Derbyshire Healthcare NHS
NHS Foundation Trust

Meeting of the Board of Directors

2 November 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 2 NOVEMBER 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 5 October 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**	Mark Powell Claire Wright Amanda Rawlings Carolyn Green
9.	2:15	Position Statement on Quality	**F**	Carolyn Green
10.	2:25	Board Committee Assurance Summaries and Escalations: Quality Committee 13 October, Audit & Risk Committee 11 October, Safeguarding Committee 7 October Ratified Minutes: Audit & Risk Committee 19 July, Quality Committee 8 September, People & Culture Committee 20 September, Safeguarding Committee 15 April	**G**	Committee Chairs
11.	3:35	Safeguarding Children Annual Report	**H**	Carolyn Green
12.	2:45	Emergency Preparedness, Resilience, Response (EPRR) Annual Report	**I**	Mark Powell
3:15 B R E A K				
13.	3:15	Deep Dive – Full Service Record (FSR)	**J**	Mark Powell
GOVERNANCE				
14.	3:35	Governance Improvement Action Plan	**K**	Mark Powell
15.	3:45	Board Assurance Framework	**L**	Sam Harrison
16.	3:55	Measuring the Trust Strategy 2016-21	**M**	Lyn Wilmott-Shepherd
CLOSING MATTERS				
17.	4:05	Any Other Business	**-**	Richard Gregory
18.	4:10	2016/17 Board Forward Plan	**N**	Richard Gregory
19.	4:20	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	**-**	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 7 December 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
Margaret Gildea	Director, Organisation Change Solutions Limited Non-Executive Director, Derwent Living	(a, b)
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)
Caroline Maley	Director – C D Maley Ltd Trustee – Vocaleyes Ltd.	(a) (a, d)
Amanda Rawlings	Director of People and Organisational Effectiveness, Derbyshire Community Healthcare Services (DCHS) Co-optee Cross Keys Homes, Peterborough	(a, d)
Dr 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)
Dr Julia Tabreham	Non-Executive Director, Parliamentary and Health Service Ombudsman Director of Research and Ambassador Carers Federation Board member, RESTORE (supporting older offenders in the criminal justice system) Lay Member - National Institute for Health and Care Excellence, Guideline Development Group, National Collaborating Centre for mental Health of Adults in the Criminal Justice System	(a, d)
Maura Teager	Non-Executive Director – Ripplez social enterprise and NHS provider of the Family Nurse Partnership	(a)

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

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

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Wednesday, 5 October 2016

MEETING HELD IN PUBLIC

Commenced: 1pm Closed: 4:40pm

PRESENT:	Jim Dixon	Deputy Trust Chair and Non-Executive Director
	Caroline Maley	Senior Independent Director
	Maura Teager	Non-Executive Director
	Julia Tabreham	Non-Executive Director
	Ifti Majid	Acting Chief Executive
	Claire Wright	Executive Director of Finance
	Carolyn Green	Director of Nursing & Patient Experience
	Dr John Sykes	Executive Medical Director
	Mark Powell	Acting Chief Operating Officer
	Amanda Rawlings	Director of People & Organisational Effectiveness
	Samantha Harrison	Director of Corporate Affairs & Trust Secretary
IN ATTENDANCE:	Anna Shaw	Deputy Director of Communications & Involvement
	Sue Turner	Board Secretary and Minute Taker
APOLOGIES:	Richard Gregory	Interim Chairman
	Margaret Gildea	Non-Executive Director
VISITORS:	John Morrissey	Lead Governor
	Mark McKeown	Derbyshire Mental Health Alliance
	Melissa Castledine	Derbyshire Mental Health Alliance
	Dave Waldram	Member of the public

DHCFT 2016/147	**DEPUTY CHAIRMAN'S WELCOME, OPENING REMARKS AND APOLOGIES** In the absence of the Interim Chairman, Richard Gregory, Jim Dixon, Deputy Trust Chair and Non-Executive Director opened the meeting and welcomed everyone. Apologies were noted as above.
DHCFT 2016/148	**SERVICE RECEIVER STORY** Chris Kirk, Clinical Team Leader/Senior Nurse for CAMHS RISE (Child and Adult Mental Health Services Rapid Intervention Support and Empowerment) accompanied service receiver Lucy to the meeting who kindly agreed to speak to the Board about her experience of CAMHS (Child and Adult Mental Health Services). Lucy had been receiving support from CAMHS for a year and had been through a programme called 'Walking the Middle Path' that focusses on young people and their parents. Lucy explained her condition when she started the programme and the positive impact which that the programme has had to enable her and her family to learn skills and establish common ground. Being able to identify and understand herself and her parents'

	perspective has made an incredible difference to Lucy. Lucy is in her last year of her A levels and is looking forward to going to university next year and is now able to see a positive future ahead of her. She was extremely happy to be talking to the Board and sharing her experiences. She feels she is in a better place than she was before and is incredibly thankful to CAMHS and the Walking the Middle Path programme. Maura Teager commended Lucy for getting her hope back for her future and asked if there was anything she would like to change about the services that she had received. When Lucy first joined CAMHS she did not know too much about the service and was quite sceptical about taking part due to the stigma surrounding mental illness, but her foster parents encouraged her to attend the sessions. She felt that promotion and understanding of the CAMHS service needs to change to make individuals less fearful. Ifti Majid asked Lucy about support received through her school. Lucy acknowledged that her secondary school had a safeguarding team but felt that more could have been done to support her. Carolyn Green asked Lucy what advice the Trust could give to the safeguarding teams in schools to help them in supporting others. In response Lucy said they should take young people's concerns seriously and make them feel they are being listened to. Carolyn Green explained to Lucy that the Trust wants to integrate mental health and physical health. Lucy felt that integrating mental health and normalising mental illness is a good idea as coming to terms with her mental health issues had been difficult because it was seen as very separate from other health areas. Members of the Board were very impressed by Lucy's articulate explanation of her story and the messages they heard about listening to young people and would certainly reflect on the way some of the Trust's services are promoted so they emphasise the importance of focussing on the family. Jim Dixon thanked Chris and the CAMHS team for their achievements in helping young people with difficult issues. Members of the Board asked Lucy to keep them updated about her future and hoped she would stay involved in mental healthcare as they thought she was tremendous advocate of mental health services. **RESOLVED: The Board of Directors expressed thanks to Lucy for sharing her experiences and appreciated the opportunity to hear her feedback first hand.**
DHCFT 2016/149	**DECLARATIONS OF INTEREST** An additional declaration of interest was recorded in respect of Amanda Rawlings' joint role as Director of People and Organisational Effectiveness with Derbyshire Community Healthcare Services (DCHS).
DHCFT 2016/150	**MINUTES OF THE MEETING DATED 7 SEPTEMBER 2016** The minutes of the meeting held on 7 September were accepted and agreed as an accurate record of the meeting subject to the following amendments: The first sentence of the penultimate paragraph of item DHCFT 2016/137, the Deep Dive into Learning Disabilities – Commissioning Differently would be amended to read *'The Board considered action to be taken and heard through Carolyn Green that the case described above by Libby Runcie would be taken to Safeguarding Adults Board as a case study to the sub groups to explore the risks for Derbyshire patients'.* The final sentence of this item would also be amended to read *'Carolyn Green informed the Board that challenges around waiting times, caseloads, capacity, recruitment and dealing with people with an autism diagnosis that were also reported in the Deep Dive but not explored in detail would be addressed within the new sub group for performance and the*

	Performance Outcomes Group'. An action is to be added to the Security and Safety item listed under DHCFT 2016/143. *'Sam Harrison is to liaise with the chairman and Non-Executive Directors to assign a lead director to the security and safety NED lead role.'*
DHCFT 2016/151	**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 2016/152	**CHAIRMAN'S VERBAL REPORT** Jim Dixon, Deputy Trust Chair and chair of today's meeting did not give a verbal report.
DHCFT 2016/153	**ACTING CHIEF EXECUTIVE'S REPORT** The Board received Ifti Majid's report which provided 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. Ifti Majid advised the Board that collaboration work between the Trust and DCHS is continuing and this will result in the Strategic Options Case (SOC) being presented to the Board in confidential session on 27 October. The Board will then share the outcome of the SOC with the Council of Governors immediately after the meeting at a separate development session. Attention was drawn to the presentation received at the Trust's Medical Advisory Committee that showcased the good work around clinical variation associated with prescribing behaviours within the Trust. Ifti Majid gave his support to medical colleagues to involve themselves in these discussions as this will improve the consistency of practice leading to better outcomes for people who use the Trust's services. Ifti Majid thanked Jonny Benjamin for his opening address at the Annual Members Meeting held on 22 September. He was pleased to note that from questions received at the event that the commitment to supporting improvements in outcomes for all the groups of people the Trust works with remains very strong. He also wished to extend thanks from the Board to all the staff who worked so hard to plan for the event. The report also contained a note received from Sukhi Katkhars, a specialist highlighting the work of North Derbyshire's Liaison Team. Ifti Majid felt this was a great example of teams working together. Maura Teager concurred as she thought this statement was a good illustration of shared experience and how they managed their work and supported each other. Julia Tabreham referred to the Perinatal Mental Health Toolkit mentioned in the report. She hoped that the Trust could implement the diverse range of resources and learning the toolkit provides which would assist members of the primary care team to deliver the highest quality care to women with mental health problems during the perinatal period, and take advantage of the opportunities the toolkit provides for intervening earlier which would improve outcomes. Julia Tabreham also asked what plans were in place to evaluate the Health Education England support in meeting national targets to expand the workforce providing children and young people's mental health services. Ifti Majid explained that the Trust is already part of a Children's and Young People Improving Access to Psychological Therapy (IAPT) service but as North Derbyshire does not have an IAPT service, the IAPT team will share their working experience to support North Derbyshire and this will be reported on and progressed through the People and Culture Committee.

	Care issues around capacity and consent and the Mental Health Act were discussed as the Board was keen see an improvement with this issue. John Sykes pointed out that a bulletin had been issued to staff that sets out the structure and points of compliance with the Mental Health Act and the Mental Capacity Act that need to be reinforced. A report on compliance with both these Acts will be submitted to the Mental Health Act Committee in November. He expected that by 31 October the Trust should be able to see progress in these areas. In addition to this, John Sykes wanted to thank the Board for the investment made in the clinical skills tutor who has been appointed to ensure clinical staff were aware of their responsibilities under the Mental Capacity Act. A compliance dashboard will be used within the Mental Health Act Committee to monitor progress which he hopes can be factored into the Integrated Performance Report. **RESOLVED: The Board of Directors noted the contents of the Acting Chief Executive's report.**
DHCFT 2016/154	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT** The Board received the integrated overview of performance as at the end of August 2016 with regard to workforce, finance, operational delivery and quality performance. Mark Powell updated the Board on operational performance. He was pleased to provide assurance that breast feeding RTT (Referral To Treatment) target had improved from August's below target performance of 92%. NHS Improvement have asked the Trust to provide an exception report explaining how this can be brought back on target and Mark Powell and Carolyn Green are in the process of discussing the short term actions with clinical colleagues. It was pointed out that although the 18 week RTT target has not been met for two consecutive months the information for the end of September indicates we have achieved September's 18 week RTT. Claire Wright stressed the fact that maintaining performance of each month was important and Mark Powell gave assurance that he was working to ensure that sustainable plans will be in place. Caroline Maley referred to the amount of DNAs (Did not Attend Appointments) as this was above the target threshold for the second time in six months. It was noted that where mobile telephone numbers are recorded on PARIS (electronic patient record system) so that message reminders about appointments can be sent to patients, these will only prove to be effective if the mobile numbers held on file are current. It was agreed that outpatient administration processes will be looked at and Mark Powell will submit a report to the Finance and Performance Committee giving further detail regarding DNAs. Julia Tabreham asked if there is any kind of peer oversight or challenge around individual clinical efficiency and whether comparisons were made against clinicians' performance. Ifti Majid assured her that parameters are set and a dashboard of clinicians' performance can be found on CONNECT (the Trust's intranet). Safer Staffing was discussed and the Board was pleased to note that there was no longer a requirement for the Trust to carry out emergency planning measures regarding staffing levels. Claire Wright updated the Board on the financial aspect of the report. She was pleased to report that the Trust was still ahead of plan financially for the year to date and that she is expecting the Trust to meet its planned control total at the end of the year. Agency spend is a key pressure and this will impact on the Trust's risk ratings however it was highlighted that agency expenditure is being contained within the overall budget. Closing the Trust's CIP (Cost Improvement Plan) gap will be challenging and there is a need to resolve cost avoidance as soon as possible, and more proactive work is required to achieve this.

	In order to provide the Board and with assurance regarding agency spend, Mark Powell pointed out that the Programme Assurance Board had met and discussed agency spend on the low secure unit, IAPT and PICU (Psychiatric Intensive Care Unit) with regard to cost avoidance plans. He was pleased to report that from the agency spend point of view we are performing better than planned and he is confident there is a robust system in place to give a good understanding of the timeline of individual posts within the recruitment process. Mark Powell also ran through the CIP and cost avoidance issues which are a challenge currently. The Trust has delivered nearly half of the CIP so far and will continue to strive to recover the full year to date requirement. Julia Tabreham felt it necessary that CIP information is presented in a different manner in the public domain. It was proposed that a single page on the CIP within the Operational Performance Report would be valuable and will be included in future reports. Amanda Rawlings drew attention to the Workforce section of the report. She was pleased to point out that compulsory training remains on track, compliance remains high and is above the 85% main contract commissioning for quality and innovation (CQUIN) target. Monthly and annual sickness absence rates continue to rise and Amanda Rawlings is trying to understand how sickness is being managed in order to actively reduce the number of sickness absences. Carolyn Green took the Board through the Quality aspect of the report. The CQC (Care Quality Commission) report was received on 23 August following their inspection of the Trust in June and she was pleased to point out that the focus on fire warden training has shown as a 27% improvement in compliance since the warning notice was received earlier in August. Julia Tabreham commended Carolyn Green on the work she had put into this initiative since the CQC report was received which she had achieved with limited resources within a short timeframe. **ACTION: Mark Powell to submit a DNA report to the Finance and Performance Committee** **ACTION: Future Operational Performance Reports to include a single page covering CIP delivery.** **RESOLVED: The Board of Directors scrutinised the content of the report and obtained assurance on the current performance across the areas presented.**
DHCFT 2016/155	**<u>POSITION STATEMENT ON QUALITY</u>** Carolyn Green delivered her report which provided the Board of Directors with an update on the continuing work to improve the quality of the organisation's services in line with the Trust's Strategy, Quality Strategy and Framework and strategic objectives. Jim Dixon thanked Carolyn Green for leading the CQC preparation work which he understood was a huge undertaking for staff. He observed that Carolyn Green was already working with the same energy and enthusiasm in making improvements as she had in the preparedness work. **RESOLVED: The Board of Directors:** **1) Received the Quality Position Statement** **2) Gained assurance on its content**
DHCFT 2016/156	**<u>BOARD COMMITTEE ESCALATIONS</u>** Assurance summaries were received from the Audit and Risk Committee, Mental Health

	Act Committee and the Quality Committee which identified key risks, assurance and decisions made. Ratified minutes of the meeting of the People and Culture Committee held on 15 July were included for information. It was noted that the draft minutes of the meeting of the Quality Committee held on 8 September were included in error in place of the ratified minutes of the August meeting. **RESOLVED: The Board of Directors received the Board Committee escalations.**
DHCFT 2016/157	**NHSI SINGLE OVERSIGHT FRAMEWORK** Claire Wright presented her report which summarised the key elements and risk areas relating to the new NHSI oversight framework. She described how the new performance rating is assessed across quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability ratings and confirmed that the Trust's current performance against the various indicators will place the Trust in segment 3, which is for trusts that are in actual or suspected breach of their licence. She advised the Board that this rating will trigger a mandated support package from NHSI. Although this report was received mainly for information purposes, the Board familiarised itself with the framework and understood that it was not required to make a decision regarding the control totals framework at today's meeting. It was noted that performance against the framework will be a helpful addition to Board reporting as this will show how the oversight framework is used to establish risk areas. **RESOLVED: The Board of Directors:** **1) Scrutinised and became familiar with the new Single Oversight Framework** **2) Noted the key risk areas for this organisation and to consider the likelihood and implications of segmentation into segment 3** **Noted that they will receive information regarding any future updates or iterations of the framework**
DHCFT 2016/158	**NHS OPERATIONAL PLANNING AND CONTRACTING GUIDANCE 2016 - 2019** Mark Powell's report provided the Board with a summary of the recently published NHS Operational Planning and Contracting Guidance for 2017 – 2019. The timeline for delivery of the operational plan was noted along with the key points within the planning guidance. The Board considered that the implementation of the Trust's strategy and the current position of the STP (Sustainability and Transformation Plan) were clear drivers to deliver a coherent operational plan. It was agreed that corporate governance involvement in the operational plan by the Board will be covered during the November and December Board Development sessions to ensure there is a clear direction in the implementation of operational policies in the five year forward view. **ACTION: Operational Plan to be included in the Board Development programme for November and December.** **RESOLVED: The Board of Directors noted the key points within the operational planning guidance.**
DHCFT 2016/159	**EQUALITY AND DIVERSITY** Amanda Rawlings presented the Board with a summary of the Trust's position with regards to the equalities agenda and statutory compliance. The Board noted the Trust's position to date and that the detailed Equalities Action Plan 2016 – 17 addressed all issues as raised by the CQC during their inspection in June. It

	was agreed that the action plan could be included as evidence to assure the CQC that the Trust is complying with its equality and diversity obligations. **RESOLVED: The Board of Directors approved the Trust's Equalities Action Plan 2016 – 17 as set out in the report.**
DHCFT 2016/160	**<u>RECOVERY OUTCOMES</u>** Carolyn Green's report delivered a two year review of patient stories heard by the Board and the continuing work to improve the quality of the Trust's services. The Board reflected on the positive and difficult experiences that service users, children, families and staff had talked about when they had attended Board meetings to tell their stories, and the impact each account had upon the learning within the organisation as well as the important impact and value experienced by the Board when hearing these stories. Discussion took place as to how these stories can be used going forward and it was agreed that Carolyn Green would work with Anna Shaw and the Communications Team to establish a wider communication of the issues and the learning obtained from the stories. It was also suggested that a foreword written by service receivers could be included in the final publication of the recovery outcomes. The Board agreed that the analysis of the recovery outcomes would be repeated on an annual basis. It was proposed that future service user stories would include the perspective of the voluntary sector and other representative groups and should also include focus on experiences that have not been positive. **ACTION: Carolyn Green to work with Anna Shaw and the Communications Team on a wider communication of patient receiver stories and the learning obtained from each.** **ACTION: Review of Recovering Outcomes to be reflected in the forward plan on an annual basis.** **ACTION: Recovery stories will also consider and include the voice of the voluntary sector and other representative groups as well as carers' views. There will also be an increase in the number of children service stories, service receivers from the criminal justice and forensic services as well as individuals in primary care with regard to access to the service and/or the representation from IAPT services.** **RESOLVED: The Board of Directors** **1) Agreed to repeat this analysis at annual intervals and consider the voice of the voluntary sector and other representative groups in addition to service receivers and carers views.** **2) Agreed to increase the number of Children service stories to be more representative of the service provision** **3) Agreed to schedule the voice of the service receivers from the criminal justice and forensic services.** **4) Agreed to consider the voice of individuals in primary care with regard to access to the service and or the voice of representation from IAPT services.**
DHCFT 2016/161	**<u>GOVERNANCE IMPROVEMENT ACTION PLAN</u>** This paper presented by Mark Powell, provided the Board with an update on the progress of delivering the Governance Improvement Action Plan (GIAP). The Board discussed the areas rated as off track and areas that contained some issues and sought assurance on each. It was acknowledged that it is the responsibility of the

	Board Committees to mitigate actions through scrutiny and the executive director lead has ownership of each recommendation area. It was agreed that outstanding issues that did not capture the required mitigation within set time frames will be monitored and challenged by the respective Board Committee at each meeting and additional evidence will be provided against each action so that the Board can obtain the required assurance on each of these areas. The Board agreed that a six month review of the GIAP will take place by each Board Committee as set out in the paper (arising from recommendations in the Deloitte preliminary report on implementation of the GIAP) in order to establish an understanding of the BRAG (Board Assurance RAG Rating) and to demonstrate to the Board that these actions have been triangulated and can be signed off within the GIAP. Sam Harrison and Mark Powell will work with each Committee to ensure a consistent approach is applied. **ACTION: Each Board committee will conduct a six month review of their respective GIAP actions and demonstrate to the Board that these actions have been triangulated and can be signed off. Sam Harrison and Mark Powell will work with each Committee to ensure a consistent approach is applied.** **RESOLVED: The Board of Directors:** **1) Noted the progress made against the GIAP** **2) Discussed the areas rated as 'off track' and 'some issues', seeking assurance where necessary on the mitigation provided** **3) Discussed Deloitte's preliminary recommendations and agreed to the suggested 6 month review of GIAP as set out in this paper** **4) Agreed at the end of the Public Board meeting whether any further changes are required to the GIAP following presentation of papers, outcomes of item specific discussions and/or other assurances provided throughout the meeting**
DHCFT 2016/162	**<u>REPORT FROM COUNCIL OF GOVERNORS</u>** The Council of Governors met on 6 September. This report provided a summary of issues discussed and was noted by the Board. **RESOLVED: The Board of Directors noted the summary report from meeting of the Council of Governors**
DHCFT 2016/163	**<u>REVISION OF ENGAGEMENT WITH THE BOARD OF DIRECTORS AND COUNCIL OF GOVERNORS POLICY</u>** This paper set out a proposed policy that has been developed from reviewing best practice and incorporated comments arising from discussion by governors at the Governance Committee at its 6 June and 7 July meetings. The governors subsequently approved the policy at the Council of Governors meeting on 6 September for onward consideration by the Board of Directors. Sam Harrison explained that the policy outlined the process for engagement between the Board of Directors and Council of Governors, noting the good practice that had been established over recent months to build an effective and open working relationship. The Board reviewed and approved the revised policy, subject to the completion of the Equality Impact Risk Analysis and agreed that it would be reviewed on an annual basis and this would be reflected in the forward plan. **ACTION: Sam Harrison to complete the Equality Impact Risk Analysis** **ACTION: Policy for Engagement between the Board of Directors and Council of**

	Governors to be captured in forward plan on an annual basis. **RESOLVED: The Board of Directors:** **1) Approved the revised Policy for Engagement between the Board of Directors and Council of Governors** **2) Agreed to review the implementation of the policy on an annual basis to ensure that it is being effectively used to the satisfaction of both the Board and Council of Governors.**
DHCFT 2016/164	**ANY OTHER BUSINESS** **Electronic Patient Record:** Caroline Maley informed the Board that while attending quality visits she had observed that some areas within the Trust were not fully compliant with the Electronic Patient Record (EPR) system and suggested that the Board receives an update on progress of EPR across the Trust. The Board agreed that in order to address Caroline Maley's observation a deep dive would be held on the Trust's Full Service Record (FSR) at the November meeting. **ACTION: Full Service Record Deep Dive to be an agenda item for the November meeting.**
DHCFT 2016/165	**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 2016/166	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK OR GIAP** None were noted and the Board considered the Board Assurance Framework was up to date. All matters relating the GIAP were recorded in item DHCFT 2016/161 above.
DHCFT 2016/167	**BOARD PERFORMANCE AND CONTENT OF MEETING** Deputy Trust Chair, Jim Dixon considered that good discussions had been held during the meeting and urged Board members to contribute outside their areas of expertise as advised by Deloitte in their report. Achievements against the strategy would be made more visible and show how they are being performance managed. Board members were reminded that all acronyms are to be more clearly explained in reports.

The next meeting of the Board held in Public Session will take place at 1pm on Wednesday, 2 November 2016.

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

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - NOVEMBER 2016			Enc C
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
25.5.2016	DHCFT 2016/080	Deep Dive - Neighbourhoods	Claire Wright	Building requirements of Neighbourhood teams in STP developments and as part of the Estates strategy to be considered by Claire Wright.	2.11.2016	The next 6 monthly progress update of the Estates Strategy 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 2016/112	Acting Chief Executive's Report	Amanda Rawlings	Engagement programme to be received at the September Board meeting and by the Council of Governors	2.11.2016	Engagement Programme has since been deferred to November Board.	Yellow
27.7.2016	DHCFT 2016/113	Integrated Performance And Activity Report	~~Carolyn Gilby~~ Amanda Rawlings	Carolyn Gilby to check whether the Trust is an outlier with regard to grievances/dignity at work/disciplinaries	2.11.2016	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. 7.9.2016 This will now be progressed by Amanda Rawlings. 5.10.2016 Amanda Rawlings has carried out a detailed review and will make comparisons with other organisations.	Amber
7.9.2016	DHCFT 2016/143	Security and Safety (under AOB)	Sam Harrison	Sam Harrison is to liaise with the chairman and Non-Executive Directors to assign a lead director to the security and safety NED lead role	5.10.2016	Awaiting formal start of the two new Non Executive Directors to identify the most appropriate NED for this role	Amber
5.10.2016	DHCFT 2016/154	Integrated Performance And Activity Report	Mark Powell	Mark Powell to submit a DNA report to the Finance and Performance Committee	2.11.2016		Amber
5.10.2016	DHCFT 2016/154	Integrated Performance And Activity Report	Mark Powell Claire Wright	Future Operational Performance Reports to include a single page covering CIP delivery	2.11.2016	As evidenced by this month's Integrated Performance Report. ACTION COMPLETE	Amber
5.10.2016	DHCFT 2016/158	NHS Operational Planning & Contracting Guidance 2016 - 2019	Sam Harrison	Operational Plan to be included in the Board Development programme for November and December	2.11.2016	Operational plan now included in the Board Development programme and is on the agenda for November meeting ACTION COMPLETE	Green
5.10.2016	DHCFT 2016/160	Recovery Outcomes	Carolyn Green	Carolyn Green to work with Anna Shaw and the Communications Team on a wider communication of patient receiver stories and the learning obtained from each	2.11.2016	To be scheduled throughout the year as part of Board stories, action being undertaken.	Amber
5.10.2016	DHCFT 2016/160	Recovery Outcomes	Sam Harrison	Review of Recovering Outcomes to be reflected in the forward plan on an annual basis	2.11.2016	Forward Plan now captures Annual Review of Recovery Outcomes ACTION COMPLETE	Green

5.10.2016	DHCFT 2016/160	Recovery Stories	Carolyn Green	Recovery stories will also consider and include the voice of the voluntary sector and other representative groups as well as carers' views. There will also be an increase in the number of children service stories, service receivers from the criminal justice and forensic services as well as individuals in primary care with regard to access to the service and/or the representation from IAPT services	2.11.2016	Scheduled for November 2016	Amber
5.10.2016	DHCFT 2016/161	GIAP	Claire Wright Carolyn Green John Sykes Sam Harrison	Each Board committee will conduct a six month review of their respective GIAP actions and demonstrate to the Board that these actions have been triangulated and can be signed off. Sam Harrison and Mark Powell will produce a guide for the committees to review their respective GIAP actions to ensure a consistent approach is applied	2.11.2016	To be scheduled throughout the year as part of Board stories, action being undertaken	Amber
5.10.2016	DHCFT 2016/163	Revision of Engagement with the Board of Directors & Council of Governors Policy	Sam Harrison	Sam Harrison to complete the Equality Impact Risk Analysis	2.11.2016	Equality Impact Risk Analysis completed. ACTION COMPLETE	Green
5.10.2016	DHCFT 2016/163	Revision of Engagement with the Board of Directors & Council of Governors Policy	Sam Harrison	Policy for Engagement between the Board of Directors and Council of Governors to be captured in forward plan on an annual basis	2.11.2016	Policy for Engagement between the Board of Directors and Council of Governors reflected in forward plan for annual review and sign off in October ACTION COMPLETE	Green
5.10.2016	DHCFT 2016/164	AOB - Electronic Patient Record	Sam Harrison Mark Powell	Full Service Record Deep Dive to be included on the agenda item for the November meeting	2.11.2016	Full Service Record Deep Dive on agenda for November meeting	Green

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

Derbyshire Healthcare NHS Foundation Trust
Report to Public Board of Directors 2 November 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. The CQC's State of health and Adult Social Care in England 2016/16 was released during October. The report gives a detailed view of the trends, influences and pressures in care across England. As the report covers both care delivered in the NHS and Local Authorities it is able to note shifts in unmet need and the impact of this on both sectors. Some of the key messages include:

   - Most services are delivering safe, high quality care through caring staff but the system is under pressure due to increased demand, financial constraints and clinical complexity.

   - Clinical and care variation remains too great with gaps opening up for specific groups including those with protected characteristics.

   - Pressures are very high on Social Care, it is at 'tipping point' and this is having a resultant impact on health providers through more presentations at emergency departments, hospital discharge delays and reduced ability to maintain people at home.

   - The CQC has recognised that sustained system wide pressures coupled with staffing shortages have impacted on providers ability to achieve the triple aim of maintaining quality, improving efficiency and driving ongoing improvement.

   - Trusts rated 'requires improvement' find it the hardest to improve as they do not get the support those organisations in special measures get. Leadership and a focus on patient centred approaches seem to be the key in those RI Trusts who do rapidly improve.

   - The report makes it clear that those most successful Trusts are the ones who are able to collaborate with all parts of the health and social care system and are central to local STP development and delivery.

2. There has been much talk over the last few months about the impact of BREXIT on the financial and social economy of the UK. As a provider of healthcare it is essential

that whilst we don't enter into the political debate we should strive to understand the potential strategic impact on the health and social care provider sector. NHS Providers have produced a helpful guide that details government and political developments as well as considering the impact on the health and social care sector. NHS Providers have determined that the health and social care sector is likely to be impacted in the following key areas:

- Workforce
- Funding
- Competition and procurement
- Science and research
- Regulation of drugs and devices
- Public health
- Reciprocal health arrangements
- Health impact of policy change around areas such as immigration

For ease of reference I have attached this helpful document at appendix 1.

3. Not wishing to remind members of the Board that the summer has drawn to a close but NHS England has now launched their cold weather plan for 2016, *Protecting Health and Reducing Harm from Cold Weather.* The Cold Weather Plan for England is a framework intended to protect the population from harm to health from cold weather. It aims to prevent the major avoidable effects on health during periods of cold weather in England by alerting people to the negative health effects of cold weather, and enabling them to prepare and respond appropriately. There are 5 key recommendations to all local areas:

    - All local organisations should consider this document and satisfy themselves that the suggested actions and Cold Weather Alerts are understood across the system, and that local plans are adapted as appropriate to the local context.

    - NHS and local authority commissioners should satisfy themselves that the distribution of Cold Weather Alerts will reach those that need to take action.

    - NHS and local authority commissioners should satisfy themselves that providers and stakeholders will take appropriate action according to the Cold Weather Alert level in place and their professional judgements.

    - Opportunities should be taken for closer partnership working with the voluntary and community sector to help reduce vulnerability and to support the planning and response to cold weather.

    - Long-term planning and commissioning to reduce cold-related harm both within and outside the home is considered core business by health and wellbeing boards and should be included in joint strategic needs assessments and joint health and wellbeing strategies.

    Within our Trust we will comply with the guidance and ensure we have a robust cascade system in place for responding to the cold weather alert system.

Local Context

4. The Derbyshire footprint in along with the other 43 nationally has now submitted its 21 October checkpoint submission. This is by no means the final plan and we expect to continue developing business cases in the coming months. Importantly we are now awaiting clarification from NHS England on when we are able to commence local engagement and communications with stakeholders and the public. I anticipate being able to present a document to our next public Board meeting that clarifies the direction of travel identified within the STP submissions.

5. The collaboration work between ourselves and Derbyshire Community Healthcare Services has now reached its first milestone. The Strategic Outcome Case was presented to a confidential Board of Directors meeting on 27 October 2016 and discussed at a private Board and Governors workshop immediately after. The Board has agreed to continue to develop proposals for closer alignment/partnership between our two organisations. Please see separate document for a more detailed update.

6. On 26 October I presented at and sat on a Q&A panel in Derby hosted by 38 degrees looking at the future of NHS services in Derby. The debate was lively and the passion from all involved was clear to see.

Within our Trust

7. During October I attended the Trusts Mortality Group chaired by Dr Paul Rowlands. The group examined data presented by the Southern Derbyshire Liaison Team based at Derby Teaching Hospitals. Key points to note included:

    - The impact and association of completed suicide with drugs and alcohol
    - The importance of Trust clinicians being notified quickly if a patient dies in primary care or other hospital
    - Counter to national evidence, locally there is a lower suicide rate for those people presenting at a weekend
    - The importance of understanding historical data in supporting changes to clinical practice and the benefit of having a research component in clinical teams.

8. I am delighted to inform the Board that following local system advertisement and a competency and values based interview, I have been able to appoint Lynn Wilmott-Shepherd as Acting Director of Strategic Development pending the standard employment check and a fit and proper persons' assessment.

9. On 19 October we had a '*Spotlight on Leaders'* session on engagement and how to be an engaging manager. The session created much discussion amongst managers present and I was struck by the synergies between our organisational values and those elements that make an engaging manager. Through some of the exercises we were clearly able to demonstrate the direct link between engaging managers and improved clinical quality for people who use our services. There is a clear link through to next month's session which is around improving personal and organisational

efficiency through use of Lean techniques.

10. Where I directly receive compliments from people who interact with our services I try to share them with the Board to add a further dimension to the information received through Board assurance processes. Last week I heard feedback from Dr Chris Scofield at Queens Medical Centre, Nottingham. Following the North Crisis Teams liaison with them about a patient he said ' *.I was impressed by the quality of assessment, communication, friendliness and how approachable and professional staff were when they made initial contact and afterwards when we continued liaising with them. He commented this approach was not something he was used to from services local to him'*. This sort of positive feedback is an essential component of teams continually learning and developing their services.

11. During October I attended a team meeting with the North Derbyshire Dales older Adult Team, part of the neighbourhood team covering Matlock and Bakewell. It was good to be able to have a direct conversation with staff about the collaboration work with DCHS and address some of the inevitable rumours head on. A couple of other themes from the conversation included:

    - The importance of the staff and clinical environment in delivering good quality care.
    - Some great examples of integration were shared by the team working closely with colleagues in both primary care and the local integrated care teams.
    - The benefits of closer working with colleagues from Derbyshire County Council.

