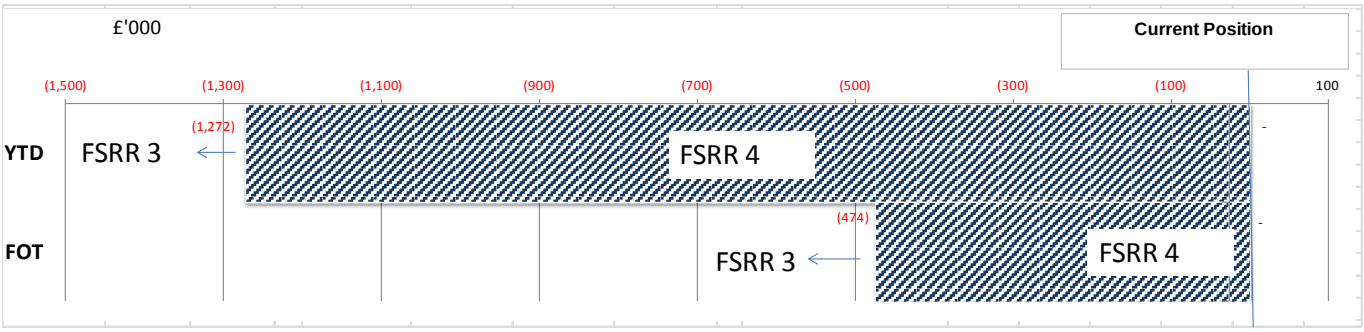
2.1 Financial Sustainability Risk Rating (FSRR)

Year to date our Financial Sustainability Risk Rating (FSRR) is an overall score of 4, with a 4 on three of the four individual metrics. The forecast FSRR is a 4 overall with a 4 on three of the individual metrics as shown below.

Financial Sustainability Risk Rating	**YTD Actual**	**Forecast**
Debt Service Cover	3	3
Liquidity	4	4
I&E Margin	4	4
I&E Margin Variance	4	4
Weighted Average	**3.75**	**3.75**
Overall FSRR	**4**	**4**

The headroom in £'000s, to a FSRR of 3 is shown in the chart below, both for year to date (YTD) and forecast outturn (FOT). This is for indicative use, based on a set of assumptions. It serves to illustrate the impact of improving or worsening revenue and cash, but there would be other variables that could also have an impact.

It is also important to note that if any individual FSRR metric scores at 1 then, regardless of the other metric score, Monitor operate an overriding rule to trigger investigation or regulatory action. It is no longer a simple average and rounding calculation.



The liquidity ratio measures the Trust's ability to pay its bills from its liquid assets in terms of days and therefore the higher the number of days, the better. At the end of December the number of days is +4.2 and is forecast to be +0.7 at the end of the financial year (which would generate a rating of 4 for that metric). The Trust Board is reminded that sector benchmarking information provided by external auditors illustrates that the peer average is nearer to +24 days, therefore our liquidity must remain a strategic priority for us to continue to improve. We expect to receive updated benchmarking soon, which will be incorporated into the analysis.

The Board are reminded that if significant financial risks materialise then our level of liquidity is a determining factor in whether we would be able to self-fund an unplanned deficit for any length of time. Current and forecast liquidity levels for 2015/16 would not support that at this stage.

2.2 Agency Nursing Rules

2.2.1 Qualified Agency Nurse ceiling

The cost ceiling for our Trust is 3%, which is based on the Trust average for last financial year. For December we have exceeded the ceiling with qualified nursing agency expenditure of 3.7%, however this is a significant improvement on the earlier months of the financial year.

2015-16 £'000s	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Total
Total qualified nursing	3,037	3,134	2,914	2,941	3,044	2,927	2,922	2,922	3,015	26,857
Agency qualified nursing	164	171	116	139	199	112	135	93	110	1,240
	5.4%	5.5%	4.0%	4.7%	6.6%	3.8%	4.6%	3.2%	3.7%	4.6%

2.2.2 Framework and price cap

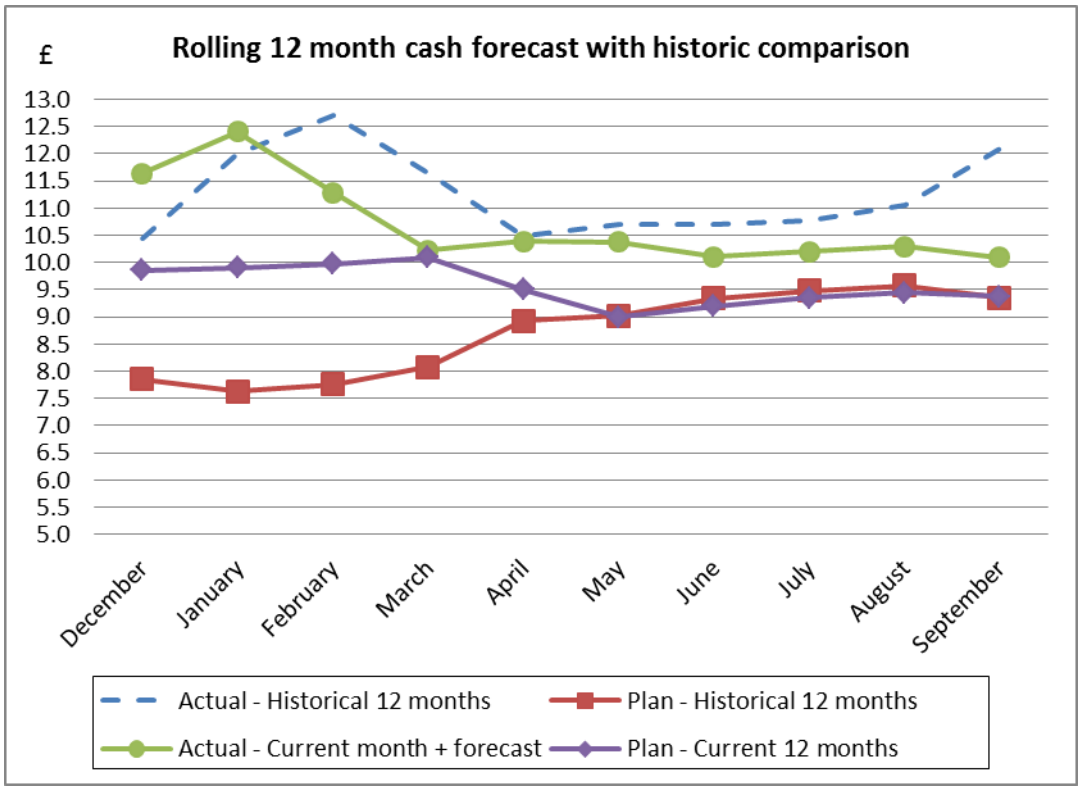
Weekly returns have been submitted to Monitor regarding the framework and price cap rules. From the start of the returns up to the end of December we have reported a total of 168 shifts that were an override of the rules. Analysis and overview of agency rules has been presented to January Finance and Performance Committee for scrutiny.

3. Efficiency / Cost Improvement Programme (CIP)

Year to date CIP achieved is £3.1m which is ahead of plan by £95k (3.2%). The reason for the CIP being ahead of plan is due to replacement schemes having a different phased delivery than that of the original schemes. The full programme has been assured which is reflected in the forecast. Programme Assurance Board continues to performance-monitor CIP delivery which is reported to Finance and Performance Committee who have delegated authority from Trust Board for oversight of CIP delivery.

4. Cash Balances

The cash balance at the end of December was £11.6m which is ahead of plan by £1.8m which is driven by the surplus and lower capital expenditure.
The levels of cash are then forecast to increase in January due to the receipt of some large invoices but then reduce in February and March due to payment of outstanding debts. Cash is forecast to be slightly above plan by £0.1m.



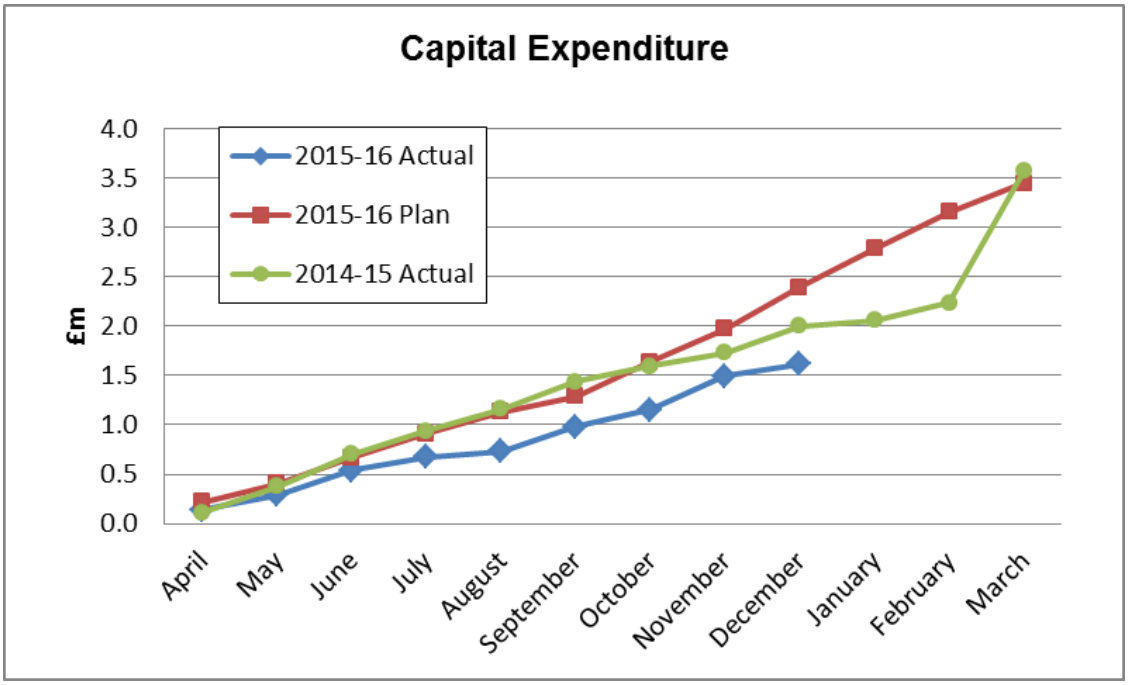
At the end of December we have achieved a net current assets position of £4.3m. We are forecasting to end the year with net current assets of £3.1m.

5. Capital Expenditure

Capital Expenditure is £774k behind the plan at the end of December.

The 2015/16 schemes are regularly reviewed by Capital Action Team (CAT) and a reprioritisation to fund clinical priorities has been approved, which is the reason for the change in expected capital expenditure profile compared to original plan.

Following the review of schemes for urgent clinical priorities, the capital expenditure is forecast to be behind plan by £0.2m at the end of the financial year.



Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 27 January 2016

Strategy Development Update

Purpose of Report

The purpose of this report is to update Trust Board on progress in developing the new Trust Strategy for the next three years.

Executive Summary

The Board of Directors has committed to developing a new Trust Strategy.

This report provides the Board of Directors with a brief update on progress to date, through the frame, diagnose, forecast and generating options element of the Monitor toolkit.

It also provides an update on stakeholder engagement and next steps.

Board members should be assured that the agreed timeline for strategy development continues to be met, however, the timeframe for delivery remains challenging.

Strategic considerations

Numerous considerations are set out within the main body of the report for further discussion by Board members.

Assurances

The Board Assurance Framework for 2016/17 will be formulated from the Trust's strategy when it has been developed and approved.

Consultation

This report has not been considered at any other meeting.

Governance or Legal issues

There are no governance or legal issues.

Equality Delivery System

Increasing collaborative working with charity sector organisations that have specific positive relationships with certain communities is likely to positively impact on outcomes for certain REGARDS groups.

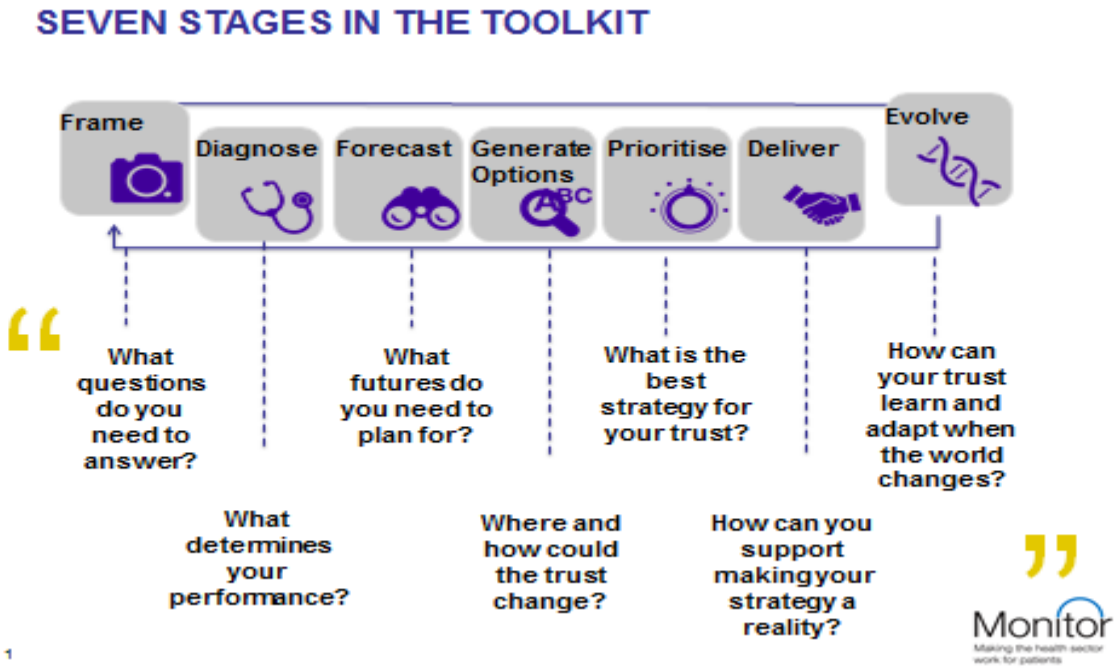
Recommendations

The Board of Directors is requested to discuss and note the content of this update report.

Report prepared by:	**Mark Powell, Director of Business Development and Marketing**
Report presented by:	**Mark Powell, Director of Business Development and Marketing**

1. Background

The Board of Directors has committed to developing a new Trust Strategy. This report provides the Board with an update on the progress made since the last report in November 2015, along with further clarity on the proposed next steps. The strategy is continuing to be developed in line with Monitor's strategy toolkit, as outlined below.



2. Frame: Developing key strategic questions

November's Board development session, which focused on the 'frame' stage of the toolkit, developed a set of key strategic questions that the strategy was to address. These were as follows:

- What is the culture we want to operate in the organisation?
- What are our Core and Core plus Services and what do we need to do to ensure they are clinically and financially sustainable?
- What is our organisational model – clinical and support services?
- What does the market/health economy want us to be doing in 5 years?
- How can we achieve a position of leadership within segments of the health economy?
- How can technology help us transform our services?
- How far do we want to collaborate/integrate/compete/grow across the care continuum into Primary, Community and Acute care?

This set of questions have since been tested with our staff and governors, to ascertain whether key stakeholders agree that these are the right set of questions and also to gain some initial feedback on the areas raised.

