Derbyshire Healthcare NHS
NHS Foundation Trust

Meeting of the Board of Directors

7 September 2016

Trust Headquarters, Ashbourne Centre, Kingsway Site, Derby, DE22 3LZ
Tel: (01332) 623700 Fax: (01332) 331254
Acting Chief Executive: Ifti Majid Interim Chairman: Richard Gregory

Better together

Derbyshire Healthcare NHS
NHS Foundation Trust

NOTICE OF BOARD MEETING - WEDNESDAY 7 SEPTEMBER 2016
TO COMMENCE AT 1.00 PM IN CONFERENCE ROOMS A&B, FIRST FLOOR,
RESEARCH & DEVELOPMENT CENTRE, KINGSWAY, DERBY DE22 3LZ

	TIME	AGENDA	ENC	LED BY
1.	1:00	Chairman's welcome, opening remarks and apologies for absence	**-**	Richard Gregory
2.	1:05	Service Receiver Story	**-**	Richard Gregory
3.	1:30	Declarations of Interest	**A**	Richard Gregory
4.	1:30	Minutes of Board of Directors meeting held on 27 July 2016	**B**	Richard Gregory
5.	1:35	Matters arising – Actions Matrix	**C**	Richard Gregory
6.	1:40	Chairman's Verbal Update	**-**	Richard Gregory
7.	1:50	Acting Chief Executive's Report	**D**	Ifti Majid
OPERATIONAL PERFORMANCE, QUALITY AND STRATEGY				
8.	2:00	Integrated Performance and Activity Report	**E**	Carolyn Gilby Claire Wright Amanda Rawlings Carolyn Green
9.	2:15	Quality Position Statement	**F**	Carolyn Green
10.	2:35	Board Committee Escalations of meetings held in August: Quality Committee (11 August) Ratified Minutes of Quality Committee held 7 July (for information only)	**G**	Committee Chairs
11.	3:45	Equality Delivery System EDS2 Update	**H**	Amanda Rawlings
3:00 B R E A K				
12.	3:30	Deep Dive – Learning Disabilities - Commissioning Differently	**I**	Carolyn Gilby
13.	3:45	Strategy Implementation Update	**J**	Mark Powell
14.	3:55	Report from Council of Governors meetings held on 12 and 21 July 2016	**K**	Sam Harrison
GOVERNANCE				
15.	4:05	Governance Improvement Action Plan - Assurance from Audit & Risk Committee	**L** **M**	Mark Powell
16.	4:15	Trust Compliance – Accessible Information Standard and Information Governance report	**N**	Carolyn Gilby
CLOSING MATTERS				
17.	4:25	Any other business	**-**	Richard Gregory
18.	4:30	- 2016/17 Board Forward Plan - Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	**O**	Richard Gregory

Questions that are applicable to the agenda, and at the Chairman's discretion, can be sent by email to the Board Secretary up to 48 hours prior to the meeting for a response provided by the Board at the meeting. Email: sue.turner2@derbyshcft.nhs.uk
The 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 will be held at 1.00 pm on 5 October 2016
in Conference Rooms A & B, Centre for Research and Development, Kingsway, Derby DE22 3LZ
Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.
Participation in meetings is at the Chairman's discretion.

Declaration of Interests Register 2016-17

NAME	INTEREST DISCLOSED	TYPE
Jim Dixon	Director – Winster Village Shop Association Director – Jim Dixon Associates Director – UK Countryside Tours Limited Patron – Accessible Derbyshire	(a) (a) (a) (d)
Carolyn Gilby	Nil	-
Carolyn Green	Nil	-
Richard Gregory	Director – Clydesdale Bank Plc (including Yorkshire Bank) Director – CYBG Plc (holding company of Clydesdale) NHS Providers Trainer/Facilitator for Board/Governor Development Member of Governwell, NHS Providers	(a) (a) (e) (e)
Phil Harris	Director – Phormative Ltd	(a, b, c)
Samantha Harrison	Nil	-
Ifti Majid	Nil	-
Caroline Maley	Director – C D Maley Ltd Trustee – Vocaleyes Ltd.	(a) (a, d)
Mark Powell	Nil	-
Jayne Storey	Nil	-
John Sykes	Independent Deprivation of Liberty mental Health Assessor undertaking assessments on BGHS patients at the request of Derbyshire County Council via my medical secretary	(b)
Maura Teager	Non-Executive Director – Ripplez social enterprise and NHS provider of the Family Nurse Partnership	(a)
Claire Wright	Nil	-

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

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

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Wednesday, 27 July 2016

MEETING HELD IN PUBLIC

Commenced: 1pm Closed: 4:40pm

PRESENT:	Richard Gregory	Interim Chairman
	Caroline Maley	Senior Independent Director
	Jim Dixon	Deputy Chair and Non-Executive Director
	Phil Harris	Non-Executive Director
	Maura Teager	Non-Executive Director
	Ifti Majid	Acting Chief Executive
	Claire Wright	Executive Director of Finance
	Carolyn Gilby	Acting Director of Operations
	Mark Powell	Director of Strategic Development
	Samantha Harrison	Director of Corporate Affairs & Trust Secretary
IN ATTENDANCE:	Hayley Darn	Nurse Consultant – Nursing & Patient Experience Team
	Anna Shaw	Deputy Director of Communications & Involvement
	Sue Turner	Board Secretary and Minute Taker
For item DHCFT 2016/108	Bev Green	Releasing Time to Care Lead (Service Improvement)
For item DHCFT 2016/108	Mr and Mrs S	Service Receivers
For item DHCFT 2016/102	Helen MacMahon	Service Line Manager – CAMHS
For item DHCFT 2016/102	Scott Lunn	Clinical IAPT Lead - CAMHS
For item DHCFT 2016/102	Alison Reynolds	Area Service Manager Complex Health Needs & Paediatric Therapies
For item DHCFT 2016/102	Sue Earnshaw	Area Service Manager
For item DHCFT 2016/102	Beth Howman	Consultant Paediatrician
APOLOGIES:	Jayne Storey	Director of Workforce OD & Culture
	Carolyn Green	Director of Nursing & Patient Experience
	Dr John Sykes	Executive Medical Director
VISITORS:	John Morrissey	Lead Governor
	Donna Cameron	Corporate Services Officer
	Carole Riley	Public Governor, Derby City East
Until 3pm	Chris Fitzclark	Representative from North Derbyshire Voluntary Action
Until 3pm	Kieron Gibson	Representative from North Derbyshire Voluntary Action
	Dave Waldram	Member of the public

DHCFT 2016/107	**INTERIM CHAIRMAN'S WELCOME, OPENING REMARKS AND APOLOGIES** The Interim Chairman, Richard Gregory, opened the meeting and welcomed everyone who was present. Apologies were noted as above. Welcome was extended to Hayley Darn, Nurse Consultant from the Nursing and Patient Experience Team, who was attending on behalf of Carolyn Green, Director of Nursing and Patient Experience.
DHCFT	**SERVICE RECEIVER STORY**

2016/108	Bev Green, Releasing Time to Care Lead, introduced Mr and Mrs S who kindly agreed to talk to the Board about their recent experience of care received from the Trust. Mr and Mrs S described the difficulties they experienced when Mr S was diagnosed with early vascular dementia and the devastating effect this had on them. Mrs S went on to describe how hard it had been caring for her husband, given his significant memory loss. Life was a struggle for the couple until they were put in touch with the right people who could offer support which eventually enabled Mr S to attend open sessions at the Dovedale Day Hospital. During these visits staff undertook therapy and taught him exercises which kept his brain active. He was also encouraged to look at photographs, and learnt how to keep a book about his life which he can refer to and this has been a tremendous help to him. These activities helped rebuild his confidence so much so that he was able to get back to doing things he enjoys such as reading again. The open sessions at the Dovedale Hospital also allowed Mr and Mrs S to learn about dementia and they also received support from experts who have taught them how to cope so they can continue to live an independent life together. The couple also attended question and answer sessions at Oaklands Village in Swadlincote and due to the activities and therapy he received from the Dovedale Day Hospital Mr S felt able to contribute to discussions. Mr S has also been invited to the Trust's Living Well sessions to talk to recently diagnosed patients about his own experience and the activities that have helped him and these have been very well received. Mr and Mrs S were very positive about the support they have received from the Trust's mental health team and felt they were lucky to live in an area where support has been available to them. Richard Gregory thanked Mr and Mrs S for telling a compelling and inspirational story. Listening to this story had shown there is a clear need for more facilities to help people suffering with dementia, their carers and their family. He felt Mr and Mrs S's story will help influence decisions made by the caring and dedicated mental health teams working with families in the community. He hoped that in future the Trust can work more effectively and help people to access the help they need and he looked forward to holding discussions with the Board at subsequent meetings to establish how this service has developed since their story was told. **ACTION: Hayley Darn will discuss how service receiver stories can be carried forward in future Board meetings with Carolyn Green.** **RESOLVED: The Board of Directors expressed thanks to Mr and Mrs S for sharing their experience and appreciated the opportunity to hear at first hand the service the Trust had provided.**
DHCFT 2016/109	**MINUTES OF THE MEETING DATED 30 JUNE 2016** The minutes of the meeting held on 30 June were accepted and agreed.
DHCFT 2016/110	**MATTERS ARISING AND ACTIONS MATRIX** The Board agreed to close all completed actions. Updates were provided by members of the Board and were noted directly on the actions matrix.
DHCFT 2016/111	**CHAIRMAN'S VERBAL REPORT** Richard Gregory updated the Board on progress made with the appointment of two new Non-Executive Directors, Julia Tabreham and Margaret Gildea. The Trust's Council of Governors had formally approved their appointments and he looked forward to them taking up their positions soon.

	Richard Gregory informed the Board that a meeting of the Remuneration and Appointments Committee had been held earlier that morning and had approved the recommendation from Ifti Majid to appoint on an interim basis a replacement for Jayne Storey, Director of Workforce, OD & Culture, who would be stepping down from her role at the end of August. The Committee also agreed to appoint an interim director to replace Carolyn Gilby, Acting Director of Operations when she retires in September. The Board had also met in confidential session earlier in the morning and discussed feedback received so far from the recent CQC inspection. Richard Gregory informed those present at the meeting that formal feedback had not yet been received from the CQC as an exchange of data was still taking place. Richard Gregory and Ifti Majid reported to the Council of Governors and staff last week on the potential collaboration between the Trust and Derbyshire Community Health Services NHS Foundation Trust (DCHS), a fellow trust provider in Derbyshire. This is in line with the ongoing Sustainability and Transformation Planning (STP) within Derbyshire to deliver a collaboration of services. There are a variety of options to define the level of collaboration and the Trust is at the very early stages of considering these. Both Boards have agreed to work in partnership to develop a 'strategic options case' which will consider the pros and cons of each option. It is anticipated that this work will then be presented to both Boards towards the end of the October for consideration.. Governors will be involved throughout this process and he committed to protect the interests of service users throughout this collaboration process. Staff have also been made aware of how the Trust is starting to explore the potential for further collaboration with DCHS. **RESOLVED: The Board of Directors noted the Interim Chairman's verbal update.**
DHCFT 2016/112	**<u>ACTING CHIEF EXECUTIVE'S REPORT</u>** Ifti Majid presented his report which provided the Board with feedback on changes within the national health and social care sector as well as providing an update on developments occurring within the local Derbyshire health and social care community. The report also updated the Board on feedback from external stakeholders such as commissioners and the Trust's staff. The report was also used to support strategic discussion on the delivery of the Trust strategy. Ifti Majid was pleased to report that the Sustainability and Transformation Plan (STP) was submitted to NHS England on time. The submission was very well received and he was part of the Derbyshire submission team group that went to London to put the plan forward. Ifti Majid referred to the consultation that is underway by Sheffield City Region as part of their devolution bid. The Trust had been urged by the Health and Wellbeing Board to respond to this consultation and share concerns about the need for joined up provision of services. It is vital that the Trust understands more about the actual and potential plans and Ifti Majid urged the Board and anyone living in the Chesterfield area to make a measured response to the consultation along the lines of retaining our mental health priorities. He would also raise this matter with the Council of Governors in September. The Board recognised the need to protect health and social care in Derbyshire and expects to be involved in any decisions that affect our service users. Ifti Majid also referred to the Trust's BME Network that requires the support of the organisation to become more established to support equality of development, promotion and wellbeing for staff from a BME background with the Trust. He proposed that a deep dive takes place at a future Board meeting to discuss the Trust's position against the national Workforce Race Equality Standard and was delighted to report that a member from this group will be invited to attend meetings of the People and Culture Committee.

	Discussions also centred around the Listen, Learn and Lead matrix contained in Ifti Majid's report which sets out the latest round of directors and team visits. Caroline Maley was concerned that some actions were still outstanding and Ifti Majid assured her that the next version received at the September meeting will indicate how actions have been satisfactorily resolved or progressed. Richard Gregory pointed out that the wider engagement programme being developed by Sue Walters supported the Listen, Learn and Lead initiative and he would like her to present the programme to the Board and Council of Governors as he was very impressed by this work. Maura Teager referred to the Nuffield Trust's report on reshaping the workforce to deliver the care patients need and asked how this report would be shared. Ifti Majid informed the Board that this report would be rolled out throughout the organisation once it had received further analysis to establish where the Trust fits into the benchmarking. Maura Teager also asked how engaged the universities were with this sector as they will help drive the initiative. Ifti Majid was of the opinion that universities recognised the importance of bursaries for students and this route would help enable our workforce work stream. **ACTION: Engagement Programme to be received at the September Board meeting and by the Council of Governors.** **RESOLVED: The Board of Directors noted the contents of the Acting Chief Executive's report.**
DHCFT 2016/113	**<u>INTEGRATED PERFORMANCE AND ACTIVITY REPORT</u>** This report provided the Trust Board with an integrated overview of performance as at the end of June 2016 with regard to workforce, finance and operational delivery and quality performance. The report showed how the high level of agency staffing has had an effect on the Trust's financial performance and work was taking place through workforce planning to improve staffing in inpatient areas. In addition to this, the Medical Director had updated approaches to consultant appointments and Royal College of Psychiatrist requirements in order to increase the speed at which doctors can be recruited. It was noted that the Radbourne Unit and Hartington Unit are equally challenged with staffing issues. Carolyn Gilby informed the Board that an ongoing rolling recruitment programme is being carried out but that this was in the context of a national shortage of registered mental health nurses. The Trust is looking to streamline recruitment process and this is being progressed through the People and Culture Committee. The Board discussed the merits of training placements and how to attract nurses to posts, and Ifti Majid proposed to progress this through the Executive Leadership Team. Dedicated resource teams are also looking at rosters and are focussing on resources for inpatient areas. Carolyn Gilby assured the Board that although an emergency process was in place at the Radbourne Unit, the unit was safely staffed and has stabilised because it is receiving support and focus, and the Board would be alerted if this situation deteriorates. The Board discussed the pressures that staff were under within the Radbourne Unit and Hartington Unit and proposed to communicate to staff that the Board are aware of and understands the recent pressures they have been experiencing. Claire Wright highlighted key issues from the finance section of the report. In the first three months the Trust has been ahead of plan and is managing costs within budget. She explained that by the end of the financial year she expects the Trust to meet its plan,

	and will meet the control total agreed with NHS Improvement (NHSI). She also explained that the Trust agency expenditure was exceeding the ceiling set by regulators. Plans to close the Cost Improvement Programme (CIP) gap continue to prove challenging and steps are being taken to explore closing this gap of £2m through both CIP and through cost avoidance. Grievances/dignity at work/disciplinaries aspects of the workforce section was also discussed and Ifti Majid suggested we compare the Trust's performance with other organisations to establish whether the Trust was an outlier. It was agreed that data regarding grievances/dignity at work and disciplinaries should be made more visible to the Board and it was recognised that the People and Culture Committee will ensure the process for investigation into cases was being followed so the timeline for completion could be assessed. The Board was concerned that sickness levels are currently running above 5% and asked for assurance that work was taking place to resolve this. It was noted that action to address sickness levels is being managed through the People and Culture Committee and evidence of progress will be reported to the Board through the Committee's minutes and assurance summaries. The Board also discussed the impact of 12 hour ED (Emergency Department) breaches which had increased recently as well as failure to follow the agreed Care and Treatment Review (CTR) process for people with learning disabilities. Carolyn Gilby informed the Board that the Trust has worked hard to ensure people with learning difficulties are not discriminated against and are able to access mental health services. Derby is seen as an outlier around general 12 hour ED breaches because the wards are full, and although out of area beds and PICU (Psychiatric Intensive Care Unit) beds can be utilised this can take time to organise. The Board was concerned about this matter from a patient experience perspective and was pleased to hear that Carolyn Gilby is working with clinical staff and ED services at Derby Royal Hospital to establish a process that can work better for patients. **ACTION: Carolyn Gilby to check whether the Trust is an outlier with regard to grievances/dignity at work/disciplinaries** **RESOLVED: The Board of Directors scrutinised the content of the report and obtained assurance on the current performance across the areas presented.**
DHCFT 2016/114	**<u>POSITION STATEMENT ON QUALITY</u>** Hayley Darn presented this report on behalf of Carolyn Green which provided the Board of Directors with an update on the Trust's continuing work to improve the quality of services it provides in line with the Trust's Strategy, Quality Strategy and Framework and strategic objectives. Hayley Darn drew attention to the positive feedback received on the Trust's work on safer staffing and markers of good practice and the thanks received from Southern Derbyshire Clinical Commissioning Group for the work of the Safeguarding team for facilitating the Markers of Good Practice quality site visit. They were impressed and assured with the evidence that the Trust's Safeguarding Children Service provided to demonstrate that the Trust is compliant with the required safeguarding children arrangements. Commissioners were also very satisfied that members of the team were able to answer questions to points that required additional information. It was noted that the Safeguarding Committee would address and plan any actions in line with feedback received from the independent multi-agency assurance group that reviewed the Trust's evidence produced for markers of Good Practice quality/part of Section 11 Audit under the Children Act to explore what this would mean to our guidelines. The report also set out the effectiveness through our work on smoking cessation and

	Hayley Darn was pleased to point out that since the introduction of smoking cessation initiatives there has been a reduction overall in those who identify as a smoker. In addition to this the Trust's work on smoking cessation will be presented at a national learning event. Work will continue to ensure support is embedded across the organisation. It was recognised that there are some areas where smoking cessation has proved challenging and support is being given to staff who are caring for people who are resistant to the smoking cessation policy. It was proposed that the Mental Health Act Committee would look at cases where patients have resisted accepting the no smoking policy and how the Mental Health Act can be used in these cases. Discussion took place on initial findings from quality visits and the work taking place on recording the results of quality visits. The Board agreed that this work would also include follow up action from service receiver stories heard at Board meetings. **ACTION: Safeguarding Committee to address and plan any actions in line with feedback received from the independent multi-agency assurance group that reviewed the Trust's evidence produced for markers of Good Practice quality/part of Section 11 Audit under the Children's Act to explore what this would mean to our guidelines** **ACTION: The Mental Health Act Committee to look at how the Mental Health Act can be used to manage patients who are resistant to the non-smoking policy.** **ACTION: Record retention of the results of quality visits to also capture follow up action from service receiver stories.** **RESOLVED: The Board of Directors:** **1) Received the Quality Position Statement** **2) Gained assurance on its content**
DHCFT 2016/115	**<u>COMPLIANCE RETURN</u>** Sam Harrison presented her report which summarised for Trust Board the key elements of the Quarter 1 compliance return for approval. The Board noted that the financial return was due for submission on 22 July (moved from 15 July) and had not required sign off by the Trust Board. The financial return had been reviewed by the chair of the Audit and Risk Committee and the chair of the Finance and Performance Committee. It was recognised that the governance return does require Trust Board sign off and the information contained in the Quarter 1 governance compliance return as shown in the report was noted. **RESOLVED: The Board of Directors:** **1) Discussed the governance statement and agreed that the interim Chairman and acting Chief Executive, on behalf of the Board of Directors, are able to sign the governance statement to confirm:** **a) For finance, that:** • **The Board anticipates that the Trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months.** • **The Board anticipates that the Trust's capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in this financial return.** **b) For governance, that the Board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk**

	Assessment Framework; and a commitment to comply with all known targets going forwards. **Otherwise the Board confirms that there are no matters arising in the quarter requiring an exception report to NHS Improvement (per the Risk Assessment Framework Table 3) which have not already been reported.** **c) Consolidated subsidiaries: '*Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds.'*** **There are zero subsidiaries included in the finances of this return and only the finances of Derbyshire Healthcare NHS Foundation Trust are included.** **2) Approved the Quarter 1 Governance return to be appropriately signed and returned to Monitor by noon 29 July 2016.**
DHCFT 2016/116	**<u>BOARD COMMITTEE ESCALATIONS</u>** Assurance summaries were received from committee chairs of the Mental Health Act Committee, Quality Committee and People and Culture Committee which identified key risks, assurance and decisions made. The Board referred to the Annual Complaints and Compliments Report received by the Quality Committee and asked for this report to be received in future by the Board once it has been received by the Quality Committee. Each summary was scrutinised and escalations were noted. The ratified minutes of the Quality Committee held in June were received for information and no issues were raised. **ACTION: Annual Complaints and Compliments Report to be received by the Board once it has been received by the Quality Committee** **RESOLVED: The Board of Directors received the Board Committee escalations and ratified minutes of meetings held in June.**
DHCFT 2016/117	**<u>ANNUAL MEMBERS' MEETING ARRANGEMENTS</u>** Anna Shaw presented her paper which updated the Board of Directors on preparation for the forthcoming Annual Members' Meeting. The Board noted that arrangements for the event are being informed by feedback received from last year's AMM. Governors have volunteered to be involved in the preparations and promotion for the event has already commenced. Similar to last year, people are being asked to put forward any questions they would like to receive answers to during the meeting. Speakers will include Ifti Majid, Claire Wright, Carolyn Green and John Morrissey (Lead Governor) and Jonny Benjamin, an award winning mental health and suicide prevention campaigner known for the 'Find Mike' campaign, has been invited to attend as guest speaker. A number of people who have used or supported individuals who have used our services will also share their experiences of the Trust. **RESOLVED: The Board of Directors noted and supported the arrangements being made for the Annual Members Meeting**
DHCFT 2016/118	**<u>DEEP DIVE – CHILDREN'S SERVICES</u>** The report produced by Helen MacMahon, Scott Lunn, Alison Reynolds, Sue Earnshaw and Beth Howman detailed the performance of Children and CAMHS (Child and Adolescent Mental Health Services). The report highlighted areas of achievement within

these services over recent time including a successful tender, and obtaining additional investment from commissioners to develop additional services. However, the service also encounters a range of challenges including the increasing demand and expectations for services which combined with difficulties in recruiting clinical staff has resulted in lengthy waiting lists in some service areas. The plans that are in place to address the waiting list difficulties were noted as was the awareness that the benefit of these changes will take time to fully impact the patient experience for children and young people in Derbyshire.

Discussions centred around waiting times and how this was being managed. Waiting times were expected to improve now that funding from commissioners had been received to take the service through to next year. The team had also amalgamated services and was using skills in different ways to move this forward. A lot of work was taking place to increase cover and a redesign of pathways by utilising ADHD nurses had been carried out using skills of nurses at the front end of the process in preparation for diagnosis.

The Board recognised that recruitment of clinical staff was a challenge and noted how the team is working with commissioners to obtain early release of funding and engaging with universities to recruit nurses and psychologists at graduate band 5 level. This is essential to sustain the future of our workforce and the Board supported recruitment to these posts.

The team drew attention to their role as gatekeepers for the pathways and how there is an overwhelming need for reform with services in the education sector as so many children and young people have very complex needs. A lot of time is spent responding to the local education authority and the influx of these requests has changed the scope of the service. A lot of work is carried out treating cases of ADHD and autism. The CAMHS team are working with schools in prevention and early help and we are part of that agenda to help and advise on some of these pathways.

The report highlighted the impact of increased integration of the service in terms of performance. The Board heard how the service was working with children and schools to identify levels of self-harm and was working with CAMHS to train staff in these areas and trying to attract staff to work in these pathways. This is starting to develop well and is a big change in the way of working and the way children are referred which will enable the family to be approached by the right services.

Maura Teager queried whether the complaints, concerns and compliments data as presented was under reported and how this is captured. The Board noted that complaints are mostly about waiting times. Complaints are dealt with by the team and may not necessarily be reported. It is hoped that by the next quarter these concerns will be recorded. The Board heard how the team likes to meet services users in the clinics as they are aware this is a vulnerable group of young people who might not know how to complain.

Phil Harris asked about the transfer from CAMHS to adult services and how this was managed. Scott Lunn responded that the transfer policy has now been improved so that CAMHS hold on to children within the service until it is felt it is the right time for each individual to transfer to adult services. Richard Gregory incidentally pointed out that at the last meeting of the Council of Governors held on 21 July it had been agreed that commissioners would be invited to the next meeting to discuss extending the CAMHS service to an appropriate age limit.

The Board felt the deep dive into children's services had been a valuable session and resolved to support the service to help resolve with the challenges it faces.

RESOLVED: The Board of Directors:

1) Acknowledged the current performance of the services

2) Noted the actions in place to ensure sustained performance

DHCFT 2016/119	**EQUALITY AND DIVERSITY WORKFORCE APPROACH FOR 2016-17** It was agreed to defer this item to September.
DHCFT 2016/120	**BOARD ASSURANCE FRAMEWORK** The Board Assurance Framework (BAF) is a high level report which enables the Board of Directors to demonstrate how it has identified and met its assurance needs, focused on the delivery of its objectives, and subsequent principal risks. This report details the second issue of the BAF for 2016/17. The Board recognised that this was the second formal presentation of the Board Assurance Framework for 2016/17 which was presented to the Audit & Risk Committee on 19 July. It was noted that the Audit and Risk Committee recommended and agreed that risks 2a) System change and 4b) Transformation would be considered for merging in the next Issue of the BAF and the Board anticipated this would be in place when the next version of the BAF is considered by the Board in November. **RESOLVED: The Board of Directors approved this second issue of the BAF for 2016/17**
DHCFT 2016/121	**GOVERNANCE IMPROVEMENT ACTION PLAN** Mark Powell presented his paper which provided the Board with an update on progress of all tasks within the GIAP, including the identification of tasks that are off track, including those that the Board has responsibility for oversight. The Board recognised there has been significant progress made on HR and people related actions and these were discussed at the People and Culture Committee on 15 July, although there is still significant work required to implement of some of these plans across the organisation as they are major areas of work. The Board approved the revised key performance indicators (KPIs) contained in the report as they reflected decisions recently made during the Board Development Session on 13 July. It was noted that updated KPIs would be presented in subsequent reports for approval by the Board. Mark Powell drew attention to FF1 the fit and proper person task (*the Trust must ensure that a fit and proper person review is undertaken for all directors in light of the findings of the employment tribunal*). It was acknowledged that this action had been closed in the light of informal CQC feedback. However, Mark Powell asked from a governance perspective whether it was correct to categorise this action as complete or whether there was a risk that the CQC could disagree with this course of action as part of their recent inspection. The Board was assured all internal processes associated with the GIAP action had been completed and a conversation would be had with the CQC at the next NHSI/CQC meeting to understand their level of external assurance Caroline Maley was concerned that some of the actions on the GIAP are shown as 'off track' although the Board assurance column was 'on track' and HR3 and HR4 were used as examples to illustrate this. Mark Powell explained that the progress 'RAG' rating column indicates the status of the action and delivery within the agreed timescale. The reason the end column is shown as green and on track is due to the People and Culture Committee's judgement from evidence of progress reviewed at the meeting. During the next few weeks different methods will be established to indicate the time frames, KPIs and internal and external assurance evidence and there will be less emphasis on key

	tasks. **ACTION: Richard Gregory and Ifti Majid will discuss the completion of FF1 with the CQC and NHSI.** **RESOLVED: The Board of Directors:** **1) Noted the progress made against a number of specific HR and People related actions** **2) Approved the revised KPI's** **3) Scrutinised the closure of recommendation FF1** **4) Reviewed the content of this paper, full GIAP and sought assurance where required** **5) Reviewed and discussed the recommendations rated as 'some issues' and sought assurance on the mitigation provided from the Responsible Director, Individual Directors or Committee Chairs** **6) Agreed at the end of the Pubic Board meeting whether any further changes are required to the GIAP following presentation of papers, outcomes of item specific discussions and/or other assurances provided throughout the meeting**
DHCFT 2016/122	**<u>CORPORATE GOVERNANCE FRAMEWORK</u>** Sam Harrison presented the revised Corporate Governance Framework to the Public Trust Board and confirmed the completion of related requirements within the Governance Improvement Action Plan. The Audit and Risk Committee, as the Committee with the role of overseeing the GIAP actions relating to the Corporate Governance Framework, considered a draft update at the Audit and Risk Committee on 24 May and recommended the Framework for approval to the Trust Board following review of a further draft at the Committee meeting on 19 July 2016. The Board noted the recommendation received from the Audit & Risk Committee and formally approved the Corporate Governance Framework. **RESOLVED: The Board of Directors:** **1) Received and ratified the Corporate Governance Framework for implementation throughout the Trust.** **2) Agreed that the GIAP actions outlined are now complete: CorpG1 (1), ClinG3 (2) and CorpG4 (1).**
DHCFT 2016/123	**<u>ANNUAL AUDIT LETTER</u>** Claire Wright reported that the Annual Audit Letter to Directors summarised the key findings arising from the work that Grant Thornton, external auditors, carried out for the Trust for the year ended 31 March, 2016. This is a procedural matter and supported the Trust's annual accounts and had been received by the Audit and Risk Committee at its meeting on 19 July. The Board received the Annual Audit Letter and commended the engagement that had taken place between Grant Thornton and the Finance, Quality and Communications teams in producing the 2015/16 Annual Report and Accounts. **RESOLVED: The Board of Directors received the Annual Audit Letter.**
DHCFT 2016/124	**<u>ANY OTHER BUSINESS</u>** Ifti Majid reminded the Board that Jayne Storey, Director of Workforce OD & Culture would be leaving the Trust at the end of August and thanked her for the dedication and support she had given to the organisation.