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

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

Consultation

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**
Acting Chief Executive

BREXIT BRIEFING: OCTOBER 2016

OVERVIEW

This is the second of our regular briefings on key Brexit developments, this time covering:

1. Government and political developments:
    a. The Brexit timetable, process and approach
    b. The Labour Party on Brexit
    c. Stakeholder reaction
    d. Brexit architecture
2. NHS Providers analysis of the emerging implications of Brexit for the health and care sector

1. Government and political developments

A recurrent theme of this year's party conference season was uncertainty surrounding Brexit: when it will happen, the government's negotiating priorities and what Brexit really means. The Government began to put forward some answers to these questions, although the Opposition parties. Our full briefing on NHS Providers' conference activities is available separately.

a) The Brexit timetable, process and approach

- Prime Minister Theresa May broke with tradition and gave a speech on the first day of conference on Brexit, in addition to the leader's speech on conference's concluding day. In this speech she made three key announcements on the timing, process and priorities for Brexit.
- On timing, May set out that Article 50 of the Lisbon Treaty will be triggered by March 2017. Thereafter, the UK will have two years in which to negotiate the terms of its withdrawal from the EU, meaning that its membership of the EU should cease no later than March 2019. In confirming this deadline, May made clear that Parliament will not be consulted on triggering Article 50. This was on the basis that MPs voted six to one for the EU referendum to be held and that the outcome grants the Government a mandate to deliver Brexit.
- On process, the Prime Minister announced that the Government will lay a Great Repeal Bill before Parliament in the 2017/18 session. This legislation will, in effect, simultaneously repeal the 1972 European Communities Act, which makes EU law sovereign in the UK, and incorporate all EU law into UK law from the day that the UK leaves the EU. In doing so, it will make the UK Parliament the sovereign legislative body once again and enable this and future Governments to retain, amend or discard EU legislation.
- On priorities for Brexit, the Prime Minister has already stated the requirement to regain control over and reduce immigration. To this, she has since added the priority of repatriating sovereignty to the UK's Supreme Court, removing the UK from the jurisdiction of the European Court of Justice.
- Mrs May also made clear that that all four nations of the UK will leave the EU, ruling out the possibility of Scotland, Wales and Northern Ireland negotiating separately to remain in the EU.
- The Prime Minister has also been unwavering in stipulating that she will not be providing a running commentary on her negotiating strategy. A Commons debate was held on 12 October where the Government confirmed recognised that Parliament must play a full part in the UK's withdrawal from the EU, while also emphasising the need to balance accountability with necessary strategic confidentiality.

c) The Labour Party on Brexit

- During the Labour conference, newly re-elected leader Jeremy Corbyn set out that the party will resist a Brexit that is "at the expense of workers' rights and social justice", with the Opposition's key issues on Brexit being (1) employment, (2) environmental and social protection, and (3) access to the single market.
- Mr Corbyn has also made clear that he does not think immigration needs to be reduced, putting him at odds with his new shadow Brexit secretary, Sir Keir Starmer QC.
- Under pressure from the Opposition, the Government has conceded that Parliament will be able to debate plans for Brexit ahead of triggering Article 50. In pushing for parliamentary scrutiny of the Government's negotiations, Starmer and shadow foreign secretary Emily Thornberry have sent 170 questions to Brexit Secretary, David Davis, to try to elicit details.

b) Stakeholder reaction

- On the basis of the Government's stated negotiating priorities, the UK appears to be heading for a 'hard' Brexit, in which it will cease being a member of the single market. Pro-Leave figureheads suggest that the UK will continue to benefit from full, tariff-free access to the single market post-Brexit. In contrast, the Office for Budget Responsibility has suggested that a hard Brexit could cost the Treasury up to £66bn a year and see GDP drop by between 5.4% and 9.5%.
- The indications for a hard Brexit without major (and, at present, seemingly unlikely) concessions on the terms of EU membership, has affected the financial markets, with the value of the pound dropping significantly, though the indication that Parliament will play a formal role in scrutinising Brexit plans ahead of triggering Article 50 may have had a stabilising effect.
- Whilst some have suggested the Great Repeal Bill's announcement is an administrative necessity, others have pointed to its significance in giving Parliament a formal role in Brexit. With the majority of MPs having voted to remain in the EU and the Government not having a majority in the House of Lords, MPs could use the Bill as a means of influencing the Government's negotiating strategy and the Lords could significantly obstruct the Bill's passage . This latter action could see Mrs May pick up where her predecessor left off on the debate around the constitutional status of the House of Lords.

d) Brexit architecture

- A Brexit select committee will be set up, chaired by a Labour MP and comprising 21 members (11 Conservative, 5 Labour and 2 Scottish National Party). The size of the Committee – almost twice as large as a typical select committees– has been questioned by senior MPs and think tanks in terms of its likely effectiveness.
- The election for committee chairmanship will take place in late October. So far, former secretary of state for international development, Hilary Benn, has thrown his hat into the ring.
- The health select committee has announced a further inquiry on Brexit, intended to identify priorities for the health sector in Brexit negotiations. NHS Providers will be making a submission to the Committee later this month.

2. NHS PROVIDERS ANALYSIS OF EMERGING IMPLICATIONS OF BREXIT FOR THE HEALTH AND CARE SECTOR

This section provides an overview of NHS Providers' initial analysis of the potential implications of Brexit for the health and care sector[1], and reiterates NHS Providers' position where applicable. Those areas where the UK's

[1] Largely informed by the following AoMRC paper: http://www.aomrc.org.uk/news-and-views/maintaining-quality-standards-healthcare-uk-leaving-eu/

decision to remain a member of the single market or not is a determining factor in developments have been marked with an asterix.

Workforce*

Retention and recruitment of EU staff

An estimated 135,000 EU nationals work in health and social care, including 10% of its doctors and 5% of its nurses, making a swift commitment to existing EU nationals working within the NHS a priority for the sustainability of the system. Immediately after the referendum there were some reports of harassment of EU staff. Trusts have sought to counter these instances by emphasising the value of those staff and addressing bullying behavior. Health secretary Jeremy Hunt and NHS England's national medical director Professor Sir Bruce Keogh have publicly recognised the contribution of EU staff and highlighted the need for a 'secure' workforce. However, the Prime Minister has been more cautious, stating that reciprocal arrangements would need to be in place to protect UK nationals in Europe before the UK will guarantee the rights of EU citizens in the UK.

Working time directive and other safeguards for workers

The European working time directive limits the working hours of NHS staff to 48 hours per week, calculated over a period of 26 weeks, although doctors are allowed to opt out and work additional hours. It is seen by some to protect key rights for workers, and by others to be too inflexible. Withdrawal from Brexit may offer the opportunity for the UK to tailor legislation to the needs of the NHS, but as the working hours cap has been included in the junior doctors' new contract, it seems unlikely that we would start from a blank sheet of paper or that the Government would wish to be seen as undermining workers' rights. In addition, health and safety in the workplace will require due consideration.

Professional regulation and education

There are a range of issues relating to professional regulation, education and training which will require consideration, including the transferability of standards and language testing. Longer term, there are opportunities to strengthen national workforce planning and to maximise recruitment opportunities from within the UK and internationally. However, it seems likely the NHS will wish to continue recruiting from the EU in addition to other countries overseas.

NHS Providers' response

NHS Providers is working in partnership with a coalition led by NHS Employers (the Cavendish Coalition), to secure an urgent commitment to the right to remain for EU citizens within the NHS and care workforce, and to ensure the health and care sector continues to have access to recruit from the EU (as well as globally and by growing its domestic workforce). We are considering encouraging the coalition to press for firmer commitments from the Government such as indefinite leave to remain for Europeans working in the NHS in oder to recognise the importance of their contribution and to safeguard public health.

Funding

The Chancellor, Philip Hammond, confirmed that funding settlements will be set out in the Autumn Statement. The Government has also confirmed it will back EU funded projects signed off before the Autumn Statement until 2020 (even if the UK leaves the EU before this date). The Treasury will consider, on a case by case basis, guaranteed funding for projects signed off after the Autumn Statement but whilst the UK is still a member of the EU. The

guarantee will encompass EU funding for universities and researchers as well as for agricultural funding. It is estimated that the cost of this could be up to £6bn a year.[2]

Commentators[3] have sought to estimate the remaining funds available to government once the UK exits the EU, including whether the Leave campaign's commitment of additional funds for the NHS could be met.[4] Realistically, the Autumn Statement forms the next milestone in our understanding of the financial impact of Brexit on the NHS. The timetable for the planning round has been brought forward this year, indicating that national policy makers expect stability within the existing CSR settlement.

NHS Providers' response
Securing adequate funding for providers remains our key priority. We will wrap the potential implications of Brexit for the sector into our longstanding influencing programme to ensure that NHS providers are adequately funded to meet rising demand, meet quality and access standards, and invest in new models of care. Our parliamentary and departmental influencing programme in the run up to the Autumn Statement will emphasise the need for an honest conversation on the options available and a clear plan.

Competition and procurement*

The UK's withdrawal from the EU may enable review of how competition policy operates within the NHS, including the commissioner/provider split, the recent emphasis on 'collaboration' over competition in a market, and the application of the CMA regime. However, as 'competition and procurement law underpin access to markets and trade'[5] the NHS may still find itself implicated in a national approach reliant on the relationship which the UK negotiates with Europe.

If the Government wishes to adopt an explicitly different approach to competition for the NHS, more in line with current collaborative practice, it will need to secure parliamentary time to amend the 2012 Health and Social Care Act, amid the wealth of legislation which will require parliamentary scrutiny. The Government could amend the procurement rules (which emanate from Europe but are standalone UK legislation). Yet if the UK remains part of the single market, it will likely need to comply with existing rules around purchasing goods and services, both in order to protect easy access to trade for British business and to purchasing European goods and services.

With these complexities in mind, it might be that existing competition and procurement law remain intact.

NHS Providers' response
We are keen to explore the potential to extricate the NHS from the existing CMA regime. We will also seek clarity for commissioners and trusts with regard to the application of procurement law as Britain exits the EU.

Science and research

The UK is one of the largest recipients of research funding in the EU, securing 15.4% of funds in the current research round (Horizon 2020), around £1 billion annually.[6] The Chancellor's backing for projects approved prior to the Autumn Statement up to 2020 will alleviate some concerns, but a number of questions remain. For example,

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[2] https://www.gov.uk/government/news/chancellor-philip-hammond-guarantees-eu-funding-beyond-date-uk-leaves-the-eu

[3] http://www.telegraph.co.uk/news/2016/08/20/leaving-the-eu-could-cost-us-even-more-than-staying-in/

[4] Crudely, £17.8bn minus the £4.9bn rebate = £12.9bn

[5] Capsticks Brexit briefing circular (July 2016)

[6] NHS European Office submission to the health select committee hearing on the implications of the EU referendum for the NHS

relating to whether this commitment is enough, flexibility for individuals to work across European boundaries, and the potential gap left by EU regulations on issues such as clinical trials and data sharing. There are also likely to be various options for the UK to secure 'associate' member status and remain a player in European research.

NHS Providers' response
We will keep a watching brief on the impact of Brexit on funding available for investment in research and innovation. Given our need to prioritise, this is an issue that we would be keen to take up in a wider partnership with others.

Regulation of drugs and devices*

The regulation and registration of medicines and devices is harmonised across Europe, heavily reliant on regulations and directives via the European Medicines Agency. The AoMRC has raised concerns about the UK's participation in European-wide approval scheme for medicines as well as losing access to the EU Clinical Trials Database and networks. Given the pressure on NHS budgets, a priority will be to ensure that any changes do not increase the costs of medicines and drugs due to administration or fees.

Public health

Evidently disease epidemics and infection do not respect international boundaries and there will be a need to sustain collaborative public health arrangements. Commentators have flagged the need to maintain, or replace, regulation for food safety, air, water and environmental quality, health in the workplace and employment conditions. Many are keen to protect the UK's participation in the European Centre for Disease Control.

Reciprocal health arrangements*

Approximately 2 million UK citizens live, work and travel in the EU. Clarification on the continuation of reciprocal health arrangements (EHIC) is therefore essential. Potential implications for the NHS include the return of a large number of ageing ex-pats from the EU with complex care needs, and the question of rolling out the approach to charging for visitors and migrants recently introduced by the Government for those outside of the EEA.

Wider social and economic policy

The UK's stance on immigration, and changes to the funding arrangements for projects affecting transport, employment, leisure, education and industry all have the potential to impact on health inequalities in the UK.

The response of the pharmaceutical industry, and other NHS suppliers, to the Brexit decision could have a significant impact on employment opportunities within the UK, as well as the smooth supply of drugs and devices to the NHS. Industry will likely see risks in a reduction in harmonisation via EU regulation, as well as potential benefits in the prospect of a new market within the UK. Early signs suggest some see the UK market as attractive regardless of the decision to leave the EU.[7]

[7] JMC Partners Brexit briefing circular, 1.07.16

Contact: Sally Percy, external affairs advisor sally.percy@nhsproviders.org

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 2 November 2016

Integrated Performance Report Month 6

Purpose of Report

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

Recommendations

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

Executive Summary

The Trust continued to deliver good performance against many of its key indicators across September Challenges have though continued to be evident across all 4 domains of performance during month 6.

This Executive Summary provides an overview of the some of the key issues during the month, assurance in a number of challenged areas and a forward look of some future risks and/or issues Board members need to be aware of.

Quality Performance

Board members will note that the quality section of the Integrated Performance report continues to be expanded to cover a greater breadth of quality indicators. In addition, existing ward staffing information has been supplemented with average bed occupancy figures to provide further information to support discussion about each service area.

A significant amount of time and effort has been invested in addressing the issues arising from the Trust's recent Care Quality Commission (CQC) inspection report. Clinical and operational teams, led by the Director of Nursing and Patient Experience have been working on delivering the actions resulting from the CQC warning notice, CQC comprehensive report, as well as the on-going improvements required to improve patient care. A number of the Trust's Committees received assurance on CQC plans.

Some of the key areas of focus have been on:

- Improving Fire warden training compliance in Campus teams which has seen a sustained improvement and is referenced in the quality dashboard
- Safeguarding children's training at Level 3, resulting in increased improvement. The Children's team have particularly focused on this area and changes to the supervision policy to gain additional support for the Safeguarding children's unit.
- Capital funding reallocation to meet CQC priority areas.
- Ensuring that supervision and appraisals are recorded.

- Developing reports on the capacity of teams such as Care co-ordination, Psychology, Paediatrician access/ waiting time and Speech and Language waiting list, management and associated mitigation plans, to be presented to the performance, contract and operational group.

The integrated approach to the management of CQC actions continues to strengthen the one team approach to our organisational effectiveness. The use of CQC portal 1 and CQC portal 2 action tracker has enabled an integrated approach to managing competing priorities and there continues to be extensive activity across all service lines to focus on environmental, clinical, policy and organisational governance priorities.

Operational Performance

Overall performance remains relatively stable, with all NHSI indicators being achieved. There are a number of areas where performance remains variable, with further detail provided in the main body of the report.

During the last month the Acting Chief Operating Officer has begun a process to review performance in a number of key and challenging areas to ensure that adequate mitigation plans are in place. This is to ensure that the Trust is able to deliver against the expectations that it has set itself, but to also fully understand the reasons why performance, may at times, fall below set thresholds. This work will inform how assurance is provided to Board members through the Integrated Performance report over the course of the coming months.

In recognition of the capacity that is currently available across all teams, and the need to prioritise resource towards addressing CQC action planning, the focus in the last month has been limited to seeking greater clarity and assurance on the following key performance indicators.

- 18 Week Referral to Treatment
- Early intervention in Psychosis Referral to Treatment within 14 days
- Improving Access to Psychological Therapies (IAPT)

Clear action plans for each of these have been requested and will be presented to the Trust's Performance, Contract and Operational Group (PCOG) on the 31st October for wider discussion and approval. The plans will continue to be monitored via PCOG to ensure that variations in performance are understood and adequately managed.

In addition, a further set of analysis has been commissioned in the following areas to better understand the issues driving performance in them.

- Outpatient Clinic Trust Cancellations
- Outpatient Clinic Do Not attend (DNA's)
- Breastfeeding rates

The analysis for these areas will be presented to December's PCOG meeting to enable a better understanding of the issues, which will result in greater clarity on the actions that are required, and by whom, to improve performance.

Financial Performance

Overall there is a 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 Cost Improvement Programme which is behind plan year to date.

Board members need to be aware of emerging financial risks that are being quantified and are currently only incorporated into the worse-case forecast. The Board should be aware that it is likely that in month 7 some of these may crystallise and become part of the likely case forecast. These additional risks include not fully closing the CIP gap, the possibility of income being removed by Commissioners, additional transactional costs, additional agency costs and backdated pay related to outstanding job evaluations.

<u>People Performance</u>

A recent key concern for the Trust has been the difficulty in recruiting to registered nurse vacancies. From July to September there has been a small improvement in this staff group, with a net improvement of circa 10 whole time equivalents. Whilst this is only a small change it is an upward trajectory following a number of months where the trajectory has been downward. In addition, two posts have been approved for the HR team to add capacity to speed up the recruitment process. These are expected to be in post before the end of November.

During the last month greater focus and scrutiny has been placed on better understanding the Trust's agency spend and the actions that are being delivered to address this.

A weekly Executive led meeting started on 10th October, reviewing a number of issues associated with agency spend including, information provision, policy and process, wage rates and the case of need for all medical agency posts.

The meeting on 17 October reviewed all agency medical spend line by line to fully understand the case of need, status of recruitment processes, wage rates and how these factored in to Trust wide financial planning. Through this governance process it was confirmed that forecast medical agency spend for 2016/17 is not likely to reduce by the end of the year due to in sufficient applications for some posts and interview panels not being scheduled until December for those posts where there has been applications.

At this stage the weekly meeting remains very transactional and needs to become much broader with a greater focus on workforce planning and long term service sustainability.

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 provides assurance across several BAF risks related to workforce, operational performance, quality performance, financial performance and regulatory compliance.

Consultation

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

Governance or Legal Issues

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

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

Equality Delivery System

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

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

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

Highlights

- FSRR (based on current metrics) on plan and forecast on plan for year end
- Surplus ahead of plan year to date 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
- Containment of agency expenditure
- Single Oversight Framework - Segmentation in segment 3

Highlights

- 18 week incomplete RTT compliance has been achieved (Q2 not achieved however no NHSi breach)

Challenges

- % 10-14 day and 6-8 Week Breastfeeding coverage has declined
- 10 day outpatient letter target has been breached due to a software issue
- Clustering of patients
- Outpatient Cancellations and DNAs

Highlights

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

Challenges

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

Highlights

- No of episodes of: seclusion, absconsion and falls on inpatient wards has decreased compared to the previous quarter
- No of recorded compliments is increasing
- 100% of CTO rights forms have been completed in older adult services
- Compliance with fire Warden training has increased to 91%

Challenges

- No of incidents of physical restrain, t patient on staff physical assault has increased compared to the previous quarter
- Level 3 safeguarding training and Think! Family training targets remain challenging
- Receipt of CTO rights and seclusion forms by the MHA office remain below target
- No of concerns has significantly increased compared to previous year average, outstanding actions following complaint investigations remains high

FINANCIAL OVERVIEW – SEPTEMBER 2016

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Governance	Financial Sustainability Risk Rating (FSRR)	Overall Financial Sustainability Risk rating	YTD	4	4	G		As at the end of September the FSRR is 4 which is in line with 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. The ratings quoted are under the Risk Assessment Framework. This will be replaced by the new Single Oversight Framework with effect from 1st October and will result in different ratings and segmentation of providers. We have been shadow segmented in segment 3.
			Forecast	4	4	G		
		Debt Service Cover	YTD	3	3	G		
			Forecast	3	3	G		
		Liquidity	YTD	4	4	G		
			Forecast	4	4	G		
		Income and Expenditure Margin	YTD	4	4	G		
			Forecast	4	4	G		
		Income and Expenditure Margin Variance	YTD	4	4	G		
			Forecast	4	4	G		
	Single Oversight Framework	NHS I Segment	YTD	n/a	3	n/a	n/a	
I&E and profitability	Income and Expenditure	Control Total position £'000	In-Month	360	193	R		The Control Total shows the position including the Sustainability Transformation Fund (STF) and the Underlying Income and Expenditure position excludes the STF. Surplus is worse 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	977	1,647	G		
			Forecast	2,531	2,531	G		
		Underlying Income and Expenditure position £'000	In-Month	291	124	R		
			YTD	562	1,232	G		
			Forecast	1,701	1,701	G		
		Normalised Income and Expenditure position £'000	In-Month	291	99	R		
			YTD	562	1,056	G		
			Forecast	1,701	1,988	G		
	Profitability	Profitability - EBITDA £'000	In-Month	963	781	R		
			YTD	4,634	5,162	G		
			Forecast	9,806	9,705	R		
		Profitability - EBITDA %	In-Month	8.4%	7.0%	R		
			YTD	6.7%	7.7%	G		
			Forecast	7.1%	7.3%	G		
Liquidity	Cash	Cash £m	YTD	11.843	13.188	G		Cash is currently above plan but is forecast to be below plan at year end due to the forecast release of some provisions. Capital is slightly behind plan YTD but is forecast to fully spend by the end of the financial year.
			Forecast	13.153	12.711	R		
	Net Current Assets	Net Current Assets £m	YTD	5.086	6.819	G		
			Forecast	7.570	5.779	R		
	Capex	Capital expenditure £m	YTD	1.459	1.136	R		
			Forecast	3.450	3.450	G		
Efficiency	CIP	CIP achievement £m	In-Month	0.358	0.184	R		CIP is currently behind plan and is forecast not to deliver the full plan at the end of the financial year. This is compensated for by other cost avoidance and underspends in the overall position.
			YTD	2.150	1.111	R		
			Forecast	4.300	2.901	R		
			Recurrent	4.300	2.051	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 – SEPTEMBER 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%	95.24%	G	↓	Compliant with all NHSI targets.
			Quarter	95.00%	96.21%	G	↓	
		CPA Reviews in Last 12 months	Month	95.00%	95.22%	G	→	
			Quarter	95.00%	95.22%	G	→	
		Delayed Transfers of Care	Month	7.50%	2.53%	G	→	
			Quarter	7.50%	2.54%	G	→	
		Data completeness - Identifiers	Month	97.00%	99.43%	G	→	
			Quarter	97.00%	99.43%	G	→	
		Data completeness - Outcomes	Month	50.00%	93.65%	G	→	
			Quarter	50.00%	93.65%	G	→	
		Community Care Data Activity - Completeness	Month	50.00%	93.53%	G	→	
			Quarter	50.00%	93.38%	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%	75.16%	G	↓	
			Quarter	50.00%	76.32%	G	↓	
		18 Week RTT incomplete	Month	92.00%	92.73%	G	→	
			Quarter	92.00%	93.47%	G	↓	
		Early Interventions New Caseload	Month	95.00%	153.60%	G	↓	
			Quarter	95.00%	153.60%	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%	98.01%	G	↓	
			Quarter	95.00%	99.30%	G	→	
		IAPT RTT within 6 weeks	Month	75.00%	84.72%	G	↓	
			Quarter	75.00%	87.43%	G	↓	
		Early Intervention in Psychosis RTT Within 14 Days	Month	50.00%	55.17%	G	↑	
			Quarter	50.00%	55.45%	G	↓	

Key:

Period

Month Current Month

Quarter Current Quarter

Achieving target

Not achieving target

Trend compared to previous month/quarter

OPERATIONAL OVERVIEW – SEPTEMBER 2016

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Locally Agreed	CPA Settled Accommodation	Month	90.00%	96.42%	G	→	The majority of clinicians now successfully manage their PbR caseloads either independently or through positive engagement with available support. There have been challenges with 5 patients follow-ups in September.
			Quarter	90.00%	96.42%	G	→	
		CPA Employment Status	Month	90.00%	97.31%	G	→	
			Quarter	90.00%	97.31%	G	→	
		Data completeness - Identifiers	Month	99.00%	99.43%	G	→	
			Quarter	99.00%	99.43%	G	→	
		Data completeness - Outcomes	Month	90.00%	93.65%	G	→	
			Quarter	90.00%	93.65%	G	→	
		Patients Clustered not Breaching Today	Month	80.00%	79.92%	R	→	
			Quarter	80.00%	80.71%	G	→	
		Patients Clustered regardless of review dates	Month	96.00%	94.76%	R	→	
			Quarter	96.00%	94.94%	R	→	
		7 Day Follow-up - all inpatients	Month	95.00%	94.87%	R	↓	
			Quarter	95.00%	95.62%	G	↓	
		Ethnicity coding	Month	90.00%	91.38%	G	→	
			Quarter	90.00%	91.38%	G	↓	
		NHS Number	Month	99.00%	99.98%	G	→	
			Quarter	99.00%	99.98%	G	→	
	Schedule 4	Consultant Outpatient Trust Cancellations	Month	5.00%	7.02%	R	→	The main reasons given for cancellation were consultant sickness, annual leave, having to attend an inquest and junior doctors on nights. The rate of DNAs was above the target threshold once again. Where mobile numbers are recorded on Paris we send out text message reminders, however these will only prove to be effective if the mobile numbers held on file are current.
			Quarter	5.00%	6.71%	R	→	
		Consultant Outpatient DNAs	Month	15.00%	16.22%	R	→	
			Quarter	15.00%	16.14%	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%	85.98%	R	↓	
			Quarter	90.00%	88.89%	R	↓	
		Outpatient letters sent in 15 working days	Month	95.00%	96.01%	G	↑	
			Quarter	95.00%	95.34%	G	→	
		Inpatient 28 day readmissions	Month	10.00%	9.24%	G	↓	
			Quarter	10.00%	6.01%	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%	99.66%	G	→	

OPERATIONAL OVERVIEW – SEPTEMBER 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 Quarterly incomplete RTT where underperformance in previous months has had a impact on the Quarterly position.
			Quarter	0	0	G	→	
		18 Week RTT incomplete	Month	92.00%	92.95%	G	↑	
			Quarter	92.00%	91.09%	R	↓	
		Mixed Sex accommodation breaches	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Completion of IAPT Data Outcomes	Month	90.00%	95.55%	G	→	
			Quarter	90.00%	95.58%	G	→	
		Ethnicity coding	Month	90.00%	91.18%	G	↑	
			Quarter	90.00%	90.91%	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%	97.41%	R	↓	Coverage can be attributed to low staffing levels, a changing service and no Infant Feeding Co-ordinator in post; a result of not being able to
			Quarter	98.00%	99.30%	G	→	
		% 6-8 Week Breastfeeding coverage	Month	98.00%	97.84%	R	→	
			Quarter	98.00%	98.05%	G	↓	
	IAPT	Recovery Rates	Month	50.00%	52.18%	G	↓	
			Quarter	50.00%	53.57%	G	→	
		Reliable & Recovery Rates	Month	65.00%	70.02%	G	↓	
			Quarter	65.00%	72.67%	G	↑	
	Safer Staffing	Inpatient Safer Staffing Fill Rates	Month	90.00%	102.4%	G	↑	Detailed ward level information shows specific variances
			Quarter	90.00%	103.8%	G	→	

WORKFORCE OVERVIEW – SEPTEMBER 2016

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance		Trend	Key Points
Workforce Dashboard	NHSI Key Performance Indicator (KPI)	**Turnover** (annual)	**Sep-16**	10%	**11.25%**	↗	G	↑	Annual turnover remains within the Trust target parameters and is below the regional Mental Health & Learning Disability average of 12.65% (as at June 2016 latest available data). The monthly sickness absence rate is 0.19% lower compared to the previous month and it is also 0.20% lower than in the same period last year (September 2015). The annual sickness absence rate has decreased by 0.06%, to 5.77%. The regional average annual sickness absence rate for Mental Health & Learning Disability Trusts is 5.04% (as at May 2016 latest available data). Anxiety/stress/depression/other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 30.21% of all sickness absence, followed by Surgery at 10.22%, other musculoskeletal problems at 9.95% and Injury/Fracture at 7.80%. Vacancy rates have increased slightly by 0.32% compared to the previous month. The number of employees who have received an appraisal within the last 12 months has decreased by 0.41% to 65.88%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £992k of which £563k related to Medical staff. Compulsory training compliance has decreased this month by 0.97% but still remains above the 85% main contract non CQUIN.
			Aug-16		10.72%		G		
		Sickness Absence (monthly)	**Sep-16**	5.04%	**5.89%**	↘	R	↑	
			Aug-16		6.08%		R		
		Vacancies (including 10% funded fte cover)	**Sep-16**	10%	**16.92%**	↗	A	↓	
			Aug-16		16.60%		A		
		Vacancies (actual)	**Sep-16**	0%	**6.92%**	↗	A	↓	
			Aug-16		6.60%		A		
		Appraisals (all staff - number of employees who have received an appraisal in the previous 12 months)	**Sep-16**	90%	**65.88%**	↘	R	↓	
			Aug-16		66.29%		R		
		Appraisals (medical staff only - number of employees who have received an appraisal in the previous 12 months)	**Sep-16**	90%	**80.73%**	↗	R	↓	
			Aug-16		79.46%		R		
		Qualified Nurses (to total nurses, midwives, health visitors and healthcare assistants)	**Sep-16**	65%	**68.07%**	↘	G	↑	
			Aug-16		68.36%		G		
		Agency Usage (£ year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Sep-16**	£0	**£992k**	↗	R	↑	
			Aug-16		£809k		R		
		Agency Usage (% year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Sep-16**	0%	**65.30%**	↗	R	↑	
			Aug-16		63.90%		R		
	Other KPI	**Compulsory Training** (staff in-date)	**Sep-16**	90%	**89.26%**	↘	G	↓	
			Aug-16		90.23%		G		

Key:

Period Current month and previous month

Plan Trust target

↗ Variance to previous month

Achieving target/within target parameters

Approaching target/approaching target parameters

Not achieving target/outside target parameters

Trend based on previous 4 months

Turnover parameters (8% to 12%)

Vacancy parameters (10% to 20%)

QUALITY OVERVIEW – SEPTEMBER 2016

Enc E

Category	Sub-set	Metric (New indicators)	Period	Plan	Actual	Variance	Trend	Key Points
Quality	Safe	No of incidents of moderate to catastrophic actual harm	Month	24	28		NA	Plan: average last fin yr. No trend added as new indicator
			Quarter	73	83		NA	Plan: average last fin yr. Actual rolling 3 mth av.
		No of episodes where patients were held in seclusion	Month	NA	NA	NA	NA	Monthly seclusion episodes data available from next month
			Quarter	35	25			Plan: Q1 data. Actual: Q2 data
		No of incidents where patients were held in seclusion	Month	20	18			
			Quarter	61	60			
		No of incidents involving physical restraint	Month	55	33			
			Quarter	165	211			
		No of incidents involving prone restraint	Month	4	13	NA	NA	Prone restraint collected as defined field only from 1/4/16. Alert re data quality.
			Quarter	15	28	NA	NA	
		No of incidents of physical assault - patient on patient	Month	15	14		NA	
			Quarter	44	42		NA	
		No of incidents of physical assault - patient on staff	Month	20	13		NA	
			Quarter	61	81		NA	
		No of falls on in-patient wards	Month	38	23		NA	
			Quarter	113	84		NA	
		No of incidents of absconsion	Month	43	25		NA	
			Quarter	130	85		NA	
		No of patients with a clinical risk plan (FACE or Safety Plan)	Month	100%	80.56%		NA	
			Quarter	100%	80.36%		NA	
		Of above, no of patients with a Safety Plan	Month	90%	0.38%		NA	Early stage of implementation. Go live from 1/11/16.
			Quarter	90%	0.37%		NA	
		% of staff compliant with Level 3 Safeguarding Children training	Month	95%	61.96%			
			Quarter	95%	NA			Qtr comparison not available
		% of staff compliant with Think Family training	Month	95%	67.06%			
			Quarter	95%	NA			Qtr comparison not available
		% of staff compliant with Clinical Safety Planning eLearning	Month	95%	90.66%			
			Quarter	95%	NA			Qtr comparison not available
		% of staff compliant with Fire Warden training	Month	90%	91.70%			In-patient areas only
			Quarter	90%	NA			
		No of people with LD or Autism admitted without a CTR (Care & Treatment Review)	Month	0	1			
			Quarter	0	NA	NA	NA	

QUALITY OVERVIEW – SEPTEMBER 2016

Enc E

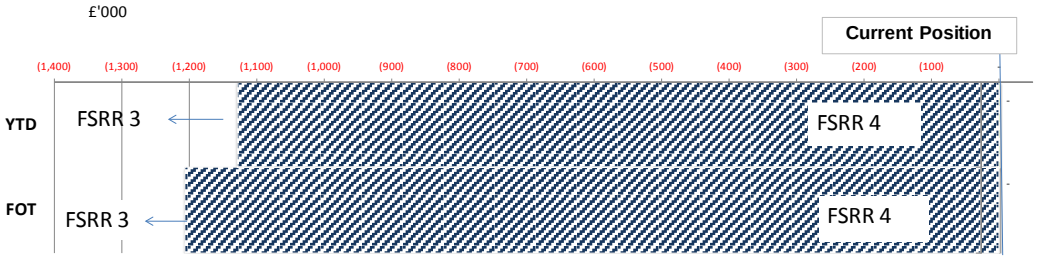
Category	Sub-set	Metric (New indicators)	Period	Plan	Actual	Variance	Trend	Key Points
Quality	Caring	No of complaints received	Month	9	9		NA	
			Quarter	26	39		NA	
		No of concerns received	Month	18	34		NA	
			Quarter	53	121		NA	
		No of compliments received	Month	72	97		NA	
			Quarter	217	292		NA	
		No of incidents requiring Duty of Candour	Month	2	1		NA	This figure will fluctuate based on the outcome of investigations.
			Quarter	8	1		NA	This figure will fluctuate based on the outcome of investigations.
	Effective	% of in-patients with a recorded capacity assessment	Month	100%	77%			
			Quarter	100%	NA	NA	NA	
		% of patients with a care plan in place, reviewed within last 12 months	Month	90%	95.29%		NA	
			Quarter	90%	95.79%		NA	
		No of seclusion forms not received by MHA Office	Month	0	NA	NA	NA	Monthly seclusion episodes data available from next month
			Quarter	0	10		NA	
		% of CTO rights forms received by MHA Office	Month	100%	75%		NA	Relates to whole cohort of patients
			Quarter	NA	NA	NA	NA	
		% of in patient older adults rights forms received by MHA Office	Month	100%	100%		NA	
			Quarter	100%	100%		NA	
	Responsive	% uptake of Flu Jabs by staff	Month	45%	26%			This is an estimated figure
			Year	45%	22.7%			Relates to 2015.16 campaign
		% of policies in date	Month	95%	91.5%		NA	
			Quarter	95%	99.3%		NA	
	Well Led	% of staff who have received Clinical Supervision, within defined timescales	Month	90%	31.93%			
			Quarter	90%	NA	NA	NA	
		% of staff who have received Management Supervision, within defined timescales	Month	90%	48.06%			
			Quarter	90%	NA	NA	NA	
		No of outstanding actions following serious Incident investigations	Month	0	0			
			Quarter	0	2			
		No of outstanding actions following complaint investigations	Month	0	44		NA	With operational teams to resolve
			Quarter	0	NA	NA	NA	
		No of outstanding actions following CQC comprehensive review report	164	0	108			86% of all the actions are either complete or in progress

Financial Section

Governance – Financial Sustainability Risk Rating (FSRR)

Enc E

The FSRR at the end of September is a 4 which is in line with plan. The forecast on the current metrics (as of end of September) continues to be a rating of 4 as per the plan.
The headroom down to a FSRR of 3 (current metrics) year to date and forecast is £1.1m 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	4	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**

Looking forward to next month when the new metrics within the Single Oversight Framework will come into effect, the performance for the last two quarters is shown below. It is important to note that the new metrics have been reversed and the best rating is a '1' as opposed to a '4'.
As part of the new framework Trusts are put into one of four segments which indicates their level of autonomy and regulatory support. We have been allocated a shadow segmentation of 3.