The feedback received broadly confirmed that the strategic questions covered the areas people wanted the strategy to address. However, a large number of comments were received regarding the language used and there was a broad feeling that this needed to be a little more simplistic, should the strategy be accessible and meaningful to all stakeholders.

A few wider issues were also raised for inclusion, reflecting a desire for the Trust to openly explore what our portfolio of services should be and how we actively develop our expertise in key areas. As a result, an updated set of strategic questions was developed, and further explored with staff at the Spotlight on our Leaders session in January 2016, as outlined further on in this paper.

- How can the ways we all work affect the care we provide?
- How can we be confident we are providing the right clinical services for the future?
- How can we ensure our services are financially viable?
- What is the best structural form for the organisation?
- What should our portfolio of services be?
    - What do we want to grow and develop?
    - What areas do we want to lead and how do we get there?
    - Where and how should we compete?
    - How do we innovate?
    - Is there anything we should stop providing?
    - What new models of care could we become involved in?
    - Do we want to specialise or diversify what we provide and where?
- Where do we want to be in five years' time?
- Where do others (commissioners/local health economy) want us to be in five years' time?
- How can we use technology to our advantage?
- How will we work with others and in what way?

It is expected that as part of this process the Trust's values will also be reviewed, with any changes being integrated within the new strategy and communicated as part of the planned roll-out. As such, values and culture have not been reflected as a separate question for the strategy development to address, although feedback from staff in particular does reflect a desire to revisit this area and an acknowledgement that culture is key to the success of the organisation at all levels.

3. Diagnose: Understanding service level data

In order to further understand our services, service level information, cross referenced with financial reports were compiled and shared with teams. This has improved teams understanding of their key performance metrics and data, in order to further highlight key issues within our services. This information was correlated with details from service level business plans and used to form the basis of the team level exercise in the January leadership event.

4. Forecast: Analysis of local and national plans for the future

Board members will know that a number of key documents have been used to inform our thinking and discussions to date. These include the following:

1. NHS England 5 Year Forward View/NHS Planning Guidance 2016/17-2020/21
2. Futures in Mind
3. Derbyshire County and Derby City Health and Well Being Strategies
4. South Derbyshire Unit of Panning transformation programme - Joined up Care
5. North Derbyshire Unit of Planning transformation programme - 21st Century Joined up Care
6. Erewash Multi-Specialty Community Provider Vanguard
7. Derbyshire Mental Health Strategy.

As part of the wider underpinning engagement to support strategy development, these documents have been made available to all staff. Senior leaders have used these to inform the wider development of the strategy of the recent Spotlight on Leaders event.

5. Generate options: Spotlight on our leaders

A leadership event, focused on strategy development took place on 12th January 2016 and was attended by 75 leaders. The session, which focused on the generating options stage of the toolkit, asked people where and how the Trust could change.

The interactive session used activities from the Monitor toolkit to support teams to look at their services and identify factors affecting their future activity and demand, and also to develop a set of activities to be undertaken over a period of time. The day closed with mixed groups focusing on the updated set of strategic questions, providing feedback and identifying any gaps in the areas being explored.

Attendees also received a presentation from Gareth Harry, Chief Commissioning Officer at Hardwick CCG, who shared a commissioner perspective on future challenges and models of care. On the same day, governors also had a dedicated finance and strategy working group, where they discussed the strategic questions and wider development of the strategy.

Whilst the detail is still being compiled from the numerous activities that took place on the day, initial feedback from those who attended and completed feedback forms (19) said the event was positive, with people reflecting their appreciation of the participative style of the event and the opportunity to influence the strategy. A further two strategy development events have been arranged for 8 February and 8 March, to further progress this involvement with the Trust's leaders. The feedback can be found in appendix 1.

There was an element of scepticism that is important to consider, with a small number of staff feeling that similar conversations and engagement had taken place before but with limited results. This is an important element of our ongoing communication and engagement regarding the development of the new strategy; to

demonstrate how and where people have influenced it, and how people can play a part in its future delivery and evolution.

6. Stakeholder engagement

A key feature in the development of the strategy is active engagement with all our key stakeholders. A plan has been developed which identifies key interested parties and how we intend to involve them in the development of the strategy, to ensure a wide input and ownership of the plan. Initial stakeholder engagement has commenced in line with this plan, and will continue to evolve over the course of the next few months.

The aim of the stakeholder engagement is to ensure that:

- People understand why the new strategy is being developed
- We identify and reflect different perspectives and requirements of the strategy
- We validate and agree data and findings
- People have the opportunity to provide direct input to the new strategy
- People have ownership of the strategic direction that is developed
- We have mechanisms in place to feedback to people and demonstrate how the strategy was shaped following stakeholder engagement.

To date existing forums and meetings have been utilised where possible, including discussion at team meetings, medical management and with senior operational staff. An initial discussion was held with governors at the Council of Governors in December and we have proactively invited our wider membership to share their hopes and wishes for the new strategy.

It is worth noting that there are some very simple, yet key themes that are coming out of the discussions that have taken place thus far, these are;

- Make the strategy short, simple and easy to understand
- Develop it so that it enables us to either make decisions and / or understand why decisions have been made
- Make sure it clearly sets out our core service portfolio

Moving forwards, external engagement will commence shortly, with discussion at the patient experience committee at the end of January and a participative session planned for the 4Es stakeholder alliance in February 2016.

Following on from the Governor working group a joint Trust Board and Council of Governors meeting is planned to discuss strategy development in more depth. It is expected that this will take place in February.

7. Next steps/action required

The update reflects progress to date and the steps we have taken through the frame, diagnose, forecast and generating options stages of the toolkit.

The written outcome from the 1st strategy development day needs to be fully understood to help inform our next steps. This will be provided at our next Board meeting.

We now move forward to begin the strategic prioritisation process.

Board members should be assured that the agreed timeline for strategy development continues to be met.

Spotlight on our Leaders Oct 15

How are you feeling about today's event?

		Response Percent	Response Total
1	Positive	0.00%	0
2	Energised	5.26%	1
3	Indifferent	0.00%	0
4	Optimistic	0.00%	0
5	Motivated	0.00%	0
6	Inspired	0.00%	0
7	Other (please specify):	100.00%	19

Analysis							
	Mean:	7.11	Std. Deviation:	1.18	Satisfaction Rate:	100.88	answered 19
	Variance:	1.38	Std. Error:	0.27			skipped 0

Other (please specify): (19)

1	13/01/16 10:24AM	involved
2	13/01/16 10:31AM	engaged hopeful
3	13/01/16 10:38AM	long day
4	13/01/16 10:42AM	Engaged - good ideas discussed
5	13/01/16 10:44AM	balanced
6	13/01/16 10:47AM	engaged, useful to
7	13/01/16 10:49AM	more informed and aware of challenges
8	13/01/16 10:51AM	confident that most people want the same quality outcomes
9	13/01/16 10:53AM	tired

How are you feeling about today's event?				
			Response Percent	**Response Total**
10	13/01/16 10:59AM	engaged better prepared thoughtful		
11	13/01/16 11:01AM	engaged and better informed		
12	13/01/16 11:04AM	engaged and little research		
13	13/01/16 11:09AM	engaged		
14	13/01/16 11:10AM	engaged		

Comments: (4)

1	13/01/16 11:09AM	- networking very valuable
2	13/01/16 11:12AM	slightly indifferent
3	13/01/16 11:16AM	Interesting day
4	13/01/16 11:20AM	better informed

On a scale of 1-5 how would you rate the day?

		Response Percent	Response Total
1	1	0.00%	0
2	2	5.26%	1
3	3	15.79%	3
4	4	57.89%	11
5	5	21.05%	4

Analysis							answered	19
	Mean:	3.95	Std. Deviation:	0.76	Satisfaction Rate:	73.68		
	Variance:	0.58	Std. Error:	0.17			skipped	0

What was the most useful thing about today's event?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	15

1	13/01/16 10:24AM	access to updates having areas across the trust opportunity to contribute workshops.
2	13/01/16 10:31AM	the contribution of my colleagues shared hope.
3	13/01/16 10:38AM	meet other disciplines organisations & colleagues
4	13/01/16 10:42AM	wide bright ideas
5	13/01/16 10:47AM	having various summary of all information
6	13/01/16 10:49AM	meeting more of team
7	13/01/16 10:51AM	listening to others views
8	13/01/16 10:59AM	some discussions have replicated experiences in other events - but useful reconfirm places for development encouraging agreement + understanding

What was the most useful thing about today's event?				
			Response Percent	**Response Total**
9	13/01/16 11:01AM	understanding the forward view and local impact of this		
10	13/01/16 11:04AM	presentation		
11	13/01/16 11:09AM	networking opportunities views from senior management + CCG		
12	13/01/16 11:10AM	understanding the wider view		
13	13/01/16 11:12AM	networking being interested in it		
14	13/01/16 11:18AM	interactive sessions intro		
15	13/01/16 11:20AM	the commissioners informative		
			answered	15
			skipped	4

Thinking about the amount of interactive work versus speaker-led presentation, was the balance about right?

		Response Percent	Response Total
1	Too little interactive work	0.00%	0
2	Too much interactive work	11.11%	2
3	About right	88.89%	16

Analysis						
	Mean:	2.89	Std. Deviation:	0.31	Satisfaction Rate:	94.44
	Variance:	0.1	Std. Error:	0.07		

answered	18
skipped	1

Any other comments?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	10

1	13/01/16 10:24AM	open it up other representatives of teams/ services if manger / level can be attained
2	13/01/16 10:31AM	please, let me know so we aren't here during the same again next year
3	13/01/16 10:38AM	been here before need to see there changes occurring
4	13/01/16 10:44AM	where did all the directors (our leaders) disappear - leadership clearly not important?
5	13/01/16 10:51AM	may have been better to have guide time
6	13/01/16 10:53AM	repetitive no trust anything will change
7	13/01/16 10:59AM	engagement from audience
8	13/01/16 11:04AM	availability agenda temporary governance
9	13/01/16 11:10AM	thanks
10	13/01/16 11:12AM	new chairman was interesting

Any other comments?		
	Response Percent	Response Total
	answered	10
	skipped	9

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 27 January 2016

People and Culture

Purpose of Report
To present to the Board the draft Terms of Reference for the new People and Culture Board level Committee and demonstrate positive progress in addressing the key people related issues.

Executive Summary

The People Strategy was established in 2011 with a 5 year view, certainly within the last two years the activities have been somewhat fragmented, with no apparent transparent delivery plan, but driven through operational need and tracked through a number of core metrics, but fundamentally has lacked cohesion or strategic focus.

This has been compounded more recently by a number of factors, the direct and indirect impact from the employment tribunal on both individuals and teams, reporting lines and activity focus. The transformation programme has continued to drive through organisation change which in turn, with the on-going financial challenges has seen additional stress on the workforce.

The annual health check (presented in June 2015) was a visual representation of the concerns heard from of the workforce and in particular will be the one of the key areas of focus of any future organisational development activity.

In 2015, two direct people related risks were identified and feature on the Trust Board risk register.

4a Failure to recruit, retain and engage capable and compassionate staff, leading to a risk that could impact on service user care

4b Failure to have sufficient capability and capacity to deliver required standard of care resulting in a risk to our service users.

These will be further refined within the risk register to add a level of granularity to where specific action to address the gaps in assurance.

Work has commenced to establish a framework that will focus activities and resources on value adding activities to address a number of the cultural issues that the Trust is facing. There seems to be an element of 'box ticking' in some areas that may reduce the overall value of a number of activities to the organisation and historic processes and policies that in current times may be ineffective which need immediate attention.

To support the delivery of the Trust strategy and meet the requirements of our service users, carers, staff and wider stakeholders, HR and associated functions now need to play a more robust role in leading the next phase of trust's development-we need clarity and to adopt a more defined direction and be more disciplined in implementation. This will mean a partnership approach and less of a service orientation to how the function(s) operates.

For the required transition a number of actions have been identified, these include a review of all HR policies and procedures, to create a **Board level committee** that will focus on **People and Culture** (Appendix 1 – draft Terms of Reference), to develop a refreshed People Strategy to enable the delivery of the Trust refreshed Strategy (deliverable mid-year). The Board level committee will be supported by a number of structured groups which will be accountable to the Board level committee.

Strategic considerations

This refreshed approach recognises the critical role that the board and board committees play in shaping and exemplifying an organisational culture that is open, accountable and caring and puts patients first.

The Trust strategy is currently being reviewed, and in parallel the People and Culture strategy (as an enabling strategy) will be refreshed and be under pinned by a set of agreed values, this will be defined through our 'Cultural Change Programme' where we will describe the broad concept of the way we want to work, and our approach to people management.

Board Assurances

The approach to realign the HR and Associated function
The agreement of the new People and Culture Board Committee

Consultation

This paper has not been previously submitted to any committee or group. Some board members have offered comment on the draft Terms of Reference

Governance or Legal issues

The Board recognises the need to focus on governance and ensure our policies and processes are best practice and meet all legal and regulatory compliance. This Board Committee is referenced within the governance well-led action plan.

Equality Delivery System
This has a neutral impact on REGARDS groups. Further work will be undertaken in line with the 'Snowy White Peaks' report and the consideration within the People Strategy refresh

Recommendations

The Board of Directors is requested to:

1) Receive and approve in principle the draft Terms of Reference for the People and Culture Committee
2) To receive the actions taken and planned actions in regards to 'Focus on our People'.

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

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

PEOPLE AND CULTURE COMMITTEE

TERMS OF REFERENCE

1. Authority

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

The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice and to secure the attendance of both internal and external officers with relevant experiences and expertise it if considers this necessary.

2. Purpose

The Committee is to provide assurance to the Board that the appropriate structures, processes and systems are in place to ensure an effective capable workforce to meet the Trusts current and future needs. The Committee will review its effectiveness as a minimum on an annual basis

3. Summary of Role

- Oversees the development and implementation of an effective People Strategy which supports the Trust Strategy
- Ensure that the People Strategy and associated plans are aligned and focussed on meeting the needs of the organisation
- To ensure a systematic approach to the management of change to deliver an empowered, high performing workforce
- The workforce plans are 'fit for purpose' and have sufficient flexibility to meet the changing needs of the Trust.
- Have an understanding of the current and future capability required and develop a robust process to inform workforce plans.
- There are robust performance processes in place for the effective management of the workforce to ensure the Trust meets it priorities.
- To drive a positive culture and high staff engagement
- To ensure the learning and education needs of the organisation are understood and met

4. Membership

4.1 The membership of the Committee will comprise:

- Non-Executive Directors x 3 (One will be appointed as the Chair)
- Director of Workforce, Organisational Development and Culture
- Director of Nursing and Patient Experience
- Medical Director
- Director of Operations
- Director of Business Development and Marketing
- Director of Corporate and Legal Affairs

Only members of the Committee have the right to attend and vote at Committee meetings. The Committee may require other officers of the Trust, and other individuals may attend all or

any part of its meetings as and when is necessary.

4.2 The Board of Directors will appoint the Chair of the Committee

4.2 The Trust Board has delegated authority to any Non-Executive Director of the Trust to act as nominated deputy in the absence of any Non-Executive and this attendance will count towards the quorum.