	As this was the last Board meeting that Non-Executive Director Phil Harris would be attending, Richard Gregory expressed his appreciation of the support he had provided to the Trust and wished him well in his retirement.
DHCFT 2016/125	**BOARD FORWARD PLAN** The forward plan was noted and would be updated in line with today's discussions. **RESOLVED: The Board of Directors noted the forward plan for 2016/17**
DHCFT 2016/126	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK OR GIAP** It was agreed at the end of the Pubic Board meeting that there were no further changes required to the GIAP or the Board Assurance Framework following presentation of papers, outcomes of item specific discussions and/or other assurances provided throughout the meeting.
DHCFT 2016/127	**BOARD PERFORMANCE AND CONTENT OF MEETING** The Board felt that good discussions were held during the meeting. Concern was raised that some papers had to be tabled and it was agreed that the submission of supporting papers would be discussed at the Executive Leadership Team meeting. It was reiterated that any questions applicable to the agenda and at the Chair's discretion should be received by the Board Secretary up to 48 hours prior to the meeting for a response to be provided by the Board at each meeting.

The next meeting of the Board held in Public Session will take place at 1pm on Wednesday, 7 September 2016.

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

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - SEPTEMBER 2016		
Date	**Minute Ref**	**Action**	**Lead**	**Status of Action**	**Current Position**	
25.5.2016	DHCFT 2016/080	Deep Dive - Neighbourhoods	Claire Wright	Building requirements of Neighbourhood teams in STP developments and as part of the Estates strategy to be considered by Claire Wright.	The next 6 monthly progress update of the Estates Strategy to Finance and Performance Committee will cover neighbourhood estate requirements and will also include a section summarising progress with the Derbyshire STP estates workstream. Will be agenda item at November F&P meeting.	Yellow
27.7.2016	DHCFT 2016/108	Service Receiver Story	Carloyn Green	Hayley Darn will discuss how service receiver stories can be carried forward in future board meetings with Carolyn Green	Carolyn Green is exploring and designing a new model and will discuss requirements and expectations with Quality lead/NED.	Green
27.7.2016	DHCFT 2016/112	Acting Chief Executive's Report	Sam Harrison	Engagement programme to be received at the September Board meeting and by the Council of Governors	Engagement Programme has since been deferred to October Board.	Yellow
27.7.2016	DHCFT 2016/113	Integrated Performance And Activity Report	Carolyn Gilby	Carolyn Gilby to check whether the Trust is an outlier with regard to grievances/dignity at work/disciplinaries	This has been difficult to ascertain as other organisations do not publish this information in their Board reports. The HR team have reported that this has been discussed at HR networks but that it is difficult to make comparisons as different organisations have different policies and procedures and every case is individual and some are simple to resolve others very complex. It was felt by the HR team that this would benefit from further discussion at People and Culture Committee and ongoing review of our own processes via our case tracker and through continued dialogue with other organisations	Amber
27.7.2016	DHCFT 2016/113	Position Statement on Quality	Carloyn Green	Safeguarding Committee to address and plan any actions in line with feedback received from the independent multi-agency assurance group that reviewed the Trust's evidence produced for markers of Good Practice quality/part of Section 11 Audit under the Children Act to explore what this would mean to our guidelines	Will be addressed through Safeguarding Committee. A new update has been included in this month's Quality Position Statement	Green
27.7.2016	DHCFT 2016/113	Position Statement on Quality	John Sykes	The Mental Health Act Committee to look at how the Mental Health Act can be used to manage patients who are resistant to the non-smoking policy	John Sykes briefed August Mental Health Act Committee - he had asked Section 12 doctors if there were any cases of people being detained partly or mainly due to non-smoking policy. He has also asked Physical Care Committee to consider whether vaping is a permissable alternative to smoking.	Green
27.7.2016	DHCFT 2016/113	Position Statement on Quality	Carolyn Green	Record retention of the results of quality visits to also capture follow up action from service receiver stories	Contained in the Quality Position Statement ACTION COMPLETE	Green
27.7.2016	DHCFT 2016/116	Board Committee Escalations	Carolyn Green	Annual Complaints and Compliments Report to be received by the Board once it has been received by the Quality Committee	This report has been to Quality Committee, Audit & Risk Committee and all details have been disclosed in the Quality Account. Director of Nursing is happy to answer any challenges or provide further information if Board requires further assurance.	Green

27.7.2016	DHCFT 2016/121	GIAP	Ifti Majid Richard Gregory	Richard Gregory and Ifti Majid will discuss the completion of FF1 with the CQC and NHSI	Discussed with James Mullins from the CQC who confirmed the approach we should take ACTION COMPLETE	Green

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors 7 September 2016

Acting Chief Executives Report to the Public Board of Directors

Purpose of Report:

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

National Context

1. NHSI continue to drive provider collaboration and have issued their first priority areas for back office collaboration against which they will benchmark providers. These are Finance, HR, IM&T, Procurement, Payroll, Governance and Risk, Estates and Facilities and Legal services. There is a strong direction from the centre for as much collaboration as possible, as soon as possible, in back office and pathology functions. There is also strong focus in the acute sector on the delivery of Carter acute productivity and efficiency programme. Providers and STPs will be required to produce STP wide back office consolidation business plans to return to NHSI by the end of September. NHSI have signalled that in time they wish to expand this work to all corporate and administrative costs.

2. Nationally the NHS is reporting that it is largely on track in the first quarter of 2016/17, however there is potential for a swing away from that later in year as pressures continue across all sectors.

3. NHSI have put the 2017/18 and 2018/19 tariff out to consultation, within that is the guidance to move away from block contracts for Mental Health service and use either episodic or capitation methods or other local contractual agreements.

4. NHS England have said they will take action in areas where funding pledged for mental health services is not reaching the front line: if commissioners and providers are not investing in services as set out in NHS England's implementation plan or hitting key performance targets, the NHSE have said they will step in.

5. NHS England has announced a £5m perinatal community services development fund whereby STPs, commissioners and providers can bid for money to expand services for women with mental health problems during or after pregnancy. The fund is part of £365m plan to expand perinatal support to an extra 30,000 women a year by 2020/21. The £5m pot for 2016/17 is the first of three payments pledged to the scheme in last month's implementation plan, with £15m due in 2017/18 and £40m the year after.

Local Context

6. The consultation in the north of the county is progressing well with lots of stakeholder consultation events taking place around the north of Derbyshire. It is now entering its

second round of consultation events. We have provided responses to questions particularly with regard to the development of a Dementia Rapid Response Team in the north of the county

7. The Derbyshire STP progressed has now been assessed by The National Team, I was part of the representation that attended. We received positive feedback about our level of ambition and the structure we have in place with respect to STP Governance. There were three specific areas of improvement that were requested:

    - Be more granular and specific in regards to setting out how the footprint will collaboratively strengthen primary care to support the shift in care from hospitals.

    - Ensure there is sufficient evidence behind the activity modelling and savings assumptions to further demonstrate ability to deliver the anticipated clinical benefits.

    - Include stronger plans for mental health drawing on the recent publication of the Forward View for Mental Health. This is a really positive comment and demonstrates the increasing commitment and focus on improving mental health services. In Derbyshire we have very clear plans for delivering the mental health five year forward view, closely aligned to our Trusts Strategy that will now be included in the core document rather than an appendix

   In addition NHS England has increased scrutiny on all STPs nationally with two weekly checkpoint meetings to monitor progress against performance. Two key areas of focus over the next month include workforce planning and engagement both with staff and our wider communities.

8. HSJ reported that Chesterfield Royal FT has won a 15 year contract to provide services at three GP practices it was previously running as an “emergency caretaker”. The trust’s primary care arm – Royal Primary Care – will be providing services to 20,000 patients from three practices in Grangewood, Staveley and Inkersall. The contract was awarded by North Derbyshire Clinical Commissioning Group following a competitive tender process

Within our Trust

6. Building on my last briefing to the Board we are continuing the work to explore the optimal degree of organisational collaboration with DCHS. The preparation of the strategic outcomes case continues on track to deliver a recommendation to the Trust Board in October. As part of the development of this case an engagement event was held for key stakeholders on 31 August that was well attended by Board members, Governors, clinical leaders and representatives from other Derbyshire Organisations.

7. We continue to work closely with other Organisations in Derbyshire around developing plans for closer collaboration between support services, (back office functions as described by NHSI). I am hopeful of being able to present initial options to the Board of Directors by the end of October

8. On 23 August the Trust received the draft report following the CQC visit during June. We are currently completing factual accuracy check on the reports and will return these to the CQC by the 7 September. There will then be a period of time where the

CQC review our comments before the public release of the final documents.

9. Of the past few months we have seen increased pressure on bed availability for adults with mental health problems resulting in increasing numbers of adults needing to be treated outside of Derbyshire. One knock on impact of this is that patients presenting at Emergency Departments have had to wait longer for a bed whilst one was sourced. This has led to an increasing number of people waiting longer than 12 hours. We recognise that this is not an acceptable experience for those individuals and the clinical teams have been working closely with counterparts in both Acute Trusts in order to improve this situation. In addition NHS England has called a meeting to review this situation and receive assurance from ourselves and other providers about actions we are taking.

10. You will be aware from recent articles in the press that junior doctors remain dissatisfied with the revised contract they have been offered and remain in discussions with the BMA. Along with all other Trusts we are implementing the revised contract and as part of that I am delighted we have appointed Dr Sugato Sarkar as the Junior Doctor Guardian who will be the designated person for junior doctors to raise concerns with about their hours.

11. Listen, Learn, Lead – Due to the holiday season there has only been 1 visit this month. These can be seen on the actions tracker in appendix 1. Some of the key themes emerging from visits this month included:

    - Uncertainty around the collaborative work with DCHS, what it might mean for frontline staff
    - Mixed feelings around the process/early draft findings associated with CQC visit
    - Positive feedback around staff feeling able to raise difficult issues with very senior managers in open forums and that this was a significant shift from how it has been in the past

    The Executive Team continue to work to clean up and close actions on the tracker and the document presented at the next Board will incorporate all updates available.

Strategic considerations

- This document is relevant to supporting the Board achieve all of it strategic objectives however the feedback from staff is particularly of note in supporting the Board being connected to service delivery

Board Assurances

- The Board can take assurance that Trust level of engagement and influence is high in the health and social care community
- Partial assurance should be derived around closing off actions linked to the listen learn lead matrix

Consultation

None

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

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

Recommendations

The Board of Directors is requested to:

1) Note the contents of the update

Report presented by:	**Ifti Majid** **Acting Chief Executive**
Report prepared by:	**Ifti Majid (supported by Claire Wright, Director of Finance)** **Acting Chief Executive**

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team	Status
24/08/2016	Physio & OT (Return Visit)	Ifti Majid	Timely meeting as we were able to discuss early CQC feedback, understand views and feelings about the experience and draft outcome. Discussed the closer collaboration with DCHS, what the work entailed and what possible implications might be for the LD Team with this being a service delivered differently by both Organisations. We talkied about understandable feelings of anxiety for staff as th eoutcome was not yet known. Good discussion about the organisational culture and openness, staff described how it had felt a number of years ago and how now they feel able to openly ask questions or raise difficult issues with very senior staff in open sessions.	None required	None required	None required	**Completed**
06/07/2016	S.Derbyshire Neighbourhood - Dale Bank View	Ifti Majid	Very well attended, staff came to see me either individually or in groups. Key themes that emerged included:speed of getting personal specific IT equipment, concerns over staffing levels and amount of temporary staff. Told there was a jobs freeze. Leading to lack of stability and poor morale. Lease car mileage not being being sufficient for high mileage users. Some concerns expressed around visibility of middle managers and communication flowing freely up and down organisation. Current duty system creating pressure and stress on team. General sense that the team felt uncontained	1. Chase up IT equipment 2. Alert Kath Lane to the issues 3. Team development time needed	Ifti Majid for all items	Items immediatley fed back supported by email on 11/07/16 IT equipment chased up and requisitioned Kath Lane alerted to issues and general Manager attended Team to discuss way forward	**Completed**
05/07/2016	Psychodynamic Psychotherapy Team, St Andrews House	Ifti Majid	Two key issues discussed, capacity of the team and associated concerns about having to ration their service and the perceived historical erosion. Secondly the role of dynamic psychotherapy in the new neighbourhoods, the link with the development of 'place' in the STP and how they were concerned around involvement in some pathways in particular the development of the complex trauma pathway.Also spoke around the issues associated with complex investigations linked to people receiving therapy.	1. review learning of complaints where action taken that may have been against clinical advice.	Carolyn Green	06/07/2016	**Action Ongoing**
28/06/2016	Early Interventions Service	Carolyn Green	I attended the clincal referrals meeting and the team meeting. This is a team which is rising to the challenge of national standards, a changing referral criteria. Clinical challenges of a wide funnel of types of individuals be referred to the service and the need to have a wide range of clinica assessment skills to meet an all age criiteria, complex presentations which are often emerging trauma, autism, rather than 1st episode psychosis and, without resourced and access referral pathways, these issues are leading to pressure on the team. Clinical flow issues with the recovery teams not having capacity are also impacting upon the service. Support from the QLT and SMT to fully resolve some of these issues would be appreciated. CG gave an overview of the strategy, clincial commissioning and context and the team felt this was helpful to understand.	1. Support from Joe Wileman to have and confirm a team away day. 2. Support from Head of Nursing / Lead professional to have a wider skill set for an all age service. A skill mix review to consider the needs of adults of working age and older adults with a first episode psychosis, including the need for access to specialised support if illness related to head in just or other causes. 3. Support form Joe Wileman and Head of Nursing on consider the needs of individuals with autsim, and have an accessible alternative waiting list. 4. Support to invest in recover y teams, to remove the pressure on EI teams to transition to recovery teams when needed. 5. Sometime the team do not have time to have supervision and development sessions. Support to ensure the team have time to have supervision and training/in-reach support form community learning disability on what is a CTR and how to do it well from Karen Billyead.	Carolyn Green		**Action Ongoing**
22/06/2016	Recovery Team 1 and Derby City Pathfinder Service	Carolyn Gilby	Visit had been difficult and manager felt that he hadn't known what to expect from his 1:1 and had reflected that maybe Quality visits could be more like a CQC visit. There was a long discussion regarding the move to St Andrews House and the parking issues mainly around safe transport of medicines. The relationship between the neighbourhood teams and Campus areas was raised as it was felt that communications had worsened and that this needed to be improved. Consultant handover between community and inpatient was felt to be worse and that the old system was better. The culture regarding risk was felt to be getting better but there was a feeling that there was still too much bureaucracy and that there is a need for positive risk taking with accountability, it was felt that the serious incident team set the tone/culture for risk taking in the organisation. Forensic community team, this was felt to be a gap in service provision but it was a much needed service.	1. Future Quality Visits themes and process lead (Carolyn Green) 2. St Andrews move and Car Parking issues lead (Claire Wright) 3. Inpatient and community communications issues lead (Carolyn Gilby) 4. Consultant Handover between Inpatient and Community lead (John Sykes) 5. Culture and tone regarding Risk and the SIG lead (John Sykes) 6. Forensic community team commissioning gap lead (Mark Powell)	1. Carolyn Green; 2. Claire Wright; 3. Carolyn Gilby; 4. John Sykes; 5. John Sykes; 6. Mark Powell.	2. Additional on site and off site parking is planned but a local parking protocol is also needed - this is being worked on to identify the fairest and most workable approach to parking for teams at St Andrews. 3. Plans in place to improve communication issues. SLM confirmed next steps. 6. Community Forensic service gap identified as part of contract negotiations with commissioners for 16/17. Commissioners made it clear that they were unwilling to commission this service.	**Action Ongoing - Updates required for 1, 4 & 5**
03/05/2016	Cubley Court	Ifti Majid	Met with nursing and medical staff. Staffing levels remaining a concern in context of increased acuity due to DRRT keeping less well at home. Concerns that senior managers and clinical leaders are not visible enough on ward area though positive feedback for SLM. Some worries about the sense of 'blame culture', particularly linked to incidents and SIRI investigations. Very hot on unit in summer and staff wondered about summer uniforms. Concerns about the speed of Paris 'go live' and support during the DGO 'live' period, mixed views about approach taken but general feeling some reconfiguration needed to make easily usable for tasks such as admissions. Medical and nursing capacity eroded by changes around DOLS and MHA.	1.Ifti to do visit to London Road site. 2.Investigate possibility of summer uniforms (scrubs) 3.Further support re training on Paris in handovers etc. to optimise use. 4.Possibility of formalising staff rotation scheme for those who want it. 5.Can physical healthcare diagnostic interventions, such as ECG, phlebotomy, be done by trained ward staff?	1. Ifti Majid 2.Carolyn Green 3.Carolyn Gilby 4.Jayne Storey 5.Carolyn Green	1. Ali arranging visit for Ifti to London Road. 3. Carolyn Gilby put team in touch with Paris training team.	**Action Ongoing**

20/04/2016	South Derbyshire Community LD Service	Ifti Majid	Discussed the issues arising out of Aston Hall and the impact this was having within LD staff group. The team spoke about how responsive and visible the middle management and clinical leaders were in the service. Discussion about delays in recruitment and impact. Parking issues in Derby City particularly at St Andrews. Access to admin is a problem as means clinical staff spending time doing admin. Briefly discussed ET media coverage and financial impact. Discussed quality visits and LD service show case and great discussion around finances and opportunities	1. Exec team to consider radical options to support St Andrews staff 2.Consideration to be given to allowing a combined LD quality visit next year in the vein of showcase. 3.Workshop type discussion around financial efficiency opportunities	1. Ifti Majid 2.Carolyn Green 3.Claire Wright	3. ~~Claire requested finance manager arrange workshop session as required.~~ Finance Manager has met with team, no new CIPs identifed as yet.	**Action Ongoing**
11/04/2016	Cherry Tree Close	Ifti Majid	Staff asked specific questions around the money linked to HM and ST. Felt moment had passed but welcomed opportunity to discuss. Staff felt indignant that Trust isn't defending itself to negative press. Staff feel communication has improved and they feel able to raise concerns. Asked questions about Governor training and induction and plans to improve. Raised issue about the absence policy and how it promoted presenteeism. Concerned about speed of recruitment and if possibility of asking student nurses to sign on our bank within their first few weeks of commencing in training.	1. Inclusion of staff/consultation with staff at CTC to pick up any ideas about developing new absence policy. 2.Look into signing up student nurses in introductory week onto bank	1. Jayne Storey 2.Carolyn Green	Email reply from Ifti Majid with respect to actions and way to take forward.	**Action Ongoing**
08/04/2016	Young Person's Substance Misuse Service	Jayne Storey	Passionate team - open dialogue – welcomed discussion. Angry recent media re: money paid due to senior managers - compared cost impact v junior doctors fighting for pay rise. Perception of leaving with good reference and pay off. AGM – Public face of the Trust, how do we justify the spend on buffet – wrong perception. Transparency of HR procedures – equitable for all – don't see adverts for secondments – just see people seconded into posts. No recognised training / professional qualifications for substance misuse team – just about to have first training in 3 years, no career progression as roles require qualifications not equivalent experience. Have raised with their Line Manager – as part of the training plan, but don't get feedback. Asked the question – How do we retain staff on the basis of the above?	1. Clear communications about this years AGM and consideration about any hospitality. 2. Need to ensure that clarity is given in JDs around use of equivalent experience as universally acceptable substitute for formal training. 3. More communications around staff packages to support recruitment and retention	1. Sam Harrison (Anna Shaw) 2.Jayne Storey 3.Jayne Storey	1. the AMM is being promoted regularly through Weekly Connect, as well as the Trust's website, Facebook page and Twitter account. A press release will be issued shortly. Members have been notified through Connections magazine and the Members News e-bulletin. Governors have been notified through various channels including Governor Connect e-bulletin.Flyers have been widely distributed to community venues across our constituencies, all of the Trust's major sites, all GPs in the County, to 30 community contacts and invitations e-mailed to 4E's stakeholders and over 40 various community contacts. Limited hospitality will be provided only to an agreed budget. No external catering costs will be incurred for food. Action Complete. Actions 2 & 3 outstanding.	**Action Ongoing**
26/02/2016	Southern Derbyshire Crisis and Home Treatment Team	Mark Powell	1. The team would like to change their name from Crisis and Home Treatment to something akin to Assessment and Home Treatment. 2. There was a request for some guidance on what could be said to patients who asked questions about the recent Employment Tribunal and media attention. 3. The impact on the image and the perception of those who are doing a very good job for the Trust at this time and what actions the Board was taking to improve the Trust's reputation. 4. The team wanted senior management to be aware of the ill feeling that some patients are expressing to them as employees of the Trust and that at times they are taking the brunt of this public ill feeling when they shouldn't be. 5. An issue was raised regarding a line in the Deloitte report regarding leadership being an issue in the team. 6. The team were concerned about the number of patients with a PD who were presenting to the service and there was a concern about Melbourne House not accepting admissions. I explained that the Trust was talking to commissioners about the development of a community PD service and that the service specification for this could be shared if required. 7. An issue was raised about staff from Melbourne House and then deployment to the Hub. 8. A question was asked about block contract payment and I explained about the 2 new proposed payment methods form 2017. 9. A question was asked about the current status of neighbourhoods as the team were unclear on this. 10. I asked if it was possible to come back to another meeting in 2 months' time and I think that the team were agreeable to this.	1. Mark Powell to see whether a name change was possible. 2. Guidance to be sent to deal with ET questions (actioned 29/02/2016). 4. Senior management to be made aware of the ill feeling from patients to staff due to the public perception following media attention. 5. Mark to talk to Michelle about a line in the Deloitte report with regard to leadership being an issue - to understand context. 6. Carolyn Gilby to talk to commissioners with regard to the development of a community PD service. 7. Issue to be resolved re: staff from Melbourne House deployed to the Hub. 8. Short summary re: block contract payment to be sent (actioned 29/02/2016). 9. Current status of neighbourhoods to be sent.	1, 4, 5 & 6 - Mark Powell 7 & 9 - Carolyn Gilby	1, 4, 5 & 6 - Mark Powell - actions complete	**Action 7 and 9 Ongoing**

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 7 September 2016

Integrated Performance Report Month 4

Purpose of Report

This paper provides the Trust Board with an integrated overview of performance as at the end of July 2016 with regard to workforce, finance, operational delivery and quality performance.

Recommendations

The Board of Directors is requested to:

1) Consider the content of the paper and consider their level of assurance on the current performance across the areas presented.

Executive Summary

Most of the high level executive summary content is found at the first page of the main report.

This month's report continues to develop the integrated reporting, with Quality baselines being established.

This month the data has been triangulated and a key theme drawn out from the information in the report.

The report continues to be modified to reflect changes requested by the Board.

Strategic considerations

This paper relates directly to the delivery of the Trust strategy by summarising performance across the four key performance measurement areas

Board Assurances

This report should be considered in relation to the relevant risks in the Board Assurance Framework.
As an integrated performance report the content of provides assurance across several BAF risks related to workforce, operational performance, quality performance, financial performance and regulatory compliance.

Consultation

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

Governance or Legal issues

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

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

Equality Delivery System

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

Report presented by: **Carolyn Gilby, Acting Director of Operations**
Claire Wright, Director of Finance
Jayne Storey, Director of Workforce
Carolyn Green, Director of Nursing

Report prepared by: **Peter Charlton, General Manager, Information Management**
Rachel Leyland, Deputy Director of Finance
Liam Carrier, Workforce Systems & Information Manager
Hayley Darn, Nurse Consultant

Highlights

- FSRR better than plan in the month, Forecast on plan for year end
- Surplus better than plan in month and forecast to achieve plan at year end
- Cash better than plan

Challenges

- CIP forecast to deliver further but not to full target
- Mitigations of Financial risks during 16/17

Highlights

- 28 Day readmission compliance has improved
- Outpatient Letters have seen a full quarters sustained achievement of both targets

Challenges

- 18 week incomplete RTT compliance
- Initial cluster of patients
- % 6-8 Week Breastfeeding coverage
- Early Intervention is showing a significant decline in performance

Highlights

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

Challenges

- Monthly and annual sickness absence rates continue to rise.
- Budgeted Fte vacancies remain high.
- Appraisal compliance rates have decreased.

This is a report section in phased development.

Highlights

- Safety Planning training has increased and is close to the 90% target.

Challenges

- Supervision rates have improved slightly with work still to be done
- Flu vaccinations for staff – planning is underway for a programme to commence October 2016

FINANCIAL OVERVIEW – JULY 2016

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Governance	FSRR	Overall Financial Sustainability Risk rating	YTD	3	4	G		As at the end of July the FSRR is 4 which is better than plan and is forecast to be a 4 at the end of the year. Each of the quarters are also forecast to be a 4.
			Forecast	4	4	G		
		Debt Service Cover	YTD	3	3	G		
			Forecast	3	3	G		
		Liquidity	YTD	3	4	G		
			Forecast	4	4	G		
		Income and Expenditure Margin	YTD	3	4	G		
			Forecast	4	4	G		
		Income and Expenditure Margin Variance	YTD	4	4	G		
			Forecast	4	4	G		
I&E and profitability	Income and Expenditure	Control Total position £'000	In-Month	223	355	G		The Control Total shows the position including the Sustainability Transformation Fund (STF) and the Underlying Income and Expenditure position excludes the STF. Surplus is better than plan in the month and due to changes in the run rate is forecast to achieve plan at the end of the financial year. The Normalised Income and Expenditure shows the financial performance adjusting for any non-recurrent costs or benefits that will not continue.
			YTD	364	1,006	G		
			Forecast	2,531	2,531	G		
		Underlying Income and Expenditure position £'000	In-Month	154	286	G		
			YTD	88	729	G		
			Forecast	1,701	1,701	G		
		Normalised Income and Expenditure position £'000	In-Month	154	301	G		
			YTD	88	832	G		
			Forecast	1,701	1,618	R		
	Profitability	Profitability - EBITDA £'000	In-Month	826	964	G		
			YTD	2,815	3,480	G		
			Forecast	9,806	9,677	R		
		Profitability - EBITDA %	In-Month	7.3%	8.6%	G		
			YTD	6.2%	7.8%	G		
			Forecast	7.1%	7.2%	G		
Liquidity	Cash	Cash £m	YTD	10.392	11.513	G		Cash is currently above plan but is forecast to be below plan at year end due to the forecast release of some provisions.
			Forecast	13.153	12.355	R		
	Net Current Assets	Net Current Assets £m	YTD	4.065	6.314	G		
			Forecast	7.570	5.587	R		
	Capex	Capital expenditure £m	YTD	0.841	0.757	R		
			Forecast	3.450	3.450	G		
Efficiency	CIP	CIP achievement £m	In-Month	0.358	0.187	R		CIP is currently behind plan and is forecast not to deliver the full plan at the end of the financial year.
			YTD	1.433	0.718	R		
			Forecast	4.300	2.900	R		
			Recurrent	4.300	1.998	R		

Key:

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

Plan In-month or Year end Trust plan

Achieving plan
Not achieving plan

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

OPERATIONAL OVERVIEW – JULY 2016

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	NHSI	CPA 7 Day Follow-up	Month	95.00%	96.15%	G	↓	Compliant with NHSI targets except incomplete RTT where demand appears greater than our ability to meet using current processes.
			Quarter	95.00%	97.35%	G	→	
		CPA Reviews in Last 12 months	Month	95.00%	95.79%	G	→	
			Quarter	95.00%	95.79%	G	→	
		Delayed Transfers of Care	Month	7.50%	2.31%	G	→	
			Quarter	7.50%	2.35%	G	→	
		Data completeness - Identifiers	Month	97.00%	99.42%	G	→	
			Quarter	97.00%	99.42%	G	→	
		Data completeness - Outcomes	Month	50.00%	93.89%	G	→	
			Quarter	50.00%	93.89%	G	→	
		Community Care Data Activity - Completeness	Month	50.00%	93.22%	G	→	
			Quarter	50.00%	93.22%	G	→	
		Community Care Data - RTT Completeness	Month	50.00%	92.31%	G	→	
			Quarter	50.00%	92.31%	G	→	
		Community Care Data - Referral Completeness	Month	50.00%	75.91%	G	→	
			Quarter	50.00%	75.28%	G	↓	
		18 Week RTT incomplete	Month	92.00%	89.84%	R	↓	
			Quarter	92.00%	89.74%	R	↓	
		Early Interventions New Caseload	Month	95.00%	167.40%	G	↓	
			Quarter	95.00%	167.40%	G	↓	
		Clostridium Difficile Incidents	Month	7	0	G	→	
			Quarter	7	0	G	→	
		Crisis Gatekeeping	Month	95.00%	100.00%	G	→	
			Quarter	95.00%	100.00%	G	→	
		IAPT RTT within 18 weeks	Month	95.00%	99.78%	G	→	
			Quarter	95.00%	99.85%	G	→	
		IAPT RTT within 6 weeks	Month	75.00%	88.22%	G	↓	
			Quarter	75.00%	88.31%	G	↓	
		Early Intervention in Psychosis RTT Within 14 Days	Month	50.00%	57.14%	G	↓	
			Quarter	50.00%	55.10%	G	↓	

Key:

Period

Month Current Month

Quarter Current Quarter

Achieving target

Not achieving target

↑ → ↓ Trend compared to previous month/quarter

OPERATIONAL OVERVIEW – JULY 2016

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Locally Agreed	CPA Settled Accommodation	Month	90.00%	96.50%	G	→	The majority of clinicians now successfully manage their PbR caseloads either independently or through positive engagement with available support.
			Quarter	90.00%	96.50%	G	→	
		CPA Employment Status	Month	90.00%	97.41%	G	→	
			Quarter	90.00%	97.41%	G	→	
		Data completeness - Identifiers	Month	99.00%	99.42%	G	→	
			Quarter	99.00%	99.42%	G	→	
		Data completeness - Outcomes	Month	90.00%	93.89%	G	→	
			Quarter	90.00%	93.89%	G	→	
		Patients Clustered not Breaching Today	Month	80.00%	81.32%	G	→	
			Quarter	80.00%	80.84%	G	→	
		Patients Clustered regardless of review dates	Month	96.00%	94.75%	R	→	
			Quarter	96.00%	94.63%	R	→	
		7 Day Follow-up - all inpatients	Month	95.00%	95.51%	G	↓	
			Quarter	95.00%	96.95%	G	→	
		Ethnicity coding	Month	90.00%	90.89%	G	↓	
			Quarter	90.00%	90.89%	G	↓	
		NHS Number	Month	99.00%	99.97%	G	→	
			Quarter	99.00%	99.97%	G	→	
	Schedule 4	Consultant Outpatient Trust Cancellations	Month	5.00%	6.45%	R	→	The main reasons given for cancellation were clinician absence from work and clinician on annual leave.
			Quarter	5.00%	6.38%	R	→	
		Consultant Outpatient DNAs	Month	15.00%	16.20%	R	↓	
			Quarter	15.00%	15.84%	R	↓	
		Under 18 admissions to Adult inpatients	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Outpatient letters sent in 10 working days	Month	90.00%	91.06%	G	↑	
			Quarter	90.00%	92.26%	G	↑	
		Outpatient letters sent in 15 working days	Month	95.00%	95.76%	G	→	
			Quarter	95.00%	96.58%	G	↑	
		Inpatient 28 day readmissions	Month	10.00%	8.20%	G	↑	
			Quarter	10.00%	5.21%	G	↑	
		MRSA - Blood stream infection	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Mixed Sex accommodation breaches	Month	0	0	G	→	
			Quarter	0	0	G	→	
		18 weeks RTT greater than 52 weeks	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Discharge Fax sent in 2 working days	Month	98.00%	100.00%	G	↑	
			Quarter	98.00%	100.00%	G	→	

OPERATIONAL OVERVIEW – JULY 2016

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Fixed Submitted Returns	18 weeks RTT greater than 52 weeks	Month	0	0	G	→	Compliant with Fixed Targets except incomplete RTT where demand appears greater than our ability to meet using current processes.
			Quarter	0	0	G	→	
		18 Week RTT incomplete	Month	92.00%	89.81%	R	↓	
			Quarter	92.00%	89.81%	R	↓	
		Mixed Sex accommodation breaches	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Completion of IAPT Data Outcomes	Month	90.00%	94.80%	G	→	
			Quarter	90.00%	94.80%	G	↓	
		Ethnicity coding	Month	90.00%	90.81%	G	↓	
			Quarter	90.00%	90.81%	G	→	
		NHS Number	Month	99.00%	99.99%	G	→	
			Quarter	99.00%	99.99%	G	→	
Other Dashboards	Health Visiting	% 10-14 Day Breastfeeding coverage	Month	98.00%	100.00%	G	→	6-8 week coverage target has been missed by 6 Health Visitor teams due to mobilisation, workforce factors and organisational change
			Quarter	98.00%	100.00%	G	→	
		% 6-8 Week Breastfeeding coverage	Month	98.00%	95.90%	R	↓	
			Quarter	98.00%	95.90%	R	↓	
	IAPT	Recovery Rates	Month	50.00%	54.35%	G	↓	
			Quarter	50.00%	54.35%	G	→	
		Reliable & Recovery Rates	Month	65.00%	73.50%	G	→	
			Quarter	65.00%	73.50%	G	↑	
	Safer Staffing	Inpatient Safer Staffing Fill Rates	Month	90.00%	104.8%	G	↓	Detailed ward level information shows specific variances
			Quarter	90.00%	104.8%	G	↓	

WORKFORCE OVERVIEW – JULY 2016

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance		Trend	Key Points
Workforce Dashboard	NHSI Key Performance Indicator (KPI)	**Turnover** (annual)	**Jul-16**	10%	**10.86%**	→	G	↑	Annual turnover remains within the Trust target parameters and is below the regional Mental Health & Learning Disability average of 12.58% (as at May 2016 latest available data). Monthly sickness absence rates continue to increase at 6.32% for July 2016. Compared to the same period last year the monthly sickness absence rate is 0.66% higher. The annual sickness absence rate continues to increase running at 5.80% as at July 2016. The regional average annual sickness absence rate for Mental Health & Learning Disability Trusts is 5.05% (as at April 2016 latest available data). Anxiety/stress/depression/other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 26.05% of all sickness absence, followed by Surgery at 14.66% and Injury/Fracture 8.74%. Vacancy rates have increased by 0.35% compared to the previous month. The number of employees who have received an appraisal within the last 12 months has decreased this month by 4.10% to 67.19%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £656k of which £410k related to Medical staff. Compulsory training compliance has decreased slightly this month by 0.18% but still remains above the 85% main contract non CQUIN.
			Jun-16		10.86%		G		
		Sickness Absence (monthly)	**Jul-16**	3.9%	**6.32%**	↗	R	↑	
			Jun-16		6.20%		R		
		Vacancies (including 10% funded fte cover)	**Jul-16**	10%	**17.83%**	↗	A	↑	
			Jun-16		17.48%		A		
		Vacancies (actual)	**Jul-16**	0%	**7.83%**	↗	A	↑	
			Jun-16		7.48%		A		
		Appraisals (all staff - number of employees who have received an appraisal in the previous 12 months)	**Jul-16**	90%	**67.19%**	↘	R	↓	
			Jun-16		71.29%		R		
		Appraisals (medical staff only - number of employees who have received an appraisal in the previous 12 months)	**Jul-16**	90%	**82.24%**	↘	R	↑	
			Jun-16		83.96%		R		
		Qualified Nurses (to total nurses, midwives, health visitors and healthcare assistants)	**Jul-16**	65%	**67.52%**	↘	G	↑	
			Jun-16		68.31%		G		
		Agency Usage (£ year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Jul-16**	£0	**656k**	↗	R	↑	
			Jun-16		445k		R		
		Agency Usage (% year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Jul-16**	0%	**65.00%**	↗	R	↑	
			Jun-16		58.00%		R		
	Other KPI	**Compulsory Training** (staff in-date)	**Jul-16**	95%	**90.31%**	↘	A	↑	
			Jun-16		90.49%		A		

Key:

Period Current month and previous month

Plan Trust target

↗ Variance to previous month

Achieving target/within target parameters

Approaching target/approaching target parameters

Not achieving target/outside target parameters

Trend based on previous 4 months

Turnover parameters (8% to 12%)

Vacancy parameters (10% to 20%)

QUALITY OVERVIEW – JULY 2016

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Quality	Quality Strategy	Percentage of current Inpatients with a recorded Capacity Assessment	Month	100.00%		R	↓	Awaiting FSR roll out (data from PARIS), Capacity assessments now recorded on PARIS as per 'Blue Light' June 2016. Monitoring underway on this indicator in advance of full FSR. Awaiting further development of FSR amd reporting capability to demonstrate care planning.
			Quarter	100.00%		R	↓	
		Percentage of all patients with a care plan in place which has been reviewed with 12 months	Month	90.00%	N/A		→	
			Quarter	90.00%	N/A		→	
		Seclusion incidents	Month	20	25	G	→	
			Quarter	60	32	G	→	
		Physical Restraint incidents	Month	55	62	G	↑	
			Quarter	165	78	G	↓	
		Clinical Supervision	Month	90	52.60%	A	↑	Sampling audit of care planning undertaken July 2016.
		Management Supervision	Month	90	68.70%	A	→	Supervision continues to increase.
		Safeguarding Supervision	Month	90	47.90%	R	↑	Metric for safeguarding supervision requires refinement as frequency is less.
		Professional Supervision	Month	90	19.70%	R	↑	Exploring combing with managerial. 3 per year
	CQUINs or contractual levy	Flu Jab Up-take	Month	45.00%	N/A		→	Flu remains unchanged. Think Family training increased by 2.5%, Safety Planning increased by 8%, now almost at target. New data collection system for CTR commenced August 2016
			Quarter	45.00%	N/A		→	
		Think Family Training	Month	90.00%	66.43%	A	↑	
			Quarter	90.00%	N/A	A	→	
		The safety plan training	Month	90.00%	89.93%	A	↑	
			Quarter	90.00%	N/A	A	→	
		The number of LD or Autism admissions without a CTR before admission	Month	0			→	
			Quarter	0			→	

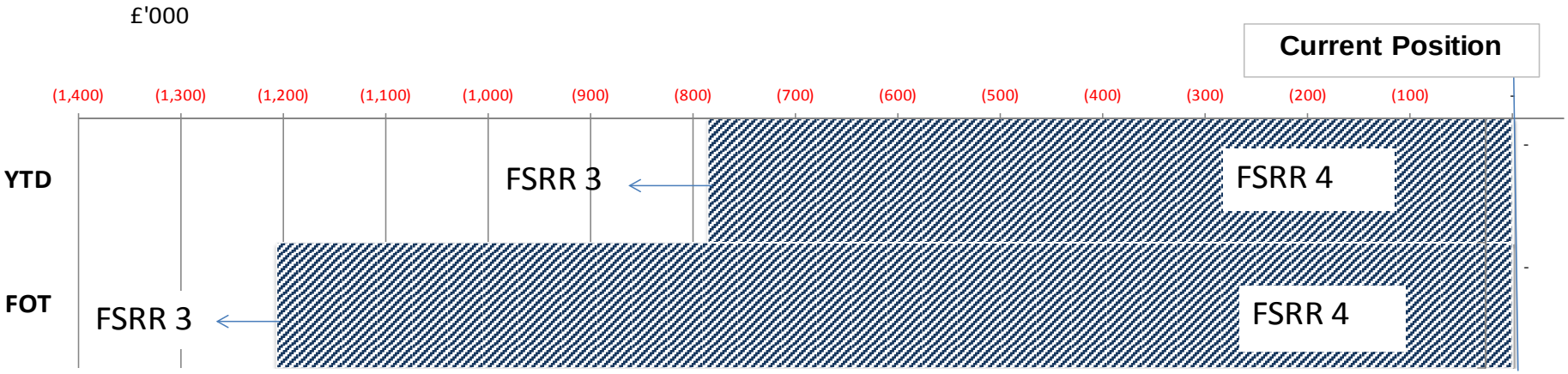
Financial Section

Governance – Financial Sustainability Risk Rating (FSRR)

Enc E

The FSRR at the end of July is a 4 which is better than plan. The forecast continues to be a rating of 4 as per the plan.

The headroom down to a FSRR of 3 year to date and forecast is £0.8m and £1.2m respectively. The headroom is shown in the graph below:



The year to date FSRR at the end of each of the quarters is shown in the table below:

	YTD @ Quarter 1		YTD @ Quarter 2		YTD @Quarter 3		YTD @ Quarter 4	
	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual
Capital Service Capacity rating	2	3	3	3	3	3	3	3
Liquidity rating	3	4	4	3	4	4	4	4
I&E Margin rating	3	4	4	4	4	4	4	4
I&E Margin Variance rating	4	4	4	4	4	4	4	4
FSRR	**3**	**4**	**4**	**4**	**4**	**4**	**4**	**4**

NHS Improvement are currently consulting on a proposed Single Oversight Framework which includes new financial metrics to measure financial sustainability, efficiency and controls.

Income and Expenditure

Enc E

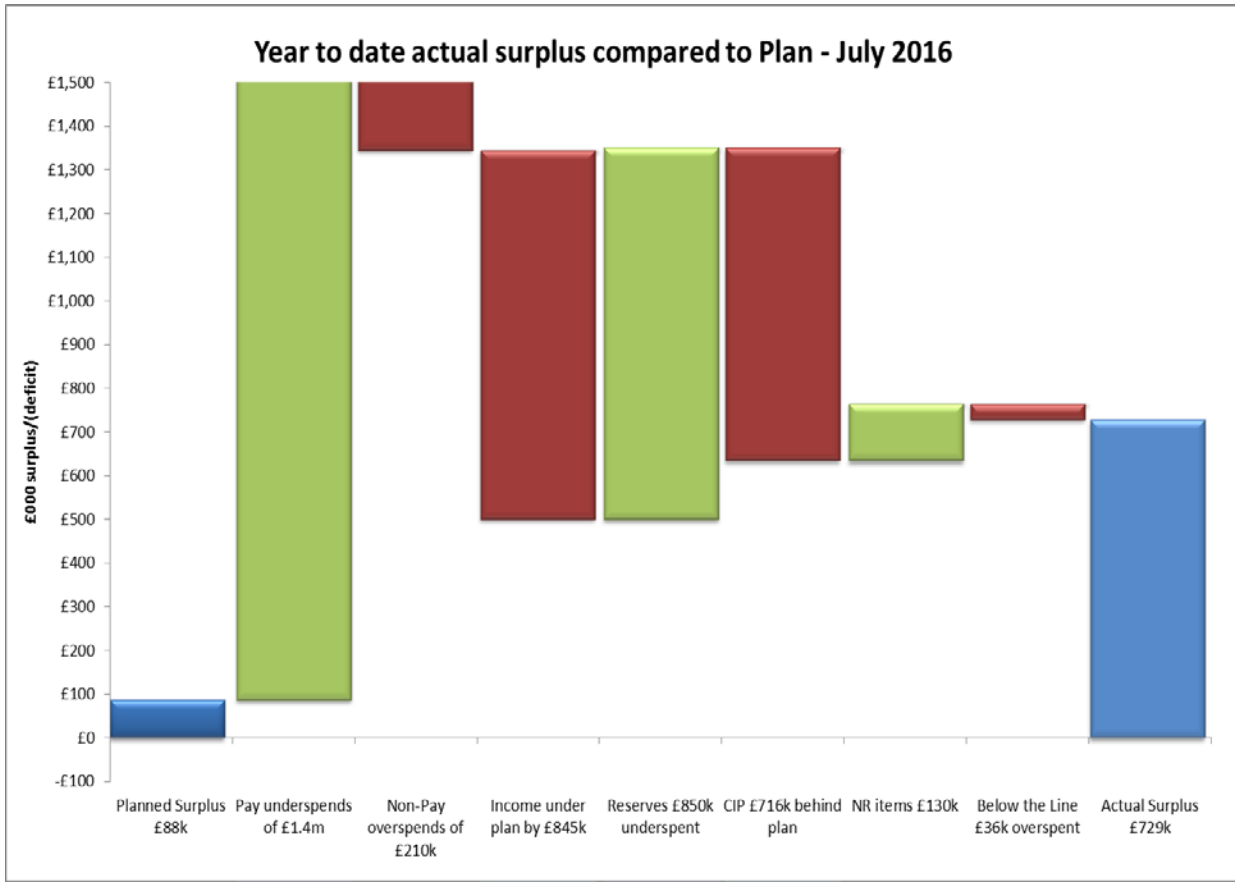
Statement of Comprehensive Income — July 2016

	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	10,520	10,419	(101)	42,357	41,306	(1,051)	127,406	124,183	(3,223)
Non Clinical Income	849	826	(23)	3,397	3,103	(293)	10,190	9,450	(740)
Employee Expenses	(8,376)	(8,003)	372	(34,197)	(32,001)	2,196	(101,492)	(96,915)	4,577
Non Pay	(2,167)	(2,279)	(111)	(8,742)	(8,929)	(187)	(26,298)	(27,040)	(741)
EBITDA	**826**	**964**	**137**	**2,815**	**3,480**	**665**	**9,806**	**9,677**	**(128)**
Depreciation	(295)	(301)	(6)	(1,178)	(1,215)	(37)	(3,534)	(3,448)	86
Impairment	0	0	0	0	0	0	(300)	(300)	0
Profit (loss) on asset disposals	0	0	0	0	0	0	0	0	0
Interest/Financing	(175)	(175)	1	(740)	(726)	14	(2,141)	(2,099)	41
Dividend	(133)	(133)	(0)	(533)	(533)	0	(1,600)	(1,600)	0
Net Surplus / (Deficit)	**223**	**355**	**132**	**364**	**1,006**	**642**	**2,231**	**2,230**	**(0)**
Technical adjustment - Impairment	0	0	0	0	0	0	(300)	(300)	0
Control Total Surplus / (Deficit)	**223**	**355**	**132**	**364**	**1,006**	**642**	**2,531**	**2,530**	**(0)**
Technical adjustment - STF Allocation	69	69	0	277	277	0	830	830	0
Underlying Net Surplus / (Deficit)	**154**	**286**	**132**	**88**	**729**	**642**	**1,701**	**1,700**	**(0)**

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

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

Clinical Income is £101k less than plan in month and is forecast to be £3.2m worse by the end of the year of which a significant proportion is due to differences in planning assumptions with offsetting expenditure reductions. There is however forecast underperformances on activity related income.
Non Clinical income is ahead of plan in the month by £23k but has a forecast outturn of £0.7m behind plan. £0.4m relates to a miscellaneous income target with no income forecast against it.
Pay expenditure is £372k less than the plan in the month and the year end position is £4.6m more favourable than plan which is due to planning assumptions (with offsetting income reductions) but also vacancies and recruitment.
Non Pay is overspent in the month by £111k which mainly relates to Drugs and PICU expenditure which is also driving the forecast overspend.



Summary of key points Enc E

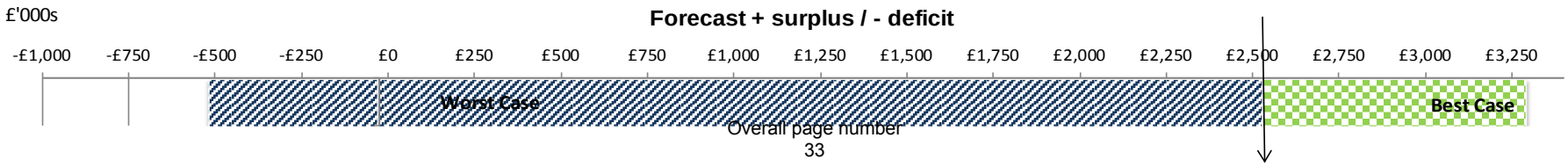
Overall favourable variance to plan year to date which is driven by the following:

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

The forecast includes a set of assumptions based on knowledge and expectations at this point in time. At this early stage in the financial year there is a large performance range from worst-case to best-case outturn which is primarily dependant on the successful mitigation of emerging risks.

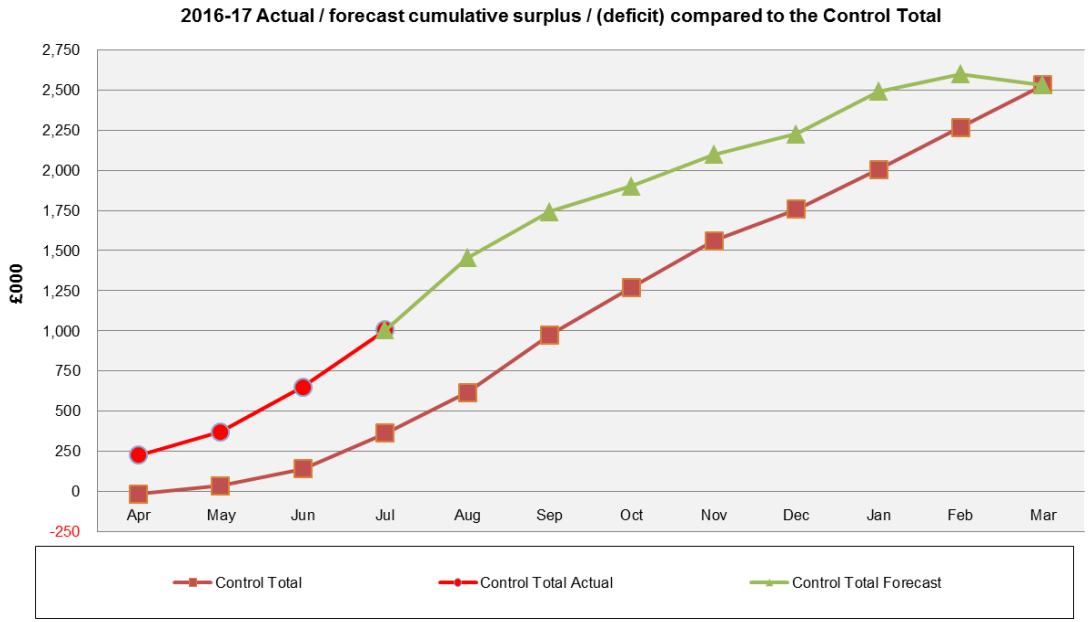
Forecast Range

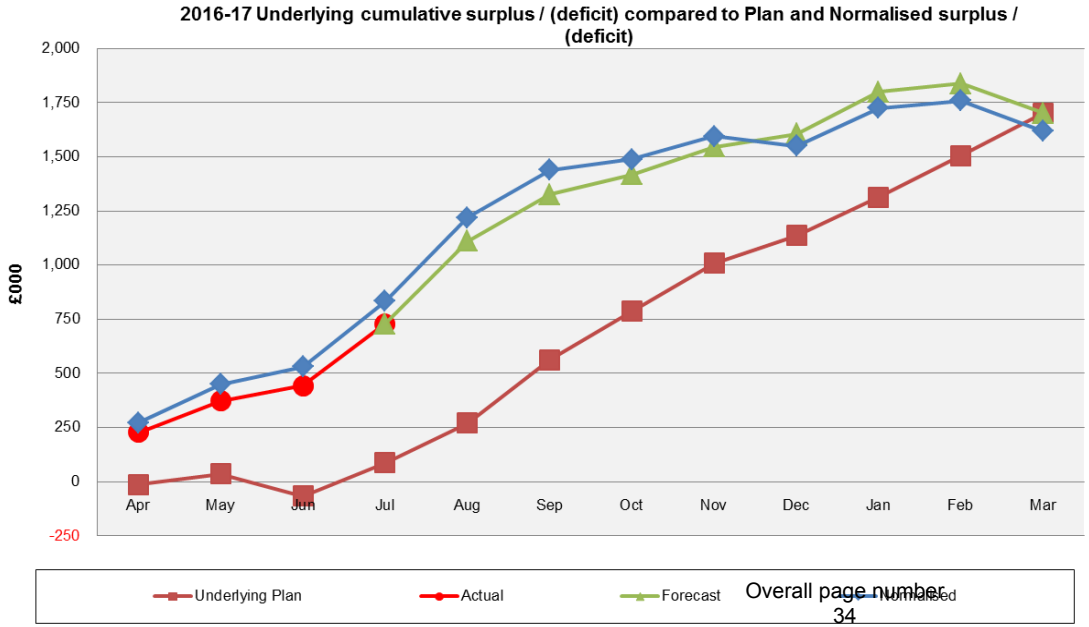
Best Case	Likely Case	Worst Case
£3.3m Surplus	£2.5m surplus	£0.5m deficit



Normalised Income and Expenditure position

Enc E





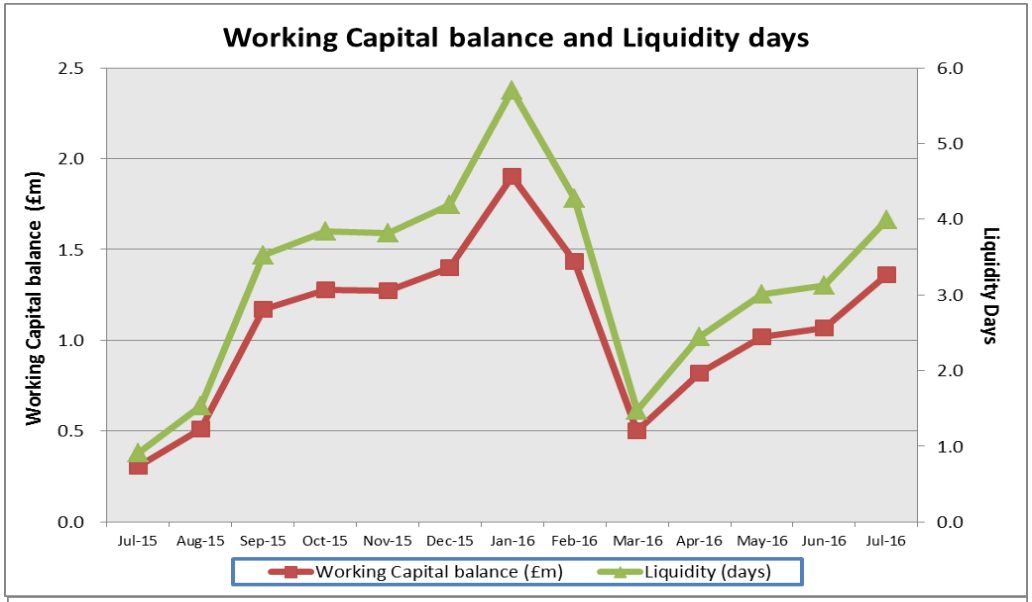
The first graph shows the actual and forecast cumulative surplus against the control total (including the Sustainability Transformation Fund (STF). The surplus is forecast to remain ahead of plan in the first part of the financial year and then slowly reduce back down to the planned control total.

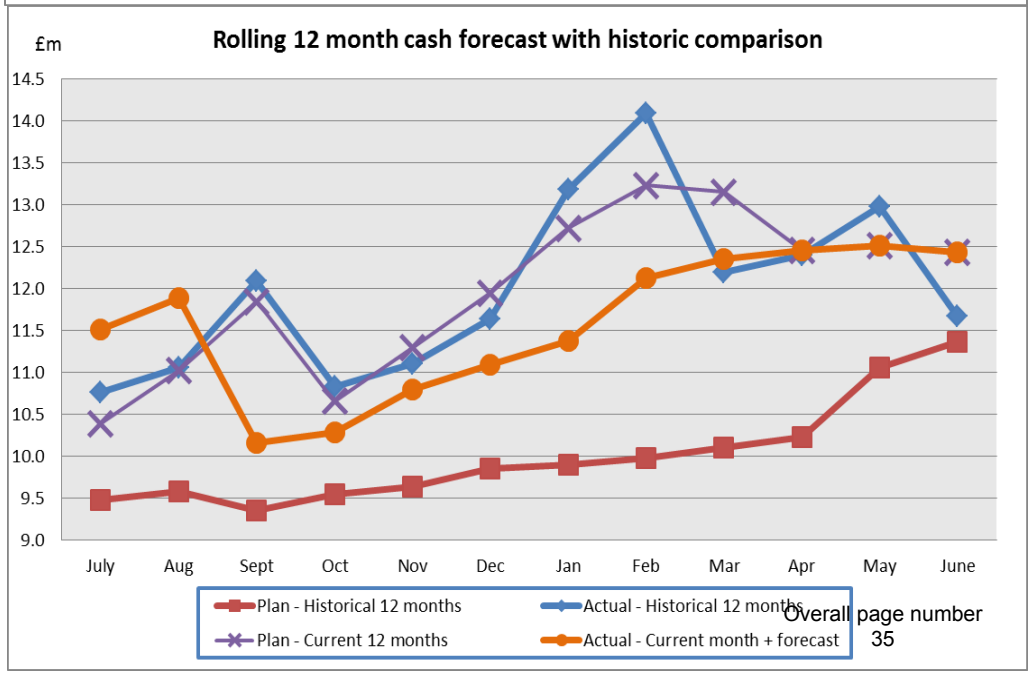
The second graph shows the underlying actual and forecast surplus against the underlying plan excluding the STF.

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

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

Liquidity





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

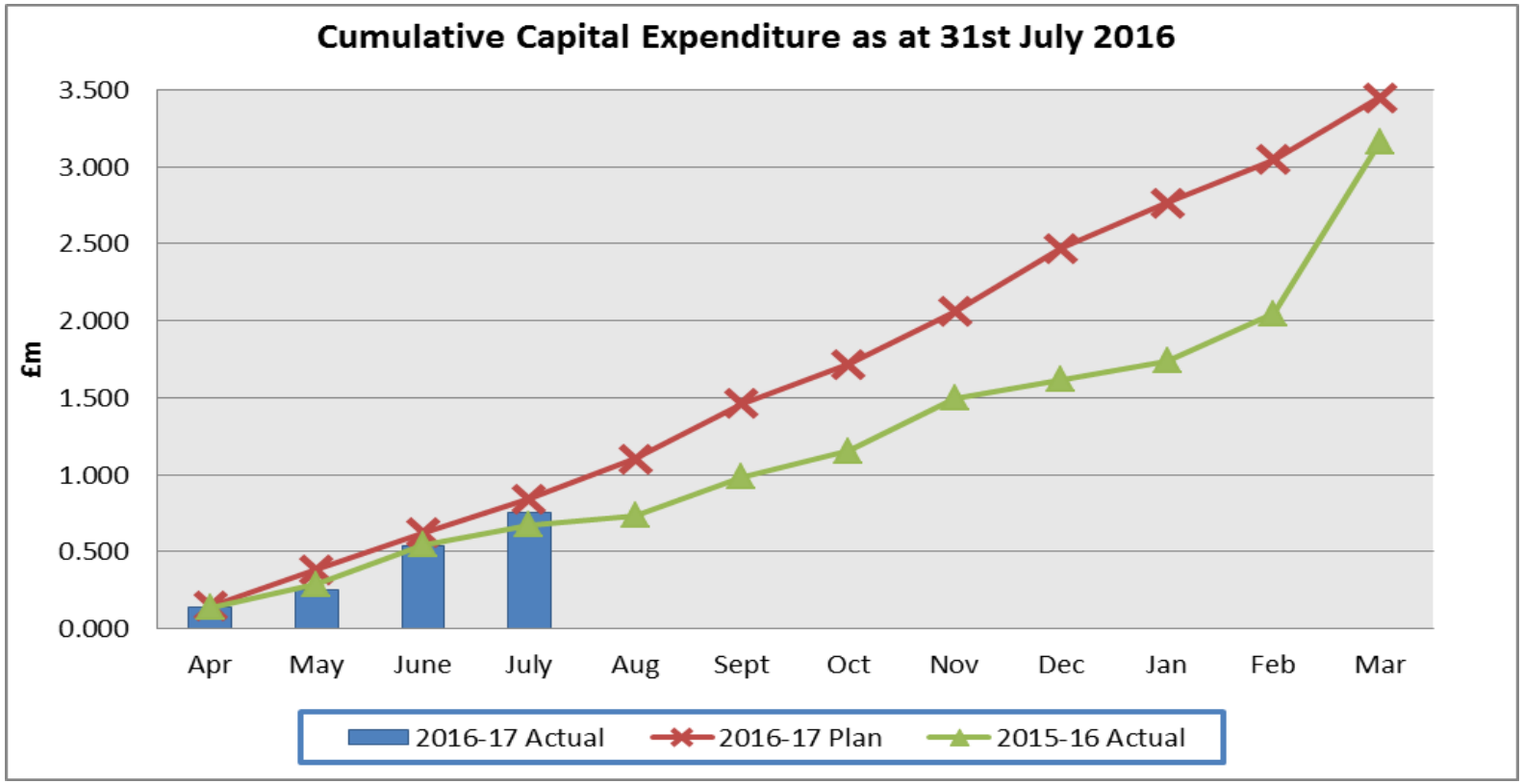
During last financial year working capital continued to improve due to improved cash levels. The downward trend at the end of last financial year is reflective of the reduction in cash due to year end transactions. July continues to show a further improvement up to 4 days which still gives a rating of 4 on that metric (-7days drops to a rating of 3).