	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	2	2	2	2
Liquidity rating	3	4	4	4	1	1	1	1
I&E Margin rating	3	4	4	4	1	1	1	1
I&E Margin Variance rating	4	4	4	4				
Difference to plan					1	1	1	1
Agency distance to cap					1	3	1	2
FSRR	3	4	4	4	1	2	1	1

Income and Expenditure

Enc E

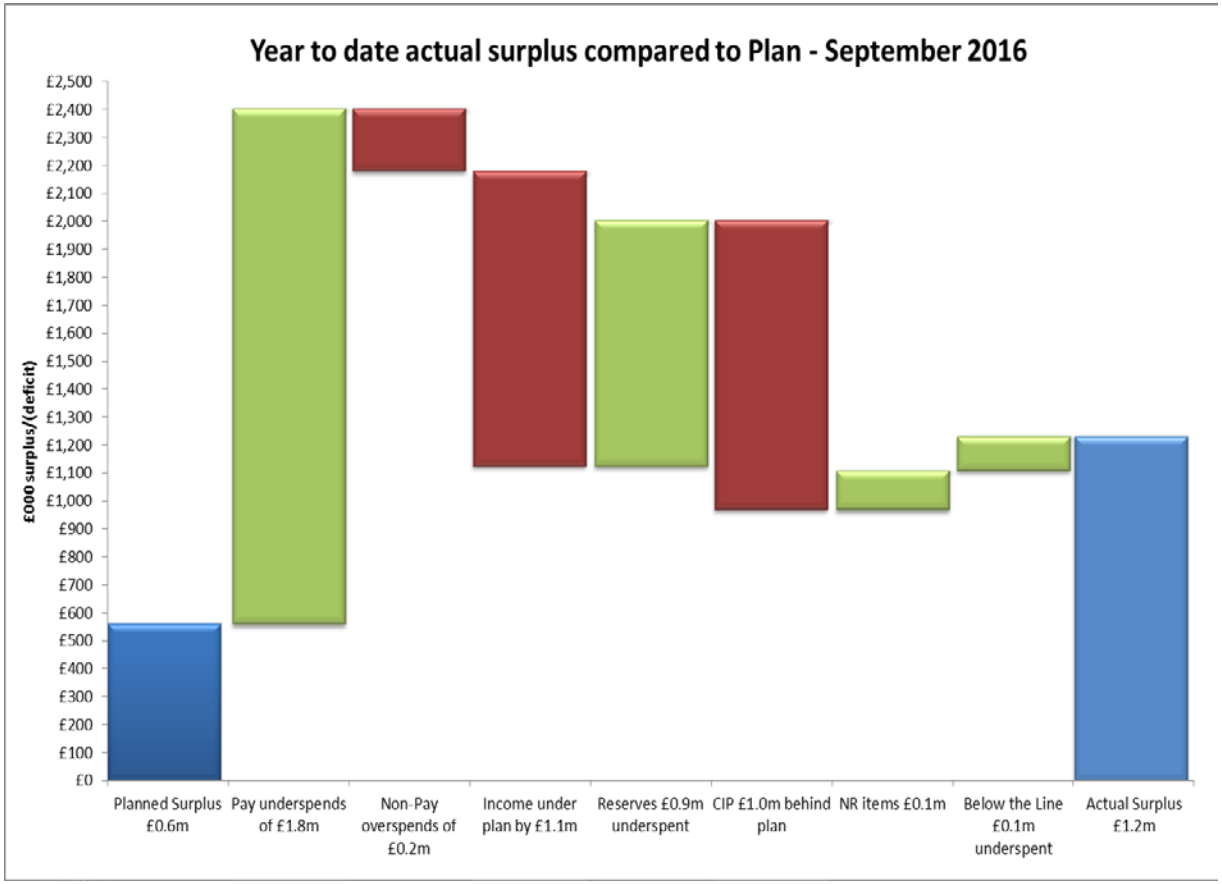
Statement of Comprehensive Income — September 2016

	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	10,654	10,362	(292)	63,559	61,978	(1,581)	127,406	124,345	(3,061)
Non Clinical Income	849	790	(59)	5,095	4,652	(443)	10,190	9,388	(802)
Employee Expenses	(8,376)	(8,048)	327	(50,948)	(48,166)	2,782	(101,492)	(96,838)	4,654
Non Pay	(2,164)	(2,322)	(158)	(13,072)	(13,301)	(230)	(26,298)	(27,190)	(892)
EBITDA	**963**	**781**	**(182)**	**4,634**	**5,162**	**528**	**9,806**	**9,705**	**(100)**
Depreciation	(295)	(271)	23	(1,767)	(1,631)	136	(3,534)	(3,452)	83
Impairment	0	0	0	0	(36)	(36)	(300)	(300)	0
Profit (loss) on asset disposals	0	0	0	0	0	0	0	0	0
Interest/Financing	(175)	(170)	5	(1,090)	(1,071)	19	(2,141)	(2,110)	30
Dividend	(133)	(146)	(13)	(800)	(813)	(13)	(1,600)	(1,613)	(13)
Net Surplus / (Deficit)	**360**	**193**	**(167)**	**977**	**1,611**	**634**	**2,231**	**2,231**	**(0)**
Technical adjustment - Impairment	0	0	0	0	(36)	(36)	(300)	(300)	0
Control Total Surplus / (Deficit)	**360**	**193**	**(167)**	**977**	**1,647**	**670**	**2,531**	**2,531**	**(0)**
Technical adjustment - STF Allocation	69	69	0	415	415	0	830	830	0
Underlying Net Surplus / (Deficit)	**291**	**124**	**(167)**	**562**	**1,232**	**670**	**1,701**	**1,701**	**(0)**

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

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

Clinical Income is £0.3m less than plan in month and is forecast to be £3.1m 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 less than plan in the month by £59k and has a forecast outturn of £0.8m behind plan. £0.4m relates to a miscellaneous income target with no income forecast against it.
Pay expenditure is £0.3m less than the plan in the month and the year end position is £4.7m 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 £158k and has a forecast outturn of £892k behind plan which mainly relates to Drugs and PICU expenditure.



Summary of key points Enc E

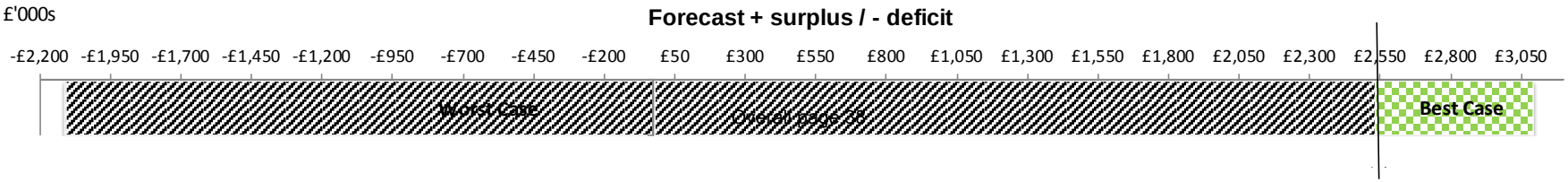
Overall favourable variance to plan year to date which is driven by the following:

- 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. There remains a large performance range from worst-case to best-case outturn which is primarily dependant on the mitigation of risks as well as factors such as recruitment, retention and agency expenditure levels.

Forecast Range

Best Case	Likely Case	Worst Case
£3.1m Surplus	£2.5m surplus	£2.1m deficit



Normalised Income and Expenditure position

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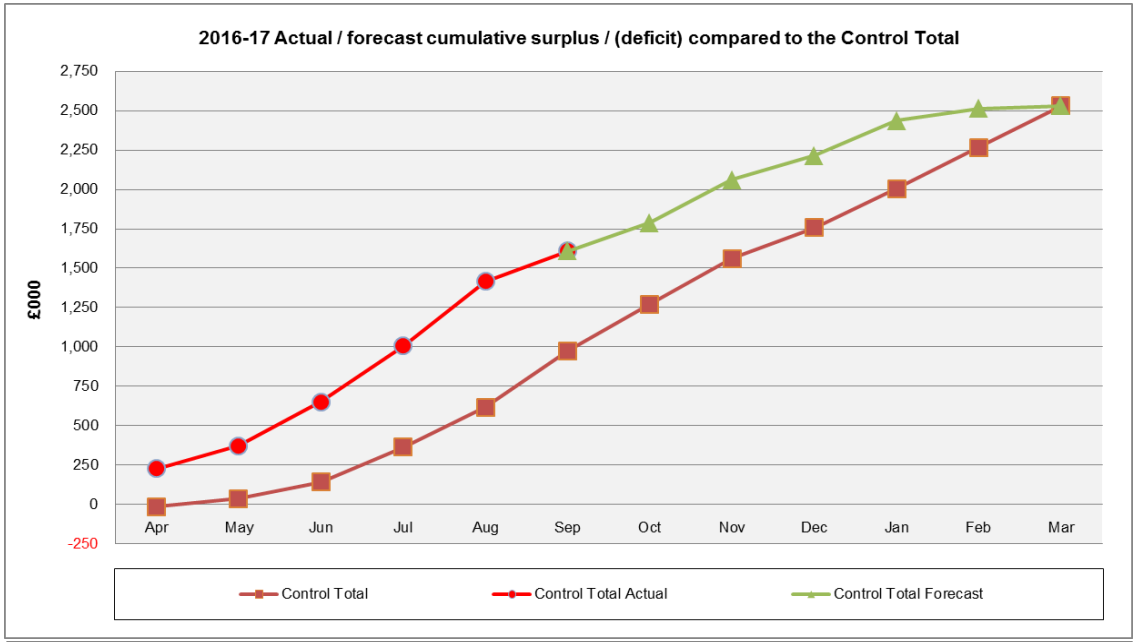
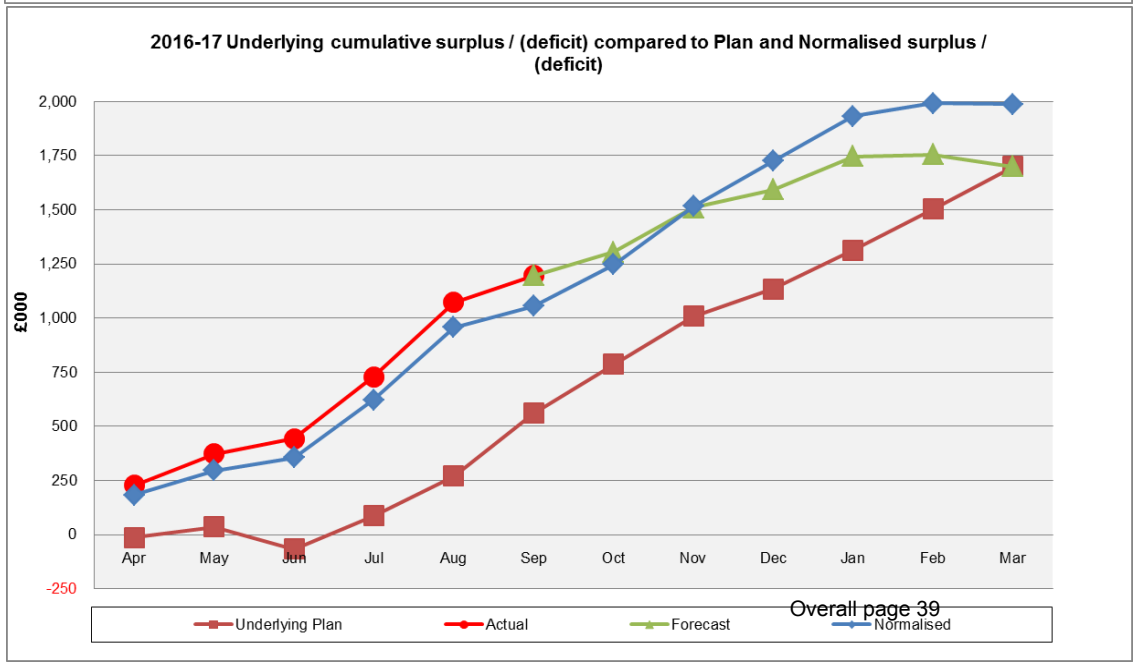




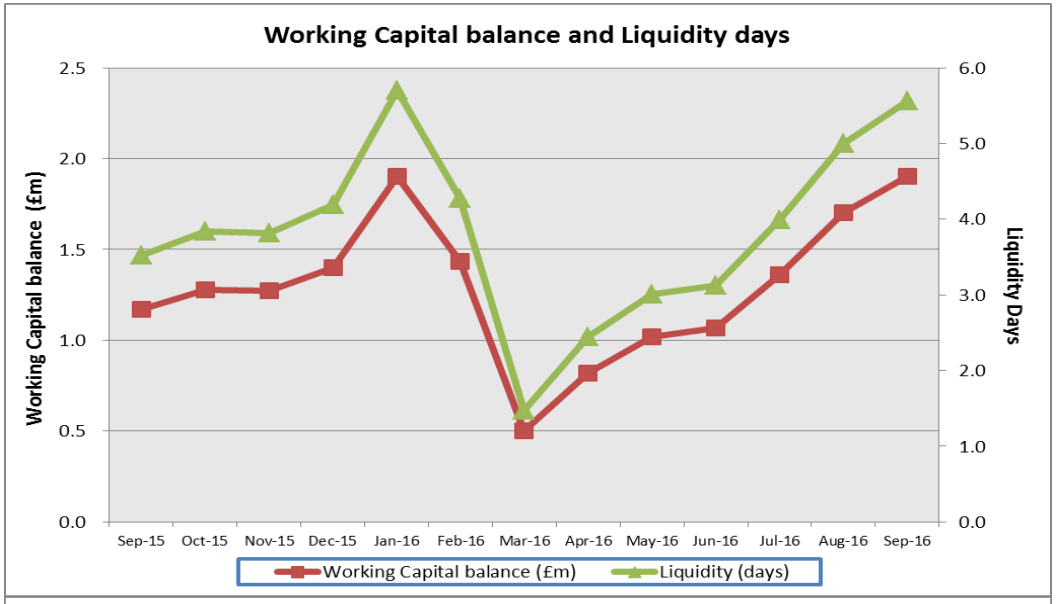
The first graph shows the actual and forecast cumulative surplus against the control total (including the Sustainability Transformation Fund (STF). The surplus is forecast to remain ahead of plan in the first part of the financial year and then slowly reduce back down to the planned control total.

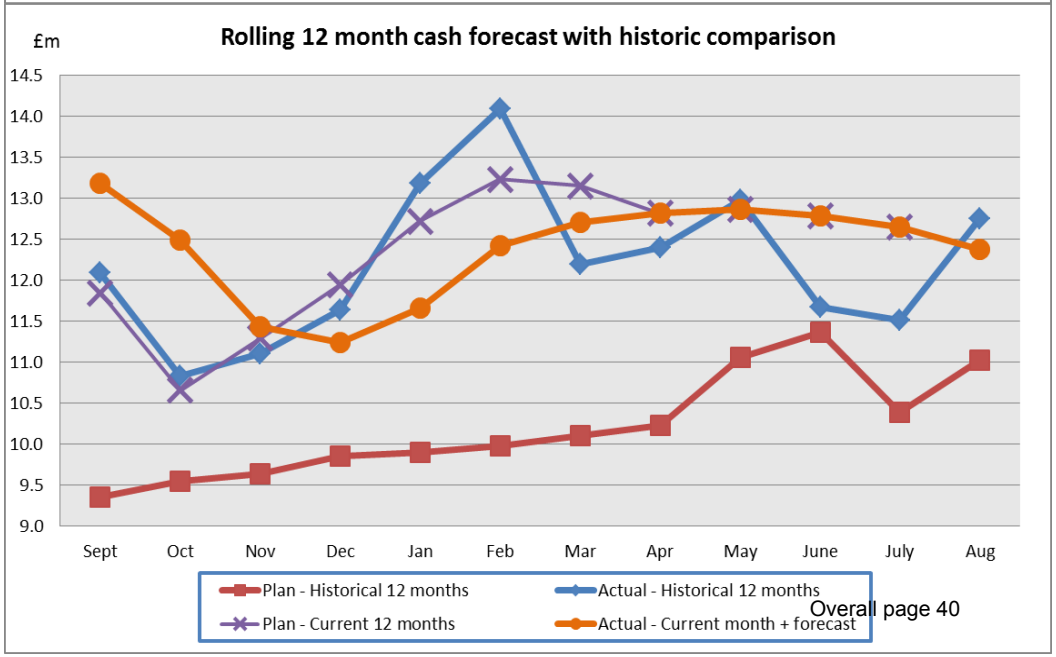
The second graph shows the underlying actual and forecast surplus against the underlying plan excluding the STF.

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 and additional resources. In the normalised position these have been removed.

Liquidity



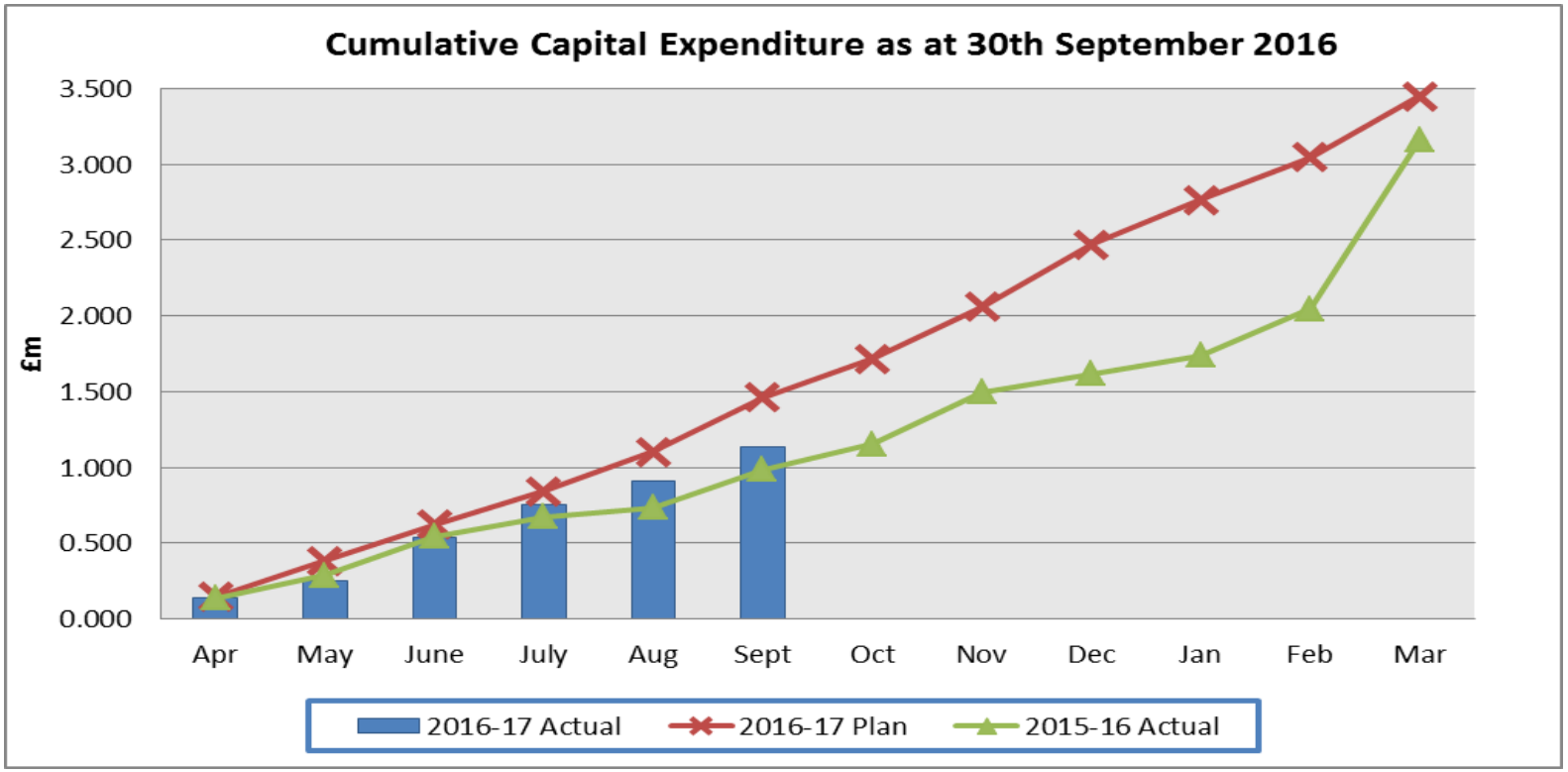


The first graph shows the working capital balance (net current assets less net current liabilities adjusted for assets held for sale and inventories) and how many days of operating expenses that balance provides.

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. September continues to show a further improvement up to 5.6 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.

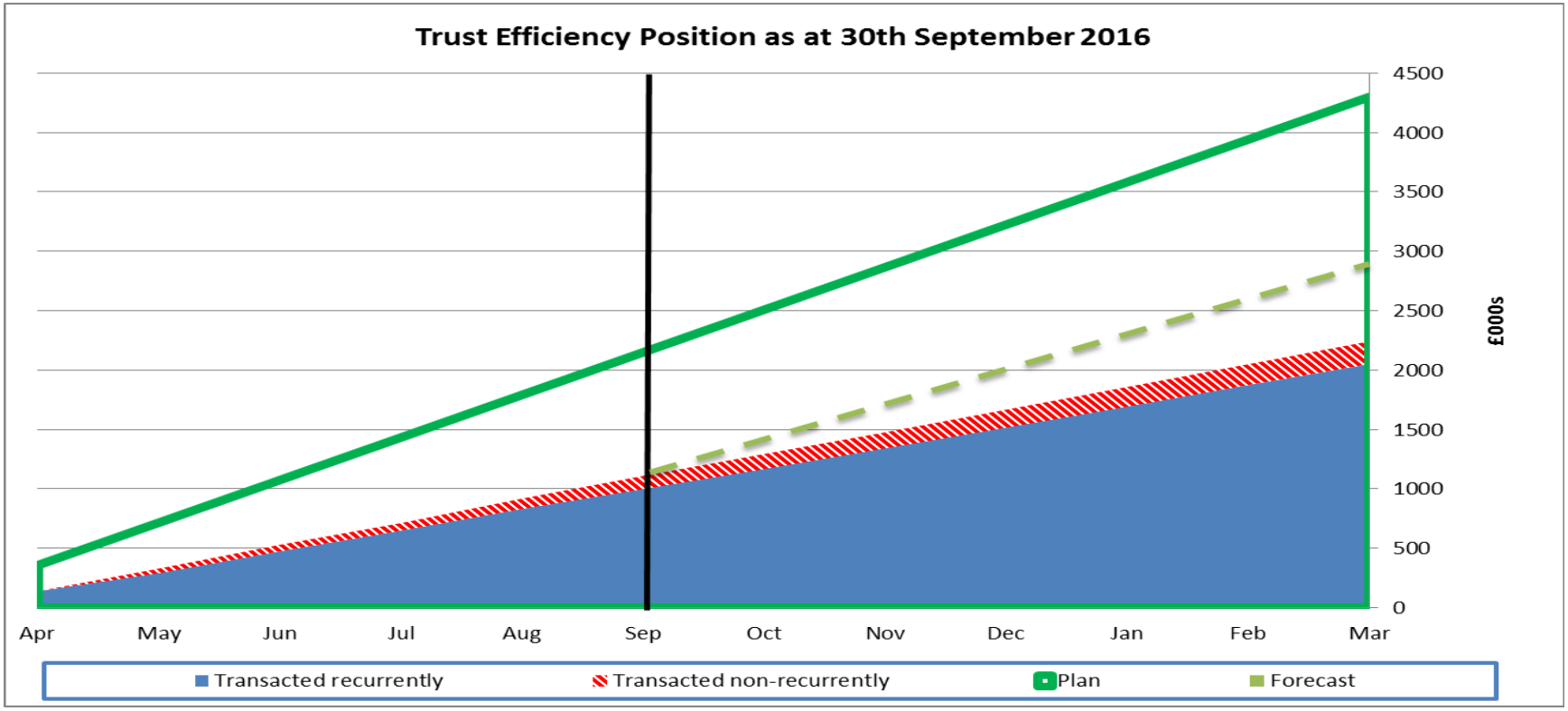
Cash is currently at £13.2m which was £1.3m better than the plan at the end of September. This is mainly driven by the Income and Expenditure surplus.



Capital Expenditure is £323k behind plan year to date but is forecast to spend to the plan of £3.45m by year end.

The 2016/17 schemes are regularly reviewed by Capital Action Team (CAT) including the reprioritisation to fund any new schemes. Some reprioritisation of schemes has already taken place to date this year in order to fund more urgent schemes. Capital Action Team members are currently collating a list of all CQC-related capital requirements in order to inform the prioritisation for the remainder of the year.

Cost Improvement Programme (CIP)



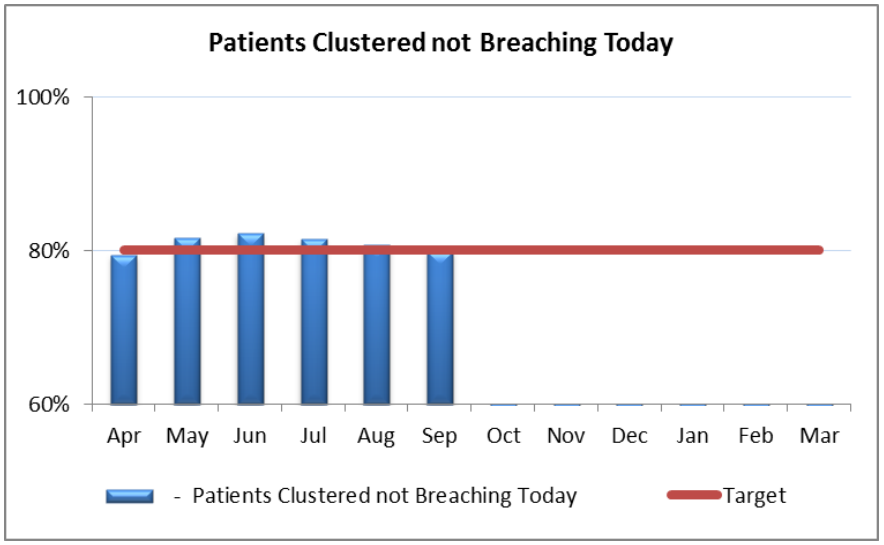
At the end of September there was a shortfall against the year to date plan of £1.039m. The full year amount of savings identified at the end of September reporting is £2.2m leaving a gap of £2.1m.

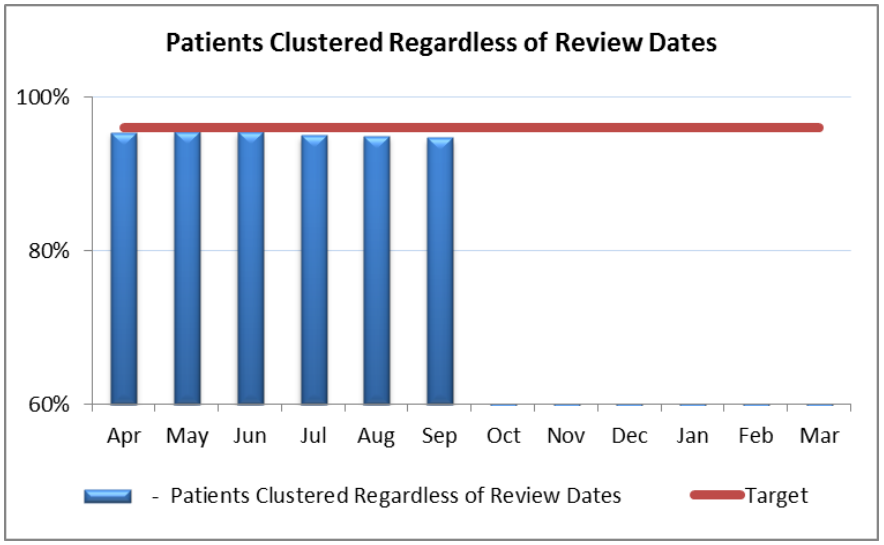
The forecast assumes that a further £0.7m will be achieved by the end of the financial year leaving unfound CIP of £1.4m. This underachievement is compensated for by cost avoidance and other underspends in the overall position.

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

Operational Section

Clustering



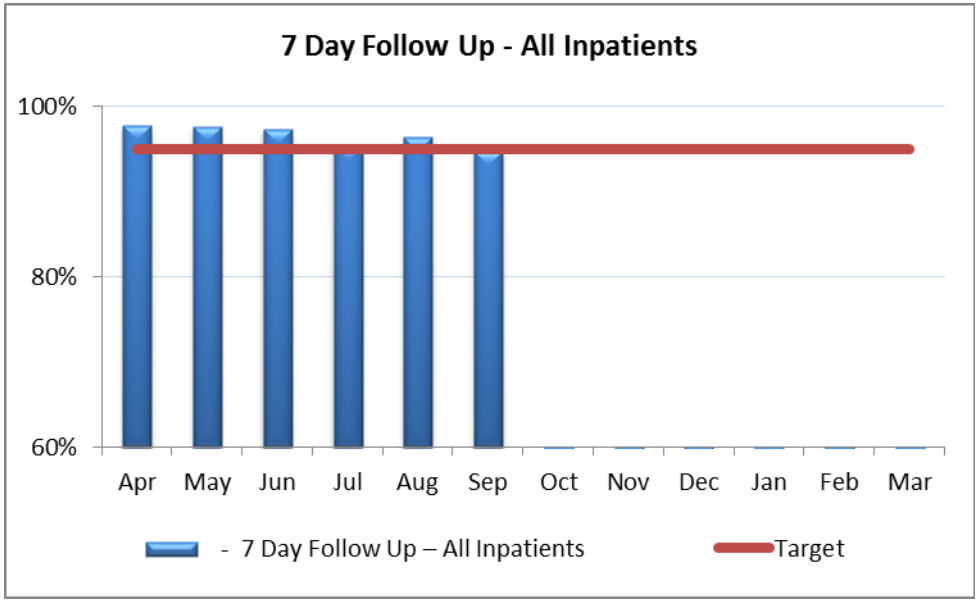


The majority of clinicians now successfully manage their PbR caseloads either independently or through positive engagement with available support.

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.

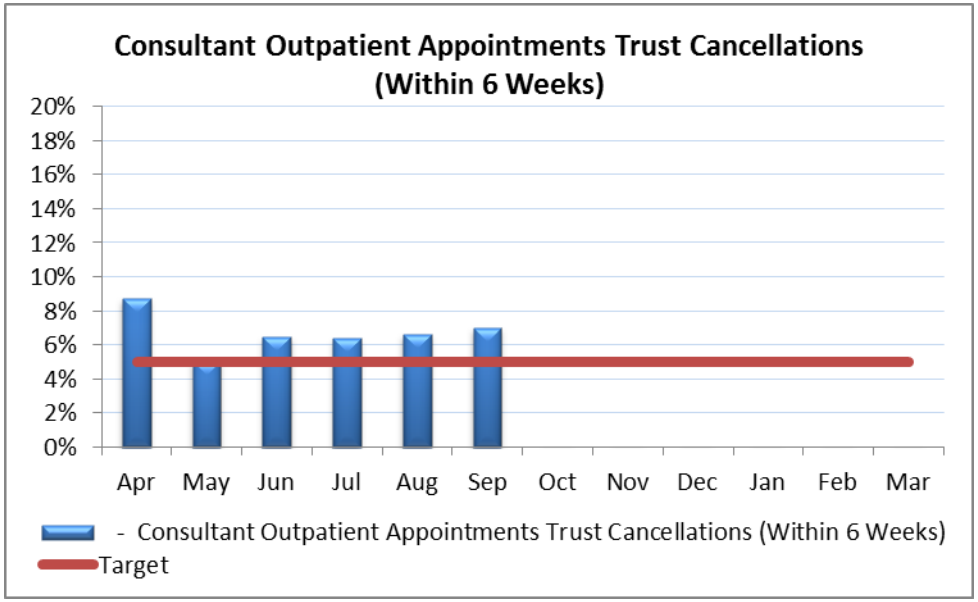
7 Day Follow Up - All Inpatients



The main reasons given for not being able to follow-up within 7 days were difficulties contacting patients despite multiple attempts. This will continue to be monitored. The specific circumstances for each breach were;

Discharge Ward	Comments
Morton Ward	Patient had a follow up appointment with In reach for 30th September 2016, he failed to show for this and did not have a telephone number for contact and had changed his address
Ward 36	Telephone contact made with patient on 5/10/2016 (day 7). Patient informed us that they were in London, has registered with a GP and is awaiting allocation of a CPN.
Tansley Ward	Patient failed to attend the follow-up appointment. Contact made with Barnados who advised that the patient had been with them most of the morning and was their usual self.
Tansley Ward	Several attempts made to make contact in person and over the telephone but without success.
Morton Ward	Discharged in their absence. No history of self-harm. No risk of suicide. Follow-up was arranged via their family member, but they failed to attend. Several attempts have been made to make contact but without success.