4.3 The Board Secretary will be in attendance and provide administrative support.

4.4 Members are expected to attend a minimum of three meetings per year. A register of attendance will be maintained and reviewed by the Committee annually.

5. Frequency of Meetings

5.1 The Committee will meet on a monthly basis with additional meetings being called when necessary.

5.2 Agenda, papers and appropriate management information will be circulated seven days prior to each meeting.

6. Quorum

A quorum shall be not less than **three** non-executive directors and ***one*** executive director.

7. Reporting

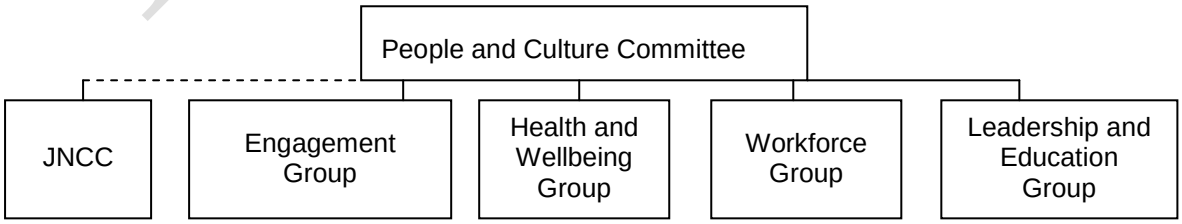
7.1 The draft minutes of the Committee will be included in the Board of Directors' agenda and papers.

7.2 The Chair of the Committee shall draw to the attention of the Board of Directors any issues that require disclosure to the full Board, or require executive action.

8. Responsibilities

8.1 To monitor the implementation of the People Strategy and report progress to the Board by exception.

8.2 A number of supporting groups / forums will be accountable to the People and Culture Committee whilst not exhaustive; it is anticipated that the following groups will have a direct or indirect relationship and will be agreed within the Committee



8.3 To oversee and monitor workforce performance.

8.4 To review and monitor the Workforce metrics and Board Assurance Framework and ensure the Board is kept informed of any significant workforce risks.

8.5 To be assured that mechanisms are in place to review and monitor the effectiveness and capability of the workforce across the whole Trust and that appropriate actions are taken to address issues of poor performance and bring about continuous quality improvement.

8.6 To be assured that the Trust identifies lessons for improvement and implements these in all relevant areas.

8.7 To be assured that National standards, guidance and best practice are systematically reviewed and embedded within the Trust.

8.8 To be assured that the views of staff and appropriate others are systematically and effectively engaged in organisational development activities.

8.9 To oversee the leadership, training and education framework and monitor progress.

8.10 To monitor the implementation of agreed action plans in relation to organisational interventions and measure the effectiveness of change.

9. Assurance Framework

The Committee will provide assurance assessments to the Board for its areas of responsibility.

10. Review

The Committee will review its effectiveness by self-assessment on as a minimum annual basis
2016 meetings will take place on:

(This will need agreeing in line with all other Committees)

Signed …….. (Chairman of the Board of Directors)

Date .....

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 27 January 2016

Remuneration Committee

Purpose of Report

To present to the Board the Terms of Reference for the Remuneration Committee.

Executive Summary

The Remuneration Committee is constituted as a standing Committee of the Foundation Trust's Board of Directors.

The committee is responsible for identifying and appointing candidates to fill all the executive director positions on the board and for determining their remuneration and other conditions of service.

These Terms of Reference are intended to ensure that the Trust's procedure for the appointment of the chief executive and other directors (excluding Non-Executive Directors) to the Board of Directors reflect these principles.

Strategic considerations

These Terms of Reference are intended to ensure that the Trust's procedure for the appointment of the chief executive and other directors (excluding Non-Executive Directors) to the Board of Directors reflects the principles contained in Monitors Code of Governance (July 2014). The code states as two of its principles that;

"There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration."

"There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. Directors of NHS foundation trusts must be "fit and proper" to meet the requirements of the general conditions of the provider licence."

Board Assurances

The agreement of the Remuneration Committee

Consultation

This paper has not been previously submitted to any committee or group.

Governance or Legal issues

The Board recognises the need to focus on governance and ensure the Trust's policies and processes are best practice and meet all legal and regulatory compliance. This Committee is referenced within the governance well-led action plan.

Equality Delivery System

This has a neutral impact on REGARDS groups.

Recommendations

The Board of Directors is requested to receive and approve the Terms of Reference for the Remuneration Committee.

Report prepared and presented by: **Jenna Davies**
Interim Director
Corporate & Legal Affairs

Remuneration Committee
Terms of Reference

1. Authority

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

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

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

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

2. Role

2.1 Monitors Code of Governance (July 2014). These terms of reference are based in part, on best practice as set out in that code and have been drafted referring to the provision in the code. The code states as two of its principles that;

2.1.1 *"There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration."*

2.1.2 *"There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. Directors of NHS foundation trusts must be "fit and proper" to meet the requirements of the general conditions of the provider licence."*

2.1.3 These Terms of Reference are intended to ensure that the Trust's procedure for the appointment of the chief executive and other directors (excluding Non-Executive Directors) to the Board of Directors reflect these principles.

2.2 To be responsible for identifying and appointing candidates to fill all the executive director positions on the board and for determining their remuneration and other conditions of service.

2.3 When appointing the chief executive, the committee shall be the committee described in Schedule 7, 17(3) of the National Health Service Act 2006 (the Act). When appointing the other executive directors the committee shall be the committee described in Schedule 7, 17(4) of the Act.

3. Appointments role

3.1 To be responsible for identifying and appointing candidates to fill all the executive director positions on the board

3.2 Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the board, making use of the output of the board evaluation process as appropriate, and make recommendations to the board, and nomination committee of the council of governors, as applicable, with regard to any changes.

3.3 Give full consideration to and make plans for succession planning for the chief executive and other executive board directors taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the board in the future.

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

3.5 Ensure that a proposed executive director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the board as they arise.

3.6 Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

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

4. Remuneration Role

4.1 Establish and keep under review a remuneration policy in respect of executive board directors

4.2 Consult the chief executive about proposals relating to the remuneration of the other executive directors.

4.3 In accordance with all relevant laws, regulations and trust policies, decide and keep under review the terms and conditions of office of the trust's executive directors and senior managers on locally-determined pay in accordance with all relevant Foundation Trust policies, including:

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

4.4 In adhering to all relevant laws, regulations and trust policies:

4.4.1 establish levels of remuneration which are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the trust;

4.4.2 use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors and senior managers on locally-determined pay, while ensuring that increases are not made where trust or individual performance do not justify them;

4.5 Monitor, and assess the output of the evaluation of the performance of individual executive directors, and consider this output when reviewing changes to remuneration levels.

5. Membership

5.1 The membership of the Remuneration Committee shall consist of:

- Foundation Trust Chair, and
- All Non-Executive Directors on the foundation Trust Board of Directors, one of which will act as Chair of the Committee.

5.2 A quorum shall be three members.

6. Attendance

6.1 Meetings of the Remuneration Committee may be attended by:

- Chief Executive;
- Director of Workforce & Organisational Development; and
- Director of Corporate & Legal Affairs; and
- Any other person who has been invited to attend a meeting by the Remuneration Committee so as to assist in deliberations.

7. Frequency of Meetings

7.1 Meetings shall be held monthly or as required.

8. Minutes and Reporting

8.1 The minutes of all meetings of the Remuneration Committee shall be formally recorded. These will be retained by the Chair and not shared with Executive Directors.

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

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

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

9. Review

9.1 The Terms of Reference of the committee shall be reviewed by the Board of Directors at least annually.

MINUTES OF THE AUDIT COMMITTEE HELD ON TUESDAY, 15 DECEMBER, 2015 AT10.30 AM HELD IN MEETING ROOM 1, ALBANY HOUSE, KINGSWAY, DERBY DE22 3LZ

PRESENT:	Caroline Maley	Chair/Senior Independent Director
	Phil Harris	Non-Executive Director
	Tony Smith	Non-Executive Director
IN ATTENDANCE:	Claire Wright	Executive Director of Finance
	Carolyn Gilby	Acting Director of Operations
	Jenna Davies	Interim Director Corporate and Legal Affairs
	Carolyn Green	Executive Director of Nursing
	Rachel Leyland	Deputy Director of Finance
	Rachel Kempster	Risk & Assurance Manager
For item AUD2015/111	Dr John Sykes	Executive Medical Director
For item AUD2015/111	Rubina Reza	Research & Clinical Audit Manager
	Ali Breadon	PricewaterhouseCoopers
	Glen Spencer	PricewaterhouseCoopers
	David Roper	Grant Thornton
	Laura Hinsley	Grant Thornton
	Sue Turner	Board Secretary and Minute Taker
VISITORS:	Danielle Sweeney	Observing from Deloitte
APOLOGIES:	Mark Stocks	Engagement Lead Grant Thornton
	Joan Barnett	Engagement Manager Grant Thornton

WELCOME AND APOLOGIES	
The Chair, Caroline Maley opened the meeting and welcomed everyone present and apologies were noted above.	
AUD 2015/099	**MINUTES OF THE AUDIT COMMITTEE MEETING DATED 8 OCTOBER 2015** The minutes of the meeting held on 8 October were accepted and approved as an accurate record of the meeting.
AUD 2014/100	**ACTION MATRIX** All updates provided by members of the committee were noted directly to the matrix.
AUD 2014/101	**MATTERS ARISING – RESPONSE FROM ELT (EXECUTIVE LEADERSHIP TEAM) ON PwC AUDIT COMMITTEE QUESTIONS** The committee reviewed the PwC questions for consideration by audit committees. The Chair considered board development (purpose and programme) to be an area that was not clear enough and it was recognised that this was in need of improvement. A correction was noted on page 4, "A 360 appraisal of the performance of the Trust Chair

	was undertaken by the Chair of the Audit Committee" and should be corrected to read "A 360 degree appraisal of the performance of the Trust Chair was undertaken by the Senior Independent Director". The Chair did not think the escalation of movement of risks within DATIX to the Board was clear. Carolyn Green will ask Rachel Kempster to test this question and give an example of movement of risks between the various committees and the Board in a report to the January meeting of the committee. Tony Smith queried the culture section starting on page 8. He felt organisational culture and human factor issues on how we listen to clinical concerns and morale issues overlapped the responsibilities of the Finance & Performance Committee and the People Forum. He also raised questions around outcomes and themes and how these link in with grievances. He felt the explanation was too light and that clarity was required around concerns about whistleblowing and the freedom to speak up. The committee felt the section on fit and proper persons' requirements was too concise and should be more clearly defined and this was noted as a concern by the committee. However, the committee recognised this was a useful exercise and received generally good assurance on the content of Claire Wright's report on the response to PwC Audit Committee questions from ELT. **ACTION: Rachel Kempster will submit a report to the January meeting that will give an example of movement and escalation of risks between the various committees and the Board.** **RESOLVED: The Audit Committee was assured by the response from ELT.**
AUD 2014/102	**PLAN FOR DEEP DIVES FOR RISKS IDENTIFIED IN THE BOARD ASSURANCE FRAMEWORK** In Rachel Kempster's absence, Claire Wright ran through the schedule for planned 'deep dives' for risks identified in the Board Assurance Framework that would be undertaken by the relevant committees. She drew attention to the Board's and the Finance & Performance Committee's lack of assurance on issues around organisational development and workforce planning and informed the committee that risk 4a and 4b would be brought forward to the January meeting of the Finance & Performance Committee. This will result in the commercial strategy risk 3b being delayed to the March meeting of the Finance & Performance Committee. **RESOLVED: The Audit Committee noted the rescheduling of planned deep dives of risks identified in the Board Assurance Framework. The Audit Committee also noted the assurance on the BAF deep dives carried out in November by the Quality Committee and the Finance & Performance Committee contained in the minutes of these committees. See AUD 2015 /104).**
AUD 2015/103	**BAF DEEP DIVE OF RISK 3a FINANCIAL PLAN** **BAF Risk 3a: "Risks to delivery of the 2015/16 financial plan. If not delivered, this would result in regulatory action due to breach of Provider Licence with Monitor."**

	Claire Wright's presentation set out the key controls and assurances that were in place and the committee was assured by the evidence presented. It was recognised that deep dives of risks provides extra assurance, together with the internal audit carried out by PwC. It was pointed out that the Finance & Performance Committee had full assurance of the systems and process in place for 2014-15 and this will be the same for this year. The PwC Annual Report to Audit Committee quoted "Our financial systems review has been rated low for the last three years and remains an area where the Trust demonstrates strong controls and processes" (AC papers, Audit reports) (systems remain in place during 2015/16). This provided the committee with positive assurance with the 2014/15 Finance systems audit which was rated a low risk. As mentioned in the previous item, both the Finance & Performance Committee and Trust Board require a greater level of assurance on strategic workforce planning, organisational development. This was noted as a gap in assurance and action to increase controls/assurance would be discussed outside of the meeting by Claire Wright and Jayne Storey as the Committee agreed that although it was a gap that affected finances, it was best placed to be captured within one of the people risks on the BAF. The committee was pleased to note that additional reporting had been produced for the Finance & Performance Committee specifically to increase controls and assurance enabling the committee to triangulate and validate overarching financial performance during change. The Audit Committee was assured that the Finance & Performance Committee had confirmed satisfaction with this level of reporting. In response to Carolyn Green, Claire Wright agreed to add content to this BAF risk regarding Monitor agency caps and examples of breaches recently reported to Trust Board. The Chair agreed the Board should consider and be assured on systems and processes in place to avoid breaching in future and confirmed this will be included as one of the dynamic changes to the BAF. Phil Harris thought this was a very clear and concise report and visibly showed gaps and assurances. He asked if an analysis had been carried out of the best and worse and most likely assumptions related to Wards One and Two CIP, which Claire Wright responded to. The Chair confirmed she was content with the evidence presented in the deep dive that showed the BAF risk was appropriately captured. **ACTION: Action to review BAF entries regarding the need to increase controls/assurance on strategic workforce planning and organisational development will be discussed outside of the meeting between Claire Wright and Jayne Storey. Jayne Storey to update the people related BAF risks** **RESOLVED: The Audit Committee received good assurance on controls in place on risk 3a Financial Plan.**
AUD 2015/104	**<u>REVIEW OF ASSURANCES FROM OTHER COMMITTEES</u>** Minutes of the meetings of the Finance & Performance Committee, Quality Committee and Safeguarding Committee were scrutinised. The Chair requested that in future, in addition to receiving minutes, it would be helpful to receive a summary to show the level of assurance received by the committees.