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

Cash is currently at £11.5m which was £1.1m better than the plan at the end of July. This is mainly driven by the Income and Expenditure surplus.

Capital Expenditure

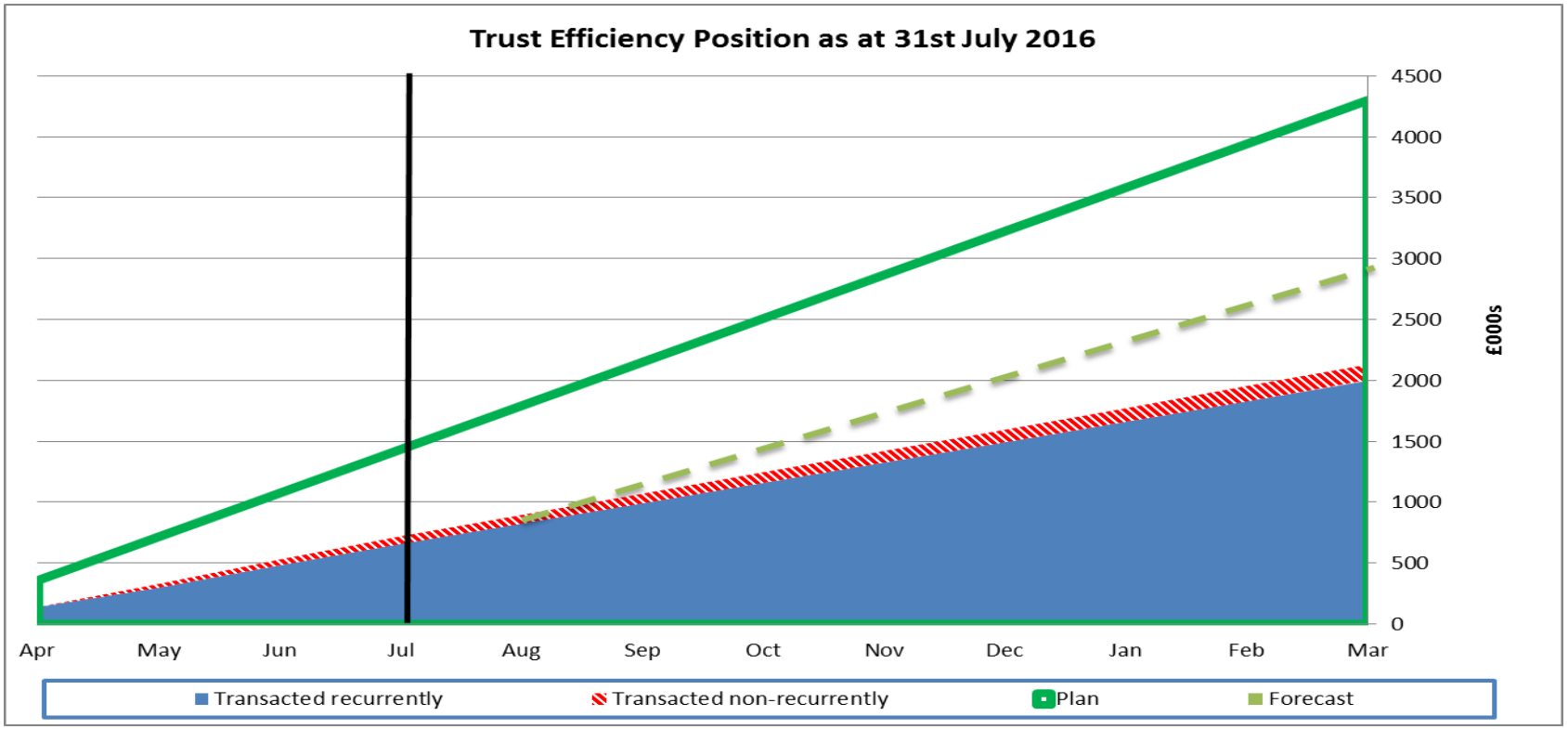
Enc E



Capital Expenditure is £84k behind plan year to date but is forecast to spend to the plan of £3.45m by year end.

The 2016/17 schemes are regularly reviewed by Capital Action Team (CAT) including the reprioritisation to fund any new schemes. Some reprioritisation of schemes has taken place to date this year in order to fund more urgent schemes.

Cost Improvement Programme (CIP)



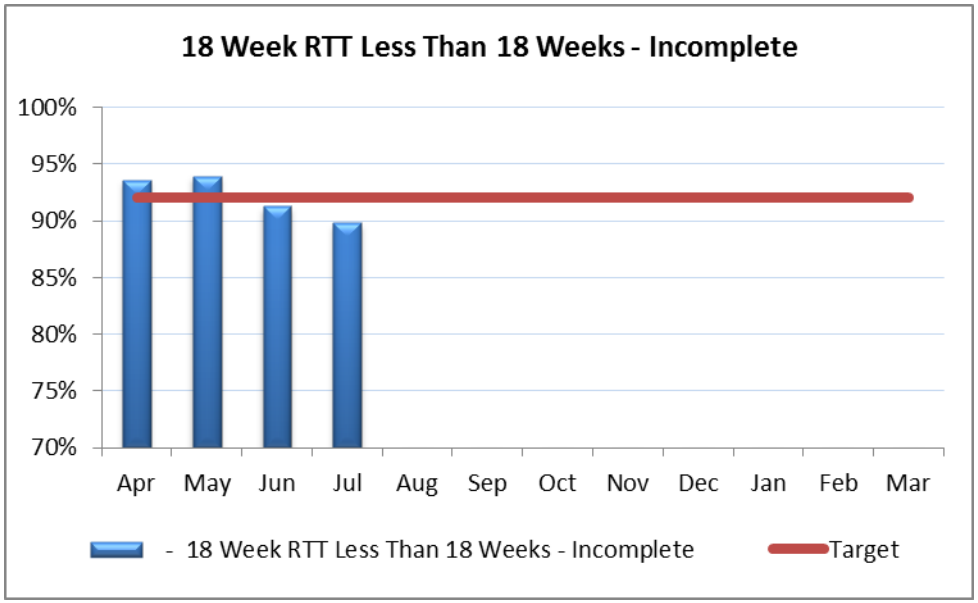
At the end of July there was a shortfall against the year to date plan of £716k. The full year amount of savings identified at the end of July reporting is £2.1m leaving a gap of £2.2m.

The forecast assumes that a further £0.8m will be achieved by the end of the financial year leaving unfound CIP of £1.4m.

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

Operational Section

18 Week RTT Less Than 18 Weeks - Incomplete

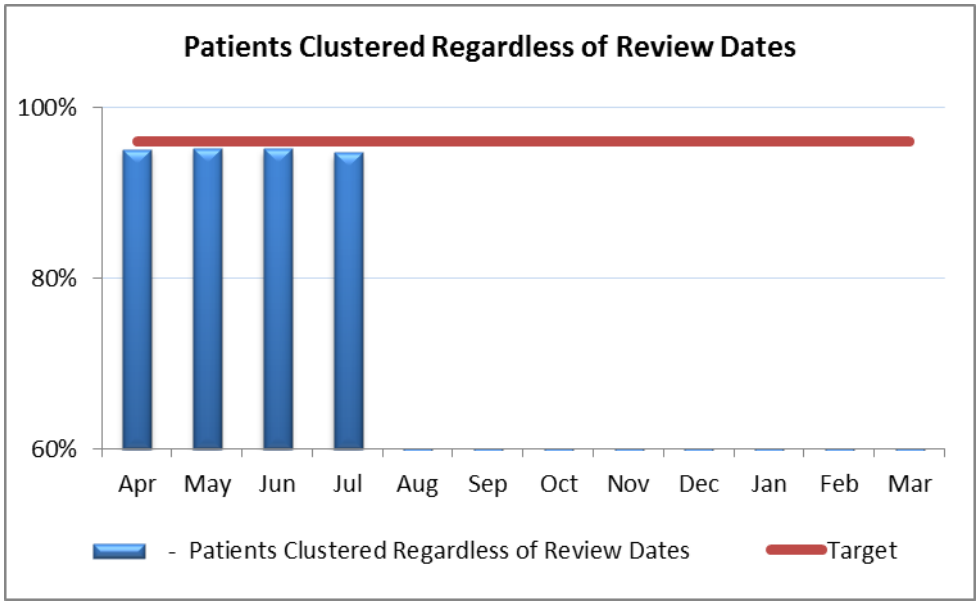


Analysis of first outpatient appointment referral and activity data for the period April 2014 to date suggests that the number of new referrals received per week outweighs the number of number of available new outpatient appointment slots.

Actions being taken:

- Review of job planning.
- Investigation is underway to establish whether any treatment has been provided during contacts with the Trust's interface services prior to onward referral to outpatients. Records will be corrected if applicable.
- To propose that assessment appointments with interface services should always include a form of treatment

Clustering

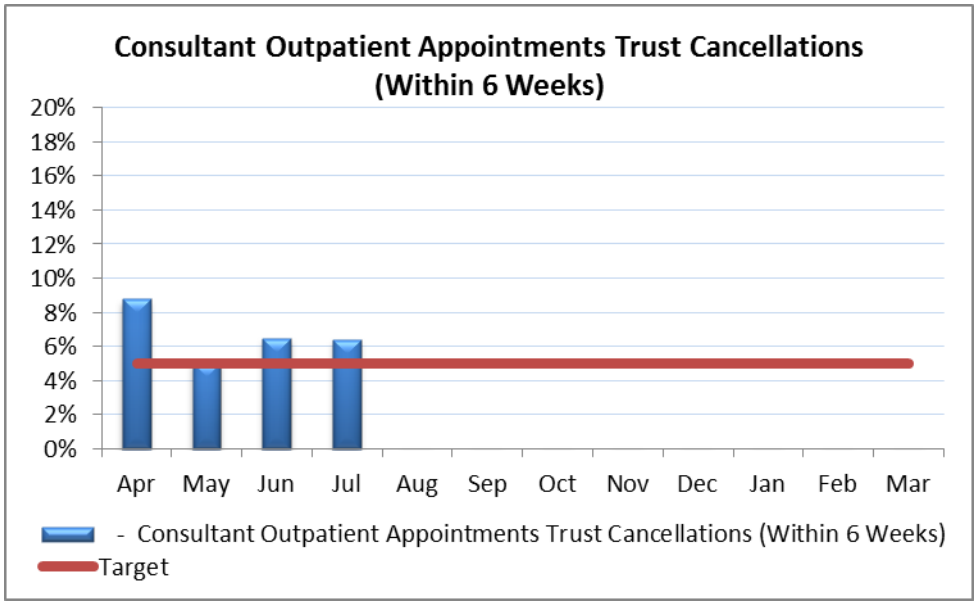


The majority of clinicians now successfully manage their PbR caseloads either independently or through positive engagement with available support.

Solutions being deployed on an ongoing basis:

- to data cleanse
- to make improvements in practitioner clustering
- to highlight to staff responsible for clustering the issues needing to be resolved
- PbR Advisors continue to target support to those clinicians with the largest clustering backlogs.
- Taught Course “Understanding HoNOS and Care Clusters – Flustered About Clusters?” has now been introduced.

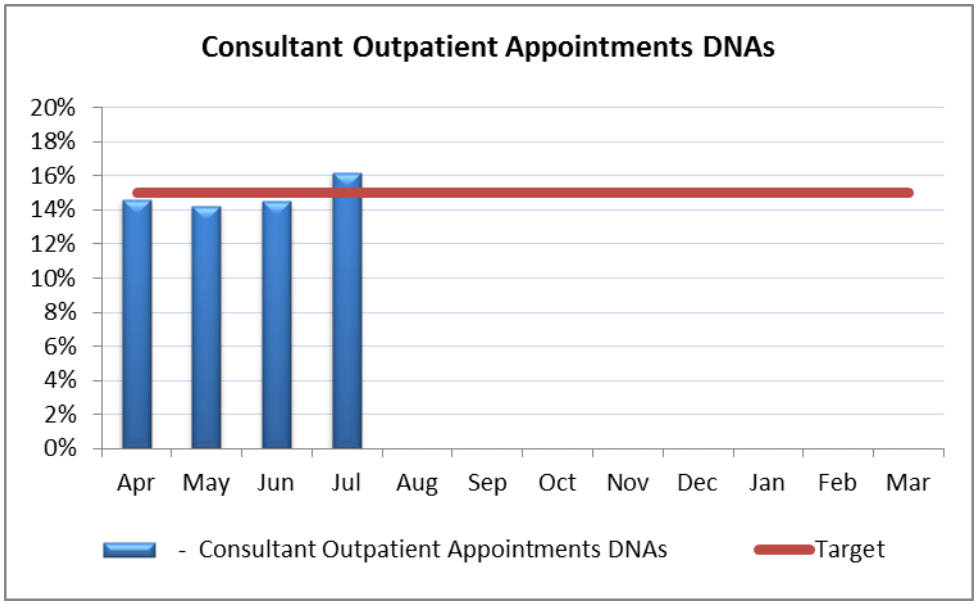
Consultant Outpatient Appointments Trust Cancelations (within 6 weeks)



The main reasons given for cancellation were clinician absence from work and clinician on annual leave.

- Associate Clinical Directors to review cancellation reasons and discuss with consultant concerned where the reason does not appear valid, if applicable.
- List of clinic cancellation reasons has been agreed and added to Paris to enable easier reporting and monitoring.
- IM&T have been asked to explore the possibility of adapting Paris to enable the recording of cancellation reasons for individual appointments, not just whole clinics.

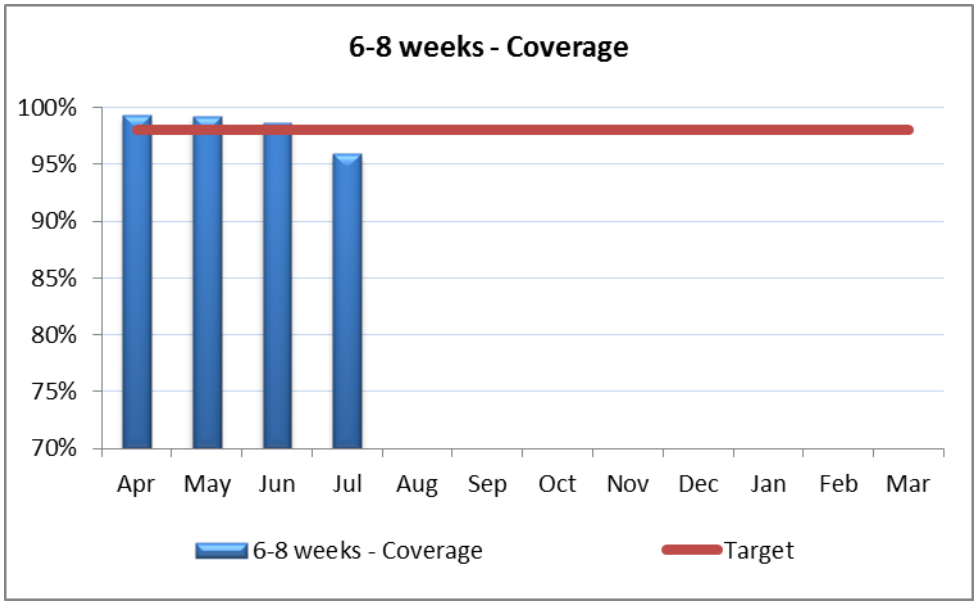
Consultant Outpatient Appointments DNAs



The rate of DNAs was above the target threshold for the first time in 6 months. In August to date it has dropped below threshold once more.

- The Divisional Admin Coordinator and Professional Lead has been requested to review outpatient administration processes.
- To continue to monitor

6-8 weeks - Coverage



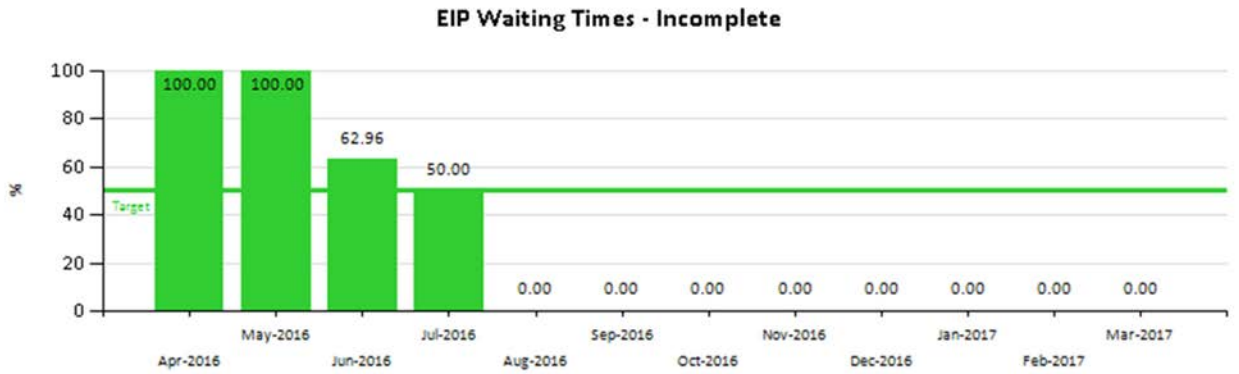
The coverage targets for July 2016 were not met in six HV teams. This has been attributed to several factors these being:

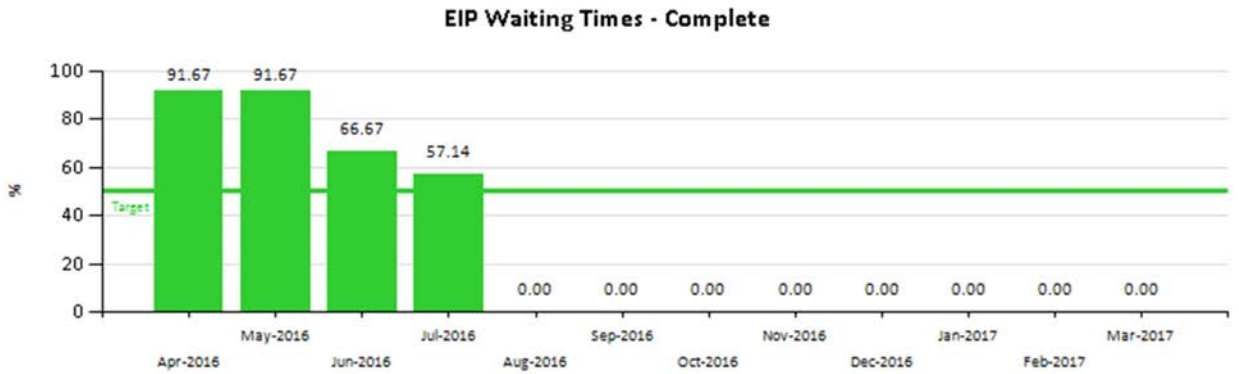
- The impact the mobilisation plan is having on staffs moral
- Reduced workforce – annual leave, sickness, under recruitment
- Change of responsibility from administrators providing the exceptions to HV teams to the HV teams. Some staff did not have authorisation to access to the data

Action:

- An email has been sent to all staff from Sue Earnshaw recognising staffs hard work in such a changing environment and will be sending out progress emails each month
- There will be a significant reduction in holidays as the summer comes to a close. Out for advert to recruit HVs in October. Staff are returning from extended sick leave
- All HV teams have now been informed again it is their responsibility to identify their own data. Also, teams have identified of two members of staff to review their reports at each allocation /team meeting to ensure the targets are met. Staff aware of how to access the data via IT.

EIP Performance Monitoring Downward Trajectory





We implemented the new access and waiting time standards from 1st April 2016 and we have experienced a greater than expected increase in referrals. All of the analysis prior to launch, supported by national and regional analysis indicated a 20% uplift due to the increase in age range beyond 35 yrs. We have experienced 100% increase in referrals. This has naturally created a challenge to see patients within the 2 week timeframe and has caused compliance to drop when previously we achieved 100% compliance.

We received additional funding to increase capacity in support of the new standards and this is underway with 3 of the 4 additional care coordinator posts recruited to (started or with start dates planned). Recruitment is continuing and has unexpectedly been added to with 2 new resignations. Factoring in 2 additional long-term absences and we have a situation where referrals have doubled and capacity is short by at least 4 whole time equivalents.

We have introduced a daily monitoring of waiting times in order that we can identify potential breaches before they happen and we are working to improve our capacity position with some short-term and longer-term actions. Both of these actions will have the effect of improving waiting time compliance.

Enc E

WARD STAFFING

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	163.3%	67.5%	112.9%	87.1%	Yes	No comment received
CHILD BEARING INPATIENT	115.6%	125.0%	100.0%	115.0%	No	
CTC RESIDENTIAL REHABILITATION	110.8%	93.3%	100.0%	106.5%	No	
ENHANCED CARE WARD	87.7%	101.6%	71.4%	113.7%	Yes	We continue to carry 3 RG vacancies one of which has been recruited into with a start date of December. All shifts have trust NIC with appropriate competencies. Shortfalls in RGs backfilled with NA cover from bank.
HARTINGTON UNIT - MORTON WARD ADULT	101.5%	100.0%	59.3%	195.7%	Yes	Morton ward we are currently carrying a number of Band 5 vacancies – at the point of these figures it was 5.36 WTE. We also have a band 5 acting up into the Band 6 position. It is therefore not possible to allocate x2 staff nurses on the night shift.
HARTINGTON UNIT - PLEASLEY WARD ADULT	107.0%	74.8%	90.6%	102.4%	Yes	The ward currently has only 7 HCA's, one of whom is on long term sick. As a result day shifts quite often have more than the planned registered staff on duty in place of HCA's which reflects the low percentage of care staff 74.8% against the 107.o% of registered staff being used on day shifts.

Enc E

WARD STAFFING

Ward name	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
HARTINGTON UNIT - TANSLEY WARD ADULT	67.8%	143.8%	54.1%	212.5%	Yes	Tansley Ward is currently running with a high level of Band 5 vacancies against funded posts. In June there are 10.2 whole time equivalent (wte) Band 5 vacancies and only 8.7 wte Band 5 nurses in post. Of those 8.7 wte Band 5 nurses in post 1 full time nurse was removed from clinical duty at the end of February pending investigation into concerns who has no potential return date. The part time Band 5 nurse having just had surgery is recovering well with a favourable prognosis and will hopefully commence a phased return in early September. I have maintained regular support and we have discussed a positive plan to support her return to duty. The impact of the vacancies and absence has been significant on our ability to maintain even minimum numbers of Band 5 nurses on shift at 2/2/1. Many actions are being taken to address. some of which are: • Rotas are written approximately 3 months in advance via the e-roster to allow for staff to plan their time and to identify any potential qualified bank shifts they can do to bring us up to minimum numbers of 2 registered nurses on early and late duties and 1 qualified nurse on night duty. • Lead and Senior nurses working clinically in the numbers and on bank to bring numbers up to minimum and provide leadership. • Block booking Bank HCA to bring overall staffing numbers up to 5/5/3
KEDLESTON LOW SECURE UNIT	116.6%	84.9%	106.5%	100.0%	Yes	

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WARD STAFFING

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 (%)		
KINGSWAY CUBLEY COURT - FEMALE	87.4%	107.1%	72.6%	121.5%	Yes	We have had high levels of Registered Nurse sickness, which is beginning to ease in August
KINGSWAY CUBLEY COURT - MALE	88.6%	125.2%	85.5%	197.9%	Yes	We currently have registered nurse vacancies which may be reflected in the figures. We are also experiencing a high level of clinical need for patients on the ward so staffing establishment is increased each shift
LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP	127.2%	99.8%	64.5%	228.9%	Yes	No comment received
LONDON ROAD COMMUNITY HOSPITAL - WARD 2 OP	104.0%	90.1%	119.3%	133.9%	Yes	No comment received
RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT	97.5%	97.7%	82.9%	108.8%	Yes	the % for night shift is correct and due to current ward Registered Nurse vacancies we are not able to meet fill rate, hence the over filling of Nursing Assistant's on nights
RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT	87.2%	114.6%	62.3%	347.1%	Yes	Ward 34 continues to carry a large number of vacancies which is being addressed via recruitment, also ward 34 have had a high number of increased engagement levels and on going high clinical activity which has increased the number of bank staff used.
RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT	61.5%	122.9%	56.7%	174.2%	Yes	No comment received
RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT	93.6%	106.1%	97.0%	117.7%	No	

Workforce Section

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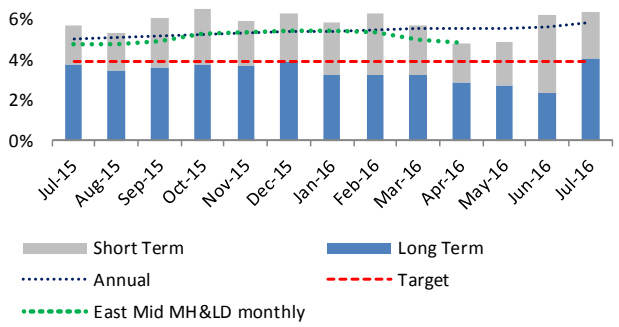
Wellbeing

Sickness Absence

(Monthly)

May-16	Jun-16	Jul-16
4.87%	6.20%	**6.32%**

Target 3.9%



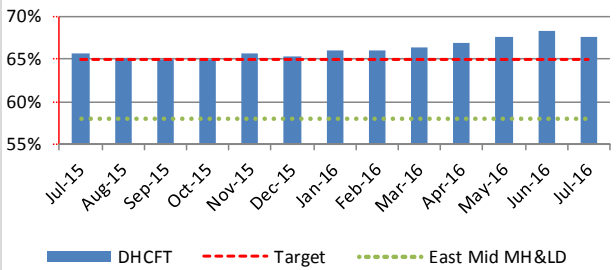
The Trust annual sickness absence rate is currently 5.80%. Monthly sickness absence rates have increased again this month by 0.12% to 6.32%. In June 2016 there was a large increase in short term absence caused by traditional long term absence reasons which has now developed into long term sickness. Anxiety/stress/depression/other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 26.05% of all sickness absence, followed by surgery at 14.66% and injury/fracture at 8.74%.

Qualified Nurses

(To total nurses, midwives, health visitors and healthcare assistants)

May-16	Jun-16	Jul-16
67.50%	68.31%	**67.52%**

Target 65%



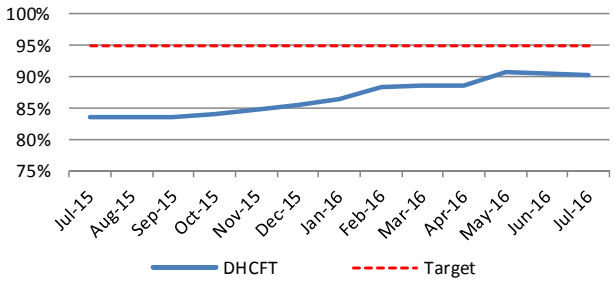
Contracted staff in post qualified nurses to total nurses, midwives, health visitors and healthcare assistants remains within target at 67.52%. Vacancy rates can impact on this measure. The NHS average is 61.38% and the East Midlands Mental Health & Learning Disability average is 58.04%.

Compulsory Training

(Staff in-date)

May-16	Jun-16	Jul-16
90.87%	90.49%	**90.31%**

Target 95%



Compulsory training compliance continues to remain high running at 90.31%, a slight decrease of 0.18% compared to the previous month. Compared to the same period last year compliance rates are 6.90% higher. Compulsory training compliance remains above the 85% main contract commissioning for quality and innovation (CQUIN) target.

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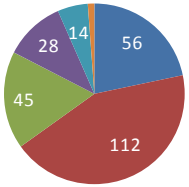
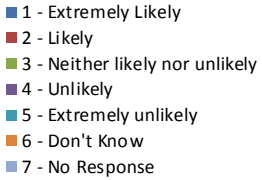
Motivation

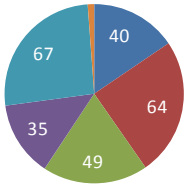
Staff FFT Q1 2016/17 & Staff Survey 2015

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





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

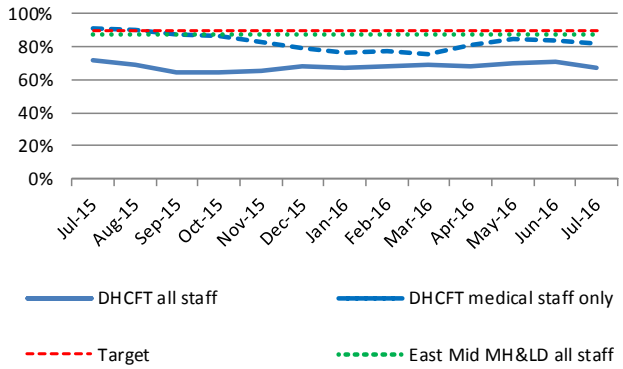


	2014	**2015**	National Average
Overall staff engagement	3.75	**3.73**	3.81

Appraisals

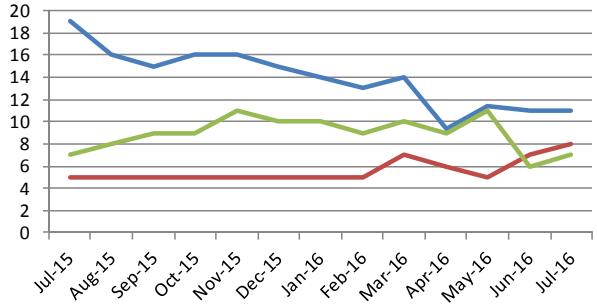
	May-16	Jun-16	**Jul-16**
(All staff)	69.59%	71.29%	**67.19%**

Target 90%

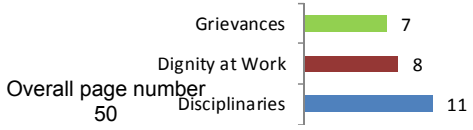


The number of employees who have received an appraisal within the last 12 months has decreased by 4.10% during July 2016 to 67.19%. Compared to the same period last year, compliance rates are 4.29% lower. Medical staff appraisal compliance rates are running at 82.24%. According to the latest staff survey results, the national average for Mental Health & Learning Disability Trusts is 91%.