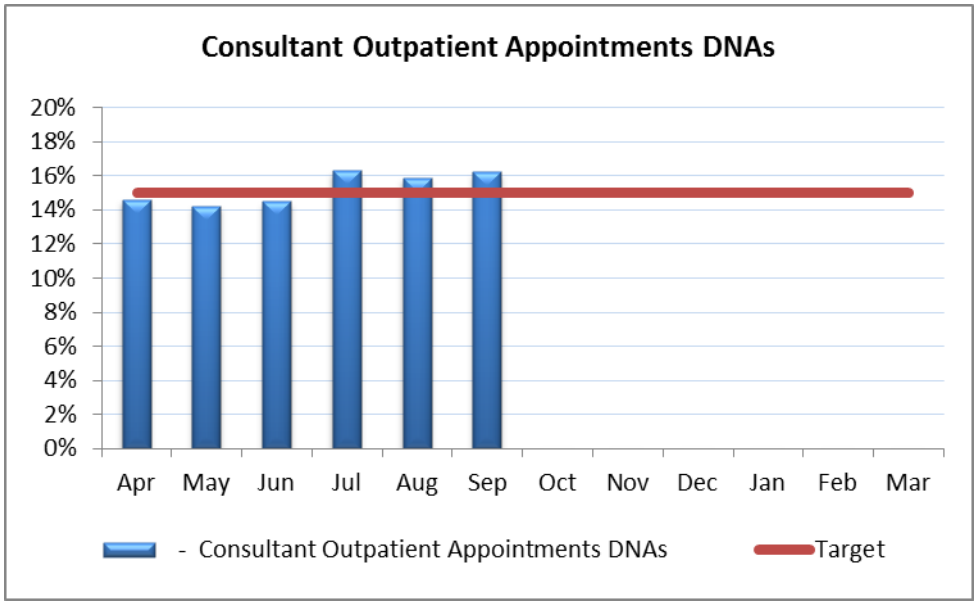
Consultant Outpatient Appointments Trust Cancellations (within 6 weeks)



The main reasons given for cancellation were consultant sickness, annual leave, having to attend an inquest and junior doctors on nights.

- 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 by IM&T to enable easier reporting and monitoring. IM&T have adapted Paris to enable the recording of cancellation reasons for individual appointments, not just whole clinics.

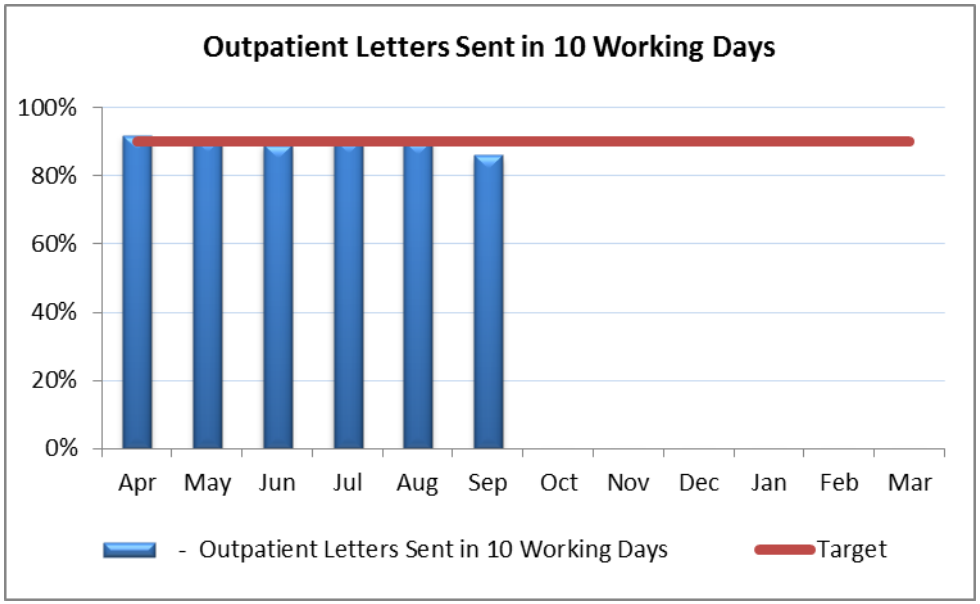
Consultant Outpatient Appointments DNAs



The rate of DNAs was above the target threshold once again. Where mobile numbers are recorded on Paris we send out text message reminders, however these will only prove to be effective if the mobile numbers held on file are current.

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

Outpatient Letters Sent in 10 Working Days



The main reason for the under performance was an IT issue which resulted in secretaries not being able to process dictations for several days. The supplier, DictateIT, has now investigated and fixed the problem.

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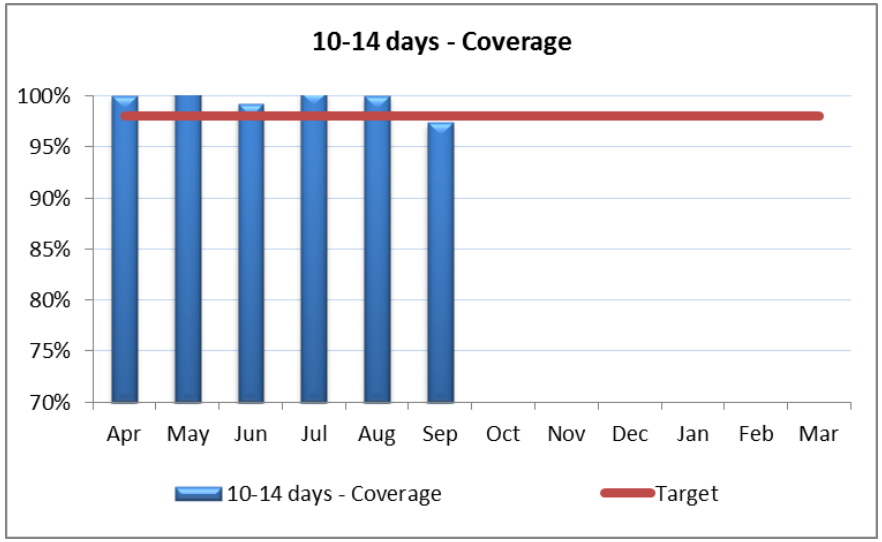
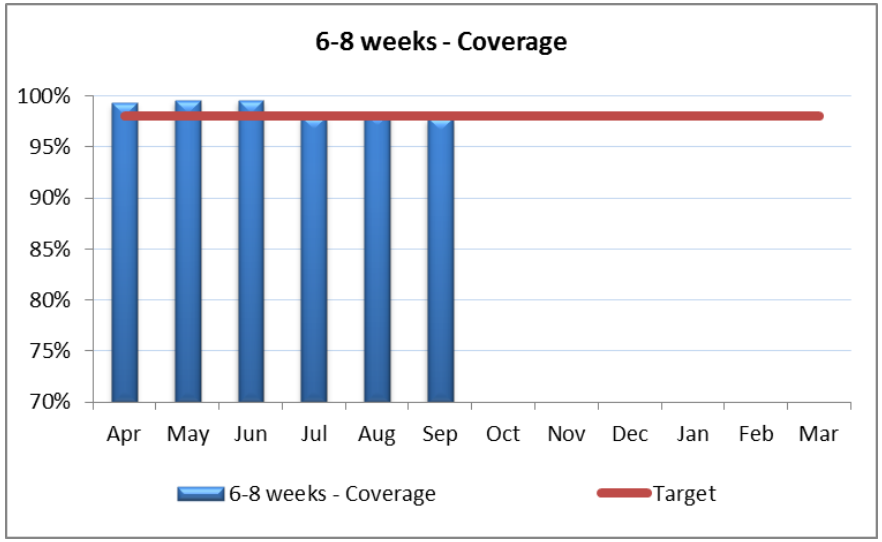
10-14 day and 6-8 weeks breastfeeding - Coverage





Coverage can be attributed to low staffing levels, a changing service and no Infant Feeding Co-ordinator in post; a result of not being able to recruit. The actions in place are;

- Accurate recording of coverage to be improved in some teams.
- To explore a temporary solution until the Infant Feeding Co-ordinator post is filled.

Enc E

WARD STAFFING

Ward name		Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Occupancy % Rate	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
AUDREY HOUSE RESIDENTIAL REHABILITATION	75.00%	169.2%	65.7%	143.3%	56.7%	Yes	We currently have two vacant RMN posts and are in the process of shortlisting at the present time.
CHILD BEARING INPATIENT	79.44%	114.9%	145.6%	100.0%	110.3%	Yes	Fill rate tolerances for care staff on days was broken due to long term sickness absence and increased engagement levels supporting mothers with infant care.
CTC RESIDENTIAL REHABILITATION	86.81%	105.4%	95.2%	100.0%	103.3%	No	
ENHANCED CARE WARD	84.67%	80.6%	110.1%	52.5%	154.0%	Yes	No comment received
HARTINGTON UNIT - MORTON WARD ADULT	93.33%	102.8%	103.1%	67.9%	189.2%	Yes	During September Morton Ward had 6.36 registered nurse vacancies, therefore the majority of the night shifts where staffed by 1 x registered nurse and 2 x Health Care Assistants, rather than the 2 x registered nurse and 1 x Health Care Assistant ratio.
HARTINGTON UNIT - PLEASLEY WARD ADULT	103.33%	101.1%	78.6%	92.6%	119.4%	Yes	Throughout September the Ward has experienced short term sickness and a period of longer term sickness, both HCA related. This had impacted on our HCA figures. Although the shifts have been put out to nurse bank and we have attempted to cover through substantive staff this has not always been successful.
HARTINGTON UNIT - TANSLEY WARD ADULT	90.56%	70.1%	137.1%	52.5%	190.3%	Yes	Tansley Ward is currently running with a high level of Band 5 vacancies against funded posts. In September there were 8.2 whole time equivalent (wte) Band 5 vacancies and only 9.7 wte Band 5 nurses in post. 2 x newly qualified Band 5 nurses commenced in post part way through September as per the information below but have started on supernumary status. The impact of the vacancies and absence has been significant on our ability to maintain minimum numbers of Band 5 nurses on shift at 2/2/1.

Enc E

WARD STAFFING

Ward name		Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Occupancy % Rate	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
KEDLESTON LOW SECURE UNIT	89.67%	106.6%	91.1%	100.0%	100.0%	No	
KINGSWAY CUBLEY COURT - FEMALE	74.81%	100.9%	89.3%	78.3%	116.7%	Yes	We have R/N vacancies - which we are actively looking to recruit into.
KINGSWAY CUBLEY COURT - MALE	88.89%	74.8%	126.8%	73.3%	150.0%	Yes	Cubley Court Male currently have 5 registered nurses vacancies out of 15 funded posts. We are struggling to recruit - this means that we are struggling to ensure two registered staff on night shifts as well as day. We have been running on higher staffing levels due to complexity of patient need which will be indicated in increased care staff levels, as well as increased care staff filling registered shifts
LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP	99.79%	127.5%	63.3%	73.3%	150.0%	Yes	During the month of September there was registered nurse and Nursing assistant sickness. There was also a week with Block training which 2 registered nurses and 1 nursing assistant attended On occasions Registered staff have supported other areas on days and nights x 12 over the course of the month which has impacted on our figures. Registered nurse 22.5 hours left the ward.
LONDON ROAD COMMUNITY HOSPITAL - WARD 2 OP	87.08%	111.7%	89.9%	116.7%	138.4%	Yes	The nursing assistant shifts were over the establishment due to observation levels and high clinical activity on the ward
RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT	92.00%	98.6%	97.7%	94.6%	100.0%	No	
RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT	94.83%	86.9%	125.8%	54.2%	366.7%	Yes	Ward 34 continue to carry a high number o0f registered nurse vacancies, 3 new starters have commenced but vacancies remain high. Clinical activity has also been consistently high with increased number of engagement levels and the increased use of bank staff.
RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT	88.17%	77.8%	124.4%	84.5%	123.1%	Yes	We have current RN vacancies which we are recruiting into.
RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT	97.33%	93.3%	110.9%	100.0%	123.4%	No	

Workforce Section

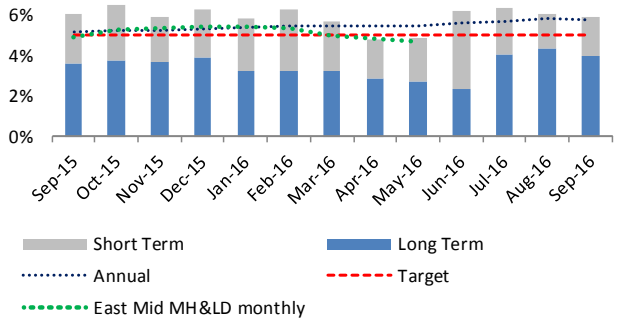
Wellbeing

Sickness Absence

(Monthly)

Jul-16	Aug-16	Sep-16
6.32%	6.08%	**5.89%**

Target 5.04%



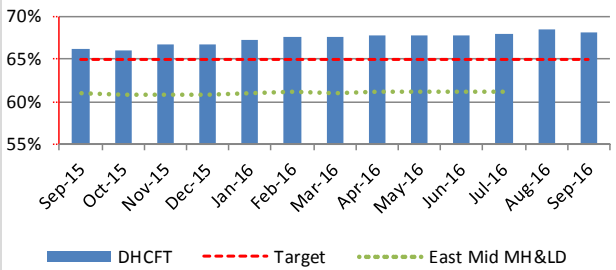
The Trust annual sickness absence rate is currently 5.77%. Monthly sickness absence is 0.19% lower than the previous month and is 0.20% lower than the same period last year. In June 2016 there was a large increase in short term absence caused by traditional long term absence reasons which has now developed into long term sickness. Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 30.21% of all sickness absence, followed by surgery at 10.22%, other musculoskeletal problems at 9.95% and injury/fracture at 7.80%.

Qualified Nurses

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

Jul-16	Aug-16	Sep-16
67.95%	68.36%	**68.07%**

Target 65%



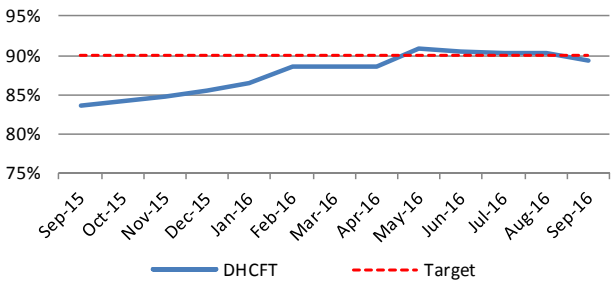
Contracted staff in post qualified nurses to total nurses, midwives, health visitors and healthcare assistants is running at 68.07%. Vacancy rates can impact on this measure. The average for East Midlands Mental Health & Learning Disability Trusts is 61.19%. Health Visitors represent 5.51% of the Trust total and are not included in the Qualified Nurses calculation. Healthcare Assistants and Nursing Support staff represent 26.42% of the total.

Compulsory Training

(Staff in-date)

Jul-16	Aug-16	Sep-16
90.31%	90.23%	**89.26%**

90%



Compulsory training compliance continues to remain high running at 89.26%, a decrease of 0.97% compared to the previous month. Compared to the same period last year compliance rates are 5.71% higher. Compulsory training compliance remains above the 85% main contract commissioning for quality and innovation (CQUIN) target and is just below the Trust target.

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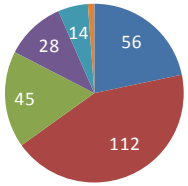
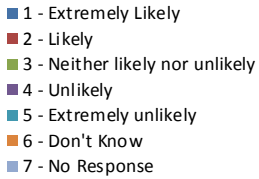
Motivation

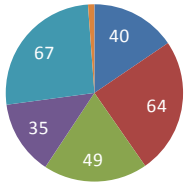
Staff FFT Q1 2016/17 & Staff Survey 2015

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





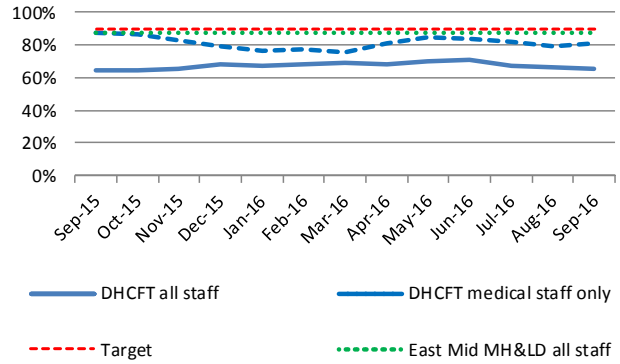
How likely are you to recommend this organisation to friends and family as a place to work.



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

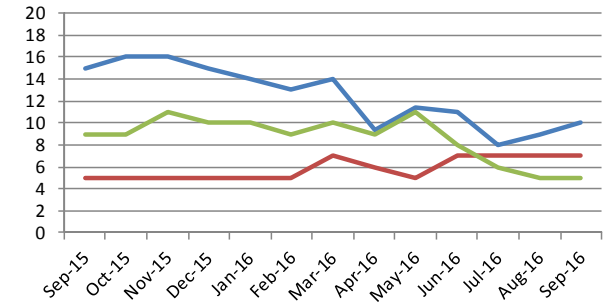
Appraisals	Jul-16	Aug-16	**Sep-16**
(All staff)	67.19%	66.29%	**65.88%**

Target 90%

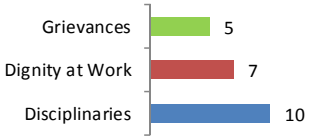


The number of employees who have received an appraisal within the last 12 months has decreased by 0.41% during September 2016 to 65.88%. Compared to the same period last year, compliance rates are 1.82% higher. Medical staff appraisal compliance rates are running at 80.73%. According to the latest staff survey results, the national average for Mental Health & Learning Disability Trusts is 91%. Local benchmarking data for a range of Trusts in the East Midlands shows an average completion rate of 77.33%.

Grievances/Dignity at Work/Disciplinaries as at 30/09/16



There are 5 grievances currently lodged at the formal stage, no new grievencies have been lodged and efforts continue to resolve the issues. There are 7 dignity at work cases currently lodged, no new cases and efforts continue to bring existing cases to a conclusion. There are 10 disciplinaries in progress, 2 cases have been resolved and 3 new cases have been received during September.



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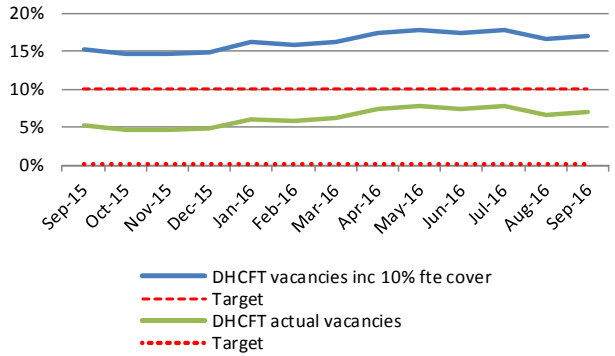
WORKFORCE DASHBOARD

Attendance

Vacancy

(Budgeted full time equivalent)	Jul-16	Aug-16	Sep-16
Including 10% funded fte cover	17.83%	16.60%	**16.92%**
Actual	7.83%	6.60%	**6.92%**

Target 10%/0%

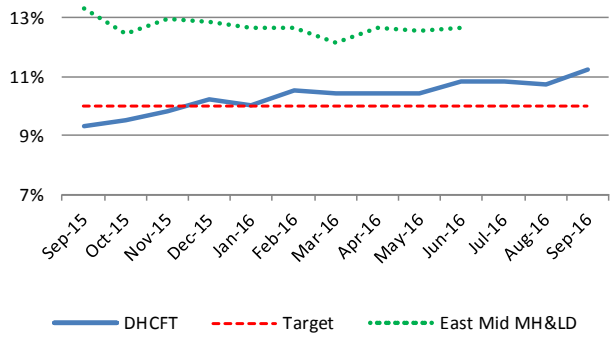


The Trust target for contracted staff in post is 90% which allows 10% funded full time equivalent (fte) surplus for sickness and annual leave cover in In-Patient areas. The budgeted fte vacancy rate has increased slightly by 0.32%. April 2016 included additional full time equivalent investment for 2016/17. New recruitment activity during September 2016 was for 73 posts. 71% were for qualified nursing, 8% additional clinical services, 7% admin & clerical, 7% allied health professionals, 4% medical, 3% scientific & technical.

Turnover

(Annual)	Jul-16	Aug-16	Sep-16
	10.86%	10.72%	**11.25%**

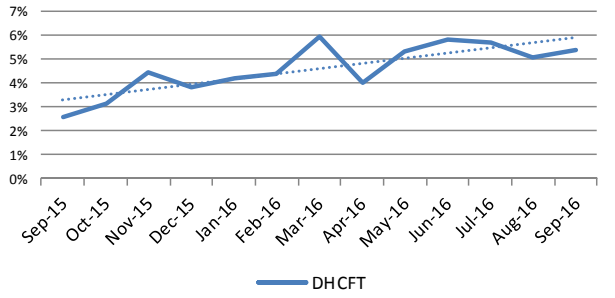
Target 10%



Annual turnover remains within Trust target parameters at 11.25% and is below the average for East Midlands Mental Health & Learning Disability Trusts. The average number of employees leaving each month remains relatively static at 22.6, however during September 2016 31 employees left the Trust which included 11 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)	Jul-16	Aug-16	Sep-16
	5.71%	5.05%	**5.39%**



Total agency spend in September was 5.39% (6.06% including medical locums). Of total agency and locum spend for all staff groups, Qualified Nursing represented 1.4%, Medical 3.5% and other agency usage 1.1%. Agency Qualified Nursing spend against total Qualified Nursing spend in September was 4.0%. Agency Medical spend against total Medical spend in September was 14.7%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £992k of which £563k related to Medical staff.

Quality Section

Strategic Risks (Board Assurance Framework)

Enc E

Risk Description	Risk rating	Trend
1a) Failure to achieve clinical quality standards	HIGH	↔
1b) Lack of compliance with equality legislation	HIGH	NEW
1c) Risk to delivery of care due to being unable to source sufficient clinical staff		NEW
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	↔
3c) Risk that turnover of the Board members could adversely affect delivery of the organisational strategy	MED	↔
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	↔

A further 2 new risks have been added to the BAF this month. These are 1b – compliance with equality legislation and 1c – sourcing of sufficient permanent and temporary clinical staff

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

Risk Description	Risk rating	Trend
Significant staffing level risks across a number of service areas remain: Radbourne Unit, pharmacy, paediatricians, psychology, neighbourhood teams. In the last month the Memory Assessment Service and CAMHS have identified high risks associated with staffing.	HIGH (Extreme for paediatricians)	↔
Associated with the number of staff vacancies, staff are identifying increases in work related stress and increased risks of violence and aggression on the Radbourne Wards	HIGH	↔
Exceeding of the agency cap for reasons of patient safety	HIGH	↑
Increased risk of fire identified on some inpatient wards associated with the smoking ban continues to be raised, although currently no increases in actual fires	HIGH	↔
New high level operational risks with respect to discharge from the DRH and transfer across neighbourhood boundaries.	HIGH	NEW

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors November 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. Strategic and clinical developments of Safeguarding Adults and Children with Derby City Local Authority and partners
2. Executive Director of Nursing attendance at the Specialist Quality Leadership team to seek assurance on their value, attendance and level of functioning and whether issues are being escalated and resolved through a quality governance system
3. Care Quality Commission comprehensive inspection action planning, reporting and the Quality Summit.
4. CQUINs and quality priorities with reference to Physical Healthcare and Family inclusive practice
5. Executive Director of Nursing attendance at the Derby City St James team and the move to the Neighbourhood team.
6. The Equalities Act and the Service Receiver and Carer Development group and the developments of a Transgender policy
7. The Nursing Associate role, developed by the Education team.

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 prepared and presented by:

Carolyn Green
Executive Director of Nursing and Patient Experience

QUALITY POSITION STATEMENT

November 2016

1. SAFE SERVICES

1.1 Safeguarding Children's and Adults service

The Multi-agency Safeguarding hub has gone live and the service is clinically operational with DHCFT clinical staff being co-located in the service for 50% of the time and recruitment for temporary posts to cover this workload are in the recruitment process.

Areas for consideration

The financial and clinical impact if this service is not financed by Southern Derbyshire CCG from March 2017. This would result in a service withdrawal in April 2017.

Overall

Our Safeguarding Committee will lead the monitoring of this work on behalf of the organisation. We will continue to monitor the impact of this multi-agency safeguarding hub which enables proactive sharing of information when safeguarding concerns are present and the monitoring of the impact of this model on identifying and addressing Adult and Child sexual exploitation, and all safeguarding concerns as multi-agency responses.

2. CARING SERVICES

2.1 Nursing and Quality, Quality visit

The Quality visits are completed; the model is now to undertake a moderation panel, to review the whole season and the results.

A model review day will be scheduled to review the operation model. So far feedback has been to:

- Return to an Executive Director chairing the panel rather than all Board members.
- Stop quality visits and change to compliance visits only.
- Review the model and add in a quality visit with a member of the panel undertaking a compliance review as part of the model, both scores are equal.

- Review all ratings and remove from the 'Outstanding', 'Good' et al model and rate as points only. The top scoring 10 teams receive an award only. The points and scores will be based upon Quality visit and compliance check as a combined score.
- Stop all Board visits entirely. Not recommended.

2.2 Triangle of care - Think Family and Family inclusive practice, a Trust quality priority

The Safeguarding Committee in November has received a strategy and associated priorities for ratification. Subject to the Committee's feedback, the Board is recommended to implement this programme of work.

3. RESPONSIVE AND EFFECTIVENESS OF OUR SERVICES

In a recent publication in the Guardian high figures showed UK nurses lacking skills to treat transgender patients. According to research, "UK nurses are failing to meet the needs of transgender patients and feel they lack training and experience to treat the growing number of transgender people seeking medical treatment in relation to their gender identity", reports the Guardian. A survey of more than 1,200 nursing staff across the UK conducted by the Royal College of Nursing found 87% of those nurses who have directly cared for a trans patient felt unprepared to meet the patient's needs. Just one-fifth of all nurses surveyed said they thought the nursing workforce had the skills to care for transgender people, while 76% said more training for all healthcare staff was needed. Wendy Irwin, RCN diversity and equalities co-ordinator, said the college was pushing for training regarding the treatment of transgender people to become a mandatory part of pre-registration nursing training as well as part of continuing professional development.

Action: The Trust has already commissioned a Transgender Policy Guidance for Community and In-patient services on the Care and Support of Transgender and Gender Nonconforming Service Users and Staff development led by Occupational Therapists and a draft policy has been produced is expected to the Quality Leadership teams to address the policy needs and additional briefing and educational events will be scheduled to support our whole workforce in considering the transgender population as part of our due positive regard to the Equalities Act.

4. WELL LED

4.1 Executive Director of Nursing attendance at the Derby City St James team and the move to the Neighbourhood team

A number of concerns have been escalated with regard to the organisational and clinical impact of moving from St James House, Mansfield Road to St Andrews House to a Neighbourhood building. The move has had a significant lead in time and the change management of the move has been affected by communication and understanding between the general management level to the clinical team through the team managers. This has been further impacted upon by limited oversight by clinical quality leads at the Neighbourhood level. This move was assessed to be a clinical operational move and the quality leadership service line leaders did not intervene until directed by the executive team. Although this was on the risk register, further exploration was not undertaken on what the concerns and alternative solutions were not sort over and above immediate assessment of the communicated need of care parking. Further complexity was present which affected the staff response and morale, as the problems and needs expressed by team members were not fully articulated. This created an environment of shifting sands and there appears to be differing levels of team meetings and communication for the three clinical teams collocated in the building. The clinical quality team as Heads of Nursing and Lead profession OT were quick to respond when directed by the executive team and spoke to staff in the team bases about the issues, concerns and solutions.

An alternative solution to complement the offer has been made by the executive team, to supplement the team base at St Andrews House. This is to be supportive of the team in transition, offer alternative clinical space for individual patients who do not wish to have community visits at home or at St Andrews House.

Action: For the executive and senior team to be solution focused and candid about the Trust financial position, what is viable within resources, what can be supplemented to support staff and what cannot be offered?

There appeared to be limited responsive leadership at team level in some of the teams on responding to staff struggling with laptops, IT literacy and general basic operational issues.

The teams would benefit from additional support in IT literacy, agile working, contemporary community mental health practice moving from a centre based community offer to a home based model of care, the Lead Professional for Neighbourhoods and the Lead OT to undertake clinical leadership and briefing sessions on symptom and social recovery models of care and solutions to develop the Neighbourhood model. There will be a focus towards unannounced visits to be

made by the Director to the Campus and Neighbourhood Quality Leadership teams.

A drop in session for IT equipment and basic understanding of working with a laptop has been requested and offered by IT to support the operational leadership on core management issues.

A follow up meeting has been scheduled for the Executive Director of Nursing and Chief Operating officer to re-visit the service to follow up.

4.2 Quality Leadership

The Executive Director of Nursing attended the Specialist service Quality Leadership team (QLTs). This was in part to review the functioning of the Quality Leadership team as an unannounced visit. This was undertaken and feedback reviewed at the Quality Committee. The group had good attendance, an appropriate agenda and discussion. Feedback was given on the need to make decision and document the rationale for the decision and what action needs to be taken based upon the information or issue raised. The team were scheduling and planning deep dives per clinical area and debating practice. Overall the Specialist Quality leadership was functioning and functioning at a higher level than previously viewed. It has some improvement work to confirm delivery against forward plan. However, the representation and discussion was appropriate and satisfactory.

The Nursing and Quality teams have scheduled additional development sessions on clinical governance and the seven pillars of clinical governance and monitoring clinical performance which have staff are now booked to attend.

Action:

To receive assurance from the Executive Director of Nursing on in-reach assurance checks on clinical governance. Further unannounced visits will occur to both QLTs and other clinical reference groups and in the provision of additional developmental sessions.

4.3 Patient Safety – CQUIN

As part of the 2016/2017 CQUIN requirements, there is a focus on physical healthcare.

The Quality Committee will be receiving at its November meeting, a briefing as a Quality Position Statement of the progress against the CQUIN and in addition a summary of work completed to date, including a summary of additional physical healthcare training.

The flu vaccination is in full swing and the Trust has reached last year's full end of year outcome as its current position at the end of October. This data is incorporated in the integrated performance report under the Quality Priorities section. Additional provision has been offered by the Human Resources and Wellbeing team and a personal email to all nurses and allied health professionals encouraging them to join the 'flu fighter campaign' has been issued by the Executive Director of Nursing.

In addition to the physical health, on the health and wellbeing agenda this month the Trust has supported some collaborative work with England Athletics in the High Peak and Dales Neighbourhood and E I North.

Our Occupational Therapists are working in partnership with a lead who is a Mental Health Ambassador from Athletics. Contact has been made with the Trust to work collaboratively with patients, staff, families and carers engaging in two fun runs for Mental Health week (8 – 14 October) as part of the national drive.

Our Trust has signed up as their partners with this and by advertising, encourages people to join the events.

Our teams embraced this as an opportunity to place onto the Wellbeing agenda for our service users, carers and staff. This was approved following risk assessments and safety checks.

4.4 Involving Service Receivers and Carers in Trust developments and briefing on Trust wider system developments

The Trust runs a Service Receiver and Carer forum to enable direct access to the Executive Director of Nursing and other Quality team members to influence Trust developments and information.

A session of the group was held during October and had attendance from Mental Health Alliance, North Derbyshire Carers and South Derbyshire Carers discussing the CQC report and explanations of the issues, how the Board will be held to account. This was in addition to the October meeting to meet with Commissioners to have a briefing on what is an STP and what are issues concerning groups at this time?

The November Committee will re-visit the CQC comprehensive visit and action plan and ask for the support of service receivers and carers in developing the action plan further and wider Trust developments. This will include comments on the draft Transgender Policy.

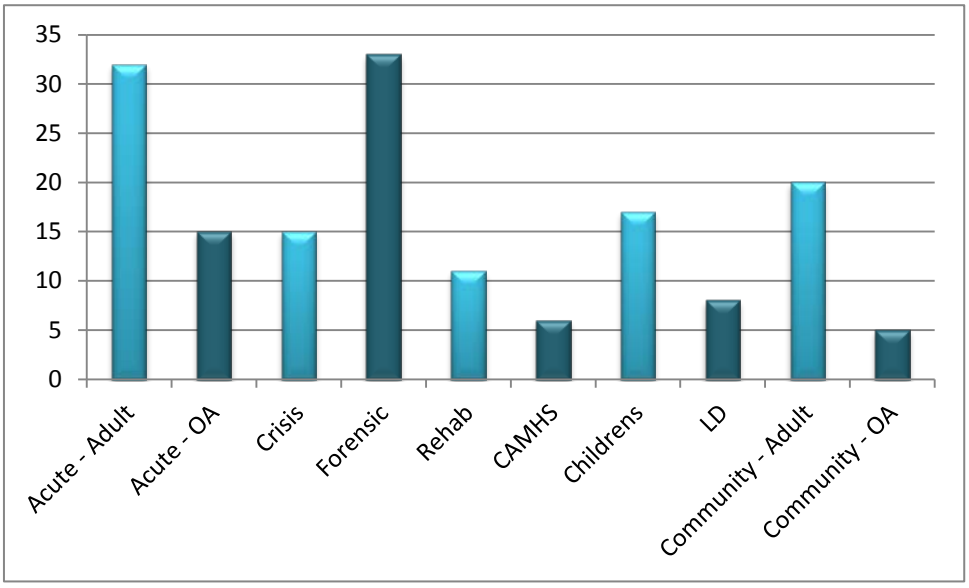
4.5 Care Quality Commission Comprehensive Inspection

The CQC full inspection report was published on 29 September 2016.