	Finance & Performance Committee: The committee received strong evidence of levels of assurance from the minutes of the Finance & Performance Committee and on the issues that were escalated to the Board. **Quality Committee:** The Quality Committee continues to receive strong evidence of levels of assurance by checking aspects of serious incidents and themes of learning are regularly discussed. There were issues earlier in the year with the outstanding number of recommendations arising from the Serious Incident reports and the Quality Committee saw this had considerably reduced in December. The Quality Committee is developing the roles of the Quality Leadership Teams. Tony Smith drew attention to matters contained in the minutes that were People Forum related and the committee agreed that the People Forum should address its membership to reduce these issues. **Safeguarding Committee:** Carolyn Green wished to point out that the Safeguarding Committee had a gap in assurance around level 3 Safeguarding Training. She also pointed out that an action plan for CQC work had been signed off by commissioners and she wished this to be noted by the committee. The Chair asked if escalation between committees is working and it was noted that each executive lead had examined the escalation of issues and obtained assurance. This enabled the Audit Committee to understand there are plans in place to address areas that have partial assurance and how they are escalated and followed up. **ACTION: Jenna Davies to provide summaries to show the each committee's assurances or gaps in assurance.** **RESOLVED: The Audit Committee was assured that other Board Committees were completing the work they were supposed to do.**
AUD 2015/105	**<u>OVERVIEW OF COMPLAINTS AND THEMES</u>** Carolyn Green's report provided the Audit Committee with an overview of the complaints system and processes, as well as compliments and outlined the current performance of the Patient Experience team. Current performance showed there had been 89 complaints this financial year with 47 final responses sent from the Chief Executive and 16 of these complaints were not responded to within the agreed timescale for this financial year. This was in part due to the complexity and the significant length of these complaints. Performance is partially due to staff capacity, team sickness and fluctuations in volumes of work. The quality of complaints and concerns handling is not a performance issue and the committee noted that the complaints process is being reviewed to understand how the management of complex complaints can be improved. Jenna Davies highlighted the good work of the Family Liaison Officer in supporting families during and after coroner court cases and explained how difficult it would be for families to attend court without the service this role provides. The Healthwatch Derby independent review was attached as an appendix to the report and it was noted that this review will be scrutinised by the Quality Committee in order to allow learning from this exercise. The Healthwatch Derby survey will also be reported to the

	Quality Committee and the Audit Committee will receive evidence of this through the assurance summary and minutes of the meeting. Due to the late circulation of this report the committee had not been allowed enough time to read the report thoroughly. It was agreed that members of the committee would fully read the report outside of the meeting and direct any questions they might have to Carolyn Green by email. The Chair also thought it worth discussing the report at the next quarterly Non-Executive Director meeting to assess how the complaints process will proceed. **RESOLVED: The Audit Committee:** **1) Noted the report, scrutinised the content and accepted the recommendations for capacity.** **2) Agreed that improvement work would be monitored through the Executive Team, and Quality Committee.**
AUD 2015/106	**<u>REVIEW OF WHISTLEBLOWING ARRANGEMENTS</u>** Jenna Davies' report provided the committee with an overview of the principles and proposed actions of the Raising Concerns at Work and Whistleblowing (freedom to speak up) arrangements which arose as a direct result of the Francis Report. Jenna Davies explained that the NHS is planning to have one standard national policy for whistleblowing. She had read the policy and felt it covered all legal aspects of the recommendations contained in the Francis report and it will provide a good step forward. The committee noted the proposed actions had been signed off by a task and finish group but these actions had not yet been reviewed by the Executive Leadership Team. Jenna Davies had updated a number of aspects from the action plan and it was understood that further work will be required once the action plan has been received by the People Forum and escalated through the correct governance channels. Carolyn Green pointed out that the organisation might not recognise the work that has taken place in its professional guise within the nursing strategy and that information guidelines have been communicated at staff inductions. She had evidence of this and asked that this be added to the action plan. The committee recognised the importance of having one integrated policy and clarity on the legal practices that shows people are being listened to. The Chair felt some of the actions were not very clear and she questioned the reality of the timeline. Jenna Davies pointed out that the People Forum will regularly receive KPIs on progress and this process is contained in the action plan. The committee was assured that this policy would be reviewed at ELT in order for it to receive the right focus and agreed there should be one standard national policy that should be expedited as soon as possible. **ACTION: Jenna Davies to ensure the freedom to speak up action plan incorporates whistle blowing training as part of staff induction.** **RESOLVED: The Audit Committee noted the arrangements and processes for raising concerns and whistleblowing.**
AUD 2015/107	**<u>WELL LED FRAMEWORK AND MONITOR ACTION PLAN</u>** Jenna Davies provided the committee with a verbal update on work carried out in relation to

	the Well Led framework and Monitor action plan. Since the last meeting the Well Led tender had been awarded and will be undertaken by Deloitte. The investigation panel is close to submitting their final report, although the second panel has experienced a delay in reporting. The Monitor action plan will soon draw to a conclusion and move into a longer objective to identify and take forward the outcomes of the investigation report, self-assessment and Well Led framework. Jenna Davies was reviewing governance processes in order to take these actions forward which will enable the Audit Committee to have a clear understanding of the committee oversight. **RESOLVED: The Audit Committee noted the verbal update report on the Well Led framework and Monitor action plan.**
AUD 2015/108	**EXCEPTION REPORTING – LOSSES AND COMPENSATIONS** Rachel Leyland's report updated the committee on the current position on the number of losses and compensations claims received so far. There have been 4 approved claims to date (7 months) to a value of £958, this is a reduction compared to month 7 in 2014/15. Of the unapproved claims and rejected claims, there continues to be a high level of incidents for loss of patient property. The committee noted that this information has been reported to operational managers who are taking some of these issues forward to ensure that policies and procedures are followed specifically in relation to patient property. These issues have also been discussed at the Performance Contracts Overview Group (PCOG) and Trust Operational Management Meeting (TOMM). The committee looked forward to seeing the result of these actions. The committee noted there were no exceptions to report in debtors and creditors or hospitality and sponsorship. **RESOLVED: The Audit Committee:** **1) Noted the information contained in the report on the number and nature of the recent losses and compensations.** **2) Noted that this information is being reported to operational managers who are taking some of these issues forward to ensure that policies and procedures are followed specifically in relation to patient property.** **3) Noted the actions put in place by ELT which are contained in the report.**
AUD 2015/109	**PwC UPDATE INTERNAL AUDIT PROGRESS** The Chair urged executives and their teams to work closely with PwC to ensure responses to draft audit reports are submitted in time for each meeting of the committee. **Internal Audit Progress Report:** Alison Breadon ran through the summary that updated the committee on internal audit activities and progress since the last meeting in October. **Cash Forecasting and Controls:** PwC reported that design processes are working well and areas of good practice had been identified. The committee noted the areas of risk that had been identified in forecast documentation and guidelines and appreciated the advice received from PwC.

	Mental Capacity Act (phase 1): This report highlighted staff understanding of the differences between the Mental Capacity Act and the Mental Health Act (MHA). An earlier draft of this report was also received by the Mental Health Act Committee which resulted in that committee supporting John Sykes' recommended actions that training, knowledge sharing and capacity of the MHA office be looked at. John Sykes proposed to complete this action and will submit the results to the next meeting of the Mental Health Act Committee scheduled to take place in February. The committee was assured John Sykes' recommendations would be put in place and that the Mental Health Act Committee will monitor progress **HR Processes:** This report assessed the approvals process for recruiting clinical and medical staff and Board reporting of safe staffing levels. The committee considered this to have been a useful check and noted that the recommendations contained in the safer staffing report will become a more automated process and will also capture bank and agency staff to address the audit findings. In terms of approvals for recruitment, this was seen as opportunity for processes to be improved and streamlined. **ACTION: The Director of Transformation will lead a review to establish the cost of sourcing and implementing an electronic system for recruitment and will produce a paper which will set out the costs of a new system against the benefits that would be expected. This will be received by the Finance & Performance Committee to establish whether a new system should be procured.** **Off Payroll Procedures:** The committee was partially assured by this report which covered a review of processes and policies for off-payroll engagements. Claire Wright pointed out that progress was being made, led by Carolyn Gilby, and commented on the executive team oversight of the progress, but did point out it is a complex and multi-layered process that has not yet concluded. **RESOLVED: The Audit Committee received and noted the update reports from PwC.**
AUD 2015/110	**<u>EXTERNAL AUDIT PLAN</u>** In the absence of Grant Thornton's Mark Stocks and Joan Barnett, David Roper and Laura Hinsley attended the meeting and highlighted key matters contained in the external audit plan which will be expanded upon at the next meeting and will focus on work taken to mitigate any risks identified. David Roper explained that for 2015/16 the Trust is subject to the requirements of the National Audit Office (NAO)'s Code of Audit Practice. The Code requires Grant Thornton to consider whether the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. This is known as the Value for Money (VfM) conclusion. The committee noted that the results of the VfM audit work and key messages arising will be contained in the Audit Findings Report and Annual Audit Letter. This will be reported by exception only if Grant Thornton are not satisfied that the Trust has proper arrangements in place to secure value for money. In terms of processes, meetings have been set up to prepare for the annual report, quality report and annual accounts and a timetable will be brought to the next meeting of the committee. The Chair requested that April and May Audit Committee meeting dates be decided as soon as possible.

	The committee noted there are no unknown risks contained in the report and looked forward to year ahead. **RESOLVED: The Audit Committee received and noted the report from Grant Thornton.**
AUD 2015/111	**REVIEW THE CLINICAL AUDIT PLAN** Rubina Reza's report provided the Audit Committee with an update on the delivery of the 2015-16 Clinical Audit Programme and future development plans. The committee was pleased to note that the Research & Development Governance Committee terms of reference, membership and attendance had been reviewed and actions were being taken to facilitate improved attendance. However, despite these efforts, attendance at the group remained low and of concern to the committee. The new Clinical Audit Co-ordinator will start in post in December and it is hoped this will help to increase the pace and completion of projects reflected in the trajectory and will help action plans to be agreed and completion of projects taken to different committees for sign off. The clinical audit project for 2015-16 project duration table was seen as an improvement to the report and this will be included in each report to show project timescales. The Chair was pleased to see an improvement in reporting and the progress of completion of projects but recognised there was still work to be done. The committee noted that this report had been scrutinised by the Quality Committee on 10 December and that a trajectory now formed part of the report which showed the prioritised projects brought through for sign off. The committee was pleased to note that Clinical Audit process would be benchmarked and improved using Healthcare Quality Improvement Partnership (HQIP) and Good Governance Institute guidance and considered it would be helpful for capacity to feature in future reports. The committee discussed the required schedule for receiving Clinical Audit Reports and it was agreed these would be received twice a year on the basis that a substantive Clinical Audit report is received by the Quality Committee in March and an update report will flow through to the March meeting of the Audit Committee that will highlight assurance / gaps. **ACTION: Next Clinical Audit Plan report will be submitted to the March meeting of the committee and the forward plan will be updated to reflect this.** **RESOLVED: The Audit Committee received and noted the content of the report.**
AUD 2015/112	**REVIEW OF FORWARD PLAN** Forward plan to be updated in line with today's discussions.
AUD 2015/113	**MEETING EFFECTIVENESS** The committee agreed the meeting was well chaired and members were clear of assurance and actions to be taken. The chair requested that late papers be avoided in future.

	ACTION: Jenna Davies to consider how the committee can engage with governors and show timelines. The Chair made Jenna Davies' aware that Alison Breadon had been asked to carry out a facilitation of Audit Committee effectiveness review. The process / options to be followed would be discussed between the Chair and PwC.
AUD 2015/114	**CLOSURE OF THE MEETING** The Chair thanked all those present for their attention and attendance and closed the meeting at 1:10 pm. **Date of next meeting:** Wednesday, 20 January at 10:30am. Venue: Meeting Room 1 – Albany House, Kingsway, Derby DE22 3LZ.

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE QUALITY COMMITTEE

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

Thursday, 10 December 2015

PRESENT:	Tony Smith	Delegated Chair & Non-Executive Director
	Phil Harris	Non-Executive Director
	Carolyn Green	Director of Nursing and Patient Experience
	Dr John Sykes	Executive Medical Director
	Carolyn Gilby	Acting Director of Operations
	Petrina Brown	Consultant Clinical Psychologist
	Sangeeta Bassi	Chief Pharmacist
	Emma Flanders	Lead Professional for Patient Safety
	Deepak Sirur	Consultant Psychiatrist in Substance Misuse
	Rachel Kempster	Risk & Assurance Manager
	Rubina Reza	Research and Clinical Audit Manager
	Catherine Ingram	Chief Executive, Derbyshire Voice
	Chris Fitzclark	Derbyshire Voice representative
	Carrina Gaunt	Health and Safety Manager
	Tracy Shaw	Training Manager
	Karen Wheeler	Acting Lead Occupational Therapist, Urgent & Planned Care
IN ATTENDANCE:	Sue Turner	Board Secretary and Minute Taker
APOLOGIES:	Maura Teager	Chair and Non-Executive Director
	Claire Wright	Executive Director of Finance
	Wendy Brown	Clinical Director
	Sarah Butt	Assistant Director of Clinical Practice and Nursing
	Clare Grainger	Head of Quality & Performance
	Jenna Davies	Interim Director of Corporate & Legal Affairs
	Bev Green	Releasing Time to Care Lead (Service Improvement)
	Jayne Storey	Director of Transformation
	Pam Dawson	Carer Forum

QC/2015/173	**WELCOME AND APOLOGIES** The delegated chair, Tony Smith, opened the meeting and welcomed everyone.
QC/2015/174	**MINUTES OF THE MEETING DATED 12 NOVEMBER 2015** The minutes of the meeting, dated 12 November 2015 were accepted and agreed.
QC/2015/175	**ACTIONS MATRIX** The committee agreed to close all completed actions. Updates were provided by members of the committee and were noted directly on the actions matrix.
QC/2015/176	**MATTERS ARISING** **QC/2015/103: Physical Care Committee End of Year Report –** Following the submission of the Physical Care Committee End of Year Report in July, it was agreed that additional training requirements would be taken to the Executive Leadership Team (ELT) and Finance & Performance Committee. An update was required from Jayne