Grievances/Dignity at Work/Disciplinaries as at 31/07/16



7 grievances currently lodged at the formal stage, 1 new case received regarding job banding and responsibilities of the role. 8 dignity at work cases currently lodged, 1 new case involving allegations of a racist nature. 11 disciplinaries in progress, 3 cases have been resolved and 3 new cases reported which includes allegations of information governance breach and patient complaints.



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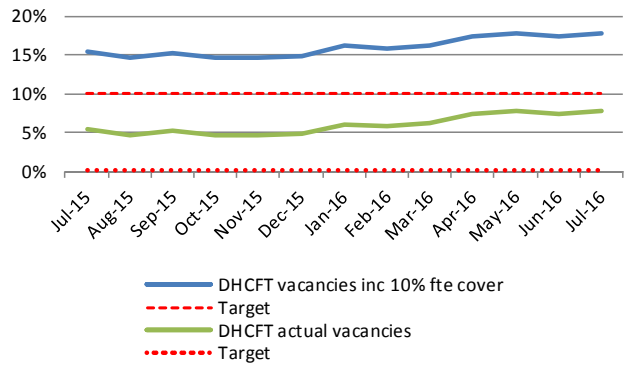
Vacancy

(Budgeted full time equivalent)	May-16	Jun-16	**Jul-16**
Including 10% funded fte cover	17.75%	17.48%	**17.83%**
Actual	7.75%	7.48%	**7.83%**

Target 10%/0%

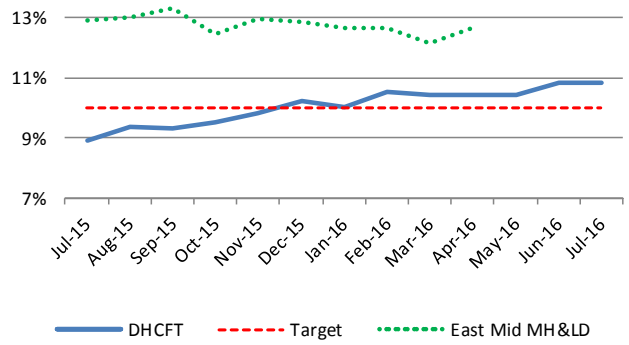


The Trust target for contracted staff in post is 90% which allows 10% funded full time equivalent (fte) surplus for sickness and annual leave cover in In-Patient areas. The budgeted fte vacancy rate has increased by 0.35%. April 2016 included additional full time equivalent investment for 2016/17. New recruitment activity during July 2016 was for 70 posts. 69% were for qualified nursing, 20% admin & clerical, 4% additional clinical services, 4% medical and 3% scientific & technical.

Turnover

(Annual)	May-16	Jun-16	**Jul-16**
	10.44%	10.86%	**10.86%**

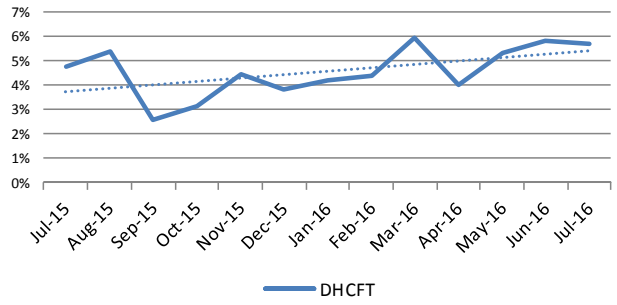
Target 10%



Annual turnover remains within Trust target parameters at 10.86% and is below the average for East Midlands Mental Health & Learning Disability Trusts. The average number of employees leaving each month remains static at 22. During July 2016 12 employees left the Trust which included 4 retirements. A key factor still remains for the increase in recent turnover rates, which is a reduction in overall contracted staff in post caused by unfilled vacancies.

Agency Usage

(Spend)	May-16	Jun-16	**Jul-16**
	5.29%	5.79%	**5.71%**



Total agency spend in July 2016 was 5.71% (6.18% including medical locums). Of total agency and locum spend for all staff groups, Qualified Nursing represented 1.2%, Medical 3.5% and other agency usage 1.5%. Agency Qualified Nursing spend against total Qualified Nursing spend in July was 3.3%. Agency Medical spend against total Medical spend in July was 17.0%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £656k of which £410k related to Medical staff.

Workforce Key Performance Indicator (KPI) Triangulation July 2016

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The triangulation focus list for key Workforce metrics identifies Wards/Teams that are most in need of attention and support. The table below list Wards/Teams that are in need of attention and support in more than one Workforce KPI. Please note that all figures relate to July 2016 and to fall into the focus list a Ward/Team must have at least 10 employees/funded fte.

Teams requiring attention and support in more than one Workforce KPI:

Ward/Team July 2016	HC	KPI	%
County North Early Intervention	15	Appraisal	40.00%
County North Early Intervention	15	Sickness Absence	8.87%
County South Early Intervention	10	Appraisal	20.00%
County South Early Intervention	10	Compulsory Training	85.39%
Derby City Early Intervention	14	Appraisal	7.14%
Derby City Early Intervention	14	Compulsory Training	81.75%
Derby City Neighbourhood - Team C	22	Appraisal	45.45%
Derby City Neighbourhood - Team C	22	Compulsory Training	80.77%
Derby City Neighbourhood - Team C	22	Sickness Absence	11.74%
Derbyshire County Substance Misuse - High Intensity	33	Appraisal	24.24%
Derbyshire County Substance Misuse - High Intensity	33	Compulsory Training	73.50%
Hope & Resilience Hub	24	Appraisal	41.67%
Hope & Resilience Hub	24	Sickness Absence	16.39%
HP+NthDales Neighbourhood - Team A	16	Appraisal	50.00%
HP+NthDales Neighbourhood - Team A	16	Sickness Absence	10.76%
HP+NthDales Neighbourhood - Team B	28	Appraisal	50.00%
HP+NthDales Neighbourhood - Team B	28	Compulsory Training	84.10%
RDH Ward 35 Adult Acute Inpatient IP	29	Appraisal	34.48%
RDH Ward 35 Adult Acute Inpatient 'IP'	29	Sickness Absence	23.14%
Rykneld CBT	13	Appraisal	7.69%
Rykneld CBT	13	Compulsory Training	85.19%
Rykneld CBT	13	Sickness Absence	12.02%
Young Persons CAMHS	10	Appraisal	40.00%
Young Persons CAMHS	10	Compulsory Training	80.00%

Quality Section

Strategic Risks (Board Assurance Framework)

Risk Description	Risk rating	Trend
1a) Failure to achieve clinical quality standards	HIGH	⟷
2a) Risk to delivery of national and local system wide change.	HIGH	⟷
3a) Loss of public confidence due to Monitor enforcement actions and CQC requirement notice and adverse media attention	HIGH	⟷
3b) Loss of confidence by staff in the leadership of the organisation at all levels	HIGH	⟷
4a) Failure to deliver short term and long term financial plans	EXTR	⟷
4b) Failure to deliver the agreed transformational change at the required pace	HIGH	⟷

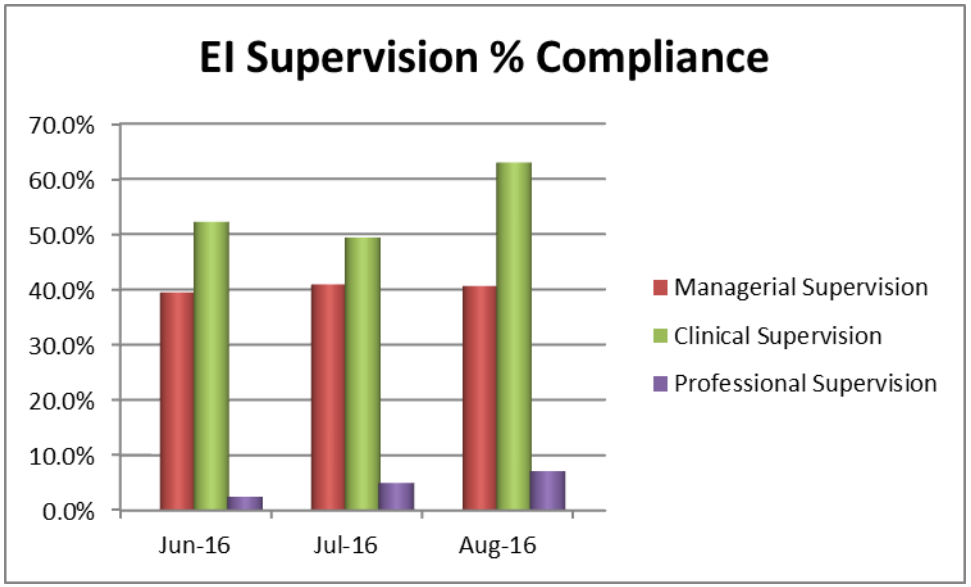
No changes to the current risk ratings identified this month.

Clinical Risks (Significant)

Risk Description	Risk rating	Trend
Long waiting lists due to difficulty in recruiting paediatricians	EXTR	⟷
Nursing vacancies, leadership and succession planning across Radbourne Unit	EXTR	↑
Non-compliance with medicine management standards. Lack of facilities to assure compliance with medicines management standards	HIGH	⟷
Lack of commissioned services: ADHD, patients discharged from prison	HIGH	⟷
Waiting times for psychological assessment, neighbourhood teams, pressure from transfer between neighbourhood teams.	HIGH	⟷
Increased risk of fire, violence and aggression, lone working and workplace stress on Radbourne Unit.	HIGH	⟷

Themes include:
Significant staffing level risks across a number of service areas;
Associated increases in work related stress;
Increased risks of violence and aggression identified on Radbourne Wards in relation to the number of staff vacancies;
Increased risk of fire identified on some inpatient wards associated with the smoking ban

EI Supervision % Compliance



A review of the Early Interventions in Psychosis Performance data, alongside the Workforce & OD indicators demonstrated the reduction in compliance with key indicators. As a key feature of integrated performance reporting is triangulation and identification of themes, this prompted a review of supervision data for that service to see if this was perhaps contributing to a dip in quality of service provision, and staff experience.

Supervision rates in the team are low, compared to the target of >90%.

Future plans for the development of the supervision aspect of the report are to consider how this may be reported in the future and what other aspects of quality could demonstrate this.

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 7 September 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

This position statement sets out:

1. Responsiveness and effectiveness in on work to deliver the Five year forward plan.
2. Safe services which includes our markers of good practice for safeguarding.
3. Well-led- Our quality visit programme

Strategic considerations

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

(Board) Assurances

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

Consultation

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

Governance or Legal issues

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

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:

1) Receive this quality position statement.
2) Gain assurance and information on its content and seek clarity or challenge on any aspect of the report.

Report presented by:	**Carolyn Green** **Executive Director of Nursing and Patient Experience**
Report prepared by:	**Clare Grainger** **Head of Quality and Performance on behalf of:**

QUALITY POSITION STATEMENT
August 2016

1. SAFE SERVICES

1.1 Safeguarding Adults Assurance framework quality site visit

The Trust has completed its Safeguarding Adults Assurance framework review with commissioners and our four CCGs lead Safeguarding adults lead and the Chair of the Adult Safeguarding Board for Derbyshire in August.

The clinical commissioners agreed to delay our meeting to one of the last interviews in Derbyshire due to the extensive additional clinical pressure the Trust is providing on behalf of our community partners and our local community and wider region and national areas for individuals requiring psychological support as they raise concerns about their experiences in a complex enquiry.

We would like to thank the CCG and the Safeguarding board chair for their time spent in the Trust exploring our Safeguarding strategy, assurances and according to our four CCG joint Safeguarding lead; the team were thanked for our staff's diligent and comprehensive completion of our evidence folder which he verbally reported as extensive and detailed.

We look forward to receiving a written report on the CCG and Safeguarding panels' formal feedback on their scrutiny visit.

In the arena of safeguarding we would like to pass our thanks to Dr Gulshan Jan for her work in the safeguarding arena and wish her well in her continued role as Associate Clinical Director for Central services and thank her for her leadership in the Learning Disability team. We welcome our newly appointed Named Dr for Safeguarding Adults Deepak Sirur who works clinically in the Substance misuse services who has recently been appointed to replace Dr Gulshan Jan.

Markers of good practice Safeguarding children scrutiny report

As reported last month on 5th July 2016 we received an e mail confirming our submission of Markers of good Practice self- assessment tool to NHS Southern Derbyshire Clinical Commissioning Group. The CCG confirmed that they were impressed and assured by our progress. For information below we have set out our scores against each of the criteria.

The RAG rating

	Compliance 1: Compliance with NHS Safeguarding Vulnerable People in the NHS Accountability & Assurance Framework									
	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8	1.9	1.10
Derbyshire Healthcare NHS Foundation Trust										

Compliance 2: Serious Case Reviews/ Learning Reviews	Compliance 3: Voice of the Child		Compliance 4: Female Genital Mutilation (mandatory requirement)		Compliance 5: PREVENT Duty		
2.1	3.1	3.2	4.1	4.2	5.1	5.2	5.3

Compliance 6: Domestic Violence/ Abuse	Compliance 7: Child Sexual Exploitation	
6.1	7.1	7.2

2. CARING SERVICES

2.1 Derbyshire Healthwatch report

We have received Derbyshire Healthwatch report on *Experiences of individuals living with substance misuse accessing health and social care services in Derbyshire.* The report covers community treatment, access to mental health services and various voluntary aspects. We are in the process of responding to the report. We would like to take this opportunity to thank Derbyshire Healthwatch for this work.

We will:

Continue to work in partnership with both Healthwatch organisations. Action planning will be completed for the recommendations.

3. RESPONSIVE AND EFFECTIVENESS OF OUR SERVICES

3.1 The Forward Vision

Our Medical Director has been attending some research and development sessions to reflect on his 360 degree appraisal and design a strategy for continual improvement to practice through research and improvement.

The NHS Five Year Forward View: health and wellbeing, quality of care and treatment, finance and efficiency. Sets the strategic direction of developing a new relationship with patients and communities is key to improvement

Nationally events and forums are planned to implement the six principles which set out the basis of good person-centred, community-focused care.

The six principles aim to give practical support to services as they deliver the Forward View's vision for a new relationship with patients and communities.

They require that:

- Care and support is person-centred: personalised, coordinated, and empowering
- Services are created in partnership with citizens and communities
- Focus is on equality and narrowing inequalities
- Carers are identified, supported and involved
- Voluntary, community and social enterprise and housing sectors are involved as key partners and enablers
- Volunteering and social action are recognised as key enablers.

These are all areas of quality improvement our teams need to be considering in their practice and areas for the development to enable our services to transform and these concepts are key areas we need to explore in our vision in our new Trust strategy and to ensure clinical improvements going forward are embedded into our plans for our Neighbourhoods, Children's, Central and Campus services.

We will:

We will need new clinical enabling strategies in the Trust to deliver these issues and a clinical leadership team in place and in stable positions to make improvements:

- In my wider Nursing and Quality team I hope to be appointing to some redesigned roles a Lead AHP/ Lead OT for Campus at a Band 8a level, in this post I hope our OT and AHP workforce can see my commitment to replace the Lead recovery post in a revised model. This post is pivotal in its work to drive forward person-centred: personalised, coordinated, and empowering care. This post is needed in our Trust to drive forward our strategies in personalised and recovery orientated care. The recruitment to this post will then release the options for the proposed Neighbourhood and Central service lead OT post again a Band 8a to focus on community service provision.

- In my wider team, since the retirement of a key professional in our trust our former CAMHS consultant nurse Laurence Baldwin over the summer, we have missed his input into quality and service improvement in the Children's and CAMHS team. We have redesigned his post to be advertised and open to all clinical professionals working in CAMHS and Children's and the post has been advertised on NHS Jobs. This senior post is so important to our clinical governance agenda and ensuring that our Central/ Specialist Quality Leadership team and its integrated Children's and CAMHS CRG develops and goes form strength to strength in its quality and service improvement agenda. As our services transform and grow we need to ensure these six principles in the NHS Five Year Forward View are put into practice and that our Trust undertakings that we always consider our duties and the requirement to undertake due positive regard to the Equalities Act and we ensure that our practice in this area expands and flourishes. This will require skilled individuals to champion the voice of the parent, carer, young carer and child as well as representing all staff directly to the Board and the reinvestment of this post is an important contribution to this agenda.

- We will be increasing our senior Clinical Leadership in Children's and CAMHS through a newly redesigned Lead professional model rather than protecting posts for single professions. Wherever possible we will open and widen recruitment to all registered clinical professionals to be considered for all senior jobs. As a senior leader for quality I believe that all clinical professionals should be given equal footing to lead and the professionals with the best match of clinical skills should be promoted

rather than always replacing like for like. There will be some posts where we have a substantial nursing workforce and a nursing professional is required but wherever possible all the assets of our organisational skills and competencies will be considered. As joint quality lead, the need to have a direct voice to Children's and CAMHS to ensure my connectivity to the Children's services and ensure we are driving forward in clinical improvements minimising safety and fully embedding clinical standards is likely to our future success.

- In Older Adults our Nurse consultant is on a 12 month secondment to another organisation, we wish her very well in her endeavours and we are advertising and interviewing for a redesigned post to really focus on clinical practice standards for Older Adults and frailty. This post will initially be focusing on the in-patient wards, we will be revisiting and replenishing clinical standards at the point of care delivery, with specific focus on the mental capacity act, best interest assessments and person-centred: personalised, coordinated, care and ensuring the integrated approaches to both mental health and physical health care planning. Clinical presence and direct feedback to care staff is critical to maintaining clinical standards. We envisage that this post holder will work hand in glove with our Acting head of nursing for the Kingsway site Sarah Ford who we have put into post to really focus on nursing and professional issues at the Kingsway site. Sarah commenced in post just prior to our June CQC inspection following the retirement of our longstanding nurse for Campus in our Trust Kate Sargeson.

- Learning Disability is a key area of our organisation in Services are created in ensuring partnership with citizens and communities and our longstanding Nurse consultant Gaynor Ward will be key to ensuring that our teams are always person-centred: personalised, coordinated, and empowering and ensure the protection of rights through their leadership with the Associate Clinical Director Gulshan Jan who will be supporting all of our clinical professionals to really focus on our Quality priorities of ensuring the safe and diligent application of the mental capacity act and best interests assessments are completed to the required standards. We have requested that one of our qualified Best interest's assessors joins the Mental Health act committee to advise the Lead Director on best interests and particularly learning and practice issues from our Learning Disability teams.

3.2 Mental Health Action Group highlight concerns about out of hours support

The Mental Health Action group is an independent service receiver led organisation.

In July they published their newsletter. In it they highlighted concerns about out- of-hours support for people experiencing a crisis at the evening or weekend. They say:

"Group members expressed their serious concern about the gaps in crisis care which many people can still drop into. Healthwatch Derbyshire confirmed that they are picking up some high quality feedback from service receivers about their experiences of crisis support. We hope this will be used by commissioners and service providers to instigate improvements where needed and to continue funding those services that are valued. "

We will:

Continue to review our crisis provision with commissioners going forward and freed into the service concerned from Mental Health Action group on the lived experience of accessing the crisis team out of hours.

4. WELL LED

4.1 Quality Leadership

The Trust will also see the retirement of one of our finest and most organisationally committed staff our Head of Quality Clare Grainger who will be retiring in September. Clare has built her life's work in this organisation and from starting out in our administration services has built her career through governance and quality and was pivotal in our Trusts successful achievement of Foundation status, and in our achievement in our CQUINS, in our provision of our full Quality visit programme, our relationship with commissioners and leading our inspections this year with the Care Quality Commission and in addition she leads our development of our Quality account each year. She will be greatly missed, and we would like to thank her for her longstanding contribution to the Trust.

Her post has been redesigned and advertised and a recruitment process has not concluded at the time of report writing Clare's post has been newly redesigned to lead Quality, governance and clinical leadership

This post was advertised and the recruitment to the position was supported through an assessment panel with staff, service receiver representatives and a carer's representative from North Derbyshire Carers association as key members /expert advisers to the panel. The panel was far more skilled and informed in its assessments thorough this approach and members were thanked for their insightful skilled and extensive contributions. Derbyshire Mental Health Alliance gave positive feedback and thanked the Trust for the continued inclusive approach that was taken. The Deputy Director of Nursing and Quality Governance post was not recruited too in the first round.

4.2 Findings from Quality visits

The Quality visit programme is well underway for 2016 and the programme will be completed by the end of September. To date we have completed over 60 visits to clinical and non- clinical teams.

These teams' visits are not clinical assurance visits, they are Board to service area site visits, for staff to have access to Board member's, commissioners and governors to present and showcase their services, ideas and innovations against the sections of the key lines of enquiries. These visits are built upon the concept of NHS organisations not always focusing upon the positive contributions of staff in showcasing what they do well and how they are struggling with adversity. Each year the theme of the visits change, this year and last year the team themes were set as the CQC key lines of enquiry to support staff understanding the regulations and being comfortable in showcasing practices against the Trusts quality regulator. The quality visits are not compliance checks against all CQC regulations and are not full quality assurance checks, as they are only one aspect of clinical quality performance management and compliance checking.

June and July visits best practice examples showcased

- In perinatal services they showed how they are bringing in peer volunteers, including dads, to share their journey, also engagement with others and wider families for such events. This significant involvement of partners is having a positive impact on mothers and their babies. The service also demonstrated low numbers of incidents due to staff spending lots of time with patients and therefore able to anticipate and pre-empt issues. They are also planning to gather patient experience outcome measures, using the same tool that is used across the East Midlands. (visit to perinatal services 14 June 2016)

- Erewash Community Learning Disabilities team showed their process for recruiting a new speech and language therapist. This was an excellent example of meaningful engagement, where the people involved had shaped both recruitment and appointment of therapists. Given the complex nature of the interventions and communication challenges faced by the people accessing the service, the commitment to improving engagement in recruitment demonstrated simple sophistication at its best. (Erewash Community Learning Disabilities Team 21 June 2016)

Examples of some the issues raised June and July visits

- The challenges around waiting times and waiting lists. Although the team are following policy and have strategies in place for safe waiting, it was commented that their capacity is impacted on by retracting Local Authority Funding and an increasing expectation the team will complete Continuing health Care Check Lists and health assessments.

- The transformation in some neighbourhood teams and the challenges of bringing teams under one roof. The panel appreciated the recent merge of the CMHTs into Neighbourhoods but still felt that there was more work to be done around working together as one team.

We will:

Continue to monitor the actions agreed during the visits and best practice examples are recorded in each report which is available on the intranet following moderation for teams to learn from. Share this feedback with the Quality leadership and senior teams to highlight feedback, and enable staff to take management actions in this area, to support teams.

We will reflect on the Quality visit feedback to date that some staff would like to revisit the Quality visit model and would like to consider revisions to the operating model this year. A review of the model will be completed after the end of this season. All Board members and Quality visit chairs are requested to reflect upon the current model and the added value and reflections on these seasons' visits and feed into the Director of Nursing on their views and recommendations in writing.

5.3 Care Quality commission inspections of Mental Health Trusts completed

The Care Quality commission have confirmed that they have completed all their inspections of mental health trusts. They have published inspection reports and ratings for 47 of the 56 mental health trusts, with reports and ratings for the remaining NHS mental health trusts

due to be released over the next few months. This will include our report and ratings following out inspection which took place week commencing 6 June.

Of the 47 mental health trusts rated so far, nearly two thirds (29) are ‘requires improvement’ and around a third are good (17). One is rated inadequate (Norfolk and Suffolk NHS Foundation Trust – currently in special measures). None has yet been rated as outstanding.

We have received our draft report and are in the process of completing the factual accuracy checks. We will have 10 working days to highlight any inaccuracies or challenge any parts of the report and write our recommendation and action plan. This is a key area of the quality team’s work at this time. The team has called meetings with the Senior leadership team and key representatives to review the reports and ask the teams feedback on factual accuracy, whether information is representative and their thoughts and ideas on action planning.

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

On behalf of: **Carolyn Green**
Director of Nursing and Patient Experience

Enc F

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1st September 2016

Carolyn Green
Director of Nursing
Derbyshire Healthcare NHS Foundation Trust
Kingsway
Derby
DE55 3LZ

Dear Carolyn

Re: SAAF Visit 17th August 2016

Thank you to you and your staff who contributed to the completion of the SAAF and the follow-up assessment visit to review the raft of evidence submitted as part of your Safeguarding Adults Assurance Framework programme for 2015/16.

Tracey Holtom your Adult Safeguarding Lead completed and submitted a well written and comprehensive SAAF return and has provided a wealth of supporting evidence. The safeguarding adult policy, submitted as part of this process, was noted to be the Derbyshire & Derby City Joint Safeguarding Adult Board Policy; as such these reflected the Care Act 2014 including the "making safeguarding personal" agenda. All other relevant policies were also noted to be updated in accordance with local and national drivers.

It was clear from our visit that the Trust has spent time re-evaluating how effective you are in being able to assure your Board that safeguarding is embedded across the organisation. This has been reflected in the number of sections on your latest return for 2015/16 that have been reduced from 'effective' to 'working towards' compared with the previous return in 2014/15. We were also grateful to you for being open and honest with us in the challenges the Trust faces, and as we discussed I would be happy to consider your request for additional resource from the CCG's to meet the growing safeguarding and public safety agenda.

As members of your internal Safeguarding Committee we are assured of robust governance arrangements across your Trust. There was strong evidence that responsibility for safeguarding is embedded across the Trust and that there is strong engagement from the Senior Team.

We were happy to acknowledge the hard work Tracey does on behalf of the organisation particularly with PREVENT and at MAPPA 3 and were pleased to hear that you have recruited a safeguarding adults doctor. We also noted your plans for the Band 7 clinical compliance post for MCA work. We look forward to the work you intend to do around thematic reporting and analysis and how this will impact on your work plan going forward.

Following our assessment of the evidence and as a result of our visit I am pleased to say that there are no immediate concerns about how the Trust safeguards those in its care. Please see this letter as an interim statement as you will receive a fuller, more detailed response to your SAAF submission in due course, and I will also be producing a thematic overview report when we have completed all the SAAF visits by the end of the summer.

Yours faithfully

Bill Nicol
Head of Adult Safeguarding Derbyshire CCG's

Board Committee Summary Report to Trust Board
Quality Committee - meeting held on 11 August 2016

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Kedleston Seclusion Plan	Planning permission approved. Design team appointed, design agreed. Verbal update provided on ligature programme.	Continuing in line with the programme for completion March 2017. Same design team that completed the ECW suite last year.	Due to new CQC guidelines the Kedleston suite does not meet the specification (the ceiling is too low). Therefore we have invested in new seclusion suite to be completed by March 2017.	Service receivers to be involved in the design of the seclusion room. We are governed by CQC guidelines, but service receivers can be included in the decoration and operational policy design. Received the update and challenge consultation with wider service users which will be closed when they become involved future work. CQC require ligature reduction programme. Update to be brought to September meeting.	None
Serious Incident Report	Report given on serious untoward incidents during July 2016.	Assurance received	None	Risk register to show CTOs gap in assurance in CTOs policies need additional reviewing. Director of Nursing and Patient Experience to brief the Chair on one incident which involved the acute trust.	None
Patient Experience Report	SB presented the patient experience report.	Some evidence of progress. However still some gaps in assurance due to emergency planning in place. Medicines management in inpatients is still a gap.	Still have commissioning gaps in children's and community and capacity in medicines management.	To explore learning from other trusts. To consider if any further audits need to take place to provide further assurance. To revisit risks again in commissioning round to mitigate gaps	None

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Dementia Strategy and Terms of Reference for Dementia Board	JS presented the report and terms of reference.	Some minor amendments to terms of reference.	None	TOR ratified with some minor amendments.	None
Governance Improvement Action Plan	Director of Nursing and Patient Experience provided a verbal update.	Assurance that there are no actions outstanding.	None	Nothing outstanding for this month Central QLT to provide terms of reference and oversee work plan for Children's and CAMHS and provide assurance to the September Quality Committee	None
Risk Escalation Report	RK presented the risk escalation report	Assurance that actions are in place to mitigate the risks on staffing.	None	Report approved. Report to be shared with emergency planning meeting.	None
Claims Handling Policy	Policy presented for scrutiny and ratifcation	Assurance that through this policy continues to operate within the membership rules as stipulated by NHSLA and as such maintains a valid insurance.		Section to be added to say that on any incidents of theft, should be reported monthly to safeguarding lead and cluster analysis should be undertaken so that safeguarding processes are followed. Ratified with the above amendment.	None
Any Other Business					Deep dive for risk 1a to be moved to go to Audit & Risk Committee in December after it has been presented to Quality Committee in October due to timing of CQC report.

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE QUALITY COMMITTEE

HELD ON 7 JULY 2016

IN MEETING ROOM 1, ALBANY HOUSE, KINGSWAY, DERBY DE22 3LZ

PRESENT:	Maura Teager	Chair and Non-Executive Director
	Phil Harris	Non-Executive Director
	Carolyn Green	Director of Nursing and Patient Experience
	Carolyn Gilby	Acting Director of Operations
IN ATTENDANCE:	Annah Swinscoe-Daniels	PA and Minute Taker
	Sangeeta Bassi	Chief Pharmacist
	Rachel Kempster	Risk & Assurance Manager
	Clare Grainger	Head of Quality & Performance
	Lesley Watson	Senior Capital Manager
	Rubina Reza	Research & Clinical Audit Manager
	Chris Fitzclark	Derbyshire Mental Health Alliance
	Sandra Austin	Derby City & South Derbyshire Mental Health Carers Forum
	Deep Sirur	Consultant Addiction Psychiatrist/Associate Clinical Director, Campus QLT
	Anne Reilly (part)	Complaints Manager
	Karen Wheeler (part)	Acting Divisional Lead Occupational Therapist, Neighbourhoods
	Petrina Brown (part)	Consultant Clinical Psychologist Campus/ Neighbourhoods QLT
	Richard Morrow (part)	Head of Nursing Campus/ Neighbourhoods and Central QLTS
APOLOGIES:	Dr John Sykes	Medical Director

QC/2016/119	**WELCOME AND APOLOGIES** The Chair, Maura Teager, opened the meeting and welcomed everyone and introductions were made around the table. Maura also welcomed both Deep Sirur and Petrina Brown to the meeting who were representing QLTS.
QC/2016/120	**MINUTES OF THE MEETING DATED 23 JUNE 2016** The Minutes of the meeting held on 23 June 2016 were accepted and agreed. It was requested that the policy dashboard is included as a standard item after the action matrix.
QC/2016/121	**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/2016/122	**SERIOUS INCIDENT REPORTING** Rachel Kempster presented the report on behalf of Emma Flanders which provided the Quality Committee with information relating to all Serious Incidents (SIs) occurring during June 2016.