Prior to this period, a number of planning events were held to review draft actions and regulation level action plans were already in development when the CQC draft report was received.

As a result of the factual accuracy checks and the action plan, development evidence was also identified to support the Trust response to some of the actions. This evidence, along with the action plans themselves, will be uploaded to the portal in readiness for the first CQC submission of action plans and evidence after the Quality Summit visit which was initially scheduled for 21 October 2016 which has been rescheduled for 8 November 2016.

The breakdown of actions per service is as follows:



Some further high level actions that have been progressed since receiving the comprehensive report and immediate feedback on areas of improvement already in progress or completed are as follows:-

1. The Safeguarding Committee has reviewed Safeguarding level 3 training and evidence. Additional training days have been commissioned by the Children's Service and have been provided.

2. A review of all CQC actions has been undertaken by the Capital Investment group and existing resources re-allocated to meet the findings of the comprehensive review. The installation of all air conditioning units has

already occurred and the additional aspects are now in full planning stage. This includes the re-development of a newly designed clinic room at the Kedleston Unit, through refurbishment of the kitchen and the activity daily living kitchen being re-provided, rather than the initial plan to close a bedroom. The planned relocation of Audrey House, due to both heating and physical environmental concerns went ahead in October. This fully mitigates the concerns raised in the Audrey House CQC comprehensive report.

3. The Trust continues to brief clinical staff on the learning and expectation of clinical practice with regard to the Mental Capacity Act. The feedback has been mixed with some staff embracing the feedback and some staff expressing concerns that the Board members are undertaking a knee jerk reaction to the CQC report due to the requirement for staff to re-visit training and their expected practice and do not agree with the assessment. Additional discussion, supportive challenge and assistance to these areas to explore their thinking and confirm the required actions is being undertaken by all senior staff and led by the Medical Director.

4. The CQC Preparedness Group continues to meet across the organisation to respond and act upon CQC data requests, review progress and the action plan and share intelligence on the Trust on its response to the comprehensive visit.

   The Executive Director of Nursing, on behalf of the executive team, has written a letter of thanks to all CQC sponsors, Associate Clinical Directors for their work. In addition, this outlines some of the high level actions for next steps. This again has received some mixed feedback, with some staff feeding back their thanks for their personal letter and some at the Associate Service Managers level reporting that they would like a different approach. There is continued feedback that the clinical services have limited learning and the clinical services have been let down by the Board. The modelling of a none blame, but accountable response with all Board members and senior team members to be responsive to challenge and support some of these views the organisation is required, to challenge and support some of these views. There are significant risks to the organisation if all levels of staff do not connect and recognise the multi-layered levels of response required to improving clinical practice and monitoring.

CQC Plan

The findings and the recommendations of the report have been designed into a CQC portal which is a repository for all named leads to review their actions and acts as a shared holding area for monthly reports to the CQC both on

recommendations progress and this contains review and analysis of the service areas, themes and regulations.

Specific key reports have been produced both for Safeguarding, Quality and the Mental Health act committee and planned adjustments to the integrated performance dashboard have included CQC action plan areas.

This report will be produced monthly both for the Quality Committee routinely from November and a report will be sent to the CQC to provide initially reassurance and assurance on the Trust implementing all learning and recommendations. This portal has an export function which enables a briefing report and the actual evidence to be uploaded directly to a secure CQC nhs.net account. An extract of the high level regulations and themes report is provided in the integrated performance report.

4.6 Nursing Associate Role

The Nursing Associate role will be implemented in the Trust as a test pilot scheme.

Heath Education England (HEE) announced on Tuesday 11 October 2016 that a partnership between healthcare providers and higher education organisations had been successful in its bid to become a ‘test-site’ for putting the new role of Nursing Associate through its paces.

It means that Chesterfield Royal Hospital, Derbyshire Community Health Services, Derbyshire Healthcare and Derby Teaching Hospitals, working with the University of Derby, will lead the way in implementing the new education programme as part of a national pilot for this pioneering route into a nursing career.

In the first instance, 36 students will be recruited to the training position across the four organisations. This will be for five associate nurses in our organisation.

The education and training programme for the role enables them to work within the nursing team at a level which fits between other healthcare support workers and fully qualified nurses. The focus of the role will be to provide hands-on compassionate patient care.

These first students, are part of a national cohort of 1,000 and are expected to start their two-year Nursing Associate programme in December 2016. This is an exciting opportunity to build on our partnership with the University of Derby and to be at the forefront of this ground-breaking development.

Action:

For nursing and education to lead on the communication and implementation plan to trial the Associate Nurse role, a key partner is the Education team and our relationships and engagement with the Unions in this development.

Report prepared and presented by

Carolyn Green
Executive Director of Nursing and Patient Experience

Board Committee Summary Report to Trust Board

Quality Committee - meeting held on 13 October2016

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Minutes & Matters Arising	Policy list was reviewed – equality impact assessment is still outstanding and overdue				Equality impact assessment is out of date and requires review and immediate action
Annual Health & Safety Report	Strong assurance at the end of March. The committee agreed the Health and safety report	Some gaps in monitoring require sustained attention - Fire warden training and additional security checks in line with NHS protect standards H&S report to be reviewed in January 2017 to ensure coverage of these areas	Scrutiny of fire warden training. Scrutiny of security measures and property. Mitigation plans as part of CQC action planning	Agreed and ratified.	
Serious Incident Report	Strong assurance provided at the monthly report.	Significant assurance Note Death rate 1.6 above national average. However the Trust Substance misuse deaths through co injecting are reported, Some Trust do not report. Additional evidence and information on Appleby homicide and suicide data will be reported in November,	NRLS data, the Trust data appears secure; however confidence in the benchmarking data of other Trusts is unconfirmed at this time. National and regional data post MAZARS, is of concern	Agreed and ratified.	Note the death rate, additional scrutiny and limited confidence in NRLS data, due to the Trust including substance misuse deaths.
Positive & Safe Monthly Progress	Exception report.	Improvement work on ensuring clinical assurance on seclusion	Changing the paper records to an electronic automated report	Agreed and confirmed. Additional exception reports	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
		pathway.	to ensure	to be provided.	
Pharmacy Update	Position statement and performance against actions from the CQC comprehensive inspection.	Improvement work on ensuring clinical assurance in medicines management, facilities and administration.	Significant improvement in performance and responsiveness.	Feedback on clinical new models of practice.	
NICE Guidelines Update Report	Governance and architecture model in place. Clinical delivery and mapping is required.	Solution on appropriate resource	Capacity and performance of the QLT to deliver NICE improvement work	Director of nursing and Medical Director and interim COO to explore issues escalated by QLT and risk manager due to concerns of capacity and and resources.	
Policy Governance Report	Policy improvement is sustained.	Solid assurance on policy performance	Significant assurance	Agreed and ratified	
Quality Leadership Team Update	Chair of the QLT provided a summary report on improvement. How the QLT is working, improvements in structure improvement and escalation Evidence of escalation from CRG and QLT. Gap in attendance for some key teams such as Early intervention team In-reach assurance visit by Director of Nursing to CRG and QLT to evidence – the level of assurance The escalation templates and assurance QLT for CRG are in	Solid assurance on policy performance Evidence of improvement.	Significant improvement	Accepted Moving QLTS into a sustained process to be full embedded by March. Significant evidence	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
	place, required to be embedding.				
Governance Improvement Action Plan	Review of all risks and actions for the Quality governance improvement action issues Significant improvement additional embedding	Evidence of improvement.	Significant improvement	Additional evidence will be provided • QLT forward plan • Escalation templates in use • Minutes and attendance of QLT members • Evidence of working to QLT plan On plan for sign off at the end of December.	
Risk Register Escalation	A risk review was provided against the risks	Significant improvement	Actions for COO to ensure he is aware of risks and mitigation		
Review of Quality Strategy and Quality Framework	Reviewed scrutinised and ratified. Some minor amendments to the format, and some text adjustments and improvements	Assurance on framework is in place Note changes may be required following the adoption of the accountability framework	Delivery of quality priorities at pace.		
Children's & Central Services QLT Minutes	Agreed and scrutinised	Evidence of appropriate work and escalation Evidence of emerging effectiveness	Improvement and delivery in line with the the GIAP Risk to delivery if accountability framework is delayed		
Neighbourhoods & Campus Services QLT Minutes	Scrutinised and agreed	Evidence of appropriate work and escalation Further analysis of group functioning will be undertaken	Improvement and delivery broadly in line with the GIAP Risk to delivery if accountability framework is delayed	Director of Nursing to complete in-reach visits to the group	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
		by the Director of Nursing			
Drugs & Therapeutics Committee Minutes	Scrutinised and agreed	Evidence of appropriate work in line with TOR			
Allied Health Professions' and Medical Scientist's Strategy– Better Together	Agreed and scrutinised The group were thanked for their extensive work.	Evidence of appropriate work. Work plan agreed and an annual report to be scheduled for 12 months	Current secondment of AHP lead to Erewash vanguard. Active recruitment to post now in progress. Review options if post not filled.		
Declaration of Interests, Hospitality & Sponsorship Policy & Procedure	Agreed and scrutinised Policy ratified, with no amendments	Ratified		Policy for dissemination and briefing	
Any Other Business	None				
Items escalated to the Board or other Committees					
Forward Plan 2016/17	Addition of the AHP paper				
Meeting Effectiveness	Feedback on the meeting and effectiveness was good. Overall good meeting, with sound papers. Attendance at meeting overall quorate with a number of apologies				

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Confidential section	Discussion on progress on key areas and escalation issue to CEO in regard to one area.				

Board Committee Summary Report to Trust Board
Audit & Risk Committee – 11 October 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)
Quarterly Review of Board Assurance Framework 2016/17	The third issue of the BAF was discussed, including noting additional risks added, reviewing the deep dives schedule and link to high level operational risks.	Assurances received as outlined. Further updates to be added prior to submission to Trust Board on 2 November. Consideration of capturing skills and knowledge on 3c to be explored (SH) Different format of presentation of BAF to be considered (RK) BAF risks reference to be added to listing of high/extreme risks (RK)	Risks noted as identified as part of BAF	BAF to be further updated where required and submitted to 2 November Trust Board as part of established reporting	Regular reporting only
Risk Management Strategy and Overview of Risk Management Controls and Assurance	Draft Risk Management Strategy was outlined and progress discussed	Caroline Maley, Rachel Kempster and Sam Harrison to meet to progress Risk Management Strategy to be completed and discussed at January/Feb 2017 Board Development Session	None	Agreed to bring back to December meeting	None
Deep Dive BAF Risk 4a Financial Plan	Claire Wright presented the current position re Risk 4a relating to delivery of the financial plan	Evidence of key controls, and assurances (internal and external) on controls were noted as assurance. Good assurance noted that financial performance and	Risks were identified as outlined in the presentation in terms of gaps in control and gaps in assurance. Ongoing risks relating	Agreed that risk rating did not require further change.	Financial issues on Board agenda. Control over Agency spend audit to be discussed at Trust Board to ensure Board are aware of outcomes and actions agreed and addressed quickly,

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
		key pressures are discussed also at Finance & Performance Committee and Board also.	Agency spend.		and to review response for NHSI questions on Agency Spend
Governance Improvement Action Plan	Sam Harrison presented the report which encompassed an update on Core 4 and also other actions listed for Audit and Risk Committee oversight. Phase 1 Deloitte report feedback was discussed which includes the recommendation to review all actions to date and ensure these satisfy original recommendations and are embedded within the organisation.	Assurance received on completed actions and core recommendations. With Core 4, 4 actions remain outstanding and 2 are on track for delivery.	None. Action is underway to progress all actions outlined.	Sam Harrison to review actions already completed and present proposals for any additional work or review of status to December Audit and Risk Committee meeting.	Comments to form part of wider GIAP report to the November Trust Board.
Committee Assurance Summary Reports: Audit & Risk 19 July, Quality 11 August and 11 September, Mental Health Act 26 August and draft minutes of the meeting of the People & Culture Committee held on 20 September	The summary reports from Committees were noted.	Assurances noted as outlined. Assurance received that this process of assurance and escalation is working now and is now embedded in the organisation	Risks noted as outlined.	It was agreed that Board Committee Assurance summaries would no longer come to Audit and Risk but be presented directly to Board	None

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Standing Financial Instructions Waiver Register	The register of waivers granted from 1 April - 30 September 2016 was presented.	Assurance given that recording process has been reviewed and clarity given to staff involved. Assurance that appropriate process has been followed as per SFIs. Further oversight to be developed including noting capital and revenue spend. Action to be taken to ensure 'future proofing' for potential reliance on particular suppliers arising from the waiver process.	Issue of reliance on single supplier to be addressed as part of future reporting.	Report to be developed as outlined and presented to Audit and Risk Committee 3 times per year.	None
Implementation of Internal and External Audit Recommendations Progress Update	Report on progress of implementation of audit recommendations was discussed.	Assurance received on actions completed but noted that this was not evidence based, being reliant on contributors' reporting. Internal audit to undertake ongoing review of outstanding actions as per agreed programme.	Disconnect in MCA internal audit report and audit recommendations update noted.	Report received and agreed to twice yearly future reports.	None
Update Report on External Audit Plan progress	Mark Thornton outlined the progress report 2016/17	No significant issues expected re the year-end audit. No significant changes in guidance. Audit Plan to be brought to the Committee in December.	Good progress on GIAP is required to address VFM conclusion for 2016/17.Impact of SOC, STP and backroom functions need to be focus of Board	Update noted	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)
Update on Internal Audit Plan progress and reports issued **Review of implementation of actions from previous reports (Mental Capacity Act and HR Policies)**	Progress updates on reviews were outlined. Sector updates and publications were noted. • Mental Capacity Act (MCA) awareness report – for discussion at MHA Committee for November • HR - report on disciplinary and grievance policies	Revised audit plan was discussed – Claire Wright noted that this focusses on areas where improvements are actively sought. Updates on reviews were given verbally: • MCA audit– limited assurance received. Update to come back to Audit and Risk Committee. Challenged medium to high risk noting CQC feedback. • Partial Assurance received. To be discussed at December People and Culture Committee.	Risks from progress report were noted and will be actioned as per action plans and via follow up	New Security Standards – to be reported into the Quality Committee from the Information Governance Committee • Update to Audit and Risk Committee in December on progress with actions re MCA report	Agency Controls report to be presented to Trust Board subject to finalisation by papers deadline
Anti Crime Circular from NHS Protect	Circular discussed including noting that 'anticrime' now used to refer to counter fraud and security management.	Noted for awareness. Assurance received that the Trust completes an annual counter fraud self - assessment and submits a comply response to the 'comply or explain' requirements for security	None	None	None
2016/17 Forward Plan	The Forward plan was noted.	Caroline Maley and Sam Harrison to review as part of ongoing agenda planning meetings	None	None	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)
Meeting Effectiveness	Review of discussions and agenda content	Discussion on overall effectiveness including positive comment from internal auditor that recurring issues arising across agenda items.	None	None	None

Board Committee Summary Report to Trust Board

Safeguarding Committee - meeting held on 7 October2016

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
SAFEGUARDING ADULTS					
Safeguarding Adults Strategy and Annual Report	Received and key achievements identified.	Demonstrated improved performance Partial assurance given that the Safeguarding agenda is emerging and developing both nationally and locally. Trust detailed information provided giving increased confidence National benchmarking	Lack of national benchmarking Lack of national information on safeguarding adults to benchmark against	Agreed in principle subject to final review in the November Safeguarding Committee meeting	PREVENT and CHANEL Gold Group CEO representation and prioritising this area
Update report on Safeguarding Adults Training Report and WRAP	Received and ratified	Assurance received on Level 1 and Level 2 training	Continued update of PREVENT training Continued uptake of level 3 developmental standards Change of trajectory for training rates of new and emerging training targets for WRAP and level 3.	Information received Please note the WRAP and level 3 adults training are development targets and no 90% at time of implementation. There will be a trajectory for improvement.	None
SAFEGUARDING CHILDREN					
Safeguarding Children Work Plan	Received and ratified	Accepted Improvement work required in the governance template to ensure AMBER rated risks have an arrow of improving or worsening position	None	Accepted and partial assurance offered with evidence of an improvement plan	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)
Safeguarding Children Audit Clinical Record Keeping/Case Conference	Received and ratified	Accepted Improvement work required in the diligence of completing the front sheet.	The operational group to review this work and consider what is the target practice at 100%, and what would be a trajectory for improved performance	Accepted and partial assurance offered with evidence of improving practice and improvement plan.	
Looked After Children Report	Received, accepted and ratified	Partial assurance on the team capacity and high level of assurance in the performance and current clinical outcomes	Commissioning capacity Risk register and commissioning intentions and capacity	Agreed and recommended to Board.	
Safeguarding Children Strategy and Annual Report	Received, accepted and ratified	Accepted and agreed. Partial assurance due to the level 3 training and ensuing safeguarding supervision is in place.	Access to training and risks Level 3 Safeguarding training and supervision	Agreed and recommended to Board.	
Safeguarding Children Markers of Good Practice/Section 11 Audit	Deferred to next meeting				
Any Other Business	Deferred to next meeting due to early finish of meeting due to restricted room availability				
Forward Plan 2016/17	Deferred to next meeting				
Meeting Effectiveness	Deferred to next meeting				

MINUTES OF THE AUDIT & RISK COMMITTEE

HELD ON
TUESDAY, 19 JULY, 2016 AT 2PM
HELD IN MEETING ROOM 1, ALBANY HOUSE, KINGSWAY, DERBY DE22 3LZ

PRESENT:	Caroline Maley	Committee Chair and Senior Independent Director
	Phil Harris	Non-Executive Director
IN ATTENDANCE:	Claire Wright	Executive Director of Finance
	Rachel Leyland	Deputy Finance Director
For item AUD 2016/071 and 072	Sam Harrison	Director of Corporate Affairs & Trust Secretary
	Carolyn Green	Director of Nursing and Patient Experience
For item AUD 2016/078	Mark Ridge	Acting Head of Transformation
	Rachel Kempster	Assurance and Risk Manager
	Joan Barnett	Engagement Manager, Grant Thornton
	Glen Spencer	PwC Manager
	Penny Gee	Acting Assistant Director, Counter Fraud Services
	Sue Turner	Board Secretary and Minute Taker
For item AUD 2016/082	John Sykes	Medical Director
For item AUD 2016/082	Rubina Reza	Research & Clinical Audit Manager
APOLOGIES:	Mark Powell	Director of Strategic Development

WELCOME AND APOLOGIES

The Chair, Caroline Maley opened the meeting and welcomed everyone present.

AUD 2016/068	**MINUTES OF THE AUDIT & RISK COMMITTEE MEETING DATED 24 MAY 2016** The minutes of the meeting held on 24 May were accepted and approved as an accurate record of the meeting.
AUD 2016/069	**ACTION MATRIX** All updates provided by members of the Committee were noted directly to the matrix.
AUD 2016/070	**CORPORATE GOVERNANCE FRAMEWORK AND BOARD COMMITTEE TERMS OF REFERENCE** The Audit and Risk Committee is the Committee with the role of overseeing the GIAP actions relating to the Corporate Governance Framework. The draft framework was considered at the previous meeting on 24 May and the revised Corporate Governance Framework submitted by Sam Harrison was reviewed at today's meeting. The Committee noted that as previously reported to the Board as part of regular GIAP reporting, the timeline outlined for completion of the tasks to redevelop the Corporate Governance Framework were not feasible due in part to the required sign-offs from Board Committees for their individual terms of reference. In order to counter this, a revised timeline was agreed as 27 July 2016 for presentation of the Corporate Governance

	Framework to the Board. In addition to this, details of the proposed nature of the review and timeline for interrelated sign-offs by Board Committees was discussed at the Board Development Session on 11 May 2016 and the updates and responses to the various GIAP actions were considered and additional comments to the draft framework documents were noted and incorporated. While reviewing the GIAP actions relating to the Corporate Governance Framework, the Committee agreed that CorpG 2(1) was complete pending some issues of clarification regarding the accountability framework and these would be addressed outside of the meeting with Sam Harrison. The Chair highlighted the fact that quarterly Non-Executive Directors and Chairs of Board Committee meetings were note required as NEDs meet on a monthly basis with the Trust's Chair before each monthly Board meeting. While discussing the Board Committee terms of reference, the Committee agreed that comments relating to membership of the Quality Committee and the Safeguarding Committee received by Maura Teager, Chair of both these committees would be incorporated into the final version of these committees' terms of reference. It was noted that a representative from the BME network will be invited to attend meetings of the People and Culture Committee and these comments will be incorporated into the final version of People and Culture Committee's terms of reference. The Chair requested that Sam Harrison meets with each individual Chair of the Board Committees and their Executive leads to ensure the structure of all the terms of reference are consistent. Year-end reporting will be consistent in all Board Committee terms of reference to indicate that year-end reports will be made directly to the Audit and Risk Committee at the March meeting. The assurance summaries received by the Board Committees will be reviewed later in the year to ensure they are working to everyone's satisfaction. Attention was drawn to the Standing Orders of the Board of Directors. The Chair asked that point 4.2 concerning the appointment of the Chair and Directors be amended to read that the Trust shall appoint a Remunerations and Appointments Committee and/or other nominated persons whose members shall be the Chair, Non-Executive Directors and the Chief Executive whose function will be to appoint the other Executive Directors of the Trust. The Chair asked for an amendment to be made to point 5.4 concerning notice of meetings. This paragraph is to be corrected to read that before each meeting of the Trust Board, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or the Trust Secretary shall be sent by email at least three clear days before the meeting. **ACTION: Sam Harrison to meet with each individual Chair of the Board Committees and their Executive leads to ensure the structure of the terms of reference is consistent when reviewed** **ACTION: Sam Harrison to amend the membership section of the terms of reference of the Quality Committee and Safeguarding Committee to reflect Maura Teager's comments and amend the People and Culture Committee's terms of reference to include that a representative from the BME network is invited to meetings.**

	ACTION: Sam Harrison to make final amendments to the Standing Orders of the Board of Directors item 4.2 so it refers to the Remunerations and Appointments Committee. **ACTION: Sam Harrison to amend point 5.4 of the Standing Orders of the Board of Directors concerning notice of meetings to read that before each meeting of the Trust Board, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or the Trust Secretary shall be sent by email at least three clear days before the meeting.** **RESOLVED: The Audit and Risk Committee:** **1) Discussed and approved the Corporate Governance Framework for ratification at the July Trust Board meeting.** **2) Agreed that the GIAP actions outlined are now complete: CorpG1 (1), ClinG3 (2) and CorpG4 (1).** **3) Agreed that CorpG 2(1) is complete pending some issues of clarification that would be addressed outside of the meeting.**
AUD 2016/071	**<u>REVIEW CHANGES TO STANDING FINANCIAL INSTRUCTIONS</u>** Standing Financial Instructions (SFIs) are reviewed on an annual basis and have recently been updated, and were presented to the Audit and Risk Committee by Rachel Leyland for approval. The SFIs were updated as follows: • General updates to reflect changes in job titles, Committee titles and Regulatory names changes • Inclusion of a policy for the use of External Auditors for non-audit work • Updates to the Banking section to clarify the process regarding direct debits • The Tendering and Contract Procedure section has been updated to add further clarity around processes • Additional narrative added to the section related to settlement agreements within the Processing of Payroll section • Additional clarity added in relation to the process for approving any consultancy expenditure • The Asset section has been updated to add further clarity on responsibility for Trust assets. While reviewing the SFIs the Chair requested that further amendments be made as follows to page 3: • ALL staff must be made aware of section 10 and not 8 of the Trust's Standing Orders – Standards of Business Conduct. • Overriding Standing Financial Instructions paragraph to be corrected to show circumstances around non-compliance would be referred to the Audit and Risk Committee for referring action or ratification. Further amendments are be made as follows to page 22 in item 10.1.1. This paragraph should indicate that the Board should formally agree and record in the minutes of its meetings, the precise terms of reference of the Remuneration and Appointments Committee and not the Remuneration and Terms of Service Committee.

	RESOLVED: The Audit and Risk Committee approved the SFIs subject to the above amendments.
AUD 2016/072	**GOVERNANCE IMPROVEMENT ACTION PLAN (GIAP)** Mark Powell was not available to present this report which provided the Audit and Risk Committee with an update in respect to its oversight of GIAP actions it is responsible for seeking assurance on delivery. The Chair informed the Committee that she was not assured that actions outlined in the GIAP had been delivered and did not feel able to sign off items listed as follows in the absence of supporting evidence: • Cling2 - The Trust would benefit from a robust and thorough policy review programme: At last meeting The Chair asked for an indication of the size of the issue and she did not feel this was included in the report. • It was requested that the Policy Tracker would be presented to the Committee at today's meeting to provide assurance of progress but this was not included in the report. The Committee was satisfied that the action CorpG12 is complete (Reintroduce short summary reports from committee chairs to the Board to supplement minutes). It was agreed that Claire Wright and Sam Harrison would discuss this version of the GIAP update of actions at the informal directors meeting in order to resolve these issues and ensure the above matters are clarified clearly in the next report. **ACTION: Claire Wright and Sam Harrison to discuss the GIAP update of actions at the informal directors meeting and ensure the above matters are clarified clearly in the next report** **RESOLVED: The Audit & Risk Committee:** **1) Received the report and was not assured that actions outlined in the GIAP have been delivered within the timeframes agreed and requested that the GIAP be discussed at the next informal directors meeting, led by Claire Wright and Sam Harrison.**
AUD 2016/073	**COMMITTEE ASSURANCE SUMMARY REPORTS (QUALITY COMMITTEE AND MENTAL HEALTH ACT COMMITTEE** Assurance summary reports were noted received from the Quality Committee held on 7 July was noted. The tabled reports from People and Culture Committee and Mental Health Act Committee were not accepted as there was no time to read and give them proper consideration. The Chair requested that reports are not tabled on the day of the meeting. **RESOLVED: The Audit & Risk Committee noted the Assurance Summaries received from the Quality Committee.**
AUD 2016/074	**OVERVIEW OF COMPLAINTS AND THEMES FOR ASSURANCE**

	Carolyn Green delivered the report on Complaints Concerns and Compliments for 2015/16. This was an edited review of the Quality Committee's assurance on the service performance and was submitted to assure the Audit and Risk Committee that the service is operating effectively. The paper focused on performance and was extremely well received. The Committee considered that the highest risk area was replying to complaints within three working days and noted the action being taken to improve the number of complaints acknowledged during this period by identifying protected time for logging new cases. This is a priority for the coming year and capacity of the team is the main driver of this performance. The Committee noted that capacity issue is a theme throughout the report. On a national benchmark level the patient experience team was rated less than it is under the national benchmark for a service of this nature, although the additional investment in the family liaison team was seen as a very positive extension. It was appreciated that with the resources available this is a highly effective team and complaints received from families as a serious incident or complex complaint process had reduced. **RESOLVED: The Audit & Risk Committee:** **1) Considered the report and was assured by the assurances the Quality Committee provided.** **2) Due to the performance level, the report outcomes gave significant assurance. However in providing full compliance against the policy standard of all complaints being received within three days, the service is not compliant and only partial assurance was received.**
AUD 2016/075	**RECEIVE ANNUAL REPORTS FROM BOARD COMMITTEES** The Audit and Risk Committee received the annual reports of the Quality Committee, Mental Health Act Committee, Safeguarding Committee and Remunerations and Appointments Committee. The Committee noted the annual reports and suggested that the Committee Chairs meet to align their annual reports to be received by the Committee in future. **RESOLVED: The Audit & Risk Committee received and noted the annual reports of the Quality Committee, Mental Health Act Committee, Safeguarding Committee and Remunerations and Appointments Committee**
AUD 2016/076	**QUARTERLY REVIEW OF BOARD ASSURANCE FRAMEWORK 2016/17** The Board Assurance Framework (BAF) provides a central basis to support the Board's disclosure requirements with regard to the Annual Governance Statement (AGS), which the Chief Executive signs on behalf of the Board of Directors, as part of the statutory accounts and annual report. The Audit & Risk Committee recognised this was the second formal presentation of the Board Assurance Framework to the Audit & Risk Committee for 2016/17 and the following points were noted: • There has been significant review and update of each risk during the last quarter • Since Issue 1 of the BAF for 2016/17 the risk rating for 2 of the 6 risks has been increased. This in relation to the risks around: achievement of quality standards; and

	delivery of the financial plan which was also discussed at the Finance and performance Committee and the Board and has since been aligned with the Operational Risk Register. • None of the risks currently identified in the BAF have revised their risk rating down. • The risks have been re-ordered in line with the Trusts revised strategic objectives, so risks previously identified as 2a, 2b etc have been amended. • A link to the operational risk register has also been included this month, with the reference number for related high/extreme operational risks cited against the relevant line in the BAF. A headline summary of these risks has also been included. • All dates for 'deep dives' of individual BAF risks are planned for the year. Currently all deep dives will be undertaken by the Audit & Risk Committee (as all risks are rated as either high or extreme) but this is subject to change dependent upon the current risk rating of each risk. • The Audit & Risk Committee (and Board) will receive the BAF four times during the year, in line with 'NHSI's governance guidance. It was noted that 'Deep dives' have become embedded into the BAF process to enable review and challenge of the controls and assurances associated with each risk. These are undertaken by the lead responsible committee for each risk. As in 2015/16, where risks on the BAF remain high or extreme (currently all risks), the Audit and Risk Committee will undertake this 'deep dive' to enable sufficient challenge to the highest risks facing the organisation and the programme for these deep dives is now embedded in the Committee's forward plan. In addition to this a wider review of the risks on the BAF in light of the revised strategic objectives will take place at ELT. The Committee formally noted that risks are discussed and addressed at ELT but considered that the BAF might benefit from regular reviews at Board Development sessions especially as a revised set of strategic objectives have been implemented. The Committee considered there is good ownership of actions identified by individual directors and these are also entered into the Datix system. In addition to this, Rachel Kempster also meets with individual directors before each iteration of the BAF Discussions took place regarding merging risks 2a) System change and 4b) Transformation and it was agreed that this would be discussed outside of the meeting between Rachel Kempster and Mark Powell and the result of these discussions would be reflected in the next version of the BAF to be considered by the Committee in October. ***Post meeting note:*** *The Audit and Risk Committee agreed and recommended to the Board at the July meeting that risks 2a) System change and 4b) Transformation would be considered for merging in the next issue of the BAF.* The Committee recognised that significant work had taken place regarding BAF risks and was satisfied that a sense of ownership was gained from observing the BAF with individual directors and through the Board Committees. **ACTION: BAF to benefit from regular reviews at Board Development sessions.** **RESOLVED: The Audit and Risk Committee approved this second issue of the BAF for 2016/17 and was assured by the review of risks on the BAF that takes place by ELT and the Board Committees.**

AUD 2016/077	**<u>OVERVIEW OF RISK MANAGEMENT CONTROLS AND ASSURANCE</u>** Rachel Kempster delivered her report which provided the Audit and Risk Committee with an overview of the Trust's risk management systems and processes and detailed current assurances and challenges that this system provides. The following points were highlighted in discussions and were noted by the Committee: • The Trust's systems and processes for risk assessment and management of risks were moved to an electronic based system during 2012 to meet the requirements of the CQC, HSE and NHSLA and to reduce the gaps identified with the paper based system. • The undertaking of 'required risks assessments' by teams has been good, with 80 – 90% of teams having completed these risk assessments. • Staff are actively reporting risks through the Datix Web: Risks system with currently around 1600 open risks on the system, reported by a range of staff. As confidence in the process has grown a wider range of risk assessments have been added e.g. risks relating to staffing levels and capacity, funding impact and gaps in service provision. • Communication and escalation of risks is strong and well embedded throughout the Trust. From July 2016, there will be a clear line from the operational risk register to the Board Assurance Framework (BAF) risk, with the reference number for the operational risk cited against the relevant line in the BAF. • Maintaining control of the review of the 1600 open risks continues to be a significant back office function of the Risk Management Team, with no automated process for reminding managers that their risks require review. Thus reviews of 138 (8%) risk assessments due for review before 1/4/16 has yet to be completed • The operational management of risks (though senior management teams and the TOMM (Trust Operational Management Meeting) is well embedded and requires a similar approach for risks held by corporate teams • The potential for competing and sometimes conflicting reporting processes (with respect to the Board, Quality Committee, Audit and Risk Committee, TOMM, operational SMT's and clinical QLT's) requires resolution • To support the above, more succinct reporting from Datix: Risks needs to be considered and developed Rachel Kempster drew the Committee's attention to the Trust's embedded electronic system for recording and managing all risks assessments using the Datix system and discussions took place on the capturing of risks around this process. It was noted that risk management training is aimed at band 7 staff and above and Rachel Kempster regularly holds Datix training surgeries. Training also takes place with the Board and is captured in in individual training passports upon completion. The Committee was pleased to note that staff are actively reporting risks through the Datix web, managers and clinical leaders are responding to email notifications on risks that have been submitted and are clearly communicating and escalating risks appropriately. The operational senior management teams use the risk register function effectively and have embedded the review of risks with a residual risk grading of moderate or above and respond to and escalate risks appropriately. As identified in the 2015/16 Health and Safety Annual Report, the percentage of teams in the clinical divisions who have completed all their health and safety risk assessments is high. The Committee heard how reporting into key committees in a timely way was challenging and recommended that a risk strategy is developed which would allow monitoring of

	performance and asked that this be brought to the next meeting of the Committee in October. The Chair felt the paper gave a clear understanding the Trust's risk management systems and processes and received assurance that a working risk management process was in place. The Committee looked forward to receiving a paper at the next meeting that would set out the Trust's risk management strategy. **ACTION: Rachel Kempster to submit a paper to the October meeting setting out the Trust's risk management strategy.** **RESOLVED: The Audit and Risk Committee:** **1) Considered the report and received assurance on what is working well with respect to risk assessment and management** **2) Considered the challenges identified by the report and recommended that a Risk Strategy be developed for consideration at the next meeting in October.**
AUD 2016/078	**DEEP DIVE RISK 2a TRANSFORMATION** **BAF Risk 2a: "Risk to delivery of national and local system wide change. If not delivered this could cause the Trust's financial position to deteriorate resulting in regulatory action."** Mark Ridge, Acting Head of Transformation delivered a presentation that set out the key controls/systems, that are in place and showed how this risk had evolved since it was first recorded. Although the agenda showed that risk 4b Transformation would be the subject of today's deep dive, the risk discussed was entitled risk 2a, but the content was related to the Transformation risk. The Committee discussed the alignment of these two risks and agreed that risks 2a System Change and 4b Transformation would be considered for merging in the next issue of the BAF to be received at the next meeting in October. Mark Ridge highlighted the new controls that were set up to assist in securing delivery of the new objective. The Committee agreed that Transformation had not yet achieved what the Trust expected it to achieve and noted the revised milestones that have been put in place: The Committee discussed the gaps in control and the evidence that showed where controls/systems had failed to be implemented and how we are failing in making them effective as follows: • Gap: Plans have not as yet identified full CIP for year and pipeline going forward: Mitigation – Continued review of CIP opportunities and seeking NHSI support for ongoing CIP delivery • Gap: Lack of clarity around collaboration and competition across the health economy: Mitigation – Development and maintenance of relationship management through CEO and lead Directors. It was considered that the new working relationship between the Trust and Derbyshire Community Health Services NHS Trust (DCHS) is helping to close this gap. • Gap: Lack of embedded coaching culture to deliver empowered leadership, accountability and delivery: Mitigation – Development of Leadership Programme as part of GIAP

	The Chair did not consider that capacity issues or strategic governance was covered in these gaps in control and asked that they be included in the BAF. The Committee noted the action/progress that had taken place in the efficiency programme and how the Trust's stakeholder and relationship management was building strong partnerships and influencing system change and the Chair considered this to be positive assurance. The Committee understood the need to fully develop transformational project plans for current and future years with assurance on cost in line with Trust strategy and national policy and noted the action and progress taken so far. It was noted that the £2m gap in the efficiency programme is being addressed by the Finance and Performance Committee and is also regularly reviewed by the Board and all the current plans are being progressed. In summarising the deep dive of risk 4b, the Chair pointed out that these gaps in assurance and the actions to increase controls refer to areas of focus that have been addressed at Board meetings and each of the executive leads has met to resolve the gaps. She considered this deep dive articulated 3 gaps in assurance and asked for a narrative and an action plan to be aligned with the BAF. She considered it would be very difficult to address this risk in total throughout the year as external risks were not articulated as much as internal risks and this could result in risks having to be mandated. **ACTION: Gaps in control regarding capacity and strategic governance to be included as risks in the BAF.** **ACTION: A narrative and an action plan is to set out the 3 gaps in assurance associated with BAF Risk 2a and is to be aligned with the BAF.** **RESOLVED: The Audit Committee noted and received the assessment of BAF risk 2a.**
AUD 2016/079	**<u>UPDATE ON EXTERNAL AUDIT PROGRESS</u>** The draft Annual Audit letter 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. Joan Barnett informed the Committee that the draft Annual Audit Letter had been agreed with the Director of Finance and she would send the final version to the Board Secretary for submission to the Trust Board at its meeting on 27 July. Joan Barnett also presented the Audit and Risk Committee with Grant Thornton's report which gave a preview of Grant Thornton's external audit work for 2016/17. **RESOLVED: The Audit and Risk Committee received the draft Annual Audit letter and update report on External Audit Progress.**
AUD 2016/080	**<u>UPDATE ON INTERNAL AUDIT PROGRESS</u>** Glen Spencer delivered the Internal Audit Progress report which summarised PWC's activity in delivering the 2016/17 Audit Plan. The Chair informed the Committee that she had met with PWC the previous week to discuss the internal audit plan for this year and this has now commenced.