	Storey at November's meeting. Jayne Storey could not attend that meeting but informed the committee via a post meeting note that an update on training requirements had been requested from key individuals in the training and education departments. None had been offered and it was hoped that a verbal update could be made at today's meeting. However, the committee had not been provided with the assurance of scrutiny of mandatory training or confirmation of the roll out of bite size physical health training. In Jayne Storey's absence it was agreed there was lack of assurance around how the committee can maintain strategic oversight of the monitoring of training programmes. The committee agreed this matter would be escalated to the People Forum and be drawn to the attention of the Board.
QC/2015/177	**SERIOUS INCIDENT REPORT** Emma Flanders, Lead professional for Patient Safety, provided the Quality Committee with information relating to all Serious Incidents (SIs) occurring during November 2015. The report showed there has been a decrease (by 4) in the number of incidents reported externally during November compared to October. There has been a slight increase the number of major incidents occurring in November, but a reduction of the number of catastrophic. There are no specific patterns or issues arising within the analysis of the major / catastrophic incidents reported in November. There are currently 16 overdue actions from SIRI investigations. A review of the actions overdue shows that there are 5 actions overdue in excess of 3 months. The Patient Safety team continue to actively support the SI Group to monitor these actions and a progress report will be incorporated at Carolyn Green's request in the next report. Phil Harris thought the report had significantly developed and the actions matrix was a big improvement. However, he was concerned that within the report it was difficult to understand the incident and whether actions were entirely appropriate. He suggested that a brief description of the incident linked to the recommendation would help provide assurance around the incident. Carolyn Green pointed out than although more incidences were being investigated they are not of such a serious nature that they required a three person investigation. It was noted that many outstanding investigation recommendations have been completed and closed. This is due to focused work in this area. The committee noted a gap in assurance in the full compliance and capability / competence of recording capacity in relation to the differences between the Mental Health Act and Mental Capacity Act. This related to a specific clinical incident and issue in older adults, with regard to an unauthorised and technical use of seclusion in an older male with behavioural disturbance. The incident review outlines the incident, the learning and the service improvements required to ensure staff learn, reflect and change their practices. Derbyshire Voice challenged whether the individual was given a de-brief and Carolyn Green explained the cognitive state of the gentlemen and the circumstances and confirmed that being open procedures had been applied and a response had been given to the individual and the family. The committee felt assured that John Sykes had formulated an action plan that will resolve this, the results of which would be reported to the Mental Health Act Committee in February. The committee discussed investigations of deaths in the Southern report, particularly of people with learning disabilities. It was agreed that John Sykes would establish if there are any gaps in investigations within the Trust regarding all incidents and of people with learning disabilities. He would invite Emma Flanders to the next meeting of the Trust Medical Advisory Committee (TMAC) to explore the learning from this report and undertake some checks and reviews from the investigation to establish any

	learning or improvements the Trust would need to take. He would also look at the analysis and training in physical and mental healthcare. As a trust our quality priorities are physical healthcare and monitoring of sudden deaths (suicide or physical) and the mortality gap. Carolyn Green raised the issue of risks arising in the transition between paper / electronic records prior to the compulsory move to full electronic records as some themes in incidents are concerned with the transfer of paper records to electronic records and the gaps in knowledge that can result in lost information that is not always accessible. It was agreed that Carolyn Gilby would look at the risks being raised by the EPR (Electronic Patient Record) Board and would provide a report to the March meeting of the committee on how these risks will be mitigated. **ACTION: Patient Safety Team will continue to actively support the SI Group to monitor overdue actions and a progress report will be incorporated in the next report.** **ACTION: Emma Flanders to provide a brief synopsis of incidents contained in the report to make it easier to understand incidents.** **ACTION: John Sykes to ensure TMAC's (Trust Medical Advisory Committee) group of sudden death looks at analysis and training in physical and mental healthcare.** **ACTION: John Sykes would invite Emma Flanders to the next TMAC meeting.** **ACTION: This SIRI report to be submitted to the People's Forum as the thematic analysis is demonstrating that care planning and communication remain key risks. The education team is to consider the thematic learning and requirements to develop skills around team communication; examples could be whilst working under pressure, effective clinical communication, patient safety planning, clinical record keeping, clinical scenarios and clinical formulation. These will be included in the training plan which will look at human factors, especially communication.** **ACTION: Carolyn Gilby to look at risks being raised by the EPR (Electronic Patient Record) Board and will provide a report to the March meeting of the committee.** **RESOLVED: The Quality Committee evaluated the report and received improved assurance in the processes involved of emergent and current issues under a monitoring brief by the SIRI Group.**
QC/2015/178	**<u>RESUSCITATION TRAINING REPORT</u>** This report, presented by Training Manager, Tracy Shaw, provided an in depth view of the Life Support training position. The committee noted that the Trust currently provides four types of resuscitation training: • Basic Life Support (BLS) for all clinical community staff • Paediatric and Adult Basic Life Support (PABLS) for all clinical staff in children's, CAMHS and perinatal services • Basic Life Support & AED for clinical support staff in in-patient settings • Immediate Life Support (ILS) for registered nurses and medics. The committee recognised that training planning had been difficult as the resuscitation

	lead had been off work since the end of April. This resulted in ILS training not being able to be delivered due to the absence of a course director. The Trust previously indicated that training should be aligned with the UK Resuscitation Council and that staff (medics and in-patient nurses) are trained in ILS. In the absence of a course director this has provided the Trust with physical and financial challenges for the ongoing financial year but it is hoped that the training trajectory will get back on course by March 2016. A compliance of 85% was seen as the target. However, the committee required further assurance that this level can be reached and this was viewed as a partial gap in assurance with a mitigation plan in place. It was agreed that strong measures would need to be adopted to mitigate the delay in ILS training. Carolyn Gilby will arrange for risk assessments to be carried out on ILS training and be identified on the risk register, together with a check on bank staff to assess their levels of training to judge if this constitutes a risk. This will be addressed by ELT to establish the tolerance level of training compliance. It was agreed that the need for the risk assessment to be updated in the BAF will require a specific narrative. **ACTION: Tracy Shaw will provide Carolyn Gilby with a report (for cascading through the operational line) to show if any staff have not completed any training. This group will be prioritised, rather than staff whose annual compliance is expiring, and will then to return to the general renewal of clinical competence through core requirement training.** **ACTION: Specific narrative on ILS training is required for the clinical risk register and a gap in assurance on the BAF under Section 1.** **ACTION: Tracy Shaw to provide an update report on training to the Quality Committee in March. Any further deterioration in performance should be escalated quickly to enable improvement** **ACTION: Carolyn Gilby will arrange for risk assessments to be carried out on ILS training and be identified on the risk register, together with a check on bank staff to assess their levels of training to judge if this constitutes a risk. This will be addressed by ELT to establish the tolerance level of training compliance.** **RESOLVED: The Quality Committee considered the report, acknowledged the interim arrangements and agreed strong measures would need to be put in place to mitigate the delay in ILS training.**
QC/2015/179	**<u>LIGATURE RISK REDUCTION UPDATE</u>** This report provided the Quality Committee with an update in relation to Ligature Risk Reduction being of high priority within the Health & Safety portfolio. The committee noted it was necessary to review all Ligature Risk Assessments in the Trust to ensure they are suitable and sufficient in line with required regulations as part of the requirements in our Trust policy. Carolyn Green reminded the committee of the CQC regulations and guidance that was circulated at the last meeting to refresh all committee members with the required regulatory standards in addition to our policy standards. Health and Safety Manager, Carrina Gaunt, highlighted the priorities for ligature risk reduction in 2014/15. She pointed out that Service Line Managers and Senior Nurses / Ward Managers were asked to ensure that point of ligature risk assessments had been either carried out or reviewed for all premises or areas they are responsible for to ensure that in their clinical opinion, managing and mitigating the risk was considered. In addition, an assurance level check had been carried out as part of the standard operating procedure to re-check the clinical and non-clinical areas to ensure staff have

	not missed any additional ligature points. This check had been undertaken with estates, health and safety and a senior nurse representative. Over the years a number of improvements and ligature minimisation had occurred and this is part of the continual process. The spread sheet of all known ligature risks, works undertaken to-date and the work plan for continued improvement was listed. This included mitigations and high visibility of the risks to services while they awaited continued and planned schedule of works and the clinical prioritisation. This captured the highest priority to bedroom and bathroom, and the clinical risk levels were agreed with the Nursing and Quality team. Carrina Gaunt noted that learning is obtained from national information shared at the Mental Health and Learning Disability Forum. This resulted in a review being carried out of all shower heads. We are continually re-visiting ligatures, and never events and environmental risks, as reported earlier in the year, to readdress ligatures. This is a continually changing level of risks as new awareness and new products come onto the market. The report also included a breakdown of the costs in order to reduce or remove the ligature risk. Phil Harris was of the opinion that there should be a continuing budget to address this. He thought the costings were high and it was understood that this was due to buildings being grade 2 listed and PFI. It was agreed these costs would be challenged and taken to the Finance & Performance Committee for a review of best values. The committee noted the contents of the report and agreed that a further update report would be received in May 2016 and this will be reflected in the forward plan. **ACTION: Update report on Ligature Risk Reduction to be included in forward plan for May 2016.** **ACTION: Costs to reduce or remove ligature risks to be challenged and will be taken to the Finance & Performance Committee for a review of best value.** **RESOLVED: The Quality Committee:** **1) Understood the current compliance level in regard to ligatures in the Trust.** **2) Was briefed on the current level of assurance being partial and the current risks mitigations and work plan.** **3) Was appraised of the current course of action to further risk reduce in these areas.**
QC/2015/180	**<u>SUPPORT FOR EMPLOYEES UPDATE</u>** This report provided the Quality Committee with an update in relation to support for employees and included an overview of the work that has been undertaken in regards to the health and wellbeing of staff. This was an action taken from the Trust Board meeting when Tony Smith requested that the Board should gain greater understanding and assurance in the health and well-being system for staff, and that a report to the Board needed to include more detail on the management of stress and sickness. The committee accepted that this work will be included in the Health and Safety Annual report to the Board next year. Tony Smith was of the opinion that the report ought to be linked in with the Staff Health Check. It should also escalate issues in Health and Wellbeing to align support to staff alongside sickness trends and be triangulated with the results of staff health survey relating to lack of role clarity, leadership etc.

	It was agreed that a Support for Employees' update would be provided to the committee at regular intervals to gain greater assurance of the system and the use of the system e.g. was the system working. This report would be submitted to the People Forum to align this support alongside sickness trends and triangulated with the health check and staff survey to identify causal factors and any required service improvements. John Sykes informed the committee that a reciprocal agreement is in place with Nottingham Healthcare for staff who would not want to be treated within this Trust. Work was also taking place with HEEM to give support to junior doctors. **ACTION: Carrina Gaunt to include more detail of sickness and stress management in all subsequent Health and Safety reports.** **ACTION: This report will be escalated to the People Forum and to Jayne Storey to align this support alongside sickness trends and be triangulated with the health check and staff survey to identify causal factors and any required service improvements. The People Forum and Jayne Storey are requested to provide a written report back to the Quality Committee on their progress by March 2016** **RESOLVED: The Quality Committee noted the contents of the report.**
QC/2015/181	**HEALTH & SAFETY FOCUSED REPORT - FRESH AND HEALTH TECHNICAL MEMORANDUM BED ASSEMBLIES** This report provided the Quality Committee with an update in relation to the implementation of the FRESH project (Going Smoke free), regarding current Health Technical Memorandum (HTM) requirements for bed assemblies e.g. bed mattresses/ structures and bedding within the Trust's healthcare settings. The committee acknowledged that smoking in non-designated areas has always been problematic and in the move to a smoke free environment these risks may increase. The Trust's analysis of its own changes in smoking in the past and in other Trusts when they moved to a smoke free environment show that risks have changed and an increase in covert or hidden smoking in high risk areas often occurs. It was noted that ELT approved a plan to replace group 5 fire resistant mattresses in acute and low secure areas with group 7 mattresses and this will be reviewed further by ELT in three months' time. The committee noted that a full update on the implementation of HTM requirements for bed assemblies will be contained within the Annual Fire Health and Safety Report to the Board, this will include assurances that all recommendations have been implemented and an analysis of fire related incidents pre and post smoke free implementation. **RESOLVED: The Quality Committee received the report and acknowledged the course of action taken.**
QC/2015/182	**OCCUPATIONAL THERAPY IN MENTAL HEALTH STRATEGY** This strategy will provide a framework for the development of Occupational Therapy Services in Mental Health within the Trust. It is in line with the current Trust Strategy and can be adapted to align with the new Trust Strategy when developed. The committee recognised that this strategy defines how Occupational Therapy will contribute to the health and wellbeing of the people who use the Trust's services. It links national directives to local delivery of neighbourhood modelling in an integrated approach enabling people to move from direct care, to shared care and to self–

	manage their recovery. The committee noted the work carried out at Bolsover and the quality of the improvements that have been made and the key clinical professional leadership that has enabled these clinical practice improvements to take place. Discussions centred around whether occupational therapy teams contain the right capacity. It was noted that the framework around leadership is being looked at as a way to move forward to neighbourhoods and operating procedures should reflect the self-care and shared care. It was suggested that there should be a change in the skill mix of the team to meet the needs and demand of our population and if the clinical model requires a re-enablement strategy, the clinical professionals with the closest skill set could be distributed and recruited to meet the greatest needs. This should and is factored into the Neighbourhood model and redesign and the WorkPro modelling and clinical skill mix reviews being undertaken. The committee liked the style of the report which contained positive comments contextualised within the strategy over five year period. It was agreed this was an enabling strategy that is not required to go to the Board but an annual report will be received by the Quality Committee showing results of the action plan. It was noted that the Trust strategy was being reviewed which may result in changes being made to this work plan and this was noted and accepted. **ACTION: Annual Mental OT Report progress against strategy to be received by the committee and will be featured in the forward plan Scheduled for December 2016.** **RESOLVED: The Quality Committee** **1) Considered the report** **2) Scrutinised the contents** **3) Agreed this was an enabling strategy that does not need to go to the Board but an annual report will come to the Quality Committee showing results of the action plan within 12 months.**
QC/2015/183	**<u>SKILL MIX ESTABLISHMENT REVIEW IN INPATIENT SERVICES</u>** This report provided the Quality Committee with the findings and recommendations relating to the inpatient skill mix review and was presented by Carolyn Green in Sarah Butt's absence. The report contained a number of recommendations on clinical operational matters that need to be improved to provide a safe and effective clinical environment that Carolyn Green asked the committee to review and endorse. Carolyn Green will circulate the skill mix to ELT to finalise the costings, and the impact of the skill mix review. This will enable her to take the recommendations to the Quality Assurance Group (QAG) and to commissioners for contracting. Petrina Brown challenged the report. She thought psychological services linked in with treatment care pathways would be an area that needs to be included in the next report. Carolyn Green confirmed that next year a wider skill mix review should include access to psychology on in-patient settings including campus. The immediate NHS England guidance was concerned with nursing numbers, however Carolyn Green and Sarah Butt had taken the skill mix wider than that but had not included a full psychological services review. It was noted that access to clinical psychology and psychological therapy in all areas was a known risk and was being factored into contractual discussions and planning. Sangeeta Bassi also challenged the review and requested that pharmacy should have

	been included as well as the provision of pharmacy and technician services to the wards. Carolyn Green reconfirmed that a wider skill mix review next year should include access to pharmacy support on in-patient settings, including campus in line with the pharmacy strategy. It was noted that pharmacy provision was a known risk and was being factored into contractual discussions. Planning had already been submitted and discussed during a Trust Board deep dive and had been presented at the commissioners quality assurance group. The committee accepted the recommendations contained in the report and agreed that ELT would address and focus on the cost issues and Carolyn Green would escalate the matter to commissioners through QAG to the January scheduled meeting. The committee received partial assurance in terms of staffing and full assurance on a plan in place and best use of current staff. It was noted that it was the inpatient and increase in community staffing capacity that is required and this would be reflected in the risk register. There were no challenges to the actual content of the report or its recommendations and these were agreed as detailed and positive recommendations. The committee agreed the review would be refreshed in six months' time and the forward plan will be updated to reflect this. **ACTION: Forward plan will be updated to reflect a refreshed Skill Mix Establishment Review in Inpatient Services being received by the committee in June 2016.** **RESOLVED: The Quality Committee** **1) Received the report** **2) Scrutinised the findings and recommendations for action** **3) Accepted the recommendations of the report**
QC/2015/184	**<u>CLINICAL AUDIT UPDATE AND TRAJECTORY</u>** This report provided the Quality Committee with an update on Clinical Audit Project status since last month's report. Rubina Reza highlighted the 16 projects shown on the action plan. These will be focused on and she was aiming to get four signed off each month. The committee was pleased to note that the Research & Development Governance Committee terms of reference, membership and attendance had been reviewed and actions were being taken to facilitate improved attendance. It was pointed out that the new Clinical Audit Co-ordinator will start in post in December and it is hoped this will help to increase the pace and completion of projects reflected in the trajectory and will help action plans to be agreed and completion of projects taken to different committees for sign off. Tony Smith did not agree with bureaucratic signing off of action plans as he could not see the value of taking this through a committee if it did not add value. John Sykes explained that service users sometimes give useful contribution to discussions and this helps with the sign off process. It also helps with the buy in of the clinical divisions to understand the audit cycle, what has been prioritised and why, and be part of the process. The audit team felt that the inclusion was essential and it did add value. The committee received partial assurance around the follow through of audit projects, recognised the capacity limitations and received and accepted the trajectory. It was