The Committee noted the following points contained in the report:

- There has been an increase of (5) externally reported incidents in June 2016, with (7) incidents reported, compared to the (2) reported in May 2016
- There has been a decrease from (12) catastrophic incidents in May to 9 in June 2016. The number of major incidents remains at (12)
- There are no specific patterns or issues arising
- There is (1) overdue action from the investigation regarding Tansley Ward and this will be chased up next week
- Duty of Candour – no breaches in discharging reported to the Commissioners at the end of June 2016

The following themes have emerged from the investigations in June as documented in section 4 and will be addressed by the QLT teams to assess what training needs may be required or other actions to brief their teams:

- Think Family
- Risk assessments and documentation
- Review of induction and role of crisis duty worker
- Female consultant cover
- Point of contact – with service receiver

No reports have been received under Schedule 28 Coroner's Investigations Regulations (2013) in June 2016. There has been an increase of 5 to 7 (from 2) incidents reported externally. There have been (3) incidents of failure to obtain bed/commissioning incidents. Carolyn Green reported that there are formal concerns about this logged with commissioners and with NHS England which are currently being investigated.

Discussion took place regarding the outstanding action shown for April 2016. Carolyn Green reported that this was escalated through the Head of Nursing to ensure completion. Maura Teager reinforced the importance of being absolutely clear about the lines of accountability to ensure recommendations are completed in a timely fashion and that as a result of this practice is changing. Rachel Kempster agreed to feed back to Emma Flanders and that an update would to be fed back to the Committee in August 2016.

For accuracy Carolyn Gilby confirmed that that the Trust does not employ 'Divisional Directors' and this section of the report will be re-worded.

Chris Fitzclark commented on the incident relating to the Radbourne Unit and asked whether proper discharge and transfer protocols were followed in the case of a discharge from a private hospital to the Trust and subsequent discharge and whether the correct assessments were made. Carolyn Green advised that the full investigation has not yet been completed and will explore all of those avenues. Until the investigation is concluded, Carolyn Green could not comment, but the cause of death is probably suspected suicide, again to be confirmed by the coroner. The wording on the form was scrutinized and this may need to change until cause of death is confirmed. Maura Teager stressed the importance of being clear about any risks associated with the case in the transitioning from young people services into adult services and to consider this within the remit of the investigation.

Carolyn Green asked Rubina Reza about this matter in terms of any planned audits within the clinical audit programme. Rubina Reza responded that there is some benchmarking for a Regional Children's and CAMHS transition that she will advise upon when findings have been completed. This may also extend to wider groups and she will advise Richard Morrow via the Quality sub-groups.

	Phil Harris asked for assurance with regard to a recommendation that all scrutiny checks were being completed by the Crisis Team. Carolyn Green advised that this investigation would be an extensive report as the person involved had experienced sustained life events and trauma, and risk assessments had been completed. Maura Teager also highlighted this as another transitional example of an individual moving from private care setting to the Trust. This investigation was concluded, the Trust is awaiting the Coroner's inquest to confirm any further learning or requirement s to change in practice in conjunction with other key partners. Chris Fitzclark referred to page 24 of the report and expressed his concern and sadness at how service receivers are discharged due to a perceived lack of engagement with staff. He also challenged the DNA policy as he felt there appeared to be a culture that staff were assessing a person who was disengaging was at fault. He would like to see a move to a positive engagement strategy not a disengagement approach to care delivery. It was questioned that staff should engage with the service receiver and not the other way around. Carolyn Green advised that the CPN and the lady referenced had sustained a good relationship. Chris Fitzclark suggested that a tool needs to be in place to support a more proactive approach. Carolyn Green suggested that a bespoke policy would be initiated to move from DNA to active engagement. **ACTION: Page 22 of the report to reflect the change in title, i.e. not using 'Divisional Directors.'** **ACTION: A bespoke policy to be developed for community and crisis proactive engagement approach for individuals and families that are hard to reach.** **RESOLVED: The Quality Committee evaluated the report and accepted the level of assurance in the processes involved of emergent and current issues under a monitoring brief by the SI Group.**
QC/2016/123	**EARLY WARNING SYSTEM FOR ILS TRAINING AND WORK PLAN** Due to Hayley Darn's unavailability, Carolyn Green presented her paper which provided the Quality Committee with an update on t work being undertaken to review the current Early Warning Scoring System. She informed the Committee that she considered the paper had been a challenging development due to a differing views, but the proposal draws upon and reflects the evidence and NICE guidelines. The paper also outlined the scope on the proposed recommendation of transferring the clinical approach to the National Early Warning Score (NEWS) from the Derbyshire Early Warning System (DEWS). It was agreed that a further paper will be submitted to the Quality Committee to confirm progress and assurances on the implementation plans although this could take up to 12 – 18 months to complete. Phil Harris asked whether the programmes would be run in parallel and Carolyn Green advised that training would targeted to higher risk areas and the DEWS system would then be suspended as part of the roll out. The Committee commended the report authors on the value of the report and its presentation of key facts and focus on evidence and recommendations. **RESOLVED: The Quality Committee confirmed its support for the transition to National Early Warning Score (NEWS) to improve patient safety.**
QC/2016/124	**ANNUAL CLINICAL AUDIT PLAN PRIOR TO GOING TO A & R COMMITTEE IN JULY** Due to the absence of Dr John Sykes, Rubina Reza presented his paper which

	provided the Quality Committee with an update on the Clinical Audit Programme for 2016-2017 prior to it being received by the Audit and Risk Committee on 19 July. The following points were noted: • The final 2015-2016 Clinical Audit Programme was closed down with 82 projects on the programme at the time of closure. 45 of these projects were completed (signed off) compared to 29 out of 90 at 2014-2015 programme closure. • The 2016-2017 Clinical Audit Programme was opened with 37 projects; 30 projects carried forward from the 2015-2016 programme and 7 new POMH UK projects (priority 1) were added to the programme. • Projects carried over to 2016-17 were those that originated in the previous year primarily, 2015-16 with a small number from the year before, 2014-15. This is a definite improvement from the 2015-16 programme which started with many more projects being carried forward from the previous programme up to 4 years previously. During the 2016-17 programme only one carried over project was delayed over 18 months compared to 8 carried over at programme closure the previous year. • The Terms of Reference have been revised. Reviews from feedback are positive and a system has been put in place to chase up projects. • QLTs were invited to comment on the revised process and confirmed that it had improved in a positive way. Carolyn Green advised that the QLTs had been challenged by this agenda but were now picking up momentum and significant time has been spent on reviewing the status of historical audits that after an extended period of time may not add value to practice. The backlog has been cleared and the QLTs should now be reviewing live audits. It was suggested that summary exception reporting of audits including actions and requirements should be produced. It was felt that the process of QLT reporting seems to be working, however some focus and clarity of what is required from the QLTs would be welcome... Petrina Brown added that some of the actions need to be expedited immediately and this could focus decision making of QLTs of audits with practice concerns. It was requested that a template could be produced for the QLT's to consider. Rubina Reza advised that the next report contain a tracker to show the progress of performance and how the priorities were determined e.g. priorities 1 and 2 were a key focus. The Committee agreed that partial but increasing assurance had been obtained from the Clinical Audit Plan. **<u>RESOLVED</u>: The Quality Committee duly noted the content of the report, ratified the Clinical Audit Programme for 2016-2017 and ratified the revised R & D Governance Committee Terms of Reference.**
QC/2016/125	**<u>COMMUNITY PAEDIATRICS PERFORMANCE REPORT – CLINICAL RISK ISSUES BAF 1a</u>** Due to the absence of Dr John Sykes, Carolyn Green presented the paper which gave an overview of the performance of the community paediatrics service.

	Currently under Regulation BAF 1a, the Trust is under pressure in its capacity to offer paediatric assessments and follow ups. The report provided further understanding of the challenges faced by the community paediatricians within the Trust. It was acknowledged that there are difficulties in managing vacancies due to the complexities of a national recruitment problem area and the report detailed the impact this had on waiting times for children and young people at this time. During the past 2 years, a number of paediatricians who have left the Trust and it was noted that age related retirement is the most significant reason for staff leaving. This is considered an area of high level of risk and this aspect is being reported to provide assurance to the Committee on mitigation plans and future service modelling led by David Tucker. This is an historic model of service delivery that requires a long-term solution to redesign this Children's care pathway. It was noted that Carolyn Gilby is awaiting a letter of confirmation from the Royal College, and is hopeful following a recent recruitment drive of appointing a strong candidate. The situation concerning the severity vacant posts was discussed. Vacant posts have been advertised, but no success made with suitable recruits. This has resulted in an ever increasing long waiting list. On 26 June a total of 1,323 children and young people were waiting to be seen by a community paediatrician. 163 of these had been waiting over 52 weeks. Management action has included authorising the use of agency paediatricians off framework and over the Monitor cap, as an override for patient safety. The complexities of the paper were discussed along with the reality of the workforce situation which could take up to a year to resolve. Debate ensued on mitigating the risk of this situation by skilling other staff to do some of the tasks normally undertaken by a paediatrician, through full service redesign with regard to prescribing. Pharmacists are also assisting with the non-medical prescribing and other options are being explored. Carolyn Green proposed that a review takes place of the lead clinicians and professionals to support the paediatric workforce. It was pointed out that Faith Sango is involved as part of the revised workforce plan. Maura Teager suggested it may be beneficial to explore alternative models, and that professionals needed to be open-minded about these approaches. Carolyn Green agreed to circulate briefing on statements of the future models of care delivery. Maura Teager thanked everyone involved for the paper and was assured that mitigating plans were being adopted for the immediate and a longer-term solution. **ACTION: Further report on the performance of the community paediatrics service to be received once further analysis has been undertaken.** **RESOLVED: The Quality Committee acknowledged the report and received some assurance for the work undertaken to date and requested sight of a fuller report once further analysis had been undertaken.**
QC/2016/126	**<u>REDUCING RESTRICTIVE PRACTICE ACTION PLAN</u>** In the absence of Sarah Butt, due to another priority, Carolyn Green presented the paper which contained an action plan to review and reduce the use of restrictive practice in local services and inpatient care settings. Carolyn Green highlighted some of the details of the 'Action outstanding' on the grid and advised their meaning to the Committee. She confirmed that there is still a

	significant amount of work to do. Carolyn Green would like Sarah Butt and the QLTs to agree what aspects drugs and therapeutics will lead upon, the leads by the QLTS and define aspects that the seclusion group will be leading on, driving from the innovation and core businesses of the QLTs, using RAG rating approach. The Healthwatch report was referenced which set out regarding restrictive practice. Out of the 100 copies circulated, only one response had been received. It was felt that this practice that needs review, although the Healthwatch survey was successful on in gathering intelligence in this area. Maura Teager sought clarification on the dates for completion referenced during 2016 and the progress made, along with a detailed explanation of why certain dates were highlighted in red. It was agreed that target dates need to be added to clearly reflect the overall picture and until demonstrable improvements are made this item would continue to be reported upon to ensure a level of pace is achieved. **ACTION: Firm target dates would be added to the Reducing Restrictive practice Action Plan. Regular Updates to be provided at future meetings – timeline to be advised.** **RESOLVED: The Quality Committee agreed to the content of the report and requested regular updates at future meetings timeline to be advised.**
QC/2016/127	**RECOVERY AND WELLBEING PROGRESS REPORT** Karen Wheeler presented her Recovery and Person Centred Approaches report which provided the Committee with an overview of work being carried out regarding: • The Trust recovery approach and personalised care as one of the Trust's quality priorities • Neighbourhood developments • Hope and Resilience Hub • Peer support work • Community Resilience • Recovery information centre web page Karen Wheeler asked the Committee to receive assurance on the work completed to date for a Trust Quality priority. She pointed out that the paper outlined that the QLTs are supporting and will be monitoring the work carried out in Recovery and Person centred approaches. The Trust is in design with some roll out of a virtual recovery college model within the campuses and it is planned to extend this further within neighbourhoods and services. Staff capacity and skill mix within the team was discussed. It was noted that recruitment is challenging but it is essential that people with the right skills are engaged who are recovery and patient centred oriented. This project is linked to the care pathway work that is being led by Mark Ridge. Discussion took place on the performance of the Radbourne Unit and the difficulties the team experienced within the initial service model. Debate took place on peer support and how this can be achieved across the organisation on a reduced budget. The Committee considered the key to this quality priority is the embedding of recovery measures, occupational measures and the new patient activation model. This area requires a baseline and follow up audit of clinical practice to evidence improvements to patient goals and their defined outcome

	measures. **ACTION: Further report on Recovery and Wellbeing to be received once further analysis has been undertaken and timeline to be agreed and included in the forward plan.** **RESOLVED: The Quality Committee acknowledged the report on Recovery and Wellbeing and obtained limited assurance for the work undertaken to date and welcomed a fuller report once further analysis had been undertaken.**
QC/2016/128	**ANNUAL COMPLAINTS AND COMPLIMENTS REPORT** Anne Reilly presented the Annual Complaints and Compliments report which set out the Trust's performance against the Policy and Procedure for Handling Patient Feedback: Comments, concerns, complaints and compliments, themes from analysis of data from the financial year 2015-16, lessons learnt and recommendations to be implemented in the financial year 2016-17 were noted by the Committee and it was suggested that a dashboard is produced to reflect these themes. Carolyn Green advised that the top ten problems concern mental health service issues rather than the wider organisation. Phil Harris commended Anne Reilly and her team, in how they handle and manage the complaints process. Debate ensued on the production of an accessible leaflet to assist people with Learning Disabilities and it was agreed that the previous model would be updated. Carolyn Green suggested Susan Krause could be involved with this project using her experience involved in Children's services. Maura Teager also advised that RIPPELZ have also carried out work in this area. Phil Harris referred to instances where staff had helped service users over and above their remit. Although this was admirable, there were concerns about the impact and expectations on boundaries. Phil Harris referred to instances where staff had helped service users over and above their role and remit. Although this was admirable, there were concerns about the impact and expectations on boundaries and future examples in the trust report, should reinforce good safe practice as best practice and not re-enforce that staff need to go above and beyond to be valued in the Trust. **RESOLVED: The Quality Committee agreed that the Annual Complains and Compliments Report reflected a high level of assurance of the service provided.**
QC/2016/129	**QUALITY GOVERNANCE AND QUALITY FRAMEWORK ADAPTATIONS AND PROPOSALS, GOVERNANCE IMPROVEMENT ACTION PLAN, VERBAL UPDATE ON TERMS OF REFERENCE OF QUALITY COMMITTEE SUB-GROUPS** Clare Grainger presented the a paper which provided the Quality Committee with an update on the progress against the delivery of the Governance Improvement Action Plan and the leadership team developments to provide operational quality governance assurance. Maura Teager suggested that the capacity of the Executive Team ought to be considered and that one or two Executive leads could be assigned to this development and not 3 as identified in the terms of reference. However, it was recognised that this level of senior officer investment was required to ensure the successful development of quality governance and this was a quality priority area.

	Carolyn Green confirmed that from an organisational development a period of not more than 12 months has been put in place to invest in this group and fast-track these requirements and therefore a substantial culture shift is inevitable which may include some resistance to change. Rachel Kempster acknowledged that re-alignment of reporting would be essential. The QLT's were also heavily committed to this plan. Improvement requirements are already a quality priority area, therefore an area that requires focused attention is improvement in performance. This aspect is a key component of moving the Trust to a clinically led and operationally supported organisation. It is anticipated the model would be ready to run by the end September 2016. A meeting will be held in August 2016. Petrina Brown advised that the QLT's have had meetings, but are wrestling with the changes, terms of reference and clarity on expectations and protocols, etc. Carolyn Green advised that a 12 month support and leadership development plan was also being explored, along with more formal support. Discussion ensued on realistic expectations and the Terms of Reference. It was agreed that the Executive Summary would be amended to read that "The paper provides an update to Quality Committee on the progress against the Governance Improvement Action Plan **and provide assurances to the Quality Committee.**" **ACTION: A further report is to be further reviewed during December 2016 and March 2017 and this will be reflected in the forward plan.** **ACTION: QLT representatives brief the QLTs on this paper and the decisions made to aid communication and ensure feedback** **RESOLVED: The Quality Committee:** **1) Acknowledged the report** **2) Obtained partial assurance for the work undertaken** **3) Requested that a fuller report be received in December 2016 and March 2017 once further progress has been made.**
QC/2016/130	**ANY OTHER BUSINESS** It was agreed that in line with arrangements already in place for agency representatives attending meetings of the Committee, an agenda pack would be provided at each meeting for Sandra Austin.
QC/2016/131	**EFFECTIVENESS OF THE MEETIING** The meeting was well attended. Deep Sirur advised that he had not attended a meeting for a while and that the style and pace had improved.

Date and Time of next meeting: The next meeting of the Quality Committee will take place on:
Thursday 11 August 2016 at 2.15 pm
Venue: Meeting Room 1 – Albany House, Kingsway, Derby, DE22 3LZ

Derbyshire Healthcare NHS Foundation Trust
Report to Public Board 7 September 2016

DHCFT Equality Delivery System EDS2 Update

Purpose of Report

The purpose of this paper is to present to the Board the four outcomes of the EDS2 and where we the Trust are against its objectives. The paper will also provide guidance as to next steps in terms of governance.

Executive Summary

At the heart of Equality Delivery System2 (*EDS2)* are 18 outcomes, against which NHS organisations assess and grade themselves. They are grouped under four goals, namely; Better health outcomes; Improved patient access and experience; A representative and supported workforce; and Inclusive leadership (see appendix 1).

These outcomes relate to issues that matter to people who use, and work in, the NHS and in particular the Trust. Among other things they support the themes of, and deliver on, the NHS Outcomes Framework, the NHS Constitution, and the Care Quality Commission's key inspection questions set out in "Raising standards, putting people first - Our strategy for 2013 to 2016".

Presently, the Trust does not have a comprehensive plan to deliver on its EDS2 work streams. This has impacted certain groups adversely both from a patient and employee point of view.

Strategic considerations

Presently the Trust does not have an over-arching strategy to combine all elements of the EDS2. Therefore, it is proposed that an Equalities Forum is brought into being. The Forum will ensure the following:

- Working with the Trust Board the newly formed Equalities Forum, will work to ensure that an overarching detailed equality and diversity strategy is developed. This will be developed detailing how the Trust intends to deliver on its workforce and patient equality and diversity issues and concerns.

- The Equalities Forum will be overseen the Quality Committee also links into and the People and Culture Committee to ensure progress across all equality work streams are progressed at the same pace. The Equalities Forum will provide oversight and future assurance and will consist of a broad inclusive membership from across the Trust.

- The Equalities Forum will work with the Trust Board and produce a yearly

Annual Equality Report.

- To re-establish credible and meaningful links with workforce stakeholders (networks) e.g. disabilities, LGBT, Age (55+), BME and Staff Side Network.

- To re-establish credible and meaningful links with our community.

Risks

As a Trust the risks associated with not taking forward the above recommendations could result in the following:

- CCGs and external partners withdrawing our services and eliminating the Trust from tendering for new business within Derby and greater Derbyshire.

- BME experience of less favourable treatment across a number of equality and diversity measures.

- The potential glass ceiling within the organisation relating BME staff not being addressed, leading to ineffective succession planning.

- Trust employee policies not being used in a transparent and consistent way to improve behaviours and relations between the Trust and its employees. This may lead to an adverse impact on patient experience.

- Equality Impact Analysis (EIA) to be undertaken across all Trust policies, work streams and committee and board papers. Failure to undertake this essential work will put the Trust at risk of not identifying adverse impact on patients and staff across the Trust and our community at large.

EDS2 Progress to date: see EDS2 progress chart (see appendix 1).

Committee Assurances

The Equality Forum together with Quality Assurance and People and Culture Committees will ensure the Trust meets its statutory duties under the Human Rights Act (1998). Equality Act (2010) and Public Sector Equality Duty.

Consultation

A consultation programme is underway to include: People and Culture Committee, 4Es - Equality, Experience, Engagement & Enablement, Black and Minority and Ethnic Committee, Joint Negotiating Consultative Committee, governors and Employees.

Governance or Legal Issues

The legal duty to comply with Equality Delivery System 2 (EDS2). Proposed as a positive impact as Race, Economic Disadvantage, Gender, Age, Religion, Disability and Sexual Orientation (REGARDS) population specifically within this paper - in developing the programme of change and engagement - clearer emphasis with regards to Equality will be identified – particularly within our systems and processes.

Equality Delivery system

Demonstrates progress and commitment to understanding of duties towards protected characteristics or REGARDS groups under the Equality Act 2010 & Human Rights Act 1998.

Recommendations

The Board of Directors if requested to:

1. Endorse the establishment of the Equalities Forum.
2. Note progress on the EDS2 goals 1, 2, 3 and 4 including actions to date for implementation
3. Agree that a separate risk to be included in the Trust BAF regarding non-compliance with EDS2

Report presented by: **Amanda Rawlings**
Director of People and Organisational Effectiveness

Report prepared by: **Owen Fulton**
Principal Employee Relations Manager

Appendix 1

Goal	*No.*	*Description of outcome*	*Undeveloped*	*In progress*	*Achieving*	*Evidence and examples*	*Gap*	*Actions*	*Target Date*	*Lead/s*
1. Better Health Outcomes	1.1	Services are commissioned procured, designed and delivered to meet the health needs of local communities	Yes			**Evidence** Trust 4E's stakeholder group meets quarterly Provider/Commissioner systems and processes Engagement with the New Communities meetings, chaired by Derby City Council, takes place quarterly. Exploring needs of refugees and asylum seekers within Derby City and access to Mental Health services. Development of the customer inclusion committee in conjunction with Derby City Social Services. Trust Strategy 2016 – 2019 (May 2016) Trust annual report and quality account (July 2016) Nursing strategy Positive and Safe Safeguarding children's and adults strategies all champion this concept and approach	Gaps in tender process Board level papers Recruitment of non-executives	The Trust executive team ensures that all service configurations and tender processes are reviewed in line with the requirements for due regard to protected characteristics and this is evidenced. The Trust Board members positively challenge each other on the quality of board papers and the impact of changes and strategic decisions are consider with due regard to the Equalities Act (2010) and this is monitored. The chair of the Trust in the recruitment of non-executive directors, during the next round of recruitment, will consider the Snowy White Peaks national reports on the workforce composition of Boards. He will also consider whether individuals can be recruited, that reflect	Oct 2016	Executive lead Executive lead Chair

Goal	No.	Description of outcome	Undeveloped	In progress	Achieving	Evidence and examples	Gap	Actions	Target Date	Lead/s
						The front sheet of every paper being presented to Board includes a requirement to state if the work described in the paper has any impact of any of the REGARDS groups. Ward to Board patient/carer testimony at Trust board Paper to Quality Committee includes response to health profiles for Derby City and Derbyshire (June 2016) Analysis of demographics patients versus population June 2016 data to Quality Committee (June 2016) Reverse commissioning work 2015/16 including training for staff and stakeholders **Examples** Disability Direct, Over 100 organisations offering services for disabled adults and children, older people, carers and professionals.		the composition of our communities (Derby City and Derbyshire) and give consideration to all being equal of positive discrimination in board level recruitment.		

Goal	No.	Description of outcome	Undeveloped	In progress	Achieving	Evidence and examples	Gap	Actions	Target Date	Lead/s
						Our positive imagery of our community diversity in our Nursing 2015 and New Trust Strategy June 2016 We are training all Derbyshire police officers in mental health awareness, and we cover directly STIGMA and issues associated with mental health including diversity				
	1.2	Individual's health needs are assessed and met in appropriate and effective ways.		Yes		Within our health care settings we have a wealth of evidence to demonstrate how we are fulfilling our responsibilities of the equalities act. The Trust Board signed the British Sign Language Charter in May 2014 **Examples** Review of gender sensitive service to consider transgender in our access to assisted bathrooms by the Quality Committee in 2015.	Clinical practice access issues	The Trust is developing transgender clinical guidelines in 2016 led by Occupational Therapy to look at clinical practice and access issues, which will be presented to the Quality Leadership Team and Quality Committee. Setting mutual expectation work with service receiver groups Our equality impact assessments, which improve the quality of	Oct 2016	Director of Nursing and Patient Experience

Goal	No.	Description of outcome	Undeveloped	In progress	Achieving	Evidence and examples	Gap	Actions	Target Date	Lead/s
								our performance in this area; key staff are trained in extended equality impact assessment within 2016		
	1.3	Transitions from one service to another, for people on Care Pathways, are made smoothly with everyone well informed.		Yes		**Evidence** Transitions policy and procedures **Examples** Application for patient activation measure- to change the balance of power. My Care leaflets.			Oct 2016	
	1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse		Yes		**Evidence** In our proportional response to Aston Hal, we emphasised our support/ lobbying for psychological therapy and action Believing individuals, who raise concerns about rough handling and act upon these concerns. Staff reflection support and sometimes suspensions Responding positively to challenges of racism with active investigations	The use of Community Treatment Orders by BME groups, the use of the Mental Health Act and use of in-patient beds require significantly more detailed analysis	Our Mental Health Act Committee reviews its monitoring of the Mental Health Act legislation and undertakes further extended assessment of the use of the Mental Health Act, Mental Capacity Act and restricted practices for BME and REGARDS groups	Oct 2016	Director of Nursing and Patient Experience and Chair of Mental Health Act Committee

Goal	No.	Description of outcome	Undeveloped	In progress	Achieving	Evidence and examples	Gap	Actions	Target Date	Lead/s
						Our work on PREVENT- tackling extremism including far right groups and other Derby groups. Getting actively involved in Channel prevention/ support work **Examples** Challenging Female Genital Mutilation and our active cases through the Safeguarding Unit The roll out of Safe Wards Our operation Retriever work with Child sexual exploitation				
	1.5	Screening, vaccination and other health promotion services reach and benefit all communities.	Yes			**Evidence** Building better communities and supporting local communities within the Erewash Area. By building better communities, we aim to improve everybody's health and wellbeing. LINKS have provided training to members of the Community Groups listed below in Mental Health First Aid. They			Oct 2016	

Goal	No.	Description of outcome	Undeveloped	In progress	Achieving	Evidence and examples	Gap	Actions	Target Date	Lead/s
						are purchasing 2 sessions weekly of Band 6 Clinical time from Derbyshire Healthcare NHS Foundation Trust (DHCFT) to provide mentorship, supervision and signposting of referrals to Services. The service is to be provided to the trained representatives of the following BME groups: Asian Association Afro Caribbean Association Chinese Community Philippino Community Polish Association Ukrainian Association Gypsy Liaison Group Muslim Welfare Muslim Association **Examples** The Think Healthy Health Watch Community Access and In Reach approach to listening to community feedback, may have assisted in community access Our health watch survey/ clinics in HINDI				

Goal	*No.*	*Description of outcome*	*Undeveloped*	*In progress*	*Achieving*	*Evidence and examples*	*Gap*	*Actions*	*Target Date*	*Lead/s*
						and URDU				
2. Improved patient access and experience	2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied on unreasonable grounds.			Yes	**Evidence** We have a contract with Pearl Linguistics for interpreting, written translation and transcription. This includes British Sign Language interpreting and Braille transcription. **Examples** Substance Misuse – East European clinic Health visitor Roma clinic work Men's- Angling for Health, Chesterfield Football Club We are supporting 50 Syrian families, who are relocating to Derbyshire, and we are advising on the psychological trauma and child health needs IAPT services have a significant increase in child sexual abuse cases; we are responding to this through an inclusive, supportive practice, which also includes supporting victims in extensive familial and		The analysis of request for single gender staff is monitored and reported through the Quality Leadership groups in order to monitor access and changes to clinical staff to ensure this is offered and accessible	Oct 2016	QLTs

Goal	No.	Description of outcome	Undeveloped	In progress	Achieving	Evidence and examples	Gap	Actions	Target Date	Lead/s
						intergenerational abuse. Our Spirituality Conference, led by the Spirituality & Wellbeing Service, in 2016 and the Trusts Multi Faith and Well-being centre may be supporting access. Approached by a Birmingham family asked to come to DHCFT to see a BME psychiatrist and staff due to inclusive approach				
	2.2	People are informed and supported to be as involved as they wish to be in decisions about their care		Yes		**Evidence** Implemented 'Accessible Information Standard: identify and record people's communication needs, including alerts on PARIS Electronic Patient System and dedicated sections for recording We have advance statements, crisis cards and life story resources for people with dementia and of working age. **Examples** Our Family and Carers		The service receiver and carer groups are asked about any access/ equality issues they would like the Trust to reflect upon or consider.	Oct 2016	Chair of Patient and Carer Committee

Goal	*No.*	*Description of outcome*	*Undeveloped*	*In progress*	*Achieving*	*Evidence and examples*	*Gap*	*Actions*	*Target Date*	*Lead/s*
						SBARD development this year to support families and carers to communicate their needs. Carer and Family handbook and our new publication, My Care, which is promoted in all areas, i.e. *no decision about me without me.* Forms on Electronic Patient System signs and symbols Adapting Care Quality Commission feedback forms for those with communication needs. Adapting signs and symbols for sexual abuse questions. BME needs in care planning and specific needs Health representation at customer inclusion meeting for safeguarding adults. A multi-agency approach. We also have dementia dates, where couples				