	Glen Spencer reported that PwC had met with Mark Powell, Director of Strategic Development and Jenna Davies the GIAP Programme Manager to discuss the GIAP. Final terms of reference have not yet been agreed for this piece of work as PwC are still in the process of discussing this with executives. Claire Wright informed the Committee that ELT had discussed how there was potential for duplication with some of the planned audit work of PwC and the required GIAP work to be undertaken by Deloitte (agreement is yet to be reached with NHSI on the business case and this is why the terms of reference have not yet been agreed). It was agreed that Claire Wright, Glen Spencer and Ali Breadon will take this forward and Claire Wright will lead the work on proposing alternative replacement audits for the areas of duplication. Caroline Maley confirmed she was content for this change to the internal audit plan. The Committee discussed the HR policies piece of work which is being split into disciplinary and grievance policies and whistleblowing. The Committee understood that this work had been hindered due to a delay in responses being from Trust staff who have had to attend inquests. For this reason the Chair asked for the disciplinary and grievance information to be contained in one report and work relating to the Whistleblowing Policy will be contained in a separate piece of work and she asked Claire Wright to take the lead with PwC on this matter. Phil Harris questioned the data security handling of the Trust's systems and the necessary back up support the organisation is charged with and it was agreed that a focus on the these issues will be taken forward by PwC. **ACTION: Claire Wright to provide feedback to the Committee on updating PwC's audit plan with regard to removing duplication with Deloitte GIAP work.** **ACTION: Claire Wright to support PwC to prompt Trust colleagues in order to ensure a report on disciplinary and grievance policies is concluded as soon as possible and a separate Whistleblowing Policy report is received at the next meeting in October.** **RESOLVED: The Audit and Risk Committee received and noted the Internal Audit Progress Report.**
AUD 2016/081	**<u>REVIEW COUNTER FRAUD PROGRESS REPORT</u>** Penny Gee presented her report which advised the Audit and Risk Committee of work completed to date in respect of the 2016/17 Counter Fraud, Bribery and Corruption Operational Plan for the Trust. The Committee was pleased to note that following a review of the Trust's corporate induction programme the Counter Fraud Service now deliver face to face training to new starters at the monthly induction events. Existing staff continue to receive update training using refresher e-learning. The Spring edition of the quarterly newsletter Fraudulent Times was released to the Communications Team for upload to the Trust's counter fraud intranet page and this would also be circulated to Committee by email. Penny Gee reminded the Committee that the Local Counter Fraud Service is a member of the Trust policy review group for both Finance and HR policies and asked that relevant

	policies be shared with her. Rachel Kempster proposed to resolve this with Penny Gee outside of the meeting. **RESOLVED: The Audit and Risk Committee noted the contents of this report and received assurance regarding work undertaken in accordance with the agreed plan and NHS Protect Standards for Providers**
AUD 2016/082	**REVIEW THE ANNUAL CLINICAL AUDIT PLAN – REPORT FROM QUALITY COMMITTEE** John Sykes and Rubina Reza provided the Audit and Risk Committee with an update report on arrangements within the Trust by which Clinical Audit is conducted as set out in the Trust Clinical Audit Framework, Policy and Procedures. This update builds upon the paper that was presented to the Quality Committee in July which focused upon the opening of the 2016-17 Clinical Audit Programme and the closure of the 2015-16 programme. Clinical Audit is assigned to the Quality Committee for assurance on progress, although the Audit and Risk Committee has an interest due to its oversight role. The Committee recognised that the report indicated that the Quality Committee received an improved level of assurance on delivery of Clinical Audit but there was a gap in assurance mainly due to the completion of projects. Representation at the R&D Governance Committee is still a cause for concern and plans to improve attendance and implement systems to capture feedback to progress the approval of projects was noted. Rubina Reza informed the meeting that she believes the QLTs involvement in the R&D Governance Committee has had a positive impact as without their support the R&D Governance Committee would not have been able to sign off as many projects. It was agreed that as the Quality Committee is the primary committee for Clinical Audit it will make objective assessments on the level of assurance received from Clinical Audit reports during the year and will provide assurance to the Audit and Risk Committee on the progress being made. The Chair proposed that further direct reports on Clinical Audit will be made to the Audit and Risk Committee twice a year. The January report will set out the new Clinical Audit plan as well as project progress which will allow Clinical Audit project close detail to be included in the Audit and Risk Committee's end of year report to the Board. In the meantime, the Chair offered to liaise with Maura Teager, Chair of the Quality Committee to ensure they are both satisfied with this level of reporting. **ACTION: Forward plan to reflect Clinical Audit Updates received twice a year in January and July. The January report will detail the new Clinical Audit Plan.** **RESOLVED: The Audit and Risk Committee:** **1) Considered the update on arrangements set in place by which the Trust conducts clinical audit.** **2) Considered and agreed that the Clinical Audit Report on the adequacy of systems in place will be brought to the Committee twice a year, noting that Clinical Audit progress is being reviewed by the Quality Committee**
AUD 2016/083	**2016/17 FORWARD PLAN** The forward work plan was noted and will be further reviewed by Sam Harrison and the

	Chair on an ongoing basis.
AUD 2016/084	**MEETING EFFECTIVENESS** The Chair thanked all those present for their attention and attendance and closed the meeting at 4:30pm. The Chair did not feel that discussion during the meeting was as efficient as it could have been due to the absence of key executives. However, it was understood that this was due to unexpected circumstances.
AUD 2016/085	**DATE AND TIME OF NEXT MEETING** The next meeting of the Audit and Risk Committee is due to take place at 2pm on Tuesday, 11 October and will be held in Meeting Room 1, Albany House, Kingsway.

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE QUALITY COMMITTEE

HELD ON THURSDAY 8 SEPTEMBER 2016
MEETING ROOM 1, ALBANY HOUSE

MEMBERS PRESENT	Maura Teager	Chair and Non-Executive Director
	Julia Tabreham	Non-Executive Director
	Carolyn Gilby	Acting Director of Operations
	Carolyn Green	Director of Nursing & Patient Experience
	John Sykes	Medical Director
IN ATTENDANCE	Petrina Brown	Consultant Clinical Psychologist
	Donna Cameron	Corporate Services Officer (minutes)
	Chris Fitzclark	Derbyshire Mental Health Alliance
	Carinna Gaunt	Health & Safety Manager
	Emma Flanders	Lead Professional for Patient Safety
	Mark Powell	Director of Strategic Development
	Rob Morgan	Health & Safety Advisor
	Rubina Reza	Research & Clinical Audit Manager
	Sandra Austen	Derby City & South Derbyshire Mental Health Carers Forum

QC/2016/150	**WELCOME AND APOLOGIES** The Chair, Maura Teager, opened the meeting and welcomed attendees. Julia Tabreham was welcomed officially in her capacity as Non-Executive Director. Julia will be taking over the Chair of Quality Committee formally in October. Apologies for absence were noted as above.
QC/2016/151	**MINUTES OF THE MEETING HELD ON 11 AUGUST 2016** The minutes of the previous meeting, held on 11 August 2016, were accepted with the following amendments: **QC2016/137 PATIENT EXPERIENCE REPORT** Paragraph three to be amended to reflect that the *"deep dive had been presented to the Commissioner's Quality Assurance Committee*. **QC2016/146 MEETING EFFECTIVENESS** Minute to be amended to read *"The Committee noted the feedback from Julia Tabreham. It was felt there had been a lot of operational discussion and the Committee would benefit from a more strategic dialogue. Julia had been impressed by the hard work and analysis to support the Committee. It was agreed to consider the suggestion that if confidential discussions are required a separate, confidential meeting of Quality Committee may be held at the end of the meeting, which is documented"*
QC2016/152	**ACTIONS MATRIX AND MATTERS ARISING** The Committee reviewed the Actions Matrix and agreed updates and amendments. It was agreed to add due date information to the matrix for all actions.

	Policies: The Quality Committee policies dashboard was noted. **ACTION: Carolyn Green is to review, with Rachel Kempster, the option to RAG rate out of date policies according to risk impact, at the request of Julia Tabreham. Confirmation of the timescale for delivery of this action will be provided at the November meeting and will require some technical changes and a lead in time.** **ACTION: An update on the completion date for the Equality Impact Assessment Policy to be discussed with Amanda Rawlings by Carolyn Green.**
QC2016/153	**SERIOUS INCIDENT REPORT** Emma Flanders, Lead Professional for Patient Safety, presented to report to update the Committee on information relating to serious incidents (SIs) that had occurred during August 2016. The Chair sought further detail on the three Mental Health Act administration errors recorded in August. Emma Flanders advised that the errors had been made on admission to Royal Derby and were received with those errors on transfer to the Trust. Sarah Butt advised a "blue light" was issued advising staff of immediate actions required to learn and rectify this practice in future. Julia Tabreham queried and scrutinised the report and specifically the SIs where missed grading had occurred. Emma Flanders advised that the SI Group had been commissioned to investigate and provide assurance to the Committee that wrongly graded historical incidents were reviewed. This analysis was the next stage of this look back with data validation and analysis raising the question "did the Trust follow its own procedures and to identify any human errors over a five year analysis of investigations". It was noted that only categories where major/catastrophic incidents occur are reported in the SI report. Julia Tabreham and John Sykes as the Executive lead agreed to discuss any potential changes in the presentation of this material in order to provide assurance and strategic direction. Julia Tabreham sought assurance on the management of overdue actions. Emma Flanders advised that overdue actions are escalated on a monthly basis to responsible individuals and their managers. Extensions can be requested for actions but the risk and vulnerabilities to patients will be factored into any such approvals. Chris Fitzpatrick expressed his concern regarding incident W22809 (2015/34375) and his frustration, from a service user's perspective, at the circumstances which had led to the patient's suicide. John Sykes assured the Committee that the investigation had reviewed the standard of care provided, lessons learned and improvements made. The Trust had been very open with the family and taken on board the response from the Coroner. The Trust continues to progress with the suicide prevention strategy. Julia Tabreham noted the incidence of points of transition and asked members for input to improve on this. Following discussion, Emma Flanders agreed to review transition data and consider whether there is a theme of elevated risk in transition, she will be considering and using internal

	information in addition to NRLS statistics, to reflect on patterns. Feedback will be given to the next meeting on initial findings. The outcome of this will determine any next steps on additional analysis required. The Committee noted that work continues on the data review and analysis of five years' worth of data, this established that 34 deaths previously recorded on Datix as deaths, may not have had the correct form of investigation and of which some have not been reported on STEIS under the correct category. This appears to be a common issue for all Trusts where both physical health care deaths may have changes in cause of death post Coroner inquest, and deaths reported as suspected suicide post Coroner inquest turn out not to be the original finding. As previously reported, the Commissioners have been notified of this and the impact on historical data, changing cause of death and the differences in types and form of investigation based upon cause of death, a one person or two person investigation. As requested at the last meeting, a brief outline on the progress of each investigation death is provided. The level of these retrospective reviews exceeds that required but is being undertaken for good practice and to maximise learning for the Trust and to establish how this may impact upon the current situation to enable continuous improvements to the procedures. The detail of all incidents was provided to the CCG Patient Safety Lead at the Trust and Commissioners Quality Assurance Group and full scrutiny of this historical data has been provided to the CCG's **ACTION: Presentation of data on major/catastrophic incidents to be reviewed.** **ACTION: Transition data to be reviewed to reflect on any emerging patterns for presentation to the October meeting.** **RESOLVED: The Quality Committee noted the report. The data review of STEIS reportable incidents will be escalated to the Board for information to confirm this work is in place and historical data findings.**
QC2016/154	**ANTI LIGATURE AUDIT** Carrina Gaunt, Health & Safety Manager, joined the meeting to provide the Quality Committee with an update on ligature risk reduction, an area of high priority within the Health Safety portfolio. The plan to identify, reduce or remove risks in the Radbourne, Hartington and Kedleston Units in bedrooms, bathrooms and WCs is on target. Resolutions have also been formed for three issues identified by the CQC outside of bedrooms, bathrooms and WCs. A detailed report on the programme will be presented to Quality Committee in the next report, scheduled for December. The report will also include an update on seclusion doors. Carinna raised a concern on progress and advised the Committee that the area of environmental handover is still outstanding. This is in supplement to the patient hourly checks and to improve environmental ownership and handover. A high level of concern was expressed by the Quality Committee regarding the lack of evidence of implementation on this within the initial

	agreed timescale. The wards have existing health and safety and ligature audits, this is a service improvement to improve patient safety and security of the environment. Richard Morrow will be invited to present an urgent update report to the October meeting. Sarah Butt will provide an interim update, between meetings to Carolyn Green. Carolyn Green briefed that some progress on compliance and developmental work has been delayed due to senior nurses having been redeployed to work within the staffing establishment as part of the emergency planning process. Carrina Gaunt took the opportunity to raise her concern with the Committee that the Health & Safety report had not been submitted according to the annual requirements. **ACTION: Interim update on development and progress of the environmental handover from Sarah Butt to Carolyn Green between meetings.** **ACTION: Richard Morrow to be invited to present an urgent update on environmental handover to the October meeting. Pending the update, the Committee will consider further escalation to the Trust Board if assurance is not gained.** **ACTION: Health & Safety Annual Report to be included in forward plan.** **RESOLVED: The Quality Committee noted the report and received limited assurance in respect of the developmental work on environmental handover.**
QC2016/155	**<u>POSITIVE AND SAFE UPDATE</u>** Sarah Butt, Assistant Director of Clinical Practice, presented her monthly report to advise Quality Committee on the progress of the reducing restrictive interventions action plan. The following points were highlighted: The Positive and Safe Steering Group and its sub-committees continue to drive delivery on key objectives in the strategy. The challenges, as set out in the Executive Summary, were noted. The Chair raised her concern that at a recent Mental Health Act Committee meeting, it was clear that there was a lack of shared understanding of the definitions of segregation/seclusion. Following discussion, it was agreed that Sarah Butt would revisit the policy to provide clarifications, in agreement with John Sykes. Safewards is being fully implemented within the Radbourne and Kingsway Units. The feasibility of extended relationships and the options for an exchange programme with Danish colleagues is being reviewed for next year. GAP analysis on inpatient practice and improvement work to cease ward rules has been undertaken and an action plan developed to address practices which would constitute blanket rules. A monthly audit programme has been implemented and shared with Quality Committee for assurance. A Mental Health Capacity Administrator who will support the Mental Health

	Act Committee lead executive John Sykes and the Mental health Act Manager has been recruited. A start date is to be confirmed. Access to independent advocacy services had been made available since April for post-incident debriefs for patients but uptake had been observed to be low. Heads of Nursing are now auditing every event of seclusion and its use is being reviewed for the wider clinical quality aspects as part of the Positive and Safe strategy in addition to the compliance under the Code of Practice, which is the domain of the Mental Health Act Committee. John Sykes raised the issue of restrictive interventions, adding that, anecdotally, there are concerns around the expectations of and from medical staff in challenging seclusions, which was raised at a medical forum. Following discussion it was agreed that John Sykes with the support of Sarah Butt would lead a 'table top review' of the policy incorporating a cross reference to staffing levels to see if any improvements can be identified in how medical staff review and challenge the use of seclusion. This will include any changes to the policy that will assist clinical staff in discharging the requirements of the Code of Practice. Petrina Brown also suggested some reflective practice (with medical staff and bleep holders) around challenging decisions and questioning practice. Debate and challenge on whether it was the policy that was reviewed or whether development of clinical practice to feel safe to challenge and scrutinise was as important as the policy. John Sykes agreed to take into account this challenge in his work and in the table top review. In relation to the Safeward exchange with representatives from Denmark, Julia Tabreham sought information on how nursing and AHP staff are able to access national and international forums, summits, opportunities and grants. Carolyn Green advised that such activities are promoted to staff through CONNECT and through professional lines and knowledge sharing of bids and research encouraged. Further discussion will be held outside the meeting as part of induction. **ACTION: Seclusion and Segregation Policy wording to be reviewed with by John Sykes and support provided from a Nursing perspective by Sarah Butt.** **ACTION: Table top exercise on restrictive interventions to be led by John Sykes and supported Sarah Butt, with particular reflection on medical challenge** **RESOLVED: The Quality Committee received and noted the report.**
QC2016/156	**<u>QUALITY LEADERSHIP UPDATE</u>** The Chair noted the lack of representation from the Quality Leadership Team (QLT) for the second consecutive meeting. Petrina Brown as a QLT member and QLT Deputy Chair confirmed that a QLT meeting had been held earlier in the week and summarised discussions. However, due to timescales and lack of admin support it had not been possible to produce minutes or a report for the Quality Committee today.

	The Chair thanked Petrina Brown for the update but expressed her concern on the progress of and maturity of governance infrastructure, which is part of delivery of the Governance Improvement Action Plan. QLTs exist to provide structure to the Quality Committee and are pivotal to enabling safe and effective patient care and in the implementation of releasing the Senior Leadership and Executive Team from operational management. The QLTs had been in place for some time now but there had been inconsistency, lack of representation and absence of feedback. In discussing next steps, the Quality Committee acknowledged that the work of the QLTs is a fundamental part of the Trust's governance. Mark Powell expressed his concern that as a smaller Trust the organisation may not have sufficient size and resource to support these arrangements. He challenged the reality of whether QLTs were therefore actually needed. Carolyn Green reinforced that they were required and that there had been movement in gathering momentum of the need and function of QLTs. Petrina Brown confirmed that developmental meetings and work of the QLT chairs had been progressing over the summer and the challenge of meeting competing priorities for QLT time was a challenge. The operational administration support had also been a challenge and this had not supported the QLTs in their development. Mark Powell confirmed that clarity of purpose is key to underpinning the accountability framework, which the Executive Leadership Team (ELT) aims to have in place by the end of October. The framework will allow, enable and support the infrastructure with leadership support. Julia Tabreham requested that Mark Powell raise the QLT matter at ELT with a view to identifying obstacles to success and establish what was required to support the teams. Carolyn Green reinforced that whilst some areas remain under emergency planning and the focus on immediate service delivery, this is not assisting the QLTs to develop their compliance and quality governance functions. **ACTION: QLT chairs or named representatives to be requested to attend ALL meetings of the Quality Committee.** **ACTION: Issue of attendance/capacity/support to be raised at ELT.** **RESOLVED: The Quality Committee noted the Quality Leadership Update.**
QC2016/157	**<u>GOVERNANCE IMPROVEMENT ACTION PLAN UPDATE</u>** Mark Powell presented the Quality Committee with an update against Core 3 of the GIAP to provide an overview of key tasks that the Committee is responsible for seeking assurance on delivery. It was noted that this paper was presented to the Trust Board on 7 September. Core Area 3 is responsible for delivery of nine recommendations. Mark Powell sought the Committee's opinion on the current status of those recommendations, as presented to the Trust Board. He also asked members if they had any questions about the process itself. The Committee proceeded to review and discuss each element of Core 3 as follows:

	ClinG1: Refresh the role of the Quality Leadership Teams to increase their effectiveness as core quality governance forums (four actions): Reflecting upon the discussion as per item QC2016/156 above, the Committee did not think this task was on track to deliver by the target date. There are obvious impacts of emergency planning preventing delivery. Carolyn Green offered support in planning and scheduling meetings. Although the role of QLT has been refreshed and the action has been completed, the wider outcome of a more effective Quality Leadership Team is not in embedded. Ad-hoc Non-Executive Director attendance had been discussed previously and the Chair offered to make herself available for this. The Chair noted concerns had been raised regarding lack of administrative support for the QLTs, which Mark Powell was asked to feedback to ELT. Minutes have been regularly provided, just not on this occasion, from the QLTs to Quality Committee, which would benefit from improvement. The use of the QLT escalation template was challenged and whether the minutes and fixed agenda that Carolyn Green had provided to the QLT was being used. ***ClinG2: The Trust would benefit from a robust and thorough policy review programme (one action):*** The Audit and Risk Committee received an assurance on the policy review programme and this is on track for delivery by the end of December. The Committee suggested this task was 'on track/green' and this decision was supported by Mark Powell. ***ClinG3: Increase the effectiveness of the Quality Committee by ensuring clear alignment of the committee with the quality strategy and associated objectives, and ensuring a clear focus on seeking assurance (four actions)*****:** The Chair considered this a work in progress. The agenda template has reverted to the old model rather than the revised template. Mark Powell noted that the agenda for this meeting did not reflect the forward plan and suggested that the Committee refocus on links to the quality priorities. Carolyn Green stated that the agenda items were all part of the quality priorities, however she conceded that the older template for the agenda had been used and this would be rectified. The Committee agreed that the rating for this task was amber, which would be flagged through the escalation template to Board. Julia Tabreham requested Mark Powell to discuss assurance processes and major quality imperatives as soon as possible. . Carolyn Green responded by confirming that the leads would be John Sykes or herself as the named Director and Quality Leads. **ACTION: Julia Tabreham to discuss assurance processes and major quality imperatives as soon as possible, as part of her induction with Executive Directors** **ACTION: Agenda template to be revised to the new template to reflect reference and links to quality imperatives and forward plan. QLT minutes to expressly identify escalation template designed for their use in their reports.** **RESOLVED: Quality Committee discussed the content of the paper and agreed risk ratings for the delivery of this core area.**

	Sarah Butt left the meeting due to a prior agreement and was released
QC2016/158	**INFORMATION GOVERNANCE (IG) UPDATE** John Sykes, Medical Director presented the Q2 IG update, detailing progress towards meeting the requirements of the 2016/17 Version 14 IG Toolkit as well as the work of the IG Committee and IG breach monitoring. Mark Powell noted the ambition to achieve 92% attainment by 2017. John Sykes assured the Committee of his high level of confidence in the personnel and department in achieving this. **ACTION: Workplan to reflect six monthly updates.** **RESOLVED: The Quality Committee acknowledged the initial IG toolkit baseline and progress made with the IG Workplan. IG Committee Terms of Reference, IG Work Plan, IG Management Framework and IG Specialist Training Plan were confirmed as fit for purpose.**
QC2016/159	**CENTRAL ALERT SYSTEM** Emma Flanders, presented the revised Central Alert System (CAS) Policy & Procedure. The policy was approved subject to minor alternations (location and author to be amended). **RESOLVED. The Quality Committee approved the policy.**
QC2016/160	**SINGLE PATIENT CARE SYSTEM** Carolyn Gilby, Acting Director of Operations, delivered a verbal update on single patient care system . A full progress review on the Paris Single Record Project was reviewed by ELT on 22 August where the retention of the Project Team was approved until the end of March. Also approved the purchase of integration software tool to resolve connectivity issues between systems and develop integration facilities between internal and external services. The Chair noted that this would be Carolyn Gilby's final Quality Committee prior to her retirement and thanked her, on half of the Committee for her contribution.
QC2016/161	**ANY OTHER BUSINESS** Noting that this would also be Chris Fitzpatrick's final meeting, the Chair thanked him for his meaningful contributions to the meeting and for representing service users to so well. Sangeeta Bassi, Chief Pharmacist, noted that the forward plan does not reflect the pharmacy strategy and medical management report. Carolyn Green to advise dates following a 6 month period post last report which would be timed for December for the data collection and for a report to be compiled and presented in January 2017. The forward plan will be amended accordingly.

	Noting that the minutes of the Drugs & Therapeutics Committee were included on today's agenda for information, the new Chair will consider if minutes of the Medicines Safety Committee are required in future as part of her induction with Carolyn Green.
QC2016/162	**ESCALATION ITEMS TO THE BOARD** • Data review of STEIS reportable incidents • GIAP change of category and rating • Anti-ligature - Estates capital improvement programme • Quality Leadership Team
QC2016/163	**FORWARD PLAN** In light of earlier conversations, the forward plan will undergo a review. **ACTION: The forward plan to be reviewed.**
QC2016/164	**MEETING EFFECTIVENESS** The Chair sought feedback on time allocation, contributions and quality of papers. Mark Powell observed that discussions had been very good. The report on the anti-ligature work had contained an escalation to the Committee, which may not have been the appropriate route for escalation. Conversations on the GIAP had been extremely helpful and honest. The meeting requires attendance of the QLT representatives. Carolyn Gilby added that with the departure of Chris Fitzclark it is important to ensure continued representation from a service receiver on this group. Carolyn Green agreed to follow this up. New representatives are required to have an induction with Carolyn Green to discuss support, the delicate and sometimes distressing nature of the incident report and the need for confirmed support and debrief arrangements prior to attending the meetings, which Carolyn will also follow up on for Sandra Austen as a Carers lead The meeting closed at 16.55. A confidential meeting with members only followed.

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE PEOPLE & CULTURE COMMITTEE

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

Tuesday, 20 September 2016

PRESENT:	Richard Gregory	Chairman
	Margaret Gildea	Non-Executive Director
	Amanda Rawlings	Director of Workforce, Organisational Development and Culture
	Mark Powell	Acting Chief Operating Officer
IN ATTENDANCE:	Sam Harrison	Director Corporate & Legal Affairs
	Karen Herriman	Deputy Director of Workforce and Organisational Development
	Rose Boulton	Principal Workforce & OD Manager
	Anna Shaw	Deputy Director of Communications & Involvement
	Lee Fretwell	Chair, Staff Side
	Liam Carrier	Workforce Systems & Information Manager
	Owen Fulton	Principal Employee Relations Manager
	Faith Sango	Head of Education
	Sue Turner	Board Secretary & Minute Taker
APOLOGIES:	Carolyn Gilby	Acting Director of Operations
	Dr John Sykes	Executive Medical Director

P&C/2016/ 078	**WELCOME AND APOLOGIES** Richard Gregory opened the meeting, welcomed everyone and introduced Non-Executive Director, Margaret Gildea who would take over as the Chair of the Committee from October. He also welcomed Karen Herriman to the meeting.
P&C/2016/ 079	**MINUTES OF THE MEETING HELD ON 16 JUNE 2016** Minutes of the meeting held on 15 July 2016 were approved.
P&C/2016/ 080	**ACTIONS MATRIX AND MATTERS ARISING** It was agreed to close all completed actions. Updates were provided by members of the Committee and were noted directly on the actions matrix.
P&C/2016/ 081	**ADOPTION OF PEOPLE & CULTURE COMMITTEE TERMS OF REFERENCE** Sam Harrison drew attention to amendments that had been made to the Committee's terms of reference to correct the shortfall in equality and diversity areas. The Committee agreed to accept the legislative aspects of these amendments. Discussion took place on to how the Committee could be reshaped and the following suggestions were made for inclusion in a revised version of the terms of reference: • Partnership working with a staff governor representative

	• Director of Nursing to join the Committee • Associate clinical director to attend when the Medical Director is unavailable. • Two of the Committee's subgroups, the Workforce Group and Leadership and Education Group could be combined • Committee will operate in a way which is serviceable and mindful of NED commitment. It was agreed that further thought will be given to the Committee's membership outside of the meeting by Amanda Rawlings and Sam Harrison and a revised version of the terms of reference would be received at the next meeting. **ACTION: Sam Harrison and Amanda Rawlings to revise the Committee's terms of reference** **RESOLVED: The People & Culture Committee accepted the legislative aspects of the Terms of reference.**
P&C/2016/ 082	**STAFF STORY** Amanda Rawlings suggested that in order to provide the Committee with a staff voice a staff story could be received at each monthly meeting and she proposed to work with HR team to produce programme of subjects for future meetings. **ACTION: Amanda Rawlings and HR team to organise programme of staff stories.** **RESOLVED: The People & Culture Committee noted the verbal proposal on Staff Stories**
P&C/2016/ 083	**STRATEGIC WORKFORCE REPORT** In order to provide the Committee with assurance, Amanda Rawlings proposed to produce a Strategic Workforce Report on a regular basis that will give a horizon scan of the HR function, HR policies and organisational development. This report will contain an update report from each of the Committee's subgroups setting out the results of each meeting. This report will also include the minutes from the JNCC (Joint Negotiation and Consultative Committee). **ACTION: Strategic Workforce Reporting schedule to be reflected in the forward plan.** **RESOLVED: The People & Culture Committee noted the proposal put forward for the Strategic Workforce Report**
P&C/2016/ 084	**WORKFORCE PERFORMANCE REPORT** Liam Carrier presented the People and Culture Committee with the latest key Workforce metrics which contained: • An overview of the latest key Workforce KPI results (August 2016) with historic data for the previous 12 months. • Supporting commentary of general observations. • Hot spots and triangulation (August 2016) • Employee Relations Tracker

	The Committee discussed the turnover of staff and it was agreed that further reports would indicate reasons why employees have left as well as internal transfers to enable a more accurate view of the organisation. Absence due to anxiety and stress and depression has remained the Trust's highest reason for sickness absence. The Committee felt the main cause for stress related absence is due to staff shortages and was pleased to hear that an improved and proactive package of support will be developed to help staff manage long term sickness absences. It was recognised that a lot of stress related absence is also due to personal and home life issues and Julieanne Trembling the officer contact between the Trust and staff and is currently handling around 70 anxiety related cases. Staff resilience is a key issue and the Committee discussed how staff sometimes react badly to change which is being addressed through the Health and Wellbeing Group are talking through this. Amanda Rawlings suggested that clear guidelines be set up to enable line managers to manage sickness absence more efficiently and she proposed that this would be part of the development programme that is being put together. The Committee looked at the recruitment statistics in the report and felt the process for filling staff vacancies is too long and bureaucratic. Amanda Rawlings will refer to the recommendations of East Midlands streamlining process to reduce the number of days involved in recruitment. An electronic DBS check system is to be implemented and will require investment. Amanda Rawlings will link this with the DCHS contract and will work with the DCHS recruitment team to see how this can be implemented. The Committee also discussed providing additional resource for the recruitment team and agreed that approval would be obtained through ELT. It was also agreed that Amanda Rawlings and Mark Powell will carry out an end to end recruitment process review and will submit a report setting out their recommendations to the next meeting in October. **ACTION: Amanda Rawlings to obtain approval from ELT for additional resource for the recruitment team** **ACTION: Mark Powell and Amanda Rawlings to develop a condensed process to manage recruitment.** The Committee discussed the uptake of staff appraisals. It was agreed that Amanda Rawlings and Karen Herriman re-examine the appraisal system and implement a chase mechanism. **ACTION: Amanda Rawlings and Karen Herriman will re-examine the staff appraisal system.** Discussion took place on enabling leaders to lead. Margaret Gildea observed that the common theme of overloaded leadership and that motivating people and managing sickness levels are all part of this theme. The Trust must focus on supporting leaders to support staff. This Committee is determined to understand these issues and make progress. The training aspect of the report was noted and it was agreed that Information Governance and mandatory training will be broken down and shown in future reports.