	noted that the Clinical Audit progress would be further reviewed in more detail by the Audit Committee on 15 December and the Quality Committee would be guided by the Audit Committee on any additional concerns and / or assurances received by the Quality Committee. **RESOLVED: The Quality Committee noted the content of the report and would be guided by the decisions made at the Audit Committee.**
QC/2015/185	**UPDATE REPORT ON CHESTERFIELD CENTRAL NEIGHBOURHOOD TEAM** This item arose from the actions matrix and Brenda Rhule joined the meeting to provide a verbal update on community capacity and concerns raised by Derbyshire Voice on caseload capacity and what is keeping people out of the reach of the Chesterfield Crisis Teams and supported by the Chesterfield Community Team Brenda Rhule informed the committee that she had observed clinics that were very well run and that patients were happy with the service they received. Use of Electronic Patient Record has been an issue and she will undertake a random audit of users to establish areas of risk in record keeping which had been identified by the divisional nurse during the visit. A training programme will be carried out with the team in January to ensure safe standards of record keeping are being followed as part of good practice training. The Quality Leadership Team (QLT) will monitor capacity across all community teams and this will be captured within a skill mix review and will be included in the design of the new clinical community dashboards. The committee noted that good progress was being made and acknowledged that this was a good example of positive support intervention and follow up of a concern raised by Derbyshire Voice. The committee was satisfied that the QLT will carry this forward which provided the committee with an up-date of the current state of play of work in progress and partial assurance was given until all actions were put in place. It was agreed that a further update report be received by the committee in March. **ACTION: Brenda Rhule and Sarah Butt to provide a report to the committee in due course on progress, scheduled for March 2016.** **RESOLVED: The Quality Committee noted the verbal update on Chesterfield Central Neighbourhood Team.**
QC/2015/186	**POLICY GOVERNANCE UPDATE** The report received by the committee in August was submitted in error due to an error in attachments and the current report was subsequently circulated by email to the members of the committee. The committee noted that 88% of policies are now in date and this demonstrated that work is significantly progressing compared to 2013 and 2014 performance. Continued targeted improvement will be required to reach full compliance and maintain this level of performance. This will be closely monitored by the Quality Committee until achieved. The revised Policy on Policy Documents was routinely reviewed and duly ratified by the committee. Rachel Kempster suggested that Urgent and Planned Care QLT and Substance Misuse QLTs have now been authorised to take the responsibility for ratifying certain policies in their area of scope and this was agreed by the committee. **RESOLVED: The Quality Committee looked forward to receiving the current**

	Policy Governance Update outside of the meeting and ratified the Policy on Policy Documents.
QC/2015/187	**STAFF FRIENDS AND FAMILY TEST** This report provided the Quality Committee with the latest Staff Friends and Family Test results (Staff FFT) and focussed on hot spots within the Trust and the action plan and contained the following: • An overview of Staff FFT results (Q1 June 2015 & Q2 September 2015) • Analysis of Staff FFT results by Division and Staff Group • June 2014 to June 2015 shows a decline in staff recommending DHCFT to friends and family if they needed care or treatment and as a place to work, however September 2015 shows for the first time an improvement in results. • Detailed analysis of Staff FFT responses 'Extremely Unlikely' • Next steps/action plan The committee agreed this was a difficult read; the personal comments of staff were of concern, although there was a slight improvement. Carolyn Gilby asked members of the committee for their thoughts on action planning and how this will be taken forward. The committee received low assurance in terms of how the Trust compared with other trusts and was disappointed in the results of staff recommending the Trust to friends and family as a place to work and a place to receive treatment. This would be escalated to the Board and to the Finance & Performance Committee and People Forum to assess the work plan and its impact. The issue of raising concerns and bullying would be benchmarked against high performing trusts to learn how they are engaging with staff and if any other organisational learning can be adopted to assist with driving forward improvement in this area of concern. Family and Friends Test results would be escalated to the Board though a Board brief. This will also be escalated to People Forum and ELT and be developed as part of a work plan and will focus on raising concerns and bullying. Staff feelings and morale within this cohort particularly need to be considered, listened to and concerns acted upon. **ACTION: Escalation of this report to the People Forum to Jayne Storey to align this support alongside other intelligence to identify causal factors and any required service improvements. The People Forum and Jayne Storey are requested to provide a written report back to the Quality Committee on their progress by March 2016** **RESOLVED: The Quality Committee considered the report and scrutinised the contents.**
QC/2015/188	**POSITION STATEMENT ON QUALITY** The report provided the Trust Board of Directors and the Quality Committee with an update on the Trust's continuing work to improve the quality of services provided in line with the Trust's Strategy, Quality Strategy and Framework and strategic objectives. This report was received by the Board in November. Carolyn Green highlighted the response times and that the team aim to begin work with patients located in ED within one hour of the team becoming aware of them. This was achieved in 94.9% of cases.

	The team aim to begin work with patients located on wards within 24 hours and this was achieved in 82% of cases. Carolyn Green also drew attention to the patient experience work plan relating to the daily routine of the wards and she informed the committee that an update will be received from the heads of nursing at the February meeting of the committee. **ACTION: Updated Patient Experience Work Plan to be submitted to the February meeting of the committee.** **RESOLVED: The Quality Committee:** **1) Noted the quality position statement and attached dashboard and trends.** **2) Scrutinised the current position and work plan and additional information to provide assurance.** **3) Agreed the Quality Committee is to receive scheduled reports on areas of improvement.** **4) Noted key areas to develop a greater understanding of performance and which committees are to have oversight with a named improvement plan:**
	a. Safety on our wards and patient experience (Sarah Butt and Positive and Safe work plan) **b. When you arrived on the ward, or soon afterwards, did a member of staff tell you about the daily routine of the ward, such as times of meals and visitors times? (Richard Morrow/ Bev Green/Kate Sargeson – information and service receiver induction/welcome to their environment patient experience work plan) (QA3)** **c. Were you able to get the specific diet that you needed from the hospital? (Patient Experience and Physical Healthcare Committee) (Q8), Hayley Darn** **d. Percentage of staff having well-structured appraisals in last 12 months (Q8) (Finance & Performance Committee / People Forum) Jayne Storey and Carolyn Gilby will produce a report to be received from the Finance & Performance Committee to the Quality Committee on improvements in this area.**
QC/2015/189	**ITEMS INCLUDED FOR INFORMATION** The following items were received and noted by the committee: • Governors Working Group Report • Specialist Services Quality Leadership Team minutes • Urgent and Planned Care Quality Leadership Team minutes
QC/2015/190	**FORWARD PLAN** The forward plan would be updated in line with today's discussions and presented for reference at the next meeting of the committee.
QC/2015/191	**ITEMS ESCALATED TO THE BOARD OR OTHER COMMITTEES** • The Board, People Forum and Finance & Performance Committee to review the strategic oversight of mandatory and developmental training programmes. • Support for Employees Escalation to People Forum to align this support alongside sickness trends and triangulated with health check and staff survey to identify

	causal factors • Finance & Performance Committee – costs associated with reduction of ligature points and building / replacement costs which appear high • ELT to address the implementation and cost issues of the skill mix review • Family and Friends Test results would be escalated to the Board though a Board brief. This will also be escalated to People Forum and ELT to develop as part of a work plan that would focus on staff feelings, morale, raising concerns and bullying.
QC/2015/192	**ANY OTHER BUSINESS** The Committee were informed that this was Chris Fitzclark's last attendance as a representative of Derbyshire Voice and thanked him for his service and wished him well for the future.
QC/2015/193	**EFFECTIVENESS OF THE MEETING** The committee felt the agenda was particularly heavy at this meeting but good essential discussions were held.
Date and Time of next meeting: The next meeting of the Quality Committee will take place on: **Thursday, 14 January 2016 at 2.15 pm** ***Venue: Meeting Room 1 – Albany House, Kingsway, Derby***	

.

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE SAFEGUARDING COMMITTEE

Held in the Board Room, Bramble House, Kingsway, Derby DE22 3LZ

Friday, 23 October 2015

PRESENT:	Maura Teager	Chair and Non-Executive Director and Deputy Trust Chair
	Tony Smith	Chair, Non-Executive Director
	Carolyn Green	Director of Nursing and Patient Experience
	Tina Ndili	Head of Safeguarding Children
	Deepak Sirur	Consultant Psychiatrist in Substance Misuse
	Gulshan Jan	Consultant Psychiatrist in Learning Disability
	Lesley Smales	Designated Nurse for Children In Care
	Tracy Shaw	Training Manager
	Samragi Madden	Healthwatch Derby
	Bill Nicholl	Southern Derbyshire CCG
	Andrew Stokes	Crime Support, Derbyshire Constabulary
IN ATTENDANCE: For item SC/2015/032	Sue Turner	Board Secretary
	Marek Hoffman	Assistant Practitioner, New and Emerging Communities Team
	Ameera Zaman	Work Experience Student
APOLOGIES:	Mark Todd	Trust Chairman
	Ifti Majid	Acting Chief Executive
	Michelina Racioppi	Southern Derbyshire CXG
	Jayne Storey	Director of Transformation
	Joanne Kennedy	Consultant Child & Adolescent Psychiatrist
	Jenna Davies	Interim Director of Corporate & Legal Affairs
	John Sykes	Executive Medical Director
	Tracey Holtom	Service Line Manager
	Brenda Rhule	Interim Head of Nursing
	Wendy Brown	Consultant Psychiatrist and Clinical Director
	Richard Morrow	Service Manager
	Hamira Sultan	Consultant in Public Health, Children and Young People
	Kate Sargeson	Divisional Nurse
	Garry Southall	Principal Workforce & OD Manager
	David Tucker	General Manager, Special Services

SC/2015/024	**WELCOME AND APOLOGIES** The Chair, Maura Teager welcomed everyone to the meeting. Introductions were made around the table and apologies were noted as listed above.
SC/2015/025	**MINUTES OF THE MEETING DATED 7 AUGUST 2015** The minutes of the meeting, dated 7 August were accepted and agreed.
SC/2015/026	**ACTIONS MATRIX** The committee agreed to close all completed actions and updates were provided by members of the committee and noted directly on the actions matrix.

SC/2015/027	**MATTERS ARISING** **SC/2015/009 Safeguarding Adults Performance Data Dashboard**: This dashboard is a matter for the City and County Safeguarding Boards. This can be included in the Safeguarding Adults work plan but it is not an action for this committee. **SC/2015/018 Safeguarding Adults – Annual Report:** Maura Teager queried whether there was a difference in the way agencies manage what appears to be variable thresholds. This is a multi-agency initiative and Tina Ndili explained that work had taken place on threshold criteria and the escalation policy. The escalation process with regard to safeguarding casework drift requires further work and Tina Ndili will progress this. **SC/2015/020 Safeguarding Adults – PREVENT Duty Guidance:** Samragi Madden was concerned that she had not received information regarding accompanying colleagues to the PREVENT training planned for October or an invitation to the PREVENT / CHANNEL meeting. Carolyn Green felt this was because the training had been delayed and she agreed to keep her informed of developments. The committee noted that Tracey Holtom attends the PREVENT Strategy / CHANNEL meetings and Tina Ndili will also attend the next meeting to represent Children's Safeguarding. Michelina Racioppi attends on behalf of the CCGs and it was noted that full police clearance is required to attend these groups and can often cause delays.
SC/2015/028	**SAFEGUARDING CHILDREN STRATEGY UPDATE** The purpose of the Safeguarding Children Strategy is to provide the Safeguarding Committee and the Trust's Board with an overview of the safeguarding children agenda. Tina Ndili emphasised the key areas within the strategy that described the team's vision, key goals and how they would be accomplished. She highlighted the five priority areas which are critical for continual improvement in order to achieve better outcomes for children, young people and their families: 1. Culture 2. Workforce 3. Leadership 4. Quality of Practice 5. Performance management and quality assurance The committee acknowledged that safeguarding is everyone's responsibility. Discussions developed around quality of practice, training and access to training and it was agreed that the leadership teams should support staff to understand they have to protect/allocate time for training. It was recognised that the strategy has the right foundations and shows forward thinking priorities. Tony Smith and Maura Teager offered to work with Tina Ndili and Joanne Kennedy to develop the strategy further. This will include matching the strategic aims to tangible outcomes and success criteria to each key domain and will enable easy measurement of achievements. The draft work plan will be linked to the April 2015 outline Strategic Priorities Position Statement. An operational group review of the strategy will take place on a six-monthly basis and a revised version of the strategy will be received by the committee at the next meeting in January. **ACTION: Sue Turner to co-ordinate a meeting with Tina Ndili, Joanne Kennedy, Maura Teager and Tony Smith to develop the strategy further.** **ACTION: Revised version of the strategy will be an item for the agenda of the**

	next meeting in January. **RESOLVED: The Safeguarding Committee challenged the detail and content of the report and recognised it was the responsibility of all professional, service receivers, carers, children and young people, their families and volunteers to implement the strategy for Safeguarding Children.**
SC/2015/029	**DRAFT SAFEGUARDING CHILDREN – WORK PLAN 2015-16** The purpose of the Safeguarding Children Work Plan is to give clear strategic direction with timescales of the work to be completed by the safeguarding team, service line managers and operational managers in order to deliver the safeguarding children strategy and agenda. The committee acknowledged the work plan was a good starting point and would be developed further once the strategy has been refined. A revised version of the work plan would be received by the committee at the next meeting in January that will prioritise the mitigation plans to reduce the risks and vulnerabilities/areas of concern and show the safeguarding governance process across partnerships linked with the terms of reference. **ACTION: Revised version of the work plan will be an item for the agenda of the next meeting in January.** **RESOLVED: The Safeguarding Committee received partial assurance on the work within DHCFT around safeguarding children and young people and the continued 'Think Family' agenda operational level planning and performance.**
SC/2015/030	**UPDATE ON SAFEGUARDING CHILDREN TRAINING REPORT** The committee received a combined update report on safeguarding training for children and adults. The committee discussed the content of the report and agreed that future updates should specify vulnerable areas of non-compliance rather than contain the level of detail shown in the report and the use of graphs would provide a better level of assurance. An operations analysis group would be asked to look for gaps in DATIX reports to establish any gaps in training. The committee's terms of reference state that the Safeguarding Committee is accountable for safeguarding training. There are concerns about achieving the required level of trajectory for training compliance and this concern would be escalated to the Executive Leadership Team. Carolyn Green pointed out that the prime focus would be to achieve level 3 and she hoped that the next report to the committee will show the actions in place to drive this forward and the engagement with key stakeholders to achieve this. Samragi Madden asked whether there was a mechanism in place to monitor number of people who do not have adult level one or children level one certification and whether this reflected an increase in incidents or lower reporting of incidents. Carolyn Green confirmed that this level of analysis was not available at this stage. **ACTION: Operations analysis group to look for gaps in DATIX reports to establish gaps in training.** **ACTION: Concerns relating to non-compliance with Safeguarding Children**