Goal	No.	Description of outcome	Undeveloped	In progress	Achieving	Evidence and examples	Gap	Actions	Target Date	Lead/s
						with dementia go out for dinner and dancing to maintain their well-being. Dementia Question and Answer sessions are open to all and are valued; these have been commenced in High Peak area. Cake and Carers groups facilitated by the Radbourne Unit.				
	2.3	People report positive experiences of the NHS		Yes		**Evidence** Trust internal patient and carer feedback systems and processes which include: You said, we did, Family and Friends Test, surveys etc. Inpatient and community patient survey results 2015 and 2016 **Examples** Health Watch reports on entering, during and after receipt of services and relevant reviews.			Oct 2016	
		People's complaints about services are		Yes		**Evidence** Visual system to monitor timeframes in place				

Goal	*No.*	*Description of outcome*	*Undeveloped*	*In progress*	*Achieving*	*Evidence and examples*	*Gap*	*Actions*	*Target Date*	*Lead/s*
		handled respectfully and efficiently.				Training is delivered quarterly and ad hoc (to be arranged) Discussed in induction of new staff Feedback is regularly monitored and analysed, compliments are recorded Staff completed e-learning training in relation to customer care **Examples** Learning disabilities – signs and symbols work, which led to a new complaint process with use of signs and symbols				
3. A representative and supported workforce.	3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels				Improved workforce data regarding protected characteristics. Workforce identifying with Disabilities increase by 7%. Staff Survey identifies that 80% of people from BME background feel there are opportunities for progression within the Trust. Recruitment training includes encouragement of positive action. Evidence of Line	Identified under representation of men within the nursing roles. Need to assess under representation in each area and vary positive action dependent on circumstances. Need to establish positive action in band 8a and above.	Establish positive action focus group which will report into People and Culture Committee. Identify under representation from band 8a and above inclusive of the Trust Board.	Oct 2016	Owen Fulton/ Liam Carrier and Emma Smith

Goal	No.	Description of outcome	Undeveloped	In progress	Achieving	Evidence and examples	Gap	Actions	Target Date	Lead/s
						Managers beginning to apply positive action in operational roles. Recruiting workforce with disabilities e.g. LD, peer support roles and recreation officers.				
	3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations				Commencement of Job Evaluation panels December 2016 after 2 years due lack of Staff Side representation. National Training provided in September 2015. Workforce data is broken down per banding and Protected Characteristics for Audit. Improvements in partnership working policy resulted in a more responsive job evaluation process.	"Needs further National training to recruit more Job Evaluators. Also need continued administration for the process. Audit results need further analysis and reflection to provide to People and Culture Committee.	"Secure continued funding for supporting the job evaluation process. Data on equal pay Audit to be provided to People and Culture Committee for analysis in comparison with all protected characteristics as well as gender.	Oct 2016	Paul Beardsley and Operational HR
	3.3	Training and development opportunities are taken up and positively evaluated by all staff				All training opportunities are advertised on Connect and recorded through the On Line Learning Management (OLM) system. Each face-to-ace training course is evaluated by the member of staff. Specific training such as Springboard and leadership training for	Need to provide access to training report via OLM to People and Culture Committee. Identify any barrier to training for protected groups.	Evidence of applying reasonable adjustments within training provision. Ensure training analysis is provided and identified skill gaps for workforce in relation to protected characteristics are provided.	Oct 2016	Owen Fulton and Learning and Development team

Goal	No.	Description of outcome	Undeveloped	In progress	Achieving	Evidence and examples	Gap	Actions	Target Date	Lead/s
						BME groups are delivered.				
	3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source				Our staff survey identifies that 14% of BME staff feel they have experienced bullying and harassment from managers or work colleagues. 41% of BME and 30% of white staff feel they have been bullied. Data collection of Dignity at Work being analysed to establish potential reasons. Bullying and harassment workshops delivered to staff in 2015. Carina Gaunt, Head of Safety, appointed as Speaking Up Guardian. The Trust has a Dignity at Work policy and Disciplinary Policy. Values Based Principles through Trust policies. See also evidence within 3.6 for further supportive services for staff who experience bullying. National research via CIPD shows that BME groups who work in the NHS across numerous	Although the Trust has protective policies and provides training, staff are experiencing bullying. We therefore need to establish the reasons behind these experiences through further analysis.	The People and Culture Committee to investigate data of the staff survey to establish long term actions. Engagement with Staff BME group to develop strategies to support staff who maybe experiencing bullying and harassment. Further analysis of DATIX records to investigate incidents of patient related bullying and harassment. Further analysis of grievance data in relation to Dignity at Work investigation and establish whether actions are followed through by management. Benchmark with other national trusts to identify action they are implementing to improve BME experiences and also promote awareness throughout the organisation.	Oct 2016	Paul Beardsley and Operational HR

Goal	No.	Description of outcome	Undeveloped	In progress	Achieving	Evidence and examples	Gap	Actions	Target Date	Lead/s
						Trusts feel they are experiencing bullying.				
	3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives				DHCFT has special leave, flexible working and work life balance policies. Staff are able to apply for career breaks. All staff apply through their managers and approval is considered in line with service requirements. Agreements are reviewed on a yearly basis to allow flexible working to apply to all members of the team when required. Flexible working arrangements are applied to staff as reasonable adjustment for individuals with long term conditions or disabilities e.g. Time Off In Lieu etc. Workforce includes staff who have annualised hours and term time only contracts. According to the Staff Survey 2015 staff feel satisfied that flexible working options are available to them. The number of staff applying for career breaks and buying	The Trust does not record number of people who have flexible working options on ESR e.g. term time contracts etc. Assessment of data based on protected characteristics not possible at the present time in the wide workforce due to not being recorded on ESR.	Workforce planning team and HR develop system of recording flexible working options utilised by staff.	Tbc	Julieann Trembling and Health and Wellbeing Group

Goal	No.	Description of outcome	Undeveloped	In progress	Achieving	Evidence and examples	Gap	Actions	Target Date	Lead/s
						annual leave is recorded, but not by protected characteristics. For the past 2 years flexible working has been actively promoted through Connect e.g. buying additional leave, career breaks etc.				
	3.6	Staff report positive experiences of their membership of the workforce				The staff survey results identify that the workforce would not recommend our Trust as a place to work. Staff nominations through Connect identify positive work of individuals within the Trust. An increase in work related stress has been identified through Health and Wellbeing statistics as well as the staff survey. Identified large scale organisational change e.g. Children's Services, Substance Misuse and CIP incentives. Impact of Tribunal on wider organisation including investigations	Need to develop sample test in line with EDS recommendations of particular pay band. Link results with ESR to relate results with staff members from protected characteristics.	Implement the workforce strategy and monitor via Workforce and Organisational Development along with the People and Culture Committee.	Tbc	Julieann Trembling and Health and Wellbeing Group

Goal	*No.*	*Description of outcome*	*Undeveloped*	*In progress*	*Achieving*	*Evidence and examples*	*Gap*	*Actions*	*Target Date*	*Lead/s*
						by external and government agencies. Trust has increased its communication events regarding updates on organisational change and also held engagement events on GIAP action plan.				
4. Inclusive leadership.	4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations				The Trust holds a 4E's group on a quarterly basis which incorporates senior members of the Trust and representatives from community groups. The 4E's group is chaired by the Chief Executive Officer and outcomes are reported to the Quality Committee. Information is reported into the Board.	Further examples of senior managers' involvement need to be identified via Communications team. Engagement events at particular community events need to be recorded.	Trust to record senior management engagement with Diversity groups.	Oct 2016	Owen Fulton/ Education and Learning Team.
	4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these				Board papers and polices are impact assessed. Currently this element is not recorded and therefore needs further development.	"Need to establish a third party assessor of Board papers. Look at a representative sample of papers. "	Work with Trust Chairman, NEDS and governors to establish monitoring.	Oct 2016	Owen Fulton

Goal	*No.*	*Description of outcome*	*Undeveloped*	*In progress*	*Achieving*	*Evidence and examples*	*Gap*	*Actions*	*Target Date*	*Lead/s*
		risks are to be managed								
	4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination				Managers ensure that staff are completing mandatory Equality and Diversity online training. Staff survey results are highlighting that staff are experiencing bullying and harassment potentially from their managers. Managers are supporting positive action incentives as highlighted in 3.1. Inclusive objectives are part of the Trust values system which runs through our appraisal process and managers are responsible for completing.	Feedback required through the appraisal process from staff that culture objectives are being thought about and supported. Particular project work development by service areas needs to be identified as part of evidence. Since 2015 team based diversity training has not been provided and therefore may need to re-established.	Organisation to provide specific team based inclusion training. 4E's/People and Culture Committee to encourage positive action projects, both within the workforce and with regard to patient care. Monitoring and evidence to audit needs to be developed.	Oct 2016	

Derbyshire Healthcare NHS
NHS Foundation Trust

Learning Disabilities and Commissioning Differently Deep Dive 07.09.2016

Better together

Service Overview

- 5 Community Learning Disability teams
- Assessment and Treatment Support Service
- Strategic Health Facilitation team
- Acute Liaison Nurse to Royal Derby and Mental Health Liaison
- Learning Disability nurse consultant
- Medics
- Learning Disability Management Team
- Commissioning Differently

Better together

NATIONAL AGENDA

STP

(Sustainability Transformation Plan)

Building the Right Support

(NHS England Framework)

Key Themes

Partnership Working

Personalisation of Support

Preventing inappropriate and or reoccurring Hospital admissions

Better together

Partnership Working

Hardwick Clinical Commissioning Group

NHS

Derby City Council

DERBYSHIRE County Council
Improving life for local people

Derbyshire Community Health Services NHS
NHS Foundation Trust

East Midlands Ambulance Service NHS
NHS Trust

Derby Teaching Hospitals NHS
NHS Foundation Trust

NHS
Southern Derbyshire
Clinical Commissioning Group

NHS
North Derbyshire
Clinical Commissioning Group

St Andrew's HEALTHCARE

Chesterfield Royal Hospital NHS
NHS Foundation Trust

NHS
Erewash Clinical Commissioning Group

Better together

Personalisation of Support

- Commissioning Differently
- Supporting personal health budgets
- Making safeguarding personal
- Care pathways
- Supporting people in crisis

Better together

Preventing Inappropriate and or Reoccurring Hospital admissions

- Activity data
- Care and Treatment reviews
- Risk Register
- Joint Solutions Group

Better together

Challenges

What we're pleased about….

Work on care pathways Happy Healthy and Safe

Recruitment

Joint solutions group in City

Commissioning Differently joint working and team development

Innovative and creative Individual and complex case management

What we worry about….

Waits

Case loads

Capacity

Recruitment and succession planning

People with an Autism Diagnosis

Better together

The Future

- Relationships are key with all stakeholders
- Future integrated Pathways across mental health, CAMHS, Social Care [Complex Behaviour], PMLD, Transforming Care
- Achieving best fit in terms of service design
- Skill mix to meet the changing needs of people with learning disabilities.
- The development of a City and County wide learning disability health offer

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 7 September 2016

Strategy Implementation Update

Purpose of Report:

The Board approved the Trust Strategy 2016-21 in May of this year. At that time a brief outline of the strategy implementation process was presented. This report is to apprise the Board of the progress of the implementation process and any current risks to delivery.

Executive Summary

The report received by the Board in May gave a brief outline of the strategy implementation process which commenced on 15 June. The key stages undertaken to-date include:

Milestones	Date	Update
'Strategy Implementation' Event – this gave greater explanation of the process, the objectives and the parameters to ensure everyone knew what was expected, what was required, timescales etc	15/06/16	Attended by 30+ managers and clinicians
Clinical Service Areas (Neighbourhood, Campus and Central Services) - initial scoping and analysis and develop of Business Plans throughout the whole process	15/06/16 to 19/09/16	This is being led by Contracting and Business Planning – process underway and linked to other workstreams
Teams working on the 7 Sustainability Transformation Plan areas and Corporate Services submitted 'Outline Solutions' (options considered) to a panel consisting of Executive Directors, Senior Managers, commissioners etc (Gateway 1)	w/c 11/07/16	'Gateway 1' - a panel of Directors, Senior Managers, Governor representation and Commissioners received presentations of initial ideas. Feedback was given to all groups and agreement was given to continue further scoping.
Pathway Workshop – this was convened following feedback from groups post Gateway 1	02/08/16	A workshop was held to review all workstreams, share outputs, look at synergies and agree the way forward
Alignment to the Sustainability and Transformation Plan – following discussions with the 'Engine Room' it was necessary to reframe the requirements of groups	19/08/16	Owing to STP requirements it was necessary to reframe the requirements of our process. Timescales and areas of work remained. However, the business case and other outputs were simplified.
Deadline for receipt of 'Proposed Solution' for each STP area	05/09/16	This remains an initial deadline as it is in-line with STP requirements. Corporate area plans have been superseded by the 'back-office' work so this area is not being held to internal deadlines

The process is progressing according to plan and is aligned with the STP. Our internal process has been cognisant of the wider health and care economy from the beginning, involving key people from other organisations, particularly Adult Care, DCHS and commissioners.

There remain several key risks to delivery:

- System wide planning – the DRAFT STP was submitted on the 30th June and the strategy implementation process was based on this submission. Clarification was sought in early August following a meeting that Chief Officers attended with Senior NHS officers in late July. Whilst there is a slight reframing of work, this is not significant and will actually make it easier for internal processes. The system wide planning represents a risk to our process although we are mitigating it by ensuring close alignment to the 'Engine Room' (the central team driving the process) and the Commissioner Leads. The risk is medium.
- Clinical and senior management involvement – whilst there is good clinical and management involvement the timing and the importance of the CQC inspection and subsequent report will mean that staff have competing priorities. Teams are trying to balance requirements although this will undoubtedly remain a high risk to delivery.
- Medical leadership – the need for Associate Clinical Directors and other senior Consultants to lead the process is a cultural change and is proving challenging. However, key senior managers are working closely with the Medical Director and ACD's to ensure that there are appropriate levels of involvement. Managers continue to provide support which helps alleviate the time commitment, which still remains considerable. This remains a high risk.

It should also be noted that where we have suitable structures in place, such as Dementia Board, CAMHs Transformation Group, we are integrating the projects into their core business to reduce complexity and demand on staff time.

The risks of the transformation programme and strategy implementation are referred to in the BAF.

The next stage for the process is 'Gateway 2' on 16th and 23rd September, where proposals will be discussed with a panel consisting of Directors, a representative from the Non-Executive Directors, a staff and public Governor representative, Senior Managers and Commissioners.

A Business Case and a two year timeline for implementation will be submitted for 'confirm and challenge' these will form the basis for inclusion within the current management structure Business Plans. All areas will have a clear view of the direction of travel over the next two years.

This will be in-line with STP timelines as the final Business Plan for Mental Health, Learning Disabilities and Children/CAMHS has got to be submitted on 14th October.

Strategic considerations

The key strategic consideration is the need for a clear link to the wider system transformation and the Sustainability and Transformation Plan (STP).

The strategy implementation process is fully cognisant of STP themes and any potential interdependencies. This is a dynamic environment and key links are made via workstream leads.

Board Assurances

The Board Assurance Framework for 2016/17 has been updated to include the strategy implementation process.

Consultation

The strategy implementation process has involved a wide group of staff as appropriate to the particular area of work. This has included Associate Clinical Directors, other clinical staff, Managers, Staff Side and team members who are able to contribute service specific expertise. The Board and Council of Governors are also engaged in the process via representation on the Strategy Panels.

External organisations including Adult Care, Commissioners and DCHS have been represented either directly or virtually.

As the process progresses the workstream groups are continuing to include a wider audience of staff, service users and external agencies including the voluntary sector.

The 'Gateway Panels' have included representatives from the Board and Council of Governors.

Governance or Legal Issues

There are currently no governance or legal issues identified at this initial planning stage as business cases are developed. However, as the implementation process progresses governance and legal issues are likely to arise and will be reported accordingly.

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:

1. Note the contents of this report
2. Receive assurance that the strategy implementation process is progressing and that appropriate measures are in place to ensure that it is in-line with the system wide STP process

Report presented by:	**Mark Powell,** **Director of Strategic Development**
Report prepared by:	**Lynn Wilmott-Shepherd** **Associate Director of Strategy and Business Development**

Derbyshire Healthcare Foundation Trust

Report from Council of Governors

The Council of Governors met on 12 July for an extraordinary confidential meeting and also on 21 July for a scheduled public meeting. This report provides a summary of issues discussed for noting by the Trust Board. Nine governors were in attendance for the extraordinary meeting and eight were present at the public meeting.

At the extraordinary confidential Council of Governors meeting held on 12 July governors discussed agenda items including:

ACTING CEO UPDATE ON PARTNERSHIP AND COLLABORATION

Ifti Majid explained the reasons behind the proposal to work collaboratively with DCHS for the benefits of patients and carers of Derby and Derbyshire. Both trusts offer a range of different services and his report set out how the Trust could collaborate more efficiently and formally with DCHS and provided information for governors to consider with regard to exploring strategic options for collaboration.

A range of options are to be considered, from informal collaboration to a full merger. Ifti Majid talked about the main system challenges for the Derbyshire health and social care system which have arisen mainly as a result of NHS funding challenges, rising demand and health inequality across the county and city, workforce shortages and the shape of NHS provision across the county. He also highlighted the opportunities that would arise through closer working with DCHS and how increased collaboration would enable the transformation of our services to support the system. Governors will be in the centre of engagement as well as other stakeholders - such as clinicians, colleagues in the CCGs, people who use our services and others in wider provider organisations.

It is anticipated that the creation of the Strategic Options Case and associated engagement would require a minimum of four months to develop and a draft paper is expected to be presented to both Boards in October setting out the next steps.

THE WIDER SUSTAINABILITY AND TRANSFORMATION PLAN (STP)

Gareth Harry, Chief Commissioning Officer from the Hardwick Clinical Commissioning Group (CCG) presented an update to governors on Parity of Esteem, 21st Century Joined Up Care proposals and consultation and the Derbyshire Sustainability and Transformation Plan (STP). He talked about the advantages of integrating mental health services and physical health services. It was highlighted how the Derbyshire STP will aim to address the gaps across Derbyshire and identify the levers for closing gaps in health and wellbeing, care quality and finance and efficiency. Governors raised a range of issues and questions on this topic. It was agreed that the STP would be a standing agenda item for discussion at each meeting of the Council of Governors going forwards.

At the Council of Governors meeting held on 21 July governors discussed agenda items including:

ACTING CHIEF EXECUTIVE'S REPORT

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

- the inaugural report of the NHS Workforce Race Equality Standard (WRES), showing results of the experiences of BME and white staff from the staff survey 2015 at every NHS trust across England had been published and would be reviewed by the People and Culture Committee to identify how the Trust could learn from best practice.
- The Trust has instigated emergency procedures to enable rapid action to be taken in the Adult Acute Service at the Radbourne Unit. The senior leadership team is meeting daily to address staffing levels to ensure safe and effective services continue to be delivered.
- The Trust has been successful in winning the contract for integrated Adult Substance Misuse Service which will commence on 1 April 2017.
- The roll out of the 'lean' programme has commenced within the Trust and training sessions have started for key clinical and operational leaders. This programme is key to delivering more efficient services of clinical pathways and support services.

APPOINTMENT OF NON-EXECUTIVE DIRECTORS

Governors were presented with recommendations from the Nominations and Remuneration Committee for the appointment of two Non-Executive Directors following a competitive recruitment process. Governors duly approved the appointments. Pre-appointment checks and compliance with fit and proper persons requirements will be carried out and confirmed prior to formal commencement with the Trust.

GOVERNORS' CODE OF CONDUCT

The Code of Conduct for the Council of Governors was presented to governors, following review by the Governance Committee at several meetings. Following discussion relating to the sections relating to liaison with the media, governors agreed to approve the Code of Conduct for immediate implementation. It was agreed that all existing governors and new starters would be required to sign up to the Code annually.

GOVERNANCE IMPROVEMENT ACTION PLAN (GIAP) – AND UPDATE ON PROGRESS WITH COUNCIL OF GOVERNORS RELATED ACTIONS

Jenna Davies presented governors with an update on progress of all tasks within the GIAP, including the identification of tasks that are off track, and those that the Council of Governors has responsibility for oversight.

It was noted that considerable work had taken place on the governor-related GIAP actions. Under wider GIAP progress significant work had taken place with Human Resources (HR) and Organisational Development related actions. Since the GIAP paper had been circulated to governors the People & Culture Committee had approved the HR model and the Trust's People Plan. This had now taken forward the culture and change and organisation development aspects of the GIAP as well as other areas around the training and development programme for staff.

EQUALITY AND DIVERSITY WORKFORCE 2016/17

Owen Fulton, Principal Employee Relations Manager presented governors with an update on the Equality and Diversity Workforce approach for 2016 /17.

It was noted that progress reports from the 4Es and the BME Group would be received by the People & Culture Committee. Assurance was obtained that progress was being made with equality and governors would be kept updated on progress.

PRESENTATION OF THE ANNUAL REPORT AND ACCOUNTS AND REPORT FROM EXTERNAL AUDITORS (GRANT THORNTON)

Claire Wright provided governors with a high level presentation that outlined the process and outputs of the annual accounts for 2015/16. Joan Barnett, external auditor, provided governors with an Annual Audit Letter presentation which summarised key findings arising from work that Grant Thornton carried out for the Trust for the year ended 31 March 2016.

The Annual Audit Letter reflected the good work being undertaken within the Trust and that the Trust has been very proactive in working in partnership to support the delivery of strategic priorities. The Trust also has adequate arrangements in place to secure financial resilience.

INTER-SERVICE DEPARTMENT WAITING TIMES

Laura McAra, Helen MacMahon and Scott Lunn from the Derby City neighbourhood team attended the meeting to discuss inter-service department waiting times as this had been requested by the Governance Committee at a recent meeting. The waiting times and action plan to improve the service was summarised.

It was proposed that commissioners be invited to a future Council of Governors meeting to discuss the commissioning of CAMHS (Child and Adult Mental Health Services) services.

INTEGRATED PERFORMANCE REPORT

This was the first time governors received the integrated report and Claire Wright highlighted key areas contained in the report which gave governors an overview of performance as at the end of May 2016 with regard to workforce, finance and operational delivery and quality performance. Governors welcomed receiving this report.

REPORT FROM GOVERNANCE COMMITTEE

The report from the Governance Committee highlighting issues discussed at the meeting held on 7 July was received and noted.

NON EXECUTIVE DIRECTOR REPORTS AND KEY THEMES RAISED

Verbal reports on the range of activities undertaken by Non-Executive Directors present, namely Caroline Maley and Maura Teager, were noted for information.

The Board is asked to:

Note the summary report from the Council of Governors

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 7 September

Governance Improvement Action Plan

Purpose of Report:

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

Therefore, the purpose of this paper is as follows;

1. To provide Board members with an update on progress on the delivery of the GIAP, including the identification of tasks and recommendations that are off track.

2. To receive assurances on delivery and risk mitigation from Board Committees and lead Directors.

3. To enable Board members to constructively challenge each other to establish whether sufficient evidence has been provided for completed actions.

4. To decide whether tasks and recommendations can be closed and archived.

Executive Summary

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

The GIAP was first approved by the Board in March along with the governance and delivery framework. Over the course of the last 4 months the Trust has made significant progress delivering specific tasks contained within the GIAP.

There is now a need to amend the way in which the GIAP is reported to provide the Board and its Committees with a greater emphasis on specific, difficult to deliver tasks and also to place much greater focus on how actions are being embedded across the organisation.

In July 2016 the Director of Strategic Development and the Governance Improvement Programme manager met with NHS Improvement and agreed a method of reporting aligned to best practice nationally.

This report therefore provides an update for Board on the key GIAP issues, as well as setting out the way in which the Board and its Committees will obtain assurance on delivery in the future.

The Board summary report has been amended to provide an overview of the entire programme of work. Each core area, as well as the total programme will be reported to show the status of each action, as well as highlighting areas which are rated as ‘off track’ or ‘some issues’

Following one to one meetings with lead directors and discussion at Board Committees since the end of July, there are 97 (71%) actions complete, 28 (21%) actions remain on track to be completed as planned; there are ‘some issues’ with the delivery of 2 actions

(1%) and 9 actions (7%) are rated as 'off track'.

Core	Number of Actions	Off Track	Some Issues	On track	Completed
Core 1 - HR and associated Functions	12				12
Core 2 - People and Culture	19	4			15
Core 3 - Clinical Governance	9			2	7
Core 4 - Corporate Governance	29	4		2	23
Core 5 - Council of Governors	10		1	1	8
Core 6 - Roles and Responsibilities of Board Members	14			10	4
Core 7 - HR and OD	20	1	1	9	9
Core 8 - Raising concerns at work	2			1	1
Core 9 - Fit and Proper	6				6
Core 10 - CQC	4				4
Core 11 - NHS improvement undertakings	11			3	8
Total	136	9	2	28	97

Board members should be assured that all actions have been reviewed in detail. The actions that are off track are covered in more detail in the main body of the report. In addition, KPI's have been updated for July and Board members should seek assurance on those that are rated red.

Board members will note that 3 of the KPI's are rated as 'tbc'. Further dialogue is required with the Director of Workforce, OD and Culture to confirm the trajectories for these.

Strategic considerations

Delivery of the GIAP links directly to NHSI enforcement action and associated license undertakings

(Board) Assurances

This paper should be considered in relation to key risks contained in the Board Assurance Framework

Consultation

This report has not been discussed at any other meeting

Governance or Legal Issues

This paper links directly to NHSI enforcement action and associated license Undertakings

Equality Delivery System

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

Recommendations

The Board of Directors is asked to;

1) Note the progress made against GIAP
2) Review the content of this paper and KPI's seeking assurance where necessary
3) Discuss the areas rated as 'off track' and 'some issues', seeking assurance where necessary
4) Discuss and approve the revised reporting process and templates for each Core area and blue completion forms
5) Agree at the end of the Pubic Board meeting whether any further changes are
6) required to the GIAP following presentation of papers, outcomes of item
7) specific discussions and/or other assurances provided throughout the meeting

Report presented by: **Mark Powell**
Director of Strategic Development

Report prepared by: **Jenna Davies**
GIAP Programme Manager

1. Introduction

The GIAP was first approved by the Board in March along with the governance and delivery framework. Over the course of the last 4 months the Trust has made significant progress delivering specific tasks contained within the GIAP.

There is now a need to amend the way in which the GIAP is reported to provide the Board and its Committees with a greater emphasis on specific, difficult to deliver tasks and also to place much greater focus on how actions are being embedded across the organisation.

In July 2016 the Director of Strategic Development and the Governance Improvement Programme manager met with NHS Improvement and agreed a method of reporting aligned to best practice nationally.

2. Summary Report

The Board report has been amended to provide an overview of the entire programme of work. Each core as well as the total programme will be reported to show the status of each action, as well as highlighting areas which are rated as 'off track' or 'some issues'

Following one to one meetings with lead directors and discussion at Board Committees since the end of July, there are 97 (71%) actions complete, 28 (21%) actions remain on track to be completed as planned; there are 'some issues' with the delivery of 2 actions (1%) and 9 actions (7%) are rated as 'off track'.

Core	Number of Actions	Off Track	Some Issues	On track	Completed
Core 1 - HR and associated Functions	12				12
Core 2 - People and Culture	19	4			15
Core 3 - Clinical Governance	9			2	7
Core 4 - Corporate Governance	29	4		2	23
Core 5 - Council of Governors	10		1	1	8
Core 6 - Roles and Responsibilities of Board Members	14			10	4
Core 7 - HR and OD	20	1	1	9	9
Core 8 - Raising concerns at work	2			1	1
Core 9 - Fit and Proper	6				6
Core 10 - CQC	4				4
Core 11 - NHS improvement undertakings	11			3	8
Total	136	9	2	28	97

There are 9 actions rated as Red (have failed to deliver to agreed timescales/are off track and unlikely to deliver to the agreed date) as detailed in the table below.

Board members should be assured that each of these will be discussed in detail at the respective Board committee, with Committee members expected to seek assurance on the mitigation that are put forward.

Core Area	Action	Mitigation
Core 2 - People and Culture	Develop a clear plan which outlines an on-going focus on pulse surveys to enable targeted activity	It has been agreed that the Trust will adopt an approach developed by DCHS who have developed a pulse check which incorporates the friends and family staff test. The First survey of this type will be distributed in September to staff.
	Based on Pulse Checks develop a focused coaching within teams	See above
	Develop and implement a leadership development programme	This task has been difficult to achieve due to staff absences in the team responsible for this. It is expected to be addressed when the new Director for Workforce, OD and Culture starts in post.
	HR and OD to undertake a refresh of the behavioural framework	It has been agreed that the NHS Employees framework will be adopted, using focus groups with staff to implement. This will be delivered between September and December 2016
Core 4 - Corporate Governance	Aligned to the Corporate Governance Framework develop and approve an organisational accountability framework	The responsibility for developing an organisational accountability framework sits with ELT. ELT will be discussing a draft framework on the 22nd August. It is expected that the outcome of this discussion will inform a wider debate with the senior leadership team for any further adaptations to it. It is expected to be agreed and implemented by the end of October 2016.
	Develop and fully engage senior staff in an accountability framework	See above
	As part of the Governance Framework review the Trust will formalise the role of PCOG	See above
	Clarifying the role of PCOG in light of the move to neighbourhoods and campuses	See above
Core 7 - HR and OD	Implement Integrated Team meetings	Due to planned sick leave of the Director of Workforce, OD and Culture it has not been possible to deliver this particular action. This is going to be addressed by the new Director of HR, Culture and OD.

There are 2 actions rated as Amber (there are some issues with delivery of the action) as detailed below:

Core Area	Action
Core 5 - Council of Governors	The Board and CoG will co-write a policy on how the Board will work in partnership
Core 7 - HR and OD	Ensure the backlog of cases made known to the CQC at the time of the inspection are concluded

3. Wider GIAP Reporting and Assurance

3.1 Core overview report

As Board members know the GIAP is split into 11 Core areas. Within each of these sit a number of recommendations (53), which in turn lead to a number of specific tasks. Focus has very much been on task delivery over the course of the last 4-5 months, however, there is now a need to place much more focus on ensuring that each of the 53 recommendations is fully delivered and that the Board is assured that they are embedded within every day working of the Trust.

Therefore, each Core area and its recommendations will now be reported individually and with its own dashboard to an identified Committee (see table below). This report will provide the Committee with oversight of the delivery of tasks, BRAG ratings for each recommendation and the Core area in its entirety.