	ACTION: Information Governance and mandatory training will be broken down and shown in future reports The Committee noted the hotspots and triangulation report was received at TOMM (Trust Operational Management Meeting) and considered this report should be regularly reviewed at ELT in order for executives to manage this information. **ACTION: Amanda Rawlings to ensure Hotspots and Triangulation report is regularly reviewed at ELT.** The Committee felt the employee relations graph was an excellent new addition to the report. It was thought that governors would be interested in this information and Sam Harrison proposed to forward this graph to Lead Governor, John Morrissey. **ACTION: Employee Relations graph to be forwarded to Lead Governor** **RESOLVED: The People & Culture Committee:** **1) Considered the report** **2) Scrutinised the contents** **3) Discussed the content, style and the recommendations in the report, and make recommendations for other additional improvements.**
P&C/2016/ 085	**<u>GOVERNANCE IMPROVEMENT ACTION PLAN</u>** The various GIAP reports were reviewed by the Committee as follows: **Update on PC2 – Pulse Check:** Although the September deadline for the introduction of a Pulse Check was not met, there is a plan for a more efficient check for January 2017 (the Pulse Check cannot be run yet until January because the staff survey is due to run at the end of September). It was acknowledged that good quality information had so far been received through Liam Carrier's work on the Staff Friends and Family Test which has informed the work on staff engagement. The Committee felt assured that a more detailed programme of work was being progressed. Mark Powell was concerned that the wider aspect of work involved in PC2 was not addressed in the report. Amanda Rawlings pointed out that the engagement presentation made at Board Development provided evidence that objectives were progressing. It was agreed that this presentation would be aligned with PC2 as it summarised the work Liam Carrier was carrying out with Sue Walters. . **Update on WOD1:** "Define and agree a process to regularly monitor the consistent application of HR policies and procedures for the full range of employee relations cases' and 'to ensure that HR policies and procedures are followed and monitored for all staff'." Karen Herriman identified the risk areas associated with WOD1 and made it clear that these could only be clarified when the review date is due and confirmed that a lot of these tasks have been completed. Sam Harrison queried the completion of internal audit review task. Karen Herriman assured her that after the internal audit review carried out by PWC, actions were being taken forward and will be reported back to this Committee and will also be received through PWC's Internal Audit reporting at the Audit and Risk Committee on 11 October. **Update on CQC2 – Staffing Update:** This report outlined plans and strategies to improve our success in recruiting staff in the context of a national shortage of

	nurses and medical staff and provided an update on recruitment progress. The report showed that recruitment was still proving difficult and set out a number of initiatives that are being explored which were discussed. Mark Powell challenged that immediate action is required on certain tasks and it was agreed that these would be discussed as a priority at the next meeting in October. **ACTION: Further CQC2 Staffing Report to be received at October meeting** **Update on W1 – Freedom to Speak Up Action Plan:** The Committee acknowledged the expected timescales for completion of the tasks yet to be completed which were clearly indicated in the report. It was noted that the Freedom to Speak Up Policy (FSU) will be looked at further and this work will be linked in with the Engagement Group to align managers' responsibility for carrying out FSU training. The Committee agreed that W1 was on track and that the raising concerns task shows we have a core plan to deliver against. The Committee agreed that overall the GIAP reports clearly showed where assurance was received regarding each piece of work. The reports also indicated recommendations that would be captured on the agenda for the October meeting. **<u>Core 1 of the GIAP</u>** An update report was also received against Core 1 of the GIAP, which focuses on the 'Reunification of HR and associated functions'. These tasks were discussed and noted as follows: **HR 1:** *The HR and OD departments should be under the management of one Executive Director* – The Committee agreed this action is now closed and can be confirmed as closed to the Board. **HR 2:** *Ensure external resources for the newly appointed Director of Workforce, OD and Culture are obtained in order to drive the transformation of HR and related functions through a combination of coaching, buddying, and mentoring support.* It was agreed that the status of this action can turn blue and full closure will be agreed outside of the meeting. **PC1:** *The Trust should adopt an Organisational Development and Workforce Committee.* The Committee agreed to recommend to the Board that we have an effective People and Culture Committee and will confirm completion of this task. **RESOLVED: The People & Culture Committee noted the progress made to date on the actions it is responsible for seeking assurance on delivery within the GIAP.**
P&C/2016/ 086	**<u>MINDFUL HEALTH AND WELLBEING STRATEGY</u>** Rose Boulton verbally updated the Committee on the Mindful Health and Wellbeing Strategy that will support staff to take responsibility for maintaining and improving their health and wellbeing. The strategy will be received at the next meeting in October and will incorporate the Health and Wellbeing CQUIN around flu vaccination and will show the activities that have taken place within the Trust. The report will also include a work plan shaped around the organisation, success measures and methods of best practice. **ACTION: Mindful Health and Wellbeing Strategy to be received at October**

	meeting. **RESOLVED: The People & Culture Committee noted the verbal update on the Mindful Health and Wellbeing Strategy**
P&C/2016/ 087	**FLU ACTION PLAN** Rose Boulton presented her report which provided the Committee with an update and action plan regarding the Flu Vaccination Programme for the Staff Health and Wellbeing CQUIN 2016-2017. It was noted that the flu vaccination programme had previously been discussed and supported via TOMM and that positive action is being taken to address this issue within the parameters identified in the report. The Committee discussed the need to promote the need for staff to be immunised and it was agreed that this would be a clinically managed campaign led by Carolyn Green, Director of Nursing and John Sykes, Medical Director. **ACTION: Mark Powell to discuss with Carolyn Green and John Sykes the need for them to clinically lead the flu vaccination programme** **RESOLVED: The People & Culture Committee noted and supported the contents of this report**
P&C/2016/ 088	**STAFF FRIENDS AND FAMILY TEST REPORT** Liam Carrier's report provided the Committee with the latest Staff Friends and Family Test results (Staff FFT) with a focus on hot spots within the Trust. The report set out the results for Q1 (June 2016), an analysis of Staff FFT results by Service Line and Staff Group, a detailed analysis of Staff FFT responses 'Extremely Unlikely & Unlikely', the next steps to be taken and an action plan. The report also explained the Trust's statutory duties and intended progress against the organisation's priorities for 2015/16 and the priorities for the current year. The Committee recognised that the report highlighted the stress staff are working under and this has affected the culture of the organisation. It was hoped that this feedback will be triangulated with other feedback that might be more positive. The Committee discussed the need to make a statement to staff regarding the comments made in the report. It was agreed that Anna Shaw would work with the Engagement Group, Staffside and staff governors to drive a communications statement to all staff. **ACTION: Anna Shaw to develop the communication with Amanda Rawlins and Lee Fretwell and to be sent to all staff** **RESOLVED: The People & Culture Committee considered the report and recommended that a communications statement be made to all staff**
P&C/2016/ 089	**STAFF SURVEY TIMELINE** In the absence of Sue Walters, Amanda Rawlings presented this report which updated the Committee on progress and preparations for the NHS Staff Survey 2016.

	The Committee noted that robust plans are in place to deliver the NHS survey which will go live on 28 September and agreed that the Staff Survey Report would be received by the Board in February 2017. **RESOLVED: The People & Culture Committee acknowledged the progress and plans for the Staff Survey and agreed for the Survey Report to be on February 2017 Board agenda**
P&C/2016/ 090	**ENGAGEMENT GROUP PROGRESS** Sue Walters' report updated the Committee on the development of the Engagement Group. The plans contained in the report were noted, together with the minutes of the Engagement Meeting held on 24 August. The Committee also supported plans to develop a pioneer role. **RESOLVED: The People & Culture Committee acknowledged the progress and plans for the Engagement Group and supported the recommendation to develop a Pioneer role.**
P&C/2016/ 091	**DEVELOPMENT OF APPRENTICESHIPS** Faith Sango's report informed the Committee of the strategic direction for development of apprenticeships across the Trust taking account that the Trust will be working collaboratively with DCHS to identify areas of common interest and potential development of joint projects. The Committee noted the current provision across the organisation and plans to increase the apprenticeship numbers by April 2017, in line with apprenticeships (in England): vision for 2020 and the anticipation that the Trust will contribute £450 000 to the apprenticeship levy from April 2017. The Committee felt this was a good opportunity for the Trust to support the apprenticeship programme and understood that a report would be received at the next meeting that will look at apprenticeship routes. Amanda Rawlings stressed the need to explore new models quickly to meet supply> Investment is required for new models of workforce to create a new pipeline of workforce through apprenticeships. As budgets are being set in October Amanda Rawlings thought this was something the Board should be focused on. Amanda Rawlings informed the Committee that she would work with Faith Sango to establish clinical models that will be shared with the clinical team. She proposed to take this forward with Mark Powell, Faith Sango, Carolyn Green and John Sykes to enable a report to be received by the Board. **ACTION: Amanda Rawlings to progress the apprenticeship programme with Mark Powell, Faith Sango, Carolyn Green and John Sykes and produce a report for the Board.** **RESOLVED: The People & Culture Committee received and noted the report on the development of apprenticeships within the Trust.**
P&C/2016/ 092	**WORKFORCE PLAN**

	The Workforce Plan had previously been presented to the Committee and the update report received which contained information regarding the recruitment and retention of staff and the development and support of the wider workforce was received for information only. **RESOLVED: The People & Culture Committee received and noted the updated Workforce Plan**
P&C/2016/ 093	**<u>EDS2 AND OTHER EQUALITIES</u>** The Committee received and noted Owen Fulton's report which covered the four outcomes of Equality Delivery System 2 (EDS2) and set out where the Trust currently stands against its objectives. The report also provided guidance as to next steps in terms of governance. The Committee understood that as the Trust does not currently have an over-arching strategy to combine all aspects of EDS2 it agreed to endorse the establishment of an Equalities Forum to ensure the implementation of the following process: • The Equalities Forum will work with the Trust Board and establish an overarching detailed equality and diversity strategy to enable the Trust deliver workforce and patient equality and diversity issues and concerns. • The Equalities Forum will be overseen by the Quality Committee linked with the People and Culture Committee to ensure progress across all equality work streams at the same pace. • Provide oversight and future assurance from across the Trust. • The Equalities Forum will also work with the Trust Board and produce a yearly Annual Equality Report. • Re-establish credible and meaningful links with workforce stakeholders (networks) e.g. disabilities, LGBT, Age (55+), BME and Staff Side Network. • Re-establish credible and meaningful links with our community. The Committee discussed the risks associated with not taking forward the above recommendations and agreed that non-compliance with EDS2 would be captured in the BAF as a separate risk. **ACTION: Non-compliance with EDS2.to be captured in the BAF as a separate risk** **RESOLVED: The People & Culture Committee:** **1) Endorsed the establishment of the Equalities Forum** **2) Noted progress on the EDS2 goals 1, 2, 3 and 4 including actions to date for implementation** **3) Agreed that a separate risk is to be included in the Trust's BAF regarding non-compliance with EDS2.**
P&C/2016/ 094	**<u>PUBLIC SECTOR DUTY (PSED)</u>** Owen Fulton delivered a position statement on the Trust's compliance with the

	Equality Act 2010 and the Public Sector Equality Duty (PSED). The report set out the organisation's current compliance and plans in place for future work. The report also included benchmarking data taken from the first national report on workforce race equality standards. It was noted that the Qualities Forum will provide feedback directly through to this Committee and the Board to offer assurance that this is being embedded and incorporated within the Trust. The Committee acknowledged the progress made so far with regard to the Trust's duties within the Equality Act and was pleased to note that the following work is included in the PSED work plan: 1. Equality impact assessments – ensure key staff are trained in extended equality impact assessment within 2016 2. The Mental Health Act Committee will review its monitoring of Mental Health Act legislation and undertake further extended assessment of the use of the Mental Health Act, Mental Capacity Act and restricted practices for BME and REGARDS groups 3. Analysis of the request for single gender staff, to be monitored and reported through the Quality Leadership Groups to access changes to clinical staff to ensure this is offered and accessible 4. The service receiver and carer groups to be asked about any access or equality issues they would like the Trust to reflect upon or consider 5. The Trust executives to ensure that all service configurations and tender process are reviewed in line with the requirements for due regard to protected characteristics and for this to be evidenced 6. The Trust Board members are to positively challenge each other on the quality of board papers and ensure the impact of changes and strategic decisions are considered with due regard to the Equalities Act and ensure this is monitored. 7. The People and Culture Committee is the lead for the workforce issues and required action plan, however the Quality Committee needs to be cognisant of the potential risks to quality associated with staff survey feedback and benchmarking demonstrating a red flag for discrimination - the Quality Committee will require assurance from the People and Culture Committee on this issue. 8. The Chair of the Trust in recruitment of Non-Executive Directors in the next round of recruitment considers the Snowy White Peaks national reports on the workforce composition of boards and whether individuals can be recruited that reflect the composition of our communities of Derby city and Derbyshire and consideration of all being equal of positive discrimination in board level recruitment. **RESOLVED: The People & Culture Committee reviewed the report and associated recommendations and noted the work plan that will ensure the Trust meets its requirements to take due regard to its responsibilities.**
P&C/2016/	**REVISED ACTING UP POLICY**

095	The Committee was satisfied that the Acting Up Policy had been reviewed and approved by JNCC. It was understood there were a number of issues raised around the triangulation of 'acting up' and that basic principles had been addressed to enable the policy to be improved with regard to advertising, expression of interest, review of recruitment. Approval of the policy was an action contained in the GIAP and the Committee was satisfied that this action was now complete. **RESOLVED: The People & Culture Committee approved the revised Acting Up Policy.**
P&C/2016/ 096	**TRAINING FRAMEWORK POLICY** The Training Framework Policy and Procedure was received for approval and was ratified by the Committee. **RESOLVED: The People & Culture Committee approved the Training Framework Policy.**
P&C/2016/ 097	**ANY OTHER BUSINESS** Margaret Gildea offered advanced apologies for the next meeting of the Committee scheduled to take place on 19 October.
P&C/2016/ 098	**FORWARD PLAN** The forward plan would be updated in line with today's discussions and presented for reference at the next meeting of the Committee.
P&C/2016/ 099	**ITEMS ESCALATED TO THE BOARD OR OTHER COMMITTEES** It was agreed that items escalated to the Board will be identified through the GIAP.
P&C/2016/ 100	**IDENTIFIED RISKS** The Committee identified the non-compliance with EDS2 as a key risk.
P&C/2016/ 101	**EFFECTIVENESS OF THE MEETING** The Chair, Richard Gregory felt it had been challenging addressing all the issues raised during the meeting and stressed the importance of following through all actions effectively within the timescales. He hoped that the Engagement Forum would help raise the profile of the Committee and enable staff to understand we are working in partnership with Staffside and across all staff groups.
Date and Time of next meeting: The next meeting of the People & Culture Committee will take place on 19 October – venue to be confirmed.	

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE SAFEGUARDING COMMITTEE

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

Friday, 15 April 2016

PRESENT:	Maura Teager	Chair and Non-Executive Director
	Caroline Maley	Senior Independent Director
	Carolyn Green	Director of Nursing and Patient Experience
	Carolyn Gilby	Acting Director of Operations
	Tina Ndili	Head of Safeguarding Children
	Tracey Holtom	Service Line Manager (part)
	Brenda Rhule	Interim Head of Nursing
	Michelina Racioppi	Southern Derbyshire CCG
	Rowena Yates	Specialty Doctor in Community Paediatrics
IN ATTENDANCE:	Sue Turner	Board Secretary
APOLOGIES:	Samantha Harrison	Director of Corporate Affairs & Trust Secretary
	Jayne Storey	Director of Workforce, OD & Culture
	John Sykes	Executive Medical Director
	Joanne Kennedy	Consultant Child & Adolescent Psychiatrist
	Wendy Brown	Consultant Psychiatrist and Clinical Director
	Gulshan Jan	Consultant Psychiatrist in Learning Disability
	Tracy Shaw	Training Manager
	David Tucker	General Manager, Special Services
	Lesley Smales	Designated Nurse for Children In Care
	Bill Nicol	Southern Derbyshire CCG
	Samragi Madden	Healthwatch Derby
	Richard Morrow	Service Manager
	Hamira Sultan	Consultant in Public Health, Children and Young People
	Kate Sargeson	Divisional Nurse
	Garry Southall	Principal Workforce & OD Manager
VISITOR:	Joanne Taylor	Derbyshire Rose

SC/2016/022	**WELCOME AND APOLOGIES** The Chair, Maura Teager welcomed everyone to the meeting. She also welcomed Caroline Maley who stepped in to replace Tony Smith as a Non-Executive Director at today's meeting. After six years' service Tony Smith had stepped down as a Non-Executive Director of the Trust's Board and she thanked him for his service and for his contribution to Committee. It is hoped that by the next meeting scheduled to take place in August a new NED would be appointed to the Trust Board and the Committee.
SC/2016/023	**MINUTES OF THE MEETING DATED 22 JANUARY 2016** The minutes of the meeting, dated 22 January were accepted and agreed, subject to the following amendments: **SC/2016/008 Serious Case Reviews KN15 and ADS15:** The first action to be amended to state that workshops and not training would be developed by Carolyn Green and Tina Ndili to capture specific learning and widen the expertise within the Serious Case Review Panel.

	SC/2016/009 Marker of Good Practice: The first two sentences of the second paragraph would be deleted and replaced with "Marker of good practice self-assessment will be used to obtain safeguarding children assurance and a front line staff audit will also be completed." The final sentence would also be amended to read "Michelina Racoippi informed the committee that by the end of the year it is hoped that both Safeguarding Board will have developed the new Section 11 document and she will continue to pursue this.".
SC/2016/024	**ACTIONS MATRIX** The Committee agreed to close all completed actions. Updates were provided by members of the committee and noted directly on the actions matrix.
SC/2016/025	**THE VOICE OF THOSE WITH LIVED EXPERIENCE** Joanne Taylor from Derbyshire Rose was invited to the meeting to provide the Committee with an example of lived experience of safeguarding and shared with the Committee what it felt like to be a victim of child abuse. She described how Derbyshire Rose had been set up as a support and self-help network for victims of abuse. The organisation works with the crisis assessment teams and helps to refer people to the appropriate authority. Derbyshire Rose has also developed techniques to encourage people back into employment and offers support which gives people the confidence when approaching the job market. This support method is used as a surrogate family network for people who have survived abuse which offers long term support and stops people relapsing. Joanne Taylor also made the Committee aware of the dark net websites that demonstrate ways of committing suicide and asked for the Trust's support in trying to get these sites shut down. She also talked about the support network Derbyshire Rose provides such as an interactive Facebook page so people can chat to each other on line. There is also a website which is covered round the clock and they have plans to set up a café in Chesterfield that will be manned 24/7. Derbyshire Rose have also developed a diary for people to use to express their feelings about abuse and to tell their story. The diary technique can also be used to develop individuals' care plan. This can be accessed by other users and gives people comfort. Carolyn Green pointed out that she would be developing training for staff so they can be aware of the dark net. She would also like to implement the diary technique within the Trust as the process would be cheap to roll out and would provide patients with experiences of the Trust's services. Maura Teager felt that the Committee could support the next steps of Derbyshire Rose. It was not within the mandate of the Committee to approve funding but Carolyn Green could speak to commissioners to help take this project forward. The Committee felt the diary and surrogate family concepts sent out very strong messages which could easily be transferable to the Trust. **ACTION: Carolyn Green to meet with Derbyshire Rose and look at developing PODCASTS to talk about asking the abuse questions and education on the dark net.**
SC/2016/026	**SAFEGUARDING CHILDREN STRATEGY UPDATE** The Safeguarding Children Strategy 2016/17 was received by the Safeguarding

	Committee in January and informed the committee of the priorities to be agreed and set by the Trust for the continual improvement of the culture, workforce, quality of practice, leadership, and performance management and quality assurance in order to achieve better outcomes for children, young people and their families. The Committee, noting that minor amendments had been made, approved the Safeguarding Children Strategy 2016/17 and would recommend the strategy to the Board. Michelina Racciopi informed the Committee that approval of the Safeguarding Children Strategy would allow her to refer the strategy to the Southern Derbyshire CCG Committee. **RESOLVED: The Safeguarding Committee approved the Safeguarding Children Strategic Aims and Strategy 2016/17.**
SC/2016/027	**SAFEGUARDING CHILDREN WORK PLAN** Tina Ndili presented the Safeguarding Children Workplan which gave clear strategic direction with timescales of the work to be completed by the Safeguarding Team, Service Line Managers and Operational Managers in order to deliver the Safeguarding Children Strategy and agenda Caroline Maley asked why time scales were not specifically included in the work plan. Carolyn Green explained that from an assurance point of view a start date and completion date should be included and show sub-tasks which will provide the Committee with assurance that these actions have been completed. Although this is not being carried out at the moment, RAG rating and status of the completion of actions was discussed in the operational groups. The Committee noted that all audits are underway and running to the new timescales and recognised that the work was progressing within the operational groups. The work plan was agreed, subject to additional measures of success and the adoption of Board committee level method of RAG rating. It was also agreed that in future the work plan detail would be provided by way of an exception report. **RESOLVED: The Safeguarding Committee agreed the work plan and gave appropriate feedback on the amended RAG rating of the plan.**
SC/2016/028	**SAFEGUARDING CHILDREN AUDIT PLAN 2016/17** Tina Ndili explained that the purpose of the report was to inform the Committee of the proposed Safeguarding Children Audit Plan for 2016/16 to allow the plan to be agreed. It was noted that the audit plan outlines the recommendations and actions from various groups and ensures that the actions have been completed and that the recommendations have an impact on practice. In addition, the completion of the audit is to provide the Trust with assurance that the learning has been disseminated throughout the organisation and that staff have changed in order to meet the identified recommendation. In response to Maura Teager's questions as to whether the Trust had been involved in any national audits, Tina Ndili informed her that the Trust was involved as a multi-agency approach to audit as a whole. The Committee understood that the Audit Plan would be reviewed through the clinical governance system and agreed the Audit Plan for 2016/17. **RESOLVED: The Safeguarding Committee approved and agreed the audit plan**

	for 2016/17
SC/2016/029	**CAMHS SERVICE DEVELOPMENT PRESENTATION** In the absence of Joanne Kennedy, Carolyn Gilby highlighted the key themes of the CAMHS Service Development presentation that was recently presented during the Midlands Cabinet visit. The Committee was pleased to note the positive impact this model had on children and young people and that the new developmental pathways across services was leading the way in partnership working. **RESOLVED: The Safeguarding Committee received the CAMHS Service Development presentation.**
SC/2016/030	**SAFEGUARDING CHILDREN REFERRALS** Tina Ndili verbally informed the Committee that she had recently carried out an audit on Safeguarding Children Referrals and it was clear that staff were not completing the referral forms correctly. In addition to this there was no evidence on the unit that could allow a check to be carried out, although it was understood that electronic records will provide evidence. The Committee recognised the need for staff to apply the correct protocol to ensure a high level of diligence and it was agreed that a report would be provided to the next meeting to inform the Committee of the action taken and next steps. **ACTION: Report to be received at the next meeting in August that sets out the action taken and next steps to ensure diligence.** **RESOLVED: The Safeguarding Committee noted the non-completion of referrals.**
SC/2016/031	**SAFEGUARDING CHILDREN TRAINING UDPATE** In Tracy Shaw's absence Carolyn Green provided an update on the Safeguarding Children training position. Significant assurance was received on level 1 training (99% compliant) and it was noted that the work plan on level 3 training is still in progress. The Committee discussed the fact the training report was still not capturing the right level of information and Carolyn Green would meet with the Education Team to address this outside of the meeting. Carolyn Green informed the Committee that a review of training would be carried out with the bank staff and she would ask our designated nurses to help ensure bank staff are trained to a satisfactory level. The Committee recognised that the gaps in assurance around bank and level 3 training are an ongoing challenge but Committee is required to obtain an acceptable level of assurance on training as it is a requirement from the Board. **RESOLVED: The Safeguarding Committee:** **1) Noted the ongoing amendments that still need to be made to ensure accuracy of reports by the Educational E-source Developer.** **2) Noted the maintenance of level 1 and 2 training internally.** **3) Noted the ongoing provision for Think Family training** **4) Noted the ongoing internal safeguarding children's training delivery in medium and long term in accordance with service need and financial**

	resources. **5) Considered the aspect of substance misuse services for frequency of level 3 training.** **6) Considered bank staff safeguarding training**
SC/2016/032	**MARKER OF GOOD PRACTICE** Michelina Racciopi provided the Committee with a verbal update on progress made to date regarding a marker of good practice self-assessment and proposed to provide the Committee with a report on front line findings at the next meeting in August. **ACTION: Report on front line findings of self-assessment to be received at the next meeting in August** **RESOLVED: The Safeguarding Committee noted the verbal update don Marker of Good Practice.**
SC/2016/033	**CQC SAFEGUARDING CHILDREN ACTION PLANS** Tina Ndili presented her report on the CQC action plan which was put in place to ensure and provide evidence that recommendations are being adequately met to timescale or show progress. Areas of concern were discussed and attention was drawn to 3.2 which is currently under discussion with commissioners. The roll out of the Purposeful Inpatient Admission model (PIPA) was discussed and Carolyn Green pointed out that this was also linked to KN15 Serious Case Review. This will also be addressed at the Quality Assurance Group and Michelina Raccioppi will include this issue as part of her CQC report. The lack of capacity within the community teams to allocate a care co-ordinator to patients will be reviewed in the Board Assurance Framework as we are at risk of not adequately managing our regulatory standards and this matter would be escalated to the Board. It was also agreed that in future the action plan would be provided by way of an exception report. **RESOLVED: The Safeguarding Committee:** **1) Monitored the progress of the CQC Action Plan to ensure compliance.** **2) Received assurance that the Action Plan is being developed within the set timescales and evidence and/or a progress report is completed.** **3) Noted that ALL the actions within Recommendation 3.2 are not possible to be completed at this stage due to commissioning issues .**
SC/2016/034	**SERIOUS CASE REVIEWS** **Summary of SCR ADS15:** The Committee recognised this report came to the Committee prematurely. Psychologists have locked down certain information which has meant information is not contained within the Trust's records. Agreement is being reached that material can be accessed through "breaking glass" file. This is not yet complete and the challenge regarding the way forward was noted. **RESOLVED: The Safeguarding Committee:** **1) Noted the SCR process and progress.** **2) Received assurance that the Trust has fully engaged in the process and the learning and recommendations have been identified** **3) Monitored the progress of the SCR ADS15.** **Summary of SCR KN15:** This summary report for case KN15 updated the Committee on progress and gave an indication of the management of the case by the main

	professionals involved and provided learning for the Trust. Tina Ndili informed the Committee that the delay with this case was due to ongoing police investigations and she would make amendments to the report which would highlight the risks to the children involved. **RESOLVED: The Safeguarding Committee:** **1) Noted the SCR process and progress** **2) Received assurance that the Trust has fully engaged in the process and the learning and recommendations have been identified** **3) Noted the issues / discussions around 'process notes' and the 'locking down' of records on PARIS** Tina Ndili gave a verbal update on SCR KN14. The Committee understood that due to recent media attention this was a very controversial case and this SCR will be revisited. The Committee also noted that CAMHS involvement was outside of the timeline of this case. The Committee expressed concern that the investigation report was not fully contained in the report that was signed by the Derbyshire Safeguarding Children Board. It was understood that this case will run for a significant amount of time and Carolyn Green proposed to submit a written report to the Confidential Board as this will be a significant and high profile enquiry. **ACTION: Carolyn Green to provide a report to the Board on SCR KN14** **RESOLVED: The Safeguarding Committee noted the verbal update on SCR KN14.**
SC/2016/035	**<u>ASSESSMENT OF CHILD SEXUAL ABUSE IN THE FAMILY NETWORK</u>** At the last meeting of the Committee, Joanne Kennedy drew attention to a thematic review of cases of familial child sexual abuse that will represent the first report of the Children's Commissioner's inquiry into child sex abuse within the family and its network. She explained that the report was a critical analysis of the scale and nature of this form of child sex abuse and the committee agreed to include this as an agenda item at the April meeting. However, this item was not discussed due to Joanne Kennedy's absence and would be deferred to the next meeting in August. **ACTION: Assessment of familial child sexual abuse to be an agenda item for August.**
SC/2016/036	**<u>SAFEGUARDING ADULTS STRATEGY</u>** Carolyn Green presented the Safeguarding Adults Strategy 2015/16 which informed the Committee of the priorities, strategic aims and direction of travel to be agreed and set by the Trust for the next three years. The Committee recognised that the strategy had been accepted at the last meeting and had since been updated to incorporate challenges raised by the CCG. Discussions took place as to how the strategy would be launched and Carolyn Green explained that a podcast would be created and the strategy would also be rolled out at clinical meetings and at TOMM. The Committee was assured that Safeguarding Adults is acknowledged as a priority area within the Trust and approved the strategy. **RESOLVED: The Safeguarding Committee:** **1) Approved and endorsed the Safeguarding Adults Strategy**

	2) Noted the challenging agenda of Safeguarding Adults within the Trust and supported Safeguarding Adults **3) Received assurance that Safeguarding Adults is fundamental to care that is undertaken and the commitment to reduce restrictive practices** **4) Noted the impact of historical abuse and inclusion in the Safeguarding agenda for the Trust.**
SC/2016/037	**UPDATE REPORT ON SAFEGUARDING ADULTS TRAINING REPORT AND WRAP (Workshop to Raise Awareness of PREVENT)** Carolyn Green presented Tracy Shaw's report which provided the Committee with the Trust's overall Safeguarding Adults training compliance levels, an overview of current training requirements, an update of PREVENT training in the organisation and updated the Committee in relation to current bank staff training. The Committee reviewed the level of training with bank staff and recognised that progress had been made on level 3 training, continued progress was being made with PREVENT training and that the Trust had met the statutory level of compliance on training. **RESOLVED: The Safeguarding Committee** **1) Noted the maintenance of level 1 and 2 training** **2) Noted the ongoing plan for safeguarding adults level 3 to increase compliance.** **3) Noted the ongoing plan for PREVENT wrap 3.** **4) Considered bank staff safeguarding training**
SC/2016/038	**UPDATE ON BULLYING AND HARRASSMENT** The Committee agreed this item would be deferred to the next meeting in August.
SC/2016/039	**GODDARD ENQUIRY PRESENTATION** Carolyn Green presented the Goddard Enquiry Report which was concerned with the Miles Bradbury case, a Paediatric Haemologist who used his role as a NHS Consultant to sexually assault child patients. The Committee discussed the need to take learning from this report which would be used prepare for cases emerging from Aston Hall as the Trust will be required show evidence of what was learnt and how our services and Safeguarding Adult and Children strategies have adapted as a result of these cases and that we are completely diligent. Safeguarding training will also be included as part of an action plan in relation to Goddard that will apply to all service users. A review would be carried out of any known cases to consider what lessons have been learnt, what still requires addressing and what we know of current cases should this situation occur again. The Committee accepted that this course of action should be considered standard practice and endorsed the proposed action plan. **ACTION: Safeguarding training to capture the learning from this report and to form a Board Development training session.** **RESOLVED: The Safeguarding Committee noted the verbal update on the Goddard Enquiry Report and endorsed the proposed action plan that would be developed from the learning taken from this report.**

SC/2016/040	**ASTON HALL UPDATE** Carolyn Green informed the Committee that a 9am – 5pm telephone help line for victims of historical abuse at Aston Hall had resulted in 60 – 65 people contacting the Trust. The Committee noted the Trust has no legal responsibility to victims and Hardwick CCG has provided funds for the Trust to offer clinical and administrative support to victims for 16 weeks. The Committee thanked Tracey Holtom and her team for the work they are carrying out to provide this support and recognised that this work is not without its consequences to individuals and the wider team and this will be relayed to the Board. **RESOLVED: The Safeguarding Committee noted the verbal update on historical abuse at Aston Hall.**
SC/2016/041	**PERSONAL RELATIONSHIPS POLICY** This policy will be submitted to the next meeting in August for ratification.
SC/2016/042	**FORWARD PLAN** The forward plan will be updated with actions arising from today's meeting
SC/2016/044	**MATTERS TO BE ESCALATED TO THE BOARD OR OTHER BOARD COMMITTEES** • We are at risk of not adequately managing our regulatory standards due to the lack of capacity within the community teams to allocate a care co-ordinator to patients. • SCR KN14: Although this case has limited Trust involvement, this court case will be brought to the attention of the Confidential Board due to its high profile media attention. • The significant impact on the wellbeing of staff receiving calls from victims of historical abuse at Aston Hall
SC/2016/045	**MEETING EFFECTIVENESS** Maura Teager thanked Caroline Maley for attending today's meeting which ensured the Committee was fully quorate. It was acknowledged that the quality of reports is key to other Non-Executive Directors attending and being effective in their role when they are not familiar with safeguarding practice. Executive summaries of reports will be revised to provide specific focus to ensure assurance. Although the absence of some key attendees was noted, constructive challenge was able to take place.

Date and Time of next meeting:

The next meeting of the Safeguarding Committee will take place on:
Friday, 5 August 2016 at 1.00 pm
Venue: Meeting Room 1 –Albany House, Kingsway, Derby

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 2 November 2016

Safeguarding Children Annual Report 2016/17

Purpose of Report

This Annual report summarises the Annual report for the year 2016 to 2017 and includes Safeguarding Children's Board Strategic plans.

Executive Summary

- The purpose of this report is to provide the Trust Board with an overview of the current issues and themes within Safeguarding Children and to provide assurance on the quality of the services provided.
- To understand Safeguarding Children service requirements in line with our community population needs.
- This report provides information to assure the Board on current training compliance, which has improved performance with the need for continued scrutiny and prioritisation of training to achieve the standards outlined in the intercollegiate guidance.
- Safeguarding unit investments and the changes. To reporting structures Child abuse has had a very high national profile over the past year, especially regarding child sexual exploitation, female genital mutilation (FGM) neglect, domestic abuse and historical sexual abuse. In addition to overarching statutory guidance the Government is introducing new requirements for health agencies regarding specific concerns.
- The report provides an overview of the Multi Agency Safeguarding Hub (MASH) arrangements both in Derby City and Derbyshire County. It also gives an overview of the future considerations for the MASH.
- The report highlights the main points and recommendations of the Bradbury report and implications for the Trust.