	Training to be escalated to Executive Leadership Team. **RESOLVED: The Safeguarding Committee received partial assurance on the level of compliance with Safeguarding Children Training, due to the change in style of the training report and this concern would be escalated to the Executive Leadership Team to rectify this reporting issue.**
SC/2015/031	**THINK FAMILY TRAINING REPORT** The Think Family training information showed the data collated from the system and was provided for information purposes. **RESOLVED: The Safeguarding Committee received Think Family Training Data.**
SC/2015/032	**NEW AND EMERGING COMMUNITIES (SM13 – SCR)** This report informed the Safeguarding Committee of the new and emerging community service and the challenges faced by this very small team and the wider workforce in child and family services. The report highlighted the roles and responsibilities of the teams within children's services and described the current projects being undertaken. The report also showed the learning from SCR SM13 of areas for consideration for staff working with new and emerging communities with regard to parenting and safeguarding. Marek Hoffman, Assistant Practitioner for the New and Emerging Communities Team Child and Family Service attended the meeting and discussed the key challenges he faces engaging with vulnerable families who are new to the UK from Eastern European countries. Marek Hoffman explained how he and Sue McCrea, a Specialist Health Visitor, work with these communities to encourage people to have confidence and trust in the services the Trust provides. Serious case examples were discussed which provided the committee with a good oversight of the concerns arising within the organisation from these new and emerging communities. The committee understood the reasons for gaps in the service and felt that a community nurse would be a valuable addition and would enable work to be carried out with children. The committee was pleased to note that Marek Hoffman was engaged with the healthy child programme and commended this work. The committee agreed that resources and capacity issues would be considered in line with the challenges the team faces delivering this service within this growing population. Carolyn Green would escalate these challenges to the Safeguarding City Adults Board and Quality Assurance Group and place this as a risk on the risk register. When Carolyn Green escalates this issue she is acutely aware of the financial envelopes operating in the Derby City public health agenda and restrictions and retractions to many services. She would escalate these risks, but did not want to give the clinical team false hope of a straight forward resolution. Samragi Madden offered Marek Hoffman support from Healthwatch Derby with health and social care services. The committee congratulated Market Hoffman and Sue McCrea on their work and recognised the challenges they face and agreed this matter would be raised on other board platforms. **ACTION: Carolyn Green will escalate the challenges of the New and Emerging Communities Team with the Safeguarding City Adults Board and Quality Assurance Group and place this as a risk on the risk register.**

	RESOLVED: The Safeguarding Committee noted the service provided by the New and Emerging Communities Team Child and Family Service and the challenges it faced and gave consideration to how this could be mainstreamed where relevant to other services within the Trust.
SC/2015/033	**SAFEGUARDING CHILDREN ADVICE THEMES – JULY – SEPTEMBER 2015** Tina Ndili's report highlighted the issues encountered when staff contacted the advice system to seek support / advice to inform strategic planning. This report was provided for information and the committee noted that information on referrals will be available at the next meeting in January. It was acknowledged that the report did not accurately capture data for children coming into care or the reasons why CAMHS are not accessing the helpline and this would be explored. Carolyn Green felt this was a cold area and there were gaps that required further analysis and she would like the CAMHS and Children's Clinical Reference Group and the ACD for CAMHS, Joanne Kennedy to pursue this action and asked that the committee support this action. in order to influence a rethink and review on why CAMHS s do not access the helpline, Although the 'Safeguarding Children Advice and Themes' national report was provided more for information, it was suggested that the report could be an item for a future agenda of Council of Governors. Carolyn Green suggested that the CAMHS CRG could be invited to attend a meeting of this committee to give a presentation on their bid submission on CAMHS future developments by ACD Jo Kennedy. **ACTION: Information on referrals will be given at the next meeting in January.** **ACTION: Gaps in CAMHS accessing the helpline requires further analysis. Joanne Kennedy to pursue this action.** **RESOLVED: The Safeguarding Committee is requested to:** **1) Appropriately challenged the process of the advice system and how this can be improved.** **2) Noted the themes and issues to gain an understanding of Safeguarding related issues and the reference to 'Think Family' and considered this information and its impact in setting the strategic direction.**
SC/2015/034	**SAFEGUARDING ADULTS STRATEGY** Carolyn Green provided a verbal report on the current status of the safeguarding adults strategy. In April 2015 the committee received a report on the strategic intentions for safeguarding adults drawing upon the population needs, the strategic plans for the two Safeguarding Boards and key requirements from national policy drivers. This document and analysis was to inform the then interim lead professional for safeguarding adults and named doctor on the key frameworks to devise the Trust's safeguarding adults strategy. Due to clinical activity of the Safeguarding Team and the need for Tracey Holtom to work part time to provide immediate cover as Service Line Manager to the Radbourne Unit, the strategy development work has been paused until direct service input

	stabilised. This has now occurred. Apologies were provided for Tracey Holtom, Lead Professional for Safeguarding Adults who was unable to attend the meeting due to an immediate serious safeguarding adults risk issue. It had been agreed that the safeguarding adults strategy presentation of the draft strategy would be deferred to the next meeting in January. Carolyn Green provided a verbal report and assurance that the strategy would be developed and the risk level to the organisation was mitigated by the interim arrangement of the strategic intentions and the current safeguarding adults work plan. Key specific areas Carolyn Green has identified as organisational priorities which may be slightly different priorities to the national agenda was in light of the development of early warning signs of staff misconduct or blurring of professional boundaries leading to relationships with patients in their care. Carolyn Green highlighted a key area of the safeguarding adults strategy and recommended that the adequacy of the Trust's service offered to victims of historical sexual abuse and the development of pathways and procedures within our organisation, or within our wider communities, both for children and adults, be developed along with clinical standards in line with the independent investigation into the care of children and young adults in Rotherham. **ACTION: Safeguarding Adults Strategy to be an agenda item for the January 2016 meeting.**
SC/2015/035	**SAFEGUARDING ADULTS WORK PLAN 2015-16** The purpose of the safeguarding adult work plan is to provide board level assurance on the strategic and operational direction. The work plan is based upon the strategic intentions of the Derby City and Derbyshire Safeguarding Boards, the Care Act, the statutory duty to the PREVENT policy and the making of a safeguarding personal policy document. This will inform the Board on timescales of the work to be undertaken within Safeguarding Adults. The lead professional for Safeguarding Adults will lead, put systems in place and inspire the workforce to deliver the Safeguarding Adult Strategy. The committee appreciated that a lot of progress had been made to the work plan and Carolyn Green explained that she would like Tracey Holtom and Gulshan Jan to work together to write the strategy. She asked for other members of the committee to forward their thoughts on the strategy directly to Tracey Holtom. Carolyn Green asked for Bill Nichol's support in developing an internal safeguarding work plan to look at the issues around institutional views and personal relationships at work. She also asked for Andrew Stokes' (Derbyshire Constabulary) support in this endeavour. The committee supported the approach to the work plan and its primary objectives and noted the work plan had been developed against local and national safeguarding adults priorities. **ACTION: Tracy Holtom and Gulshan Jan to work together and write the Safeguarding Adults Strategy** **RESOLVED: The Safeguarding Committee:** **1) Reviewed the work plan** **2) Accepted and agreed the work plan and bi-monthly subsequent up-date**

	priorities.
SC/2015/036	**UPDATE ON PREVENT DUTY GUIDANCE AND TRAINING** Bill Nichol presented the update on this guidance which is designed for the specified authorities on the duty in the Counter-Terrorism and Security Act 2015 to have due regard to the need to prevent people from being drawn in to terrorism. The Act states that the Trust as a NHS provider must have regard to this guidance when carrying out its duty and place an appropriate amount of weight on the need to prevent people being drawn into terrorism. The committee acknowledged that in fulfilling section 26 of the Act, the Trust will participate fully in the work to prevent people from being drawn into terrorism. The PREVENT Strategy has 3 specific strategic objectives: • Respond to the ideological challenge of terrorism and the threat we face from those who promote it • Prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support; and • Work with sectors and institutions where there are risks of radicalisation that we need to address It was understood that this is a high profile extremism strategy and will be circulated to the committee for information and it would assist in the development of a PREVENT Policy statement that would inform staff of what to do if they have a concern. The committee discussed the appropriate progression of training frontline staff so they understand how to obtain support for people who may be exposed to radicalising influences. Tina Ndili will be the children's PREVENT lead and Tracey Holtom will be the Adult PREVENT lead for the Trust. **The named professional has confirmed that the Safeguarding Adults Level 3 Learning Objectives meets the required standard.** The committee acknowledged the good work being carried out and felt the strategy was a good way for organisations to share risks. **ACTION: PREVENT Strategy to be recirculated to members of the committee.** **RESOLVED: The Safeguarding Committee received and noted the PREVENT Duty guidance update and full assurance that a named lead is in place, a PREVENT policy is in place and a training plan. A future up-date will be included in the Safeguarding adults work plan presentations.**
SC/2015/037	**UPDATE ON SAFEGUARDING ADULTS TRAINING REPORT AND RAP** The committee received a combined update report on safeguarding training for children and adults. As with safeguarding children, the committee would prefer future updates to specify vulnerable areas of non-compliance rather than contain the level of detail shown in the report and the use of graphs would provide a better level of assurance. The committee noted that training is progressing well and there were no concerns with training or groups. WRAP 3 is included in Safeguarding Level 2. Level 2's will be put

	in place this year for induction days. There were concerns about achieving the required level of trajectory for training compliance and partial assurance was obtained on the level of compliance with safeguarding adults training. **RESOLVED: The Safeguarding Committee received full assurance on the training plan and limited assurance on the level of compliance with Safeguarding Adults Training due to the report format.**
SC/2015/038	**MIXED SEX ACCOMMODATION AND SEXUAL SAFETY (GENDER SENSITIVE SERVICES)** Carolyn Green's report provided the Safeguarding Committee with a review of the Trust's current compliance with safe working practices, dignity for service receivers, standards, required standards of practice and CQC regulations. This report was also received and discussed at length by the Quality Committee on 15 October. The committee acknowledged this as a comprehensive report that examined all the risks and mitigations and showed how the Trust had engaged with the CQC and commissioners. The committee was satisfied that the Trust was meeting the required regulations with mixed accommodation and noted that Carolyn Green would meet outside of the meeting to discuss the challenges and progress collaborate work with Andrew Stokes of Derbyshire Constabulary and Healthwatch Derby colleagues on a potential event in the Trust to develop sexual safety in our services. **RESOLVED: The Safeguarding Committee:** **1) Noted the complexity of the report and considered the risks associated with bed occupancy and additional changes to gender sensitive services. The regulators feedback and potential recommendations.** **2) Received assurance on the Trust's position and work plan.**
SC/2015/039	**FORWARD PLAN** The forward plan will be updated with actions arising from today's meeting.
SC/2015/039	**MEETING EFFECTIVENESS** The meeting ran to time and included some good discussions. Membership of the committee would be looked at. It was suggested that the children/adult agenda could be alternated at future meetings..
Date and Time of next meeting: The next meeting of the Safeguarding Committee will take place on: **Friday, 22 January 2016 at 1.00 pm** ***Venue: Meeting Room 1 –Albany House, Kingsway, Derby***	

MINUTES OF THE MENTAL HEALTH ACT COMMITTEE MEETING HELD ON FRIDAY, 27 NOVEMBER 2015 MEETING ROOM 1, ALBANY HOUSE, KINGSWAY

Present:	Tony Smith	Chair and Non-Executive Director
	Maura Teager	Non-Executive Director
	Christine Henson	Mental Health Act Manager
	Dr John Sykes	Medical Director
	Carolyn Gilby	Acting Director of Operations
	Hilary Beckett	Associate Hospitals Manager
	Kath Lane	General Manager, Planned Care, Urgent and Planned Care Division
	Tracey Holtom	Lead Adult Safeguarding
	Carolyn Green	Executive Director of Nursing and Patient Experience
	Dr Ritu Gupta	Consultant Psychiatrist
	Rachel Kempster	Risk & Assurance Manager
	Emma Flanders	Lead Professional for Patient Safety
	Beth Masterson	Junior Doctor
	Paul Emerson	Senior Practitioner/AMHP deputising for Jacky Ingerson
	Nicola Bishop	Deputising for Griff Hones
In Attendance:	Sue Turner	Board Secretary and Minute Taker
	Tina Ndili	Head of Safeguarding Children - observing
Apologies:	Jenna Davies	Interim Director of Corporate and Legal Affairs
	Sarah Butt	Assistant Director of Clinical Practice and Nursing
	Jacky Ingerson	Service Manager Central (AMHP) Team
	Griff Jones	Head of Safeguarding Adults
	Carole Robinson	Group Manager Mental Health, MCA & DoLS, Derbyshire County Council

MHA 2015/062	**WELCOME AND APOLOGIES** The Chair, Tony Smith welcomed everyone to the meeting and noted the apologies received above.
MHA 2015/063	**MINUTES FOM THE MEETING HELD ON 28 AUGUST 2015** The Minutes of the meeting held on 28 August, were agreed and accepted. It was noted that in future the term ED (Emergency Department) would be used rather than A&E.
MHA 2015/064	**MATTERS ARISING FROM THE ACTIONS MATRIX AND THE MINUTES** The committee agreed to close all completed actions and updates were provided by members of the committee and were noted directly to the matrix. **MHA2015/069 Statistics for Section 136 Implementation Group:** Jacky Ingerson was due to report on relapses in Section 136. In her absence Paul Emerson mentioned that relapse statistics were 55 out of 119 which is about 50% and this data would be circulated to members of the committee after the meeting.
MHA 2015/065	**RE-AUDIT CONSENT TO TREATMENT SECTION 58** Dr Edward Komocki's presentation demonstrated the progress achieved on the Re-audit of Consent to Treatment Section 58. The committee noted that this analysis is presented to TMAC (Trust Medical Advisory Committee) once a year along with the plan of action

	and that the Mental Health Act proposes the work to ensure this is processed and carried out. Also noted were the recommendations for the system that were contained in the presentation: • Continued use of the Section 58 flow chart attached to reminder letters. • To continue with the practice of utilising the established "MHA Supporters" to engage with all appropriate RC's when Section 58 needs to be considered. • To consider implementing an electronic alert on Paris (electronic notes) to remind clinicians. • Further presentations at TMAC and other relevant meetings. • DHCFT is heading towards utilising an EPR, but MHA documentation will still be of the paper variety. New paper form could be considered for handwritten completion which will act as both a prompt AND a record of all the required components of the Section 58 process. (All forms should be completed on Paris to ensure they form part of the EPR, handwritten hard copies should no longer be considered.) This could then be filed with all other MHA paperwork ensuring ease of access for all staff for reference and for future audits. (MHA paperwork will no longer be retained in hard format, other than original statutory documents. • The audit will be repeated annually to ensure compliance. Dr Komocki explained that this system will be simpler to use and will result in one piece of paperwork, the Mental Health Act Form. He also circulated the consent for treatment form during the meeting that will be produced on line and will be included in patient records. The committee recognised the effort that had produced some very positive results. The committee was assured by the progress that had been made, supported the recommendations that will be embedded into the action plan and agreed that a re-audit will take place in 12 months. **RESOLVED: The Mental Health Act Committee received and assured by the results of the Re-audit Consent to Treatment Section 58.**
MHA 2015/066	**MENTAL HEALTH ACT COMMITTEE REPORT AND UPDATE ON AHM TRAINING** Christine Henson provided the committee with her quarterly report covering the period 1 July to 30 September and highlighted key themes. From the data shown in Table 2 (Mental Health Act and Informal Admissions by ethnicity) it could be seen that 73.5% of people admitted under Section 2 were of white British origin and 26.5% were from other ethnic groups. 66% admitted under Section 3 were of white British origin and 34% were from other ethnic groups. The committee considered the fact that data is monitored is helpful and the reason for this result might be because other ethnic groups are a hard to reach community. The Seclusion Summary showed there were a total of 24 patients secluded and 69 episodes of seclusion during this period. The committee considered the reason for this increase might be due to NPS (legal highs) use. Tracey Holtom explained to the committee that she felt the Exception Report was not fit for purpose in following the seclusion policy. Clinical staff were reporting within too many mechanisms and the Seclusion Group will be asked to review the recording systems for monitoring and recording seclusion. This will be escalated to named individuals to take through the