Core	**Committee**	**Lead Director**
Core 1 - HR and associated Functions	People and Culture	Director of HR, OD and Culture
Core 2 - People and Culture	People and Culture	Director of HR, OD and Culture
Core 3 - Clinical Governance	Quality	Director of Nursing
Core 4 - Corporate Governance	Audit and Risk	Director of Corporate Affairs
Core 5 - Council of Governors	Council of Governors	Director of Corporate Affairs
Core 6 - Roles and Responsibilities of Board Members	Remuneration and Appointments	Acting Chief Executive
Core 7 - HR and OD	People and Culture	Director of HR, OD and Culture
Core 8 - Raising concerns at work	People and Culture	Director of Corporate Affairs
Core 9 - Fit and Proper	Remuneration and Appointments	Director of Corporate Affairs
Core 10 - CQC	People and Culture	Acting Director of Operations
Core 11 - NHS improvement undertakings	Board of Directors	Director of Strategic Development

There will be clear escalations from Committees of any risks or issues identified to the delivery of tasks and/or recommendations, with Leads and Committees providing monthly assurance to Trust Board.

In addition, the report will also highlight recommendations to Committees and the Board of Directors where the Executive lead believes that there is sufficient evidence to warrant a ‘blue’ completed BRAG rating.

Examples of Core overview reports are provided in the appendix for further discussion.

3.2 Blue completed form

The Blue completed form will be completed when all actions within a recommendation have been delivered and there is sufficient evidence for the Committee and the Board to obtain assurance that the recommendations have been addressed, and the actions have been embedded.

The forms will be the responsibility of the executive lead to complete, which will outline why the BRAG rating is being recommended as complete, provide the evidence that the actions have been completed and embedded and how ongoing monitoring will take place.

An example of a Blue completed form for FF1 has been included in the appendix for discussion.

Derbyshire Healthcare NHS Foundation Trust
Report to People and Culture Committee 20 September 2016

Governance Improvement Action Plan

Purpose of Report

The paper provides People and Culture Committee with an update against Core 1 of the GIAP.

Executive Summary

This paper provides an overview to the Committee of Core 1 GIAP key actions that it is responsible for seeking assurance on delivery.

<table>
<tr><td colspan="2">Core Area

1. Reunification of HR and Associated Functions</td><td colspan="6">Executive Lead

Director of HR, OD and Culture</td></tr>
<tr><td rowspan="2">Overall BRAG rating;

Green

On Track</td><td rowspan="2">Reporting period;

September 2016</td><td colspan="4">Action Rag Rating</td><td colspan="2">Recommendation BRAG Rating</td></tr>
<tr><td>R</td><td>A</td><td>G</td><td>B</td><td>HR1</td><td></td></tr>
<tr><td rowspan="2">Total Number of Actions
12</td><td>0</td><td>0</td><td>0</td><td>12</td><td>HR2</td><td></td></tr>
<tr><td colspan="4"></td><td>HR3</td><td></td></tr>
<tr><td colspan="4"></td><td>HR4</td><td></td></tr>
<tr><td colspan="4"></td><td>HR5</td><td></td></tr>
</table>

Key

R	Has failed to deliver by target date/off track and now unlikely to deliver by target date.
A	Some issues to delivery, recovery action planned to bring back on track.
G	On track to deliver by target date.
B	Completed.

Exception Report

None to report

Risks and Issues

None to report

Recommendations Regarding Delivered and Embedded Actions

None to report

Strategic considerations

- Delivery of the GIAP links directly to NHSI enforcement action and associated license undertakings.

Assurances

- This paper should be considered in relation to key risks contained in the Board Assurance Framework.

Consultation

- This report hasn't been discussed at any other meeting.

Governance or Legal issues

- This paper links directly to NHSI enforcement action and associated license undertakings.

Recommendations

The People & Culture Committee;

- **Review** the content of this paper, Core 1 GIAP (attached) and seek assurance where required

Report prepared by: **Jenna Davies (GIAP Programme Manager)**

Report presented by: **Mark Powell (Director Strategic Development)**

Derbyshire Healthcare NHS Foundation Trust
Report to People and Culture Committee 20 September 2016

Governance Improvement Action Plan

Purpose of Report

The paper provides People and Culture Committee with an update against Core 2 of the GIAP.

Executive Summary

This paper provides an overview to the Committee of Core 2 GIAP key actions that it is responsible for seeking assurance on delivery.

<table>
<tr><td colspan="2">Core Area

2. People and Culture</td><td colspan="6">Executive Lead

Director of HR, OD and Culture</td></tr>
<tr><td rowspan="4">Overall BRAG rating;

Amber

Some Issues</td><td rowspan="2">Reporting period;

September 2016</td><td colspan="4">Action Rag Rating</td><td colspan="2">Recommendation BRAG Rating</td></tr>
<tr><td>R</td><td>A</td><td>G</td><td>B</td><td>PC1</td><td></td></tr>
<tr><td rowspan="2">Total Number of Actions
19</td><td rowspan="2">4</td><td rowspan="2">0</td><td rowspan="2">0</td><td rowspan="2">15</td><td>PC2</td><td></td></tr>
<tr><td>PC3</td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td>PC4</td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td>PC5</td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td>PC6</td><td></td></tr>
</table>

Key

R	Has failed to deliver by target date/off track and now unlikely to deliver by target date.
A	Some issues to delivery, recovery action planned to bring back on track.
G	On track to deliver by target date.
B	Completed.

Exception Report: Red / Amber actions				
Action	**Target Completion Date**	**Status**	**Explanation for RAG rating**	**Expected completion date**
PC2 - Develop a clear plan which outlines an on-going focus on pulse surveys to enable targeted activity	31/07/2016			
PC2 - Based on Pulse Checks develop focused coaching within teams	31/08/2016			
PC2 - Develop and implement a leadership development programme	31/07/2016			
PC5 - HR and OD to undertake a refresh of the behavioural framework	31/07/2016			

Risks/ Issues to Highlight to Committee	Mitigating Action	Status
PC1 - Failure of the People and Culture Committee to remain strategic and be well supported by functioning sub-groups will reduce its efficiency and ability to maintain oversight of the GIAP actions	Agenda of the People and Culture committee will be aligned to the key strategic headings of people plan to ensure that the Committee is effective and remains strategic	Deloitte will review the effectiveness of the Committee against the TOR and the agenda.
PC2 - Outcomes of the pulse checks are not adequately considered and change embedded.	The Trust has implemented a feedback system and feedback from staff will be monitored through the Trusts engagement group. Common themes and concerns will be escalated to people and culture committee.	The engagement group is currently being established and will report to Septembers meeting of people and culture

Recommendations regarding delivered and embedded actions

Action	Blue action form Submitted	Comments
PC4 - Refresh People Plan including reporting metrics	Y	

Strategic considerations

- Delivery of the GIAP links directly to NHSI enforcement action and associated license undertakings.

Assurances

- This paper should be considered in relation to key risks contained in the Board Assurance Framework.

Consultation

- This report hasn't been discussed at any other meeting.

Governance or Legal issues

- This paper links directly to NHSI enforcement action and associated license undertakings.

Recommendations

The People & Culture Committee;

- **Review** the content of this paper, and seek assurance where required
- **Discuss** the recommendations rated as 'off track' and seek assurance on the mitigation provided from the Lead Directors
- **Discuss** and **approve** the recommendations put forward as 'complete' for closure

Report prepared by: **Jenna Davies (GIAP Programme Manager)**

Report presented by: **Mark Powell (Director of Strategic Development)**

Blue Action Form - Board of Directors

Recommendation	Current BRAG Rating	Recommended BRAG rating
FF1- The Trust must ensure that a fit and proper person review is undertaken for all directors in light of the findings of the employment tribunal.	Completed	Assurance received

Detail;

Regulation 5 fit and proper persons has been introduced as a direct response to the failings at Winterbourne View Hospital and the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust, which recommended that a statutory fit and proper person's requirement be imposed on health service bodies.

The Trust will make every reasonable effort to assure itself about existing post holders and new applicants and to make specified information about board directors available to CQC on request.

As part of the focused inspection which took place in January, CQC recommended as a 'must do', that the trust must ensure that a fit and proper person review is undertaken for all directors in light of the findings of the employment tribunal

The Trust has delivered and completed a number of actions to fulfil the fit and proper requirement including ensuring a fit and proper person policy is in place, processes are in place to ensure ongoing compliance against the fit and proper requirements and the Chair has confirmed through an annual declaration that he considers Board Members are fit and proper.

Evidence	
Fit and Proper person Policy	Evidence document embedded
Annual Declaration of fit and proper	As above
Fit and Proper HR Tracker	As above

On-going monitoring arrangements:

Will be further reviewed by CQC and also monitored on an annual basis by the Board.

Core 1 - HR and Associated Functions	target	Monthly rolling/Annual	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Documentary evidence of demonstrable outcomes	Comments
1) Sickness absence rate	5.04%	Monthly	5.50%	6.20%	6.32%	tbc	tbc	tbc	tbc	tbc	tbc	tbc	5.04%	1) Positive assurance received from internal audit on a number of audits related to the delivery of the GIAP 2) Revised HR model in place 3) HR team metrics in place with evidence of improvement 4) Improvement in organisational HR metrics evidenced through Integrated Performance report 5) Trust Board minutes 6) P&CC minutes	1) The first 5 metrics and the associated targets are taken from the Trusts integrated performance report. 2) From notice given to appointee in post measure will be complete once the information is available. 3) The Trust annual sickness absence rate reflects the East Midlands average
2) Vacancy rates	10%	Monthly	17.30%	17.48%	17.83%	tbc	tbc	tbc	tbc	tbc	tbc	tbc	10%		
3) Staff appraisals	90%	Monthly	69.59%	71.29%	67.19%	tbc	tbc	tbc	tbc	tbc	tbc	tbc	90.12%		
4) Staff turnover	10.00%	Monthly	10.44%	10.86%	10.88%	10.30%	10.26%	10.22%	10.18%	10.14%	10.1%	10.6%	10%		
5) Mandatory training	90%	Monthly	90.87%	90.49%	90.31%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90%		
6) Agency spend	3million	rolling	£745,000	£1,350,000	£1,666,000	£1,910,000	£2,080,000	£2,250,000	£2,420,000	£2,590,000	£2,760,000	£2,930,000	£2.999,999		
7) From notice given to appointee in	TBC	Monthly													
Core 2 - People and Culture Committee															
1) Improvement in Pulse Check scores	TBC	Quarterly												1) P&CC minutes 2) Evidence of the delivery of the People plan 3) External assurance of the effectiveness of the People and Culture Committee 4) Evidence of the delivery of the Communications Plan	1) We are currently using the Friends and Family test to track improvements in this area. This KPI specifically relates to the question "would you recommend the Trust as a place to work".
2) Staff Friends and Family Test	62%	Quarterly	38%	x	x	x	50%	x	x	x	62%	x	x		
Core 3 - Clinical Governance															
1) Trust Policies that are in date	95%	Monthly	99%	99%	97%	95%	95%	95%	95%	95%	95%	95%	95%	1) Revised Policy for Policies 2) Internal Assurance report on policy compliance 3) External Assurance report on effectiveness of QLTs 4) Quality Committee TOR	
Core 4 - Corporate Governance															
1) 100% of Board Committee ToRs reviewed annually	100%	Annual	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	1) Well led External review 2) Committee's TOR 3) Completed actions matrix 4) Board Development programme agendas 5) 360 feedback reports and associated actions	1) All the terms of reference for each Board Committee have been reviewed and a further review is due to take place in December 2) The second metric relating to the circulation of papers, is based on the monthly cycle of meetings and when the papers are distributed. Some months there are less meetings than others. 3) The action matrix figure is based on the action matrix which is circulated to the respective Board Committee meetings on a monthly basis
2) 90% papers circulated 5 days prior to meeting (unless the Chair has agreed that a paper can be tabled)	90%	Monthly	71%	71%	71%	77%	79%	81%	83%	85%	87%	89%	91%		
3) 80% of actions on the Integrated action matrix are on track or completed	80%	Monthly	65%	75%	98%	69.5%	71%	72.5%	74%	75.5%	77%	78.50%	80%		
Core 5 - Council of Governors															
1) All new Governors completed induction within three months of starting in post	100%	rolling	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	1) Well led External review 2) Engagement Policy 3) Code of Conduct 4) Lead Governor role description	
Core 6 - Role & Responsibilities of Board Members															
1) Each Board member has attended 75% of the Board Development programme	75%	Rolling	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	1) Board Development programme agendas 2) 360 feedback reports and associated actions 3) Succession plans 4) Well led External review 5) Board Effectiveness Review	1) Board member attendance at Board Development will be measured on a rolling basis.
2) 100% of Board Members have undergone a 360 appraisal	100%	Annual	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%		
3) Exec Directors have attended at least 75% of the executive development sessions	75%	Monthly	75%	75%	75%	76.5%	77%	77.5%	78	78.5%	79%	79.5%	80%		
4) All Directors 100% compliance with their training requirements	90%	Monthly	74%	76.5%	81%	81.5%	84%	86.5%	89%	91.5%	94%	96.50%	100%		
Core 7 - Workforce and OD															
1) Improvement of KF 27- % reporting most recent experience of harassment, bullying or abuse	47	Annual	57	x	x	x	x	x	x	x	x	x	57	1) Board and Committee minutes 2) HR SLA delivery 3) Staff Survey	
2) KF 21% believing the organisation provides equal opportunities for career progression / promotion	89%	Annual	84%	x	x	x	x	x	x	x	x	x	89%		
3) 90% of Managers trained on HR policies before 31st December	90%	Monthly								90%					
Core 8 - Raising Concerns															
1) 100% compliance against the whistleblowing policy	100%	6 month IA												1) Raising Concerns policy 2) Freedom to Speak up / Raising concerns action plan 3) Internal Audit assurance on compliance with the Raising Concerns policy	
2) Improve scores in staff survey score Q13a- % saying if they were concerned about unsafe clinical practice they would know how to report it	96%	Annual	98%	x	x	x	x	x	x	x	x	x	98%		
3) Improve scores in staff survey score Q13b- "I would feel secure raising concerns about unsafe clinical practice"	71%	Annual	67%	x	x	x	x	x	x	x	x	x	71%		
4) Improvement in score against Q13c "I am confident that the organisation would address my concern"	59%	Annual	52%	x	x	x	x	x	x	x	x	x	59%		
Core 9 -Fit and Proper person Test															
1) All Directors are fully compliant with the Fit and Proper person test	100%	Annual	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	1) Board Minutes 2) Fit and Proper person evidence files	
2) 100% of Directors personal files evidence fit and proper persons requirements	100%	Annual	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Core 11 - NHS improvement															
1) 80% of BRAG ratings are on Track or Completed	80%	Monthly	77%	85%	86%	85%	85%	85%	85%	85%	85%	85%	85%	1) External assurance reports on the GIAP and governance Framework 2) Enforcement notice removed 3) External well led governance review 4) Board minutes	

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 7 September 2016

Governance Improvement Action Plan

Purpose of Report

At the Audit and Risk Committee meeting on the 19 July, members of the Committee were not assured on the progress of the GIAP actions which Audit and Risk Committee has oversight. This paper aims to provide assurance and evidence of progress against each of the actions which the Committee has oversight.

Executive Summary

The Audit and Risk Committee has oversight of 25 Actions. The Committee has at its meetings in April and May approved the following actions as completed;

CorpG3 (Task 1) – The Board and its committees need to have a greater focus on capturing, recording and holding to account for agreed actions.

The Board development programme was approved by the Board in March 2016 which included a session on holding the Board to account. The holding to account session took place on13 July 2016.

CorpG3 (Task 2) – Ensure a fit for purpose action log process is in place ensuring that the Board and Board committee action trackers are revised so that all actions captured have a clear close date, 'current position' and 'status of action'; and that RAG ratings are more clearly utilised to demonstrate progress

The Director of Corporate Affairs reviewed the Trusts action logs and discussed the current process with ELT and with the Board at the May Development Session and it was agreed that no further action was required following improvements set in place to review and capture actions earlier in the year.

CorpG4 (Task 3)- Review ED attendance at Committees

The review of Executive Directors attendance at Board Committees was discussed at ELT and the revised attendance of EDs at Board Committees has been incorporated into the terms of reference of each committee.

CorpG4 (Tasks 2) – Arrange for Committee Chairs to meet on a quarterly basis

Dates for Committee chairs to meet have been established

CorpG4 (Task 4) – Review the minutes of the Board and Board Committees and consider the use of action notes as a more effect way of recording debate and actions

The Executive Leadership Team has considered the use of action notes, but it is acknowledged that as part of ongoing scrutiny and review by external parties it is important that extensive and detailed minutes are recorded of the Trust Board and Board Committees.

<u>CorpG4</u> (Task 5) – Embed a process for the yearly review of the effectiveness of Board Committee against TOR

A yearly review of effectiveness is now included in al terms of reference.

<u>CorpG5</u> (Tasks 1, 2 & 3) – Undertake a review of the Finance and Performance Committee

The Finance and Performance Committee reviewed their TOR in April and these have been also considered by the Director of Corporate Affairs as part of the refresh of the Governance Framework. In addition the Committee has an agreed work plan.

<u>CorpG6</u> (Tasks 1, 2 & 3) – The Audit Committee should reaffirm its role in seeking assurance over systems, controls and processes and not matters of operational or managerial detail.

The Audit and Risk Committee reviewed their TOR and these have been also considered by the Director of Corporate Affairs as part of the refresh of the Governance Framework. In addition the Committee has an agreed work plan.

<u>CorpG13</u> (Task 1) -Develop and Agree BAF 16/17

The Board Assurance framework was agreed in March and considers all risks relating to the delivery of the Trust Strategy.

Actions to be approved at the July Meeting

A number of actions were approved and completed at the July meeting of the Audit and Committee;

<u>ClinG3</u> (Task 2) As part of the review of all Committee TOR ensure there is clarity of Quality Committee TOR and work plans in relation to the Audit Committee and People and Culture Committee

It was confirmed that the Quality Committee agenda is now reflective of CQC domains as well as the Quality Priorities. *Further details giving assurance of completion of this task are outlined in the Corporate Governance Framework GIAP update paper.*

<u>CorpG4</u> (Task 1) – Undertake a comprehensive review of the Board Committee structures including TOR

The Board Committee structure has been reviewed in the context of current priorities and following annual review of effectiveness of each Committee. It is proposed that a further review take place in December 2016.

CorpG12- (Task 1) Reintroduce short summary reports from committee chairs to the Board which identify key risks, successes and decisions made / escalated from the meeting.

Assurance Summary Report - This action was signed off by the Committee as complete, but after the Board meeting in April it was agreed further changes were required to the summary reports. These were duly made and agreed at the June Board meeting. The amended summary report template was further approved by Audit and Risk Committee as part of the Governance Framework.

Outstanding actions

ClinG2- (Task 1) Undertake a review of Trust policies

A paper which addresses this action was presented to Quality Committee in July and was due to be presented to Audit and Risk Committee in July. This paper is attached for reference. This action is due for completion in December 2016.

CorpG7/CorpG9 (6 Actions) – in light of the changing governance and accountability structures (such as neighbourhoods, campuses and QLTs), an accountability framework should be designed

Both these recommendations relate to the alignment of the Trust's Accountability Framework to the Trust's revised Corporate Governance Framework. As part of the Deloitte report the recommendations are based on the current accountability structure, a review of the current structure has been undertaken by the Executive Leadership Team and newly created Senior Leadership Team (SLT) which has identified that a new structure is required. An accountability framework together with a revised structure is currently being developed with senior leaders within the Trust and is due to be discussed by SLT at the end of August.

WOD1- (Task 5) – HR policy Audit

Internal Audit review of control process and assurance to demonstrate sustained improvement in HR policy compliance levels. This action is due for completion in Q4 and will be added to the internal audit scope.

WOD7- (Task 2)- HR policy Audit

The audit has been completed and Trust is awaiting the final report. Task target date September 2016.

Strategic considerations

- Delivery of the GIAP links directly to NHSI enforcement action and associated license undertakings.

Assurances

- This paper should be considered in relation to key risks contained in the Board Assurance Framework.

Consultation

- This report has not been discussed at any other meeting.

Governance or Legal issues

- This paper links directly to NHS Improvement enforcement action and associated license undertakings.

Recommendations

The Board of Directors are requested:

- To **receive** this report and note the update of the actions.
- **Discuss** and **approve** that ClinG3 (2), CorpG4 (1) and CorpG (12) are complete.

Report prepared by: **Jenna Davies (GIAP Programme Manager)**

Report presented by: **Mark Powell (Director Strategy Development)**

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 07 September 2016

Trust Compliance – Accessible Information Standard

Purpose of Report:
This report provides our compliance update with the Accessible Information Standard. Previous compliance update reported to the Board 30 June 2016.

Executive Summary
- The Accessible Information Standard was published 3 July 2015. Full implementation of the standard was required by 31 July 2016.

Strategic considerations
- To maintain high level of standard compliance within our organisation and also to support partnering organisations.

(Board) Assurances
- Full assurance implementation plan monitoring and complete
- Full assurance for our Accessible Information Standard compliance
- Full assurance post implementation monitoring and audit

Consultation
- Learning Disability Clinical & Professional Reference Group (Derbyshire County Wide)
- Information Governance Committee – Accessible Information Standard now a routine agenda item following meeting in July 2016.

Governance or Legal Issues
- This information standard is published under section 250 of the Health and Social Care Act 2012.

Equality Delivery System
- Successful implementation will lead to improved outcomes and experiences, and the provision of safer and more personalised care and services to those individuals who come within the standard's scope.

Recommendations

The Board of Directors is requested to:
1) Acknowledge full implementation and Trust compliance
2) Acknowledge post implementation monitoring and audit

Report presented by: Carolyn Gilby (Acting Director of Operations)

Report prepared by: Alex Rose

Accessible Information Standard Report

Introduction

This report provides information on our compliance with the Accessible Information Standard (http://www.hscic.gov.uk/isce/publication/scci1605).

This standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.

The standard applies to service providers across the NHS and adult social care system, and effective implementation will require such organisations to make changes to policy, procedure, human behaviour and, where applicable, electronic systems. Commissioners of NHS and publicly-funded adult social care must also have regard to this standard, in so much as they must ensure that contracts, frameworks and performance management arrangements with provider bodies enable and promote the standard's requirements.

Background

This standard was published 03 July 2015 with full implementation required by 31 July 2016.

The standard can be broken down into key compliance areas:

- Electronic Patient Record Systems
- Website and supporting material
- Policies and Procedures
- Leaflets
- Staff training and awareness

Action so far

The following key actions have already been completed:

- Electronic Patient Record Systems

PARIS, TPP SystmONE and IAPTUS have all been tested. Systems confirmed to have the capacity to allow staff to record information and communication needs and for these to be highly visible and promoted as alerts.

Electronic Patient Record user guides created and published specific for compliance with the Accessible Information Standard, announcement to all staff on Connect.

- Website and supporting material

Trust external website has been updated:
http://www.derbyshirehealthcareft.nhs.uk/accessibility/

This also includes a text reading system for people with visual impairments, called BrowseAloud.

Trust internal Connect website has been updated:
http://connect/Corporate/PerformanceAndIMT/SitePages/Accessible%20Information.aspx

Dedicated site page to support staff understand and access materials and training for Accessible Information Standard.

Trust Core Care Standards website has been updated:
http://www.corecarestandards.co.uk/accessibility/

- Buttons to translate the website into other languages
- Includes Easy Read, picture and symbol options in a number of sections, particularly the Keeping Well area, and a section in Learning Disability Services about support with accessible information, links to videos.
- Uses large print to alert people to the viewing options
- Includes a standard on Involvement and choice, and a principle on Information
- Has been written in clear straightforward language, using reading tools to gauge accessibility

Forms:

- Assessment and Care Planning forms include a section on Communication
- A booklet on 'Writing Good Care Plans' has been published which gives advice on accessibility of care plans – distributed to all clinical staff.
- The Trust has a translation and Interpreting service for any forms needed

- Policies and Procedures

Trust policies have been reviewed and updated to reflect the need to raise awareness and support compliance for the Accessible Information Standard.

The Minimum Standards for Health Records Policy has been updated and renamed:
Minimum and Accessible Information Standards for Health Records Policy

The Data Quality Policy and Procedure has also been updated to reflect the need to enforce collection and recording of key information related to the Accessible Information Standard:
Data Quality Policy and Procedure

- Leaflets

All public facing leaflets contain a message offering to provide information in other formats. Trust uses Pearl Linguistics to support translations and Braille transcriptions.

Trust has created a suite of easy-read materials on our public-facing website:
http://www.derbyshirehealthcareft.nhs.uk/about-us/publications/easy-read-health-information-guides/

- Staff Training and Awareness

Accessible Information Standard covered as part of mandatory block training for Core Care Standards and Care Plan Approach.

User guides available for staff to support Accessible Information Standard compliance for electronic patient record systems.

Learning Disability Services have an extensive collection of forms in easy-read and Widget symbols, and staff trained to use these

Additional online e-learning available:
http://www.e-lfh.org.uk/programmes/accessible-information-standard/open-access-sessions/

Post Implementation Report – Accessible Information Standard

This report reflects on the action to date in consideration that continuous review and improvement is an ongoing feature of the Trust's forward plan.

No.	Recommendation	Action Update	Action Lead *(only **one** name for each action)*	Action Deadline Date	Evidence	Date completed
1	The standard will be adopted across the Trust by 31/07/16	In place: A) the standards will be audited through the annual Health records audit as part of standard B) IG spot-checks – a question will be added to the annual spot checks as part of the IG Awareness checking. C) Obtain patient feedback from Healthwatch, DIDB Focus groups and CQC Community Survey D) A question will be added to the SAR feedback form for user feedback E) 3rd quarter datacheck will focus on this	C Gilby	31/01/17	Audit	31/07/16

No.	Recommendation	Action Update	Action Lead *(only **one** name for each action)*	Action Deadline Date	Evidence	Date completed
		specific item.				
2	Review all electronic systems to ensure compliance	All systems are compliant	A Rose	01/07/16	Information can be captured on the EPR	01/07/2016
3	Review CCS and forms to ensure compliance	Compliant. All forms have been reviewed and the CPA manager confirms they are compliant	W Slater	30/06/16	CCS Website	30/06/2016
4	Review Policies and add as necessary to ensure compliance	Compliant. Data Quality and Minimum Standards for Record keeping updated	A Rose	10/06/16	On Intranet and has been disseminated to all staff through Policy Briefing e-mail	10/06/2016
5	Review information leaflets and rewrite if needed to ensure compliance	All electronic leaflets compliant. Work ongoing with paper format on request.	R Eaton	31/07/16	Internet/Intranet Leaflets	31/07/2016
6	Produce staff briefings and training materials	Clinical line briefings to take place	J Fleeman	31/07/16	On Intranet and has been disseminated to all staff through Briefing e-mail and announcement on Intranet Board report on Internet.	31/07/2016

2015-2016 Board Annual Forward Plan

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	Apr-16	May-16	Jun-16	Jul-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
		Deadline for papers	**18 Apr**	**16 May**	**20 Jun**	**18 Jul**	**26 Aug**	**26 Sep**	**24 Oct**	**28 Nov**	**3 Jan**	**23 Jan**	**20 Feb**
RG	Apologies given		X	X	X	X	X	X	X	X	X	X	X
SH	Declaration of Interests	FT Constitution	X	X	X	X	X	X	X	X	X	X	X
RG	Minutes/Matters arising/Action Matrix	FT Constitution	X	X	X	X	X	X	X	X	X	X	X
RG	Board Forward Plan	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X	X
RG	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													
RG	Chairman's report	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X	X
IM	Chief Executive's report	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X	X
MP/ CW	APR Monitor Annual Plan submissions and governance statements, including financial plan and budgets (subject to change for Monitor deadlines each year) *Confidential*	FT Constitution/Monitor Risk Assurance Framework (RAF)	X										X
CW	Monitor Compliance Return (Public)	Monitor Risk Assurance Framework (RAF)		X	X				X		X		X
CG	Information Governance Updates	Strategic Outcome 1 Strategic Outcome 3 Information Gov toolkit	X						X			X	
JSt	Staff Survey Results and Action Plan	Strategic Outcome 3 and 4	X										X
SH	Review S.O.'s, SFI's, SoD	FT Constitution Standing Orders						X					
SH	Trust Sealings	FT Constitution Standing Orders		X									
SH	Annual Review of Register of Interests	FT Constitution Annual Reporting Manual	X										
SH	Board Assurance Framework Update	Licence Condition FT4				X		X			X		X
SH	Raising Concerns (whistleblowing)	Strategic Outcome 1 Public Interest Disclosure Act			X						X	X	
SH	Whistleblowing Policy - annual nomination of NED role (one year rotation)	Francis Report		X									

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	Apr-16	May-16	Jun-16	Jul-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
SH	Committee Reports (following every meeting) - Audit - Finance & Performance - Mental Health Act - Quality Committee - Safeguarding -People Committee	Strategic Outcome 3	X	X	X	X	X	X	X	X	X	X	X
MP	Governance Improvement Action Plan	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X	X
SH	Fit and Proper Person Declaration	Licence Condition FT4		X									X
OPERATIONAL PERFORMANCE													
CG, CW, JSt, CG	Integrated performance and activity report to include Finance, Workforce, performance and Quality Dashboard	Licence Condition FT 4 Strategic outcome 1 Strategic Outcome 3	X	X	X		X	X	X	X	X	X	X
JSt	HR Investigation Action Plan				X			X			X		
QUALITY GOVERNANCE													
CG	Position Statement on Quality (Incorporates Strategy and assurance aspects of Quality management)	Strategic Outcome 1 CQC and Monitor		X	X		X	X	X	X	X	X	X
CG/ JSy	Safeguarding Children Annual Report	Children Act Mental Health Standard Contract						X					
CG/ Jsy	Safeguarding Adult Annual Report	CQC Mental Health Standard Contract						X					
CG	Control of Infection Report	Health Act Hygiene Code		X									
CG/ JSy	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 Community Patient Survey	Clinical Practice CQC							X				
JSy	Re-validation of Doctors	Strategic Outcome 3			X								