Strategic considerations

- In order that standards remain high, organisational commitment to Safeguarding children is required to ensure current practice is safe, to drive forward Trust performance in line with Safeguarding Board strategic intentions and the organisational Safeguarding Children Strategy and fully embed the Trust requirement for the Children's Act.
- Planning for transformation of services needs to take into account due concern to Safeguarding Children's practice as part of planning and delivery, as well as service retraction in other Children services in the local authority.
- A commitment to supporting staff in delivery of high standards is required – attendance at training and monitoring of training performance and mitigation of the risks associated with gaps in performance needs to be put in place.

Consultation

- This report has been reviewed by members of the Safeguarding team the Safeguarding Children Operational meeting and has been signed off by the Safeguarding Committee.

Governance or Legal Issues

- The legal framework to protect children is contained in Working Together to Safeguard Children (2015)
- Section 11 (s11) of the Children Act 2004 places a statutory duty on key persons and bodies to make arrangements to ensure that in discharging its functions, they have regard to the need to safeguard and promote the welfare of children and that the services they contract out to others are provided having regard to that need. Improving the way key people and bodies safeguard and promote the welfare of children is crucial to improving outcomes for children.
- There are no other legal issues identified within this report that require consideration outside of our compliance NHS executive standards for healthcare provision
- This paper brings update on governance and regulatory aspects around Safeguarding Children's standards which may form part of a CQC inspection or enquiry. These would be around Safeguarding Children's practice, clinical standards, patient safety, leadership, responsiveness and effectiveness. Standards are set in the Derby City and Derbyshire within existing Safeguarding Children's procedures and standards

Recommendations

The Board of Directors are requested to:

1) Note the Safeguarding Annual Report to receive assurance on the trust annual activity and to agree the Trust Safeguarding committee to lead and set the future direction for Safeguarding Children in the Trust.
2) To give constructive feedback.
3) To agree this Annual report and its recommendations.

Report prepared by: **Tina Ndili**
Head of Safeguarding Children
Joanne Kennedy
Named Doctor for Safeguarding Children

With input from: **Tracy Shaw**
Training Manager

Report presented by: **Carolyn Green**
Director of Nursing and Quality

Safeguarding Children Unit Report:

Was last reported to the Board on August 2015. The Looked After Children and Adult Safeguarding Annual Reports will be presented separately.

Safeguarding children and young people and promoting their welfare means:

- Protecting children from maltreatment
- Preventing wherever possible impairment of children's health or development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care, and
- Taking action to enable all children to have the best outcomes.
- Child protection is defined as being part of safeguarding and promoting welfare. It is the work done to protect specific children who are suffering, or are likely to suffer, significant harm.

The Working Together to Safeguard Children 2015 guidance states that:

"Children are best protected when professionals are clear about what is required of them individually, and how they need to work together."

In addition, the guidance states that "effective safeguarding of children can only be achieved by putting children at the centre of the system and by every individual and agency playing their full part, working together to meet the needs of our most vulnerable children."

These changes and developments in part were the catalyst for re-considering the strategic and systemic importance of Safeguarding children and the need to continually link to our geographical safeguarding boards and develop our new direction travel towards Safeguarding Children and families through a Board level committee. The Committee which commenced from April 2015 was appointed to provide assurance to the DHCFT board that the organisation is effectively discharging and fulfilling its statutory responsibility for Safeguarding to ensure better outcomes for children and vulnerable adults and develop innovations to support Safeguarding families and to ensure that the Trust embed 'Think Family principles' within all aspects of care and service developments to enable 'Flourishing Families'.

Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2014:

All health staff must have the competences to recognise child maltreatment and to take effective action as appropriate to their role. They must also clearly understand their responsibilities and should be supported by their employing organisation to fulfil their duties.

The latest version of Safeguarding Children and Young People: roles and competencies for Health Care staff, jointly published by the Royal Colleges and professional bodies were updated to emphasise the crucial role of the Executive

Team and Board members, while also taking into account the structural changes which have occurred across the NHS. The framework is applicable across all four countries of the UK and sets the standards and requirements expected of all health staff.

Whist the responsibility of ensuring staff have access to appropriate safeguarding training and learning opportunities rests with healthcare organisations, the emphasis in the framework continues to be upon maximising flexible learning opportunities to acquire and maintain knowledge and skills, drawing upon lessons from research, case studies and serious case reviews.

The framework will be reviewed again in 2017 and the Trust reviewed the guidance and feedback to Commissioners on immediate changes that were required and a paper outlining the capacity of the Safeguarding Unit staff was submitted in 2014 and 2015 which is detailed in the next section the 'Safeguarding Unit Reporting Structure.'

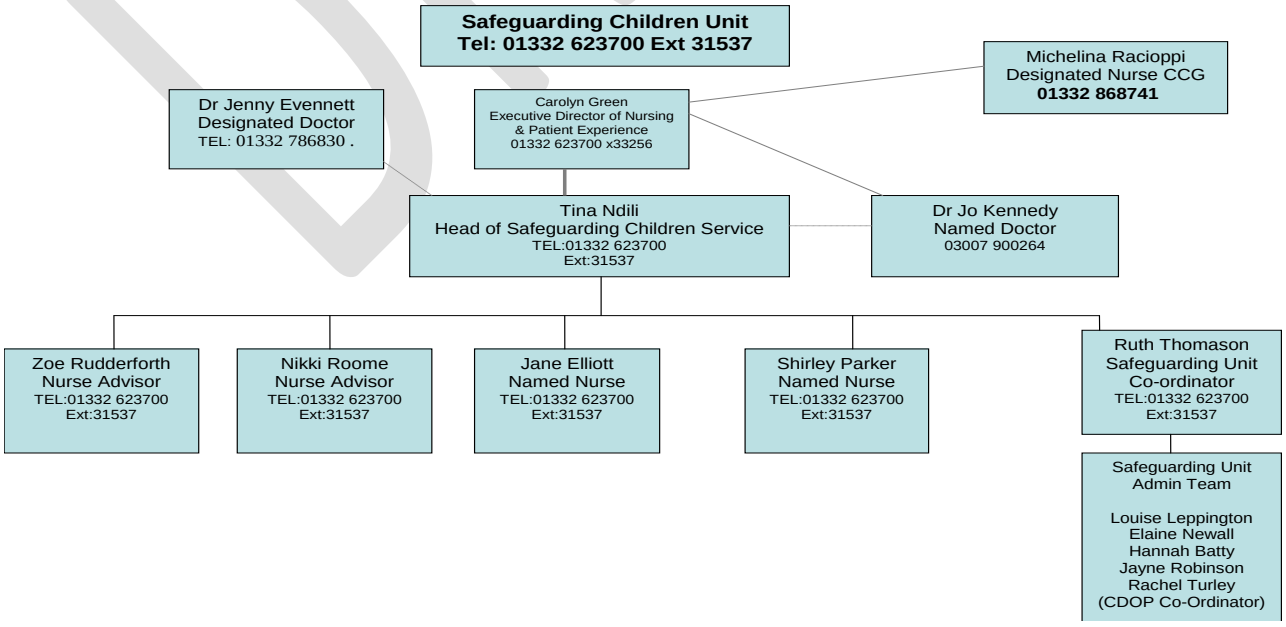
Safeguarding Unit Reporting Structure:

Last year the Board of Directors reviewed its Safeguarding governance in line with intercollegiate guidance Safeguarding Children and Young People: roles and competencies for health care staff (2014). The two specific recommendations are now being met these are that the Head of Safeguarding Children and Named Doctor for Safeguarding Children report directly to the Executive Lead for Safeguarding Children for their Work. The Designated Nurse and Doctor for Safeguarding Children sit within Southern Derbyshire Clinical Commissioning Group.

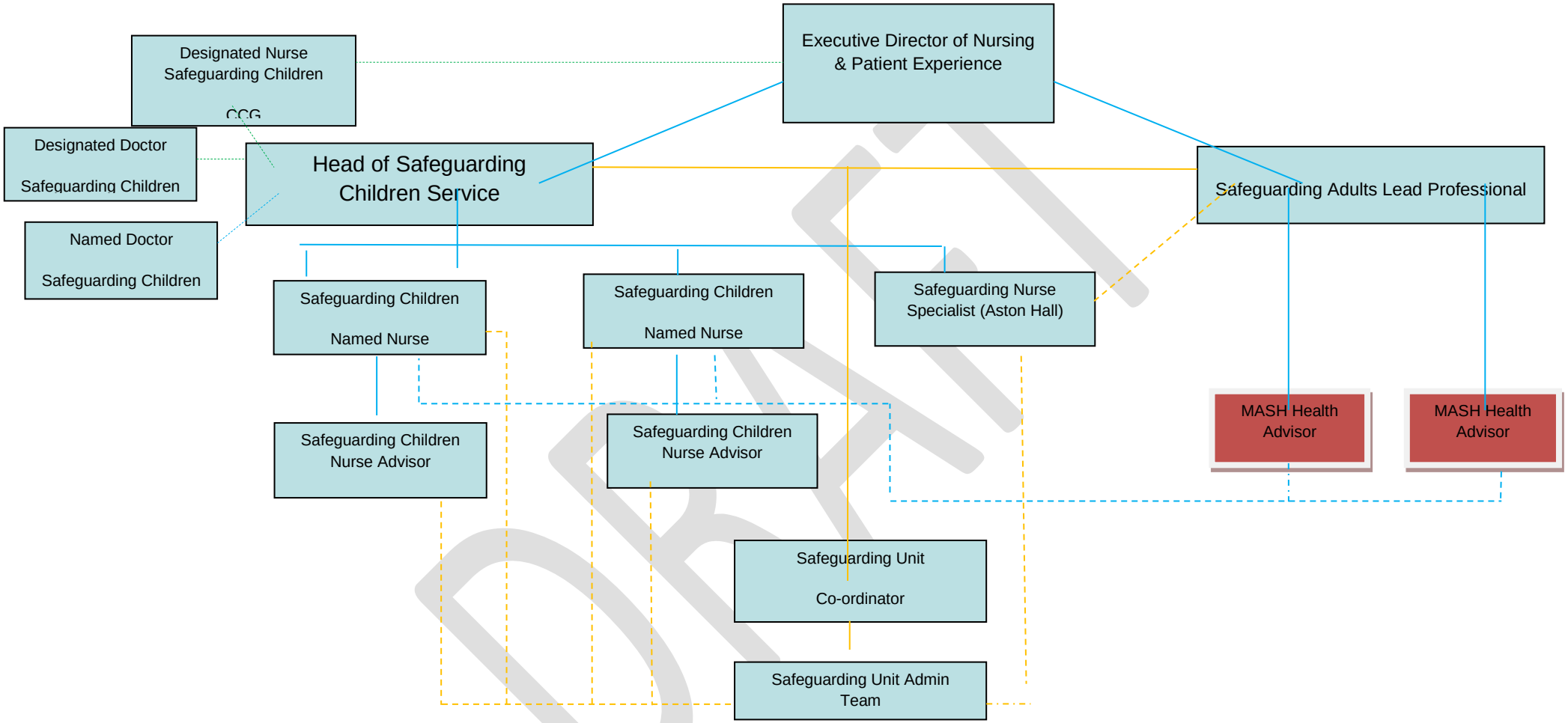
Current Structure

Safeguarding Children Unit Structure:

Derbyshire Healthcare NHS Foundation Trust
Safeguarding Children's Service



Proposed Structure 2016-2017

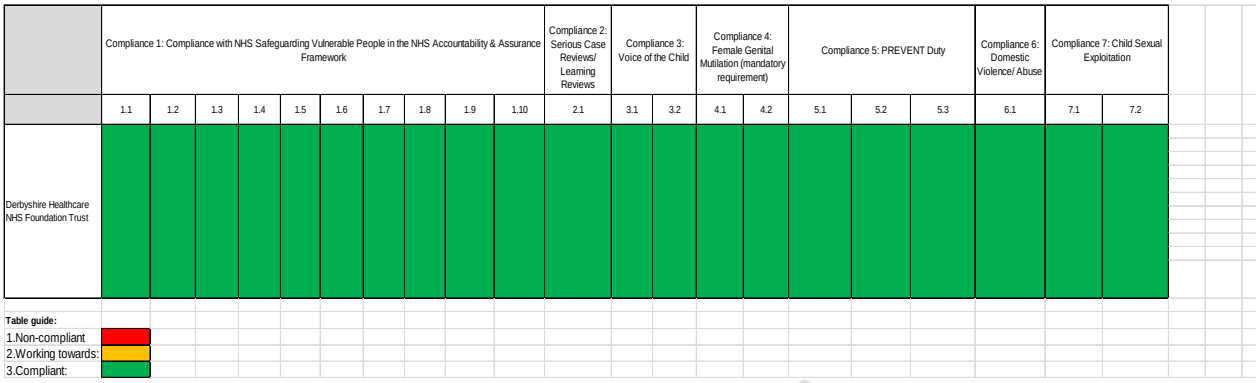


A successful workforce capacity review was submitted and as a result the Head of Safeguarding lead was able to appoint a full time permanent Safeguarding Children Nurse advisor to the Safeguarding team. Due to the extensive work involved with the Aston Hall response, one of the Named Nurses has been seconded over to the Aston Hall Team for a 12 month secondment. This was due to the Named Nurse having the skills and competencies required to fill the post. As a result the Head of Safeguarding was able to appoint a 12 month secondment to backfill. The fulltime Safeguarding Children Nurse advisor role complements the existing Team bringing valuable skills, competencies and experience in CAMHS. The Safeguarding Children Team continues to provide a solid Service throughout the organisation and the team objectives is to increase its presence through an in-reach model within the Adult Services within the organisation by attending multidisciplinary meetings to support and increase the awareness of the Safeguarding Children and Think Family agenda.

The Markers of Good Practice Audit 2015/16:

The Markers of Good Practice 15/16 built on previous success and showed DHCFT's continued commitment to Safeguarding Children and how the organisation has provided assurance to meet the seven areas of compliance successfully the team have been RAG rated Green on all recommendations. Areas of compliance and an organisational frontline audit were undertaken by Commissioners to provide assurance of staff's awareness around Safeguarding Children. They agreed with the team statement that DHCFT Safeguarding Children is now in a better position and has a strong foundation within a supportive culture. It was fed back by the assessing panel that there was excellent Safeguarding Leadership. It was acknowledged that there is significant improvement when reviewing cases brought to the Serious Incident Learning Review Group and that staff are now more proactive in the Think Family principles and record what actions have been taken in relation to wider family. All Serious Case Reviews and Learning Reviews are reviewed monthly by the Head of Safeguarding and the internal amalgamated Action Plan is monitored via the Safeguarding Children Operational meeting. Safer recruitment practices and safeguarding Children Policies are all up to date and monitored monthly via the policy dashboard. There have been some difficulties embedding the new supervision arrangements which will now be resolved when the two new Safeguarding Children Nurse advisors take up their positions in September. There is good evidence to show partnership across DHCFT and partner agencies. Obtaining different examples of evidence of the Voice of the child beyond CAMHS was difficult but this is improving and good examples were submitted. Our assurance document is appended including the results of the frontline audit the Traffic Light Summary completed by the CCG. There were no challenges as a result of the Quality Visit and an action plan is in place with all recommendations complete. We have also submitted the strategic and organisational self-assessment section 11 audit tool to the safeguarding Children Boards. We await the Safeguarding Children Board response.

The summary below provides a progress report on the Markers of Good Practice Self-Assessment - based on the 7 areas of compliance that incorporate 21 standards within it.



	Compliance 1: Compliance with NHS Safeguarding Vulnerable People in the NHS Accountability & Assurance Framework										Compliance 2: Serious Case Reviews/ Learning Reviews	Compliance 3: Voice of the Child		Compliance 4: Female Genital Mutilation (mandatory requirement)		Compliance 5: PREVENT Duty			Compliance 6: Domestic Violence/ Abuse	Compliance 7: Child Sexual Exploitation	
	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8	1.9	1.10	2.1	3.1	3.2	4.1	4.2	5.1	5.2	5.3	6.1	7.1	7.2
Derbyshire Healthcare NHS Foundation Trust																					

Table guide:
1.Non-compliant
2.Working towards:
3.Compliant:

Markers of Good Practice Action Plan 2016

Compliance Ref	Standard	Action agreed	Evidence	Action complete	Action in progress and time scale for completion
N/A	**Front-line staff audit**	To disseminate findings and address recommendations made within the front-line staff audit.		Completed Circulated September 2016	Recommendations to be addressed – November 2016
N/A	**See section 2.0 within MoGP minutes**	To share the findings of internal review with LSCB safeguarding children Board (Review of 4 people being released from prison)			October 2016
1.2	**See section 3.0 within MoGP minutes**	To send updated Markers of Good Practice assurance document that was shared at Quality site visit.		The updated self-assessment has been submitted post-meeting.	Completed September 2016
1.2	**Local accountability and assurance structures**	Head of Safeguarding to closely review that there is regular and consistent attendance at the Child Sexual Exploitation (CSE) Operational Group and Vulnerable Young People's LSCB sub-group.		Membership confirmed and in place	Completed August 2016

Compliance Ref	Standard	Action agreed	Evidence	Action complete	Action in progress and time scale for completion
1.2	**Local accountability and assurance structures**	DHcFT CSE champions list to be forwarded for information.		This information has been forwarded post meeting	Completed August 2016
1.9	**Whistleblowing Policy/Allegations against staff**	To forward DATIX data report produced for DHcFT CQC inspection as evidence.			November 2016
3.1/ 3.2	**Voice of the Child**	To share the CYPIAPT evaluation/ carer feedback		Presentations received from HM	Completed September 2016
4.1	**Female Genital Mutilation**	Designated Nurse to forward FGM campaign information.	Information forwarded post-quality site meeting.	Complete	Completed August 2016
7.1	**Child Sexual Exploitation**	To add the use of the CSE tool-kit/ impact/ evaluation on DHcFT audit plan.		Added to the 2016/17 audit plan.	Completed September 2016
7.2	**Representation at CSE operational group**	Designated Nurse to forward details of the CSE profiling group to Head of Safeguarding. Head of Safeguarding to monitor CSE operational group attendance is regular and consistent.	E-mail sent to Gareth Meadows CC: Tina Ndili post-quality site visit – to inform Tina of future dates.	Complete	Completed August 2016

The population that we serve in the context of Safeguarding Children (2016/17)

Derby is a compact city of 30 square miles in the East Midlands. It has a population of 252,463 representing 182 nationalities, speaking 71 languages and 83 distinct dialects (2014, ONS). Approximately 25% of Derby's population are from BME communities, with its largest (5.9%) ethnic group comprised of the Asian / Asian British community. Migrants from Eastern Europe made up 3.9% of Derby's population in 2011, making it the third largest BME group in the city. BME communities have increased over the last 10 years with a notable rise in new communities in recent years. It is among the 41 places in the nation where the

population has developed by more than 10% in 10 years. The population growth of the city has been greatest in the last 4-5 years and it is expected this pace of growth will continue. The BME population increased from 15.7%to 24.7%. The city is divided into 17 wards and is ranked as the 55th most deprived local authority area in England (out of 326), with some of our wards being the most deprived in the country. Pockets of deprivation are mainly concentrated within Arboretum, Normanton, Sinfin, Alvaston, Derwent and Boulton, all of which are within the top 20% of the most deprived areas in England. These wards are characterised by higher than average rates of unemployment and households with a lower than average annual income. The growing child population is most likely the result of births in the UK to young migrant families, and child migrants during the last decade. 37.5% of school aged children are from BME backgrounds with a higher than average percentage of pupils having English as an additional language.

0.14% of Derby's population are British Sign Language (BSL) users, which is the highest number of BSL users outside of London (national average 0.04%).

There is a higher than national average rate of children with a child protection plan (Derby 55.7 per 10,000 versus a national average of 42.9 per 10,000 – Q1 2016/17 = 342 Total Children on a plan) and despite recent reductions our overall rate of looked after children is also above the national average (Derby 72.6, national average of 60 per 10,000 – Q1 2016/17 = 452 Total Looked after Children). Furthermore, there is a higher than national average level of SEND within Derby City's looked after population. Unsurprisingly given the levels of deprivation the health of Derby City Children is poorer than the National average and self-harm presentation, rates of teenage pregnancy are higher than average.

Derbyshire is a largely rural County with a mix of affluent market towns, villages and some former mining areas with pockets of high deprivation in Chesterfield, Ilkeston, Bolsover and Iron Ville. The total population is estimated at 790,000. The Child Well-being Index places Derbyshire within the top 20% of all Local Authorities in England. Yet, pockets of deprivation and severe unemployment have meant that the life chances for some children have been severely compromised. Approximately 16.3% of the Local Authority's children under the age of 16 are living in poverty. This compares with 19.2% in the country as a whole. The proportion of children entitled to free school meals in Derbyshire primary schools is 15.1% (the national average is 17.0%), and in secondary schools is 13.2% (the national average is 14.6%). Derbyshire's population is largely white British (96%) with the largest BME group being Irish at around 1%. Children and young people under the age of 20 years make up 22.4% of the population of Derbyshire and 5.0% of school children are from a minority ethnic group. The health and wellbeing of children in Derbyshire is generally better than the England average though this masks those areas where child poverty and poorer health outcomes occur. Derbyshire's rate of children in care or on a Child protection Plan population aged remains significantly below the statistical neighbour average and England rate.

DHCFT provides Adult Mental Health Services to the City and County including Substance Misuse and Perinatal Services; Universal Children's Services to the City and some specialist Children's Services including Child and Adolescent Mental Health Services to Southern Derbyshire and the City. The demographics of our local

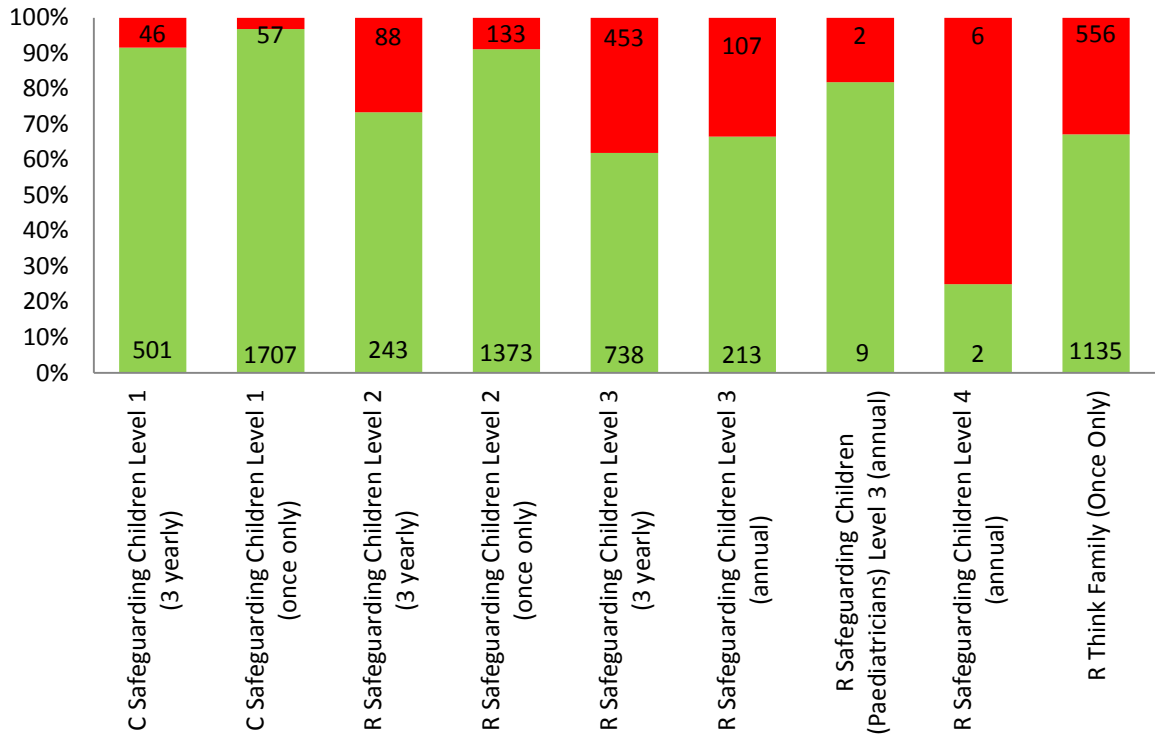
population are changing through immigration, birth patterns and global conflict. This presents challenges to the organisation in meeting the health and safeguarding needs of an increasingly diverse and transient population. A further challenge will be the impact of current conflict in the Middle East leading to people fleeing war or destitution. A National Dispersal Scheme for unaccompanied minors has been announced in addition to the dispersal scheme for Asylum Seekers managed by G4S. This is planned not to exceed more than 1 in 200 people in every local authority without that County Councils approval. The County currently has very small numbers of asylum seekers and cites finding suitable social housing as a major limiting factor but these numbers will rise. Derbyshire County has 13 children living in Derbyshire and another 97 children are due to arrive from Kent. These children are the responsibility of the Local Authority. The City is also expecting to have children arriving of the order of 35. Derby City already takes a larger proportion of asylum seekers.

Action: The challenges will be faced by all partners and the impact will be monitored closely by both SCBs through the QA meetings. The Head of Safeguarding will keep the Trust informed of specific considerations and challenges via operational meetings and the Committee and make recommendations for changes to strategy or additional checks to ensure these equality and access issues are consider in the safeguarding developments and monitoring.

Training

The Trust's training performance as of 10 October 2016:

Training Name	Target Group	Compliant	Non Compliant	Compliant %	Compared to Dec 15
C Safeguarding Children Level 1 (3 yearly)	547	501	46	91.59%	↑
C Safeguarding Children Level 1 (once only)	1764	1707	57	96.77%	NEW
R Safeguarding Children Level 2 (3 yearly)	331	243	88	73.41%	↓ Amendments to the group
R Safeguarding Children Level 2 (once only)	1506	1373	133	91.17%	NEW
R Safeguarding Children Level 3 (3 yearly)	1191	738	453	61.96%	NEW
R Safeguarding Children Level 3 (annual)	320	213	107	66.56%	↓
R Safeguarding Children (Paediatricians) Level 3 (annual)	11	9	2	81.82%	↑
R Safeguarding Children Level 4 (annual)	8	2	6	25.00%	↓
R Think Family (Once Only)	1691	1135	556	67.12%	↑



Summary

- To provide a report for overall trust safeguarding children training (including Think Family) compliance levels as at 10th October 2016.
- To update the group as to the current safeguarding training provision.
- To promote an awareness of the training requirements and training pathway for DHCFT staff within DHCFT.
- To provide an update of the training passports in line with the training framework requirements.
- To promote a proactive approach for operational leads in ensuring staff undertake relevant and timely training and ensuring the group has accountability of compliance.

Strategic considerations

- Ensure compliance to meet legal commitments and ensure that staff are trained and competent in line with CQC requirements. Concerns have been raised in relation to compliance levels.
- Ensure new starters have a progressive safeguarding children training pathway in line with job roles and commence in their employment within DHCFT.
- Ensure that training is consistently aligned to the *Safeguarding children and young people: roles and competencies for health care staff (3rd Edition. March 2014)* intercollegiate document
- Recent CQC interim report have identified areas of improvement in compliance of training

- The contract for the part time safeguarding trainer expires at the end of December 2016. In-house planning needs to be undertaken to ensure the continuity of a robust plan to support the training needs of the organisation in addition to the training board. It should also be noted that demand for external courses are high and results in staff not always being able to attend relevant training. Exploration of potential shared resources across Derbyshire provider organisations should also be considered.

Training Compliance

There is some confusion as to the training target being over 90% in the trust and where this has originated from. There are concerns expressed by the Safeguarding leads that this target is set too high in comparison with other organisations when an analysis of other Trusts eligibility groups and compliance targets were reviewed. When this is taken into account there is still a shortfall in some areas if this was set at 85% such as level 3 annual (staff in children and young people services), level 3 paediatricians and level 4 (senior safeguarding staff). However services where the contracts are with NHS England the target is nationally set at 95% + (i.e. Kedleston Unit, Perinatal services). Achieving and maintaining the targets requires ongoing commitment from all areas and operational leads to ensure compliance.
Concerns continue in relation to the levels of compliance in safeguarding children training in some key areas. Some staff have not forwarded their certificates from external training and a resolution with partner agencies to share training information still remains unresolved. Work has been undertaken in relation to getting names from both Derby and Derbyshire Safeguarding Children's board to input onto electronic training monitoring systems it should be noted that some staff have undertaken a variety of courses within the same year. This would put pressure on the supply and demand to the local authority training provision when the expectation for some staff groups is an annual training (one level 3 course per annum).

Main areas of low compliance:

- Level 3 annual (staff working in children's service)
- Level 3 (Paediatricians)
- Level 4 senior staff in safeguarding roles.

It should be noted that the level 3 (3 yearly) is currently low but this is steadily increasing due to the change from Level 2 to level 3 for clinical staff in adult services in the last year as a result of the uptake in Think Family training.

Actions

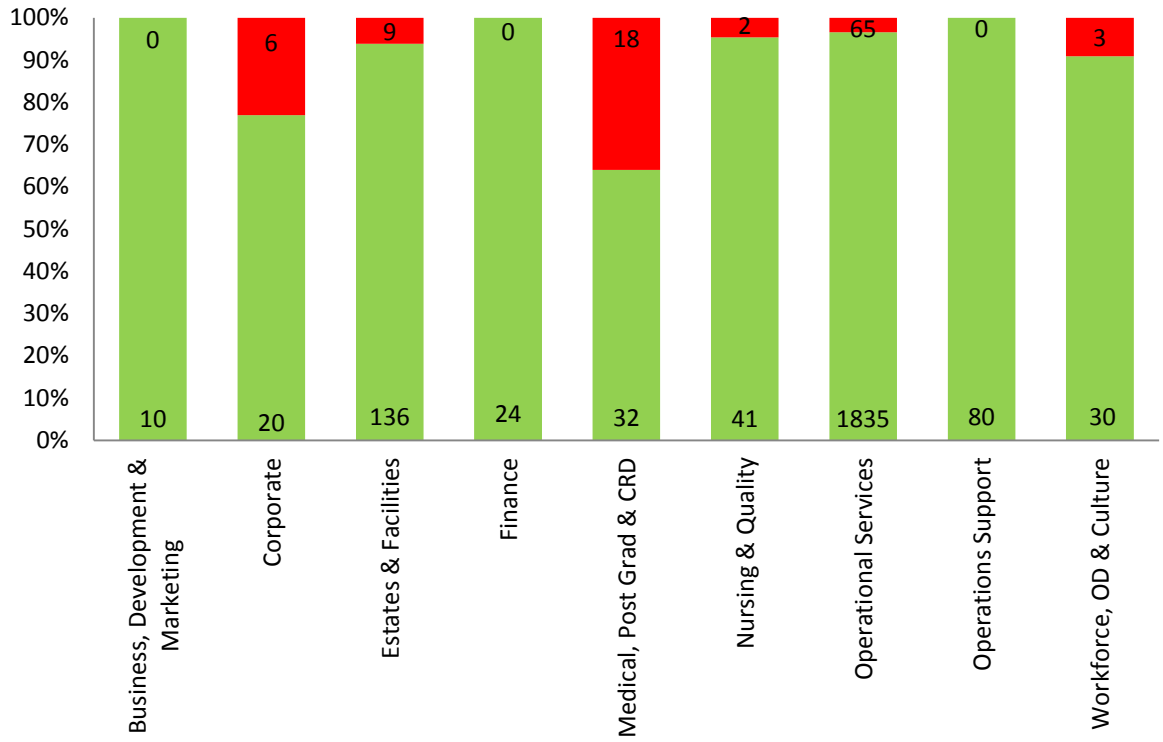
- Training reports and exceptions are routinely provided at the Safeguarding Children Operational Meeting for members to action in their service areas.
- Internal training is advertised via the Connect site with dates and times.
- Training performance is raised at performance meetings.

- Periodically emails are sent to individuals to promote uptake of internal courses.
- DSCB courses are advertised on the Connect Safeguarding Children page.

Training Compliance by Division

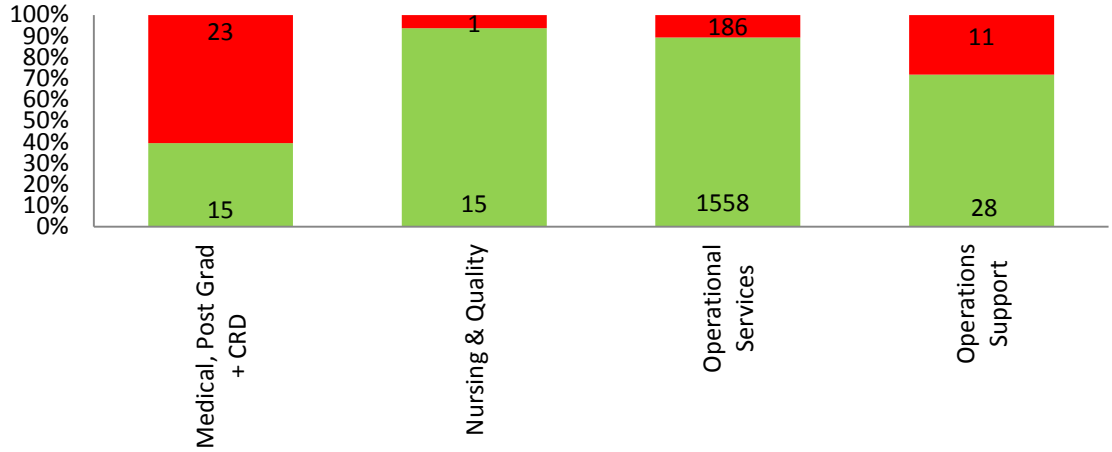
Safeguarding Children Level 1 - Divisional Compliance

Training Name	Target Group	Compliant	Non Compliant	Compliant %
Business, Development & Marketing	10	10	0	100.00%
Corporate	26	20	6	76.92%
Estates & Facilities	145	136	9	93.79%
Finance	24	24	0	100.00%
Medical, Post Grad & CRD	50	32	18	64.00%
Nursing & Quality	43	41	2	95.35%
Operational