	Seclusion Group for the process to be re-evaluated. This will ensure the process is captured through EPR and Tracy Holtom will attend the Seclusion Group meeting to raise this as an issue and look at ways of rationalising the system of seclusion reporting. The committee noted the appropriate use of section 5(2) and the increase of informal admissions that had increased the amount of section 5(2). It was agreed that Griff Jones will monitor this activity and will include the results in his next report to the committee an February. **ACTION: Tracy Holtom will attend the Seclusion Group meeting to ensure the system of seclusion reporting is rationalised.** **ACTION: Seclusion episodes will be monitored and reported on at the next meeting in February.** **Section 5(4):** There had been an increase in section 5(4) and which was thought to be due to an increase in informal admissions. **Community Treatment Orders:** Christine Henson highlighted the fact that Community Treatment Orders saw a reduction in activity. Dr Gupta felt this may be due to the new decision tool working effectively and she was pleased to report that this will be reinforced at TMAC (Trust Medical Advisory Committee) at the December meeting. **Update on AHM Training:** Hilary Beckett informed the committee that the AHM training had been a highly successful event and everyone gained a lot from the training. Thanks were given to Christine Henson and her team for organising the event. The only matters outstanding from the training were risk assessments and management of clinical risks and these will be covered in another training session next year. **ACTION: Jenna Davies will be asked to look into the use of Honorary contracts for Associate Hospital Managers.** **ACTION: Christine Henson to attach an action plan on AHMs to her next report.** **RESOLVED: The Mental Health Act Committee received and noted the Mental Health Act Committee Report 1 July to 30 September 2015.**
MHA 2015/067	**<u>CONSULTATION PAPER 222</u>** John Sykes's report summarised the Trust's response to the Law Commission's consultation. The present system revolving around the Mental Capacity Act and Deprivation of Liberty Orders has been criticised as complex and impracticable. The costs of operating and administrating the system are soaring nationally. In some areas supervising bodies cannot keep up with their statutory responsibility. The Law Commission was asked by the government to review the situation. A 200 page consultation document has been published and a response was required by 2 November. John Sykes was pleased to report that this work has now been completed and the response submitted. John Sykes pointed out that Derbyshire County Council were concerned about the increase in workload and drew the committee's attention to the anticipated resource implications that will come to light when the final outcome of this consultation is known. The committee wished this to be escalated to the Trust Board and be discussed at ELT (Executive Leadership Team). The committee agreed that full assurance was not obtained regarding the response to the Consultation Paper 222. The committee was also concerned by the increase in workload

	and demand on resource implications and wished to escalate this matter to the Board and ELT. **ACTION: John Sykes to address at ELT the committee's concerns regarding resource implications that will come to light when the final outcome of this consultation is known.** **RESOLVED: The Mental Health Act Committee** **1) Noted the reply to the Law Commission's consultation.** **2) Anticipated that when the final outcome of this will be known and note that there may be resource implications.**
MHA 2015/068	**DRAFT MENTAL CAPACITY REPORT** John Sykes explained that this report had been commissioned by the Audit Committee and it was recommended that the report should be received by the Mental Health Act Committee prior to being submitted to the Audit Committee. He explained this was a draft report which did not include the management response. The management response will be progressed from this draft and will include further development of the Mental Capacity policy. This policy will be supported by a new training programme that will include best practice groups for inpatient training. John Sykes asked the committee to agree for him to take the lead in developing the action plan. **ACTION: Rachel Kempster will carry out a joint review of MHA policies and will work with Tracey Holtom on this who will review the Mental Capacity policy.** **ACTION: Christine Henson and Rachel Kempster will review capacity of the Mental Health Act Team and establish the MHA administration training that is required.** **ACTION: John Sykes will circulate to the committee a version of the report complete with the management response.** The Chair considered the good report drew attention to an area that needed further reassurance and he hoped the action plan would take this further. The committee acknowledged the work of PWC in producing this report and the Chair will commend their work to the Audit Committee. **RESOLVED: The Mental Health Act Committee was assured by the recommendations contained in the Draft Mental Capacity Report.**
MHA 2015/069	**APPROVED MENTAL HEALTH PROFESSIONALS UPDATE (AMHP)** **(a) Derby City Council:** In Griff Jones absence, Nicola Bishop presented the Derby City Council AMHP report which showed that activity had seen a fall back to the level of the previous year. She informed the committee that DCC are reviewing their AMHP service, to include an options appraisal of setting up a specialist AMHP team. This recommendation will be made to the Directorate Leadership group at the Council in April 2016. Tony Smith was interested to know the likely impact of this and considered that a joint service of AMHP and doctors would be an ideal solution i.e. a joined up approach. The committee admired the style of the report and headline information and considered it would be useful to receive an integrated approach and style of reporting with Derbyshire County and Derby City. **(b) Derbyshire County Council:** In Jacky Ingerson's absence Paul Emerson

	presented the Derbyshire County Council AMHP report. He informed the committee that although there was an unusually high level of activity in Q1 of 2015, Q3 (as with Q2) had settled down and is comparable generally with 2014 statistics. Paul Emerson agreed to discuss with Jacky Ingerson ways of producing a similar report to the DCC report. **RESOLVED: The Mental Health Act Committee noted the statistics contained in the AMHP Update Reports.**
MHA 2015/070	**<u>REVIEW OF POLICIES REQUIRED BY THE MHA CODE OF PRACTICE</u>** Rachel Kempster's report provided the committee with an initial gap analysis of the compliance of the Trust with the policies, procedures and guidance which the MHA Code of Practice says should be in place locally. She explained that some policies required changing as part of the code and some of the policies will need updating. She also provided a spread sheet that gave an indication of the scope of this work and showed progress was being made. The committee agreed that Kath Lane will work with Rachel Kempster to address the policies to be developed and progressed. The committee acknowledged the excellent work done to date. Partial assurance was received and this gap will be carried through the BAF on risk 1a. The committee recognised that some policies need to be reviewed in line with the Code of Practice and it was agreed to take a pragmatic approach to the amendment of policies so that in future only significant changes to policies will be required to be reviewed by the committee. **ACTION: Kath Lane and Rachel Kempster will work together to address the policies to be developed and progressed in line with MHA Code of Practice.** **RESOLVED: The Mental Health Act Committee:** **1) Received this report as assurance that a process to ensure policies required by the Code are being followed up and revised** **2) Supported the authors of this report to fully complete the gap analysis** **3) Agreed to receive an update on progress at the next meeting**
MHA 2015/071	**<u>SECTION 5(2) POLICY FOR RATIFICATION</u>** The Section 5(2) Policy was ratified by the committee, although Maura Teager asked if Physical Healthcare should be included in 1.10 on page 75. The policy on the Use of Mobile Camera Phones was an additional policy presented to the committee by Rachel Kempster and was duly reviewed and ratified. **RESOLVED: The Mental Health Act Committee ratified the Section 5(2) Policy and the Policy on use of Mobile Camera Phones.**
MHA 2015/072	**<u>FORWARD PLAN</u>** The Chair asked that more planned approach be applied to items brought to the committee and that the Forward Plan template received by the committee be populated with the CQC Mental Health Act Reports, Clinical Audit Reports, Annual Reports. The Forward Plan would also be circulated to executives for additional items to be included. **ACTION: Sue Turner will circulate the Forward Plan to executives for additional items to be included.**

	RESOLVED: The Mental Health Act Committee received the Forward Plan template.
MHA 2015/073	**ISSUES ESCALATED TO BOARD, AUDIT COMMITTEE OR OTHER BOARD COMMITTEES** • Consultation Paper 222 – assurance was not received by the committee and concerns regarding resource implications will be escalated to the Board. This would also be an action for John Sykes to take to ELT. • Draft Mental Health Capacity Report will be taken forward to the Audit Committee.
MHA 2015/074	**MEETING EFFECTIVENESS** The committee was pleased to receive a manageable agenda. Observers thought this was a very interesting meeting.

DATE OF NEXT MEETING

Friday, 26 February, 2015 at 10.00am,
Meeting Room 1, Albany House, Kingsway site.

If you are unable to attend, please advise your apologies to Sue Turner, Board Secretary, extension 31203, for recording in the minutes.

2015-2016 Board Annual Forward Plan

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	Apr-15	May-15	Jun-15	Jul-15	Sep-15	Oct-15	Nov-15	Jan-16	Feb-16	Mar-16	Apr-16
		PAPERS DUE	**17-Apr**	**15-May**	**12-Jun**	**17-Jul**	**18-Sep**	**19-Oct**	**16-Nov**	**18-Jan**	**15-Feb**	**21-Mar**	**18-Apr**
MT	Apologies given		X	X	X	X	X	X	X	X	X	X	X
JD	Declaration of Interests	FT Constitution	X	X	X	X	X	X	X	X	X	X	X
MT	Minutes/Matters arising/Action Matrix	FT Constitution	X	X	X	X	X	X	X	X	X	X	X
MT	Board Forward Plan	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X	X
X	Comments from observers during meeting	Statutory Outcome 3	X	X	X	X	X	X	X	X	X	X	X
MT	Board review of effectiveness of the meeting	Statutory Outcome 3	X	X	X	X	X	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE													
MT	Chairman's report	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X	X
IM	Chief Executive's report	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X	X
MP	APR Monitor Annual Plan submissions and governance statements, including financial planning (subject to change for Monitor deadlines each year) *Confidential*	FT Constitution/Monitor Risk Assurance Framework (RAF)	APR Progress update/ approval	APR Progress update/ approval						Self-assessm't if not covered in Bd Devpmt	APR Progress update	Approve start budgets. APR progress update/approval	APR Progress update/ approval
CW	Monitor Compliance Return *Confidential*	Monitor Risk Assurance Framework (RAF)	X			X		X		X			X
IM	Monitor Feedback	Monitor Risk Assurance Framework (RAF)		X						X			
MP	Commercial Strategy updates *Confidential*	Licence Condition FT4			X		X				X		
CW	Estates Design and Agile Working Strategy update *Confidential*	Monitor Risk Assurance Framework (RAF)	X						X				X
CW	5 Year Capital Programme (required by Monitor)	Monitor Risk Assurance Framework (RAF)							X				
CW/CG	Annual Accounts and Annual Report and Quality Report & Annual Governance Statement (sign-off of final versions is delegated to Audit Committee annually)	FT Constitution	*Drafts* to be issued to Board for comment	Summary of key changes raised at Audit Com		Annual audit letter			Board to consider deleg'n of sign off to Audit Com				*Drafts* to be issued to Board for comment

2015-2016 Board Annual Forward Plan

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	Apr-15	May-15	Jun-15	Jul-15	Sep-15	Oct-15	Nov-15	Jan-16	Feb-16	Mar-16	Apr-16
IM	Strategic review/quarterly progress to include Transformation Board update	Strategic Outcomes (all)		X					X			X	
MP	IM&T Strategy Updates that will include update on optimisation of EPR	Strategic Outcome 1 Strategic Outcome 2			X					X			
MP	Information Governance Updates	Strategic Outcome 1 Strategic Outcome 3 Information Gov toolkit	X					X				X	
MP	Communications Strategy - Yearly Report	Strategic Outcome 3					X						Next one Sept 2016
JSt	People Strategy / Updates	Strategic Outcome 4 Licence Condition FT4		X		X			X		X		
JSy	Research & Development Strategy	Strategic Outcome 1 and 3			X					X Progress Report			
JSt	Staff Survey Results & Follow up activity	Strategic Outcome 3 and 4			Progress Report		Progress Report				X Results		
JD	Review S.O.'s, SFI's, SoD	FT Constitution Standing Orders					X						
JD	Trust Sealings	FT Constitution Standing Orders	X										
JD	Annual Review of Register of Interests	FT Constitution Annual Reporting Manual	X										
CG	Board Assurance Framework Update	Licence Condition FT4		X				X				X	
JD	Raising Concerns (whistleblowing)	Strategic Outcome 1 Public Interest Disclosure Act			X					X		X	
JD	Whistleblowing Policy - annual nomination of NED role (one year rotation)	Francis Report								X			
JD	Committee Reports (following every meeting) - Audit - Finance & Performance - Mental Health Act - Quality Committee - Safeguarding	Strategic Outcome 3	X	X	X	X	X	X	X	X	X	X	X

2015-2016 Board Annual Forward Plan

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	Apr-15	May-15	Jun-15	Jul-15	Sep-15	Oct-15	Nov-15	Jan-16	Feb-16	Mar-16	Apr-16
JD	Corporate Governance Framework											X	
MT	Annual Members' Meeting - arrangements	FT Constitution				X							
OPERATIONAL PERFORMANCE													
CGi	Integrated performance and activity report to include pre agreed deep dive based on risk	Licence Condition FT 4 Strategic outcome 1 Strategic Outcome 3	X	X	X	X	X	X	X	X	X	X	X
CW	Financial Performance Report	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X	X
CW	Reference Cost Sign Off	Best practice		X									
QUALITY GOVERNANCE													
CG	Position Statement on Quality (Incorporates Integrated Governance, Patient Experience and Patient Safety Reports) and Quality Dashboard	Strategic Outcome 1 CQC and Monitor		X	X	X	X	X	X	X	X	X	X
CG	Safeguarding Children Annual Report	Children Act Mental Health Standard Contract					X						
CG	Safeguarding Adult Annual Report	CQC Mental Health Standard Contract					X						
CG	Control of Infection Report	Health Act Hygiene Code		X									
CG	Integrated Clinical Governance Annual Report including MHA/Governance/Complaints and Compliments/SIRI's/Patient Safety/NHS Protect (LSMS) and Emergency Preparedness/H&S (including H&S and Fire Compliance and Associated Training)	CQC and H&S Act						X					
CG	Annual Patient Survey	Clinical Practice CQC						X					
CG	CQC Update - Verbal unless report required *Confidential*	Monitor Risk Assurance Framework (RAF)	X	X	X	X	X	X	X	X	X	X	X
JSy	Re-validation of Doctors	Strategic Outcome 3			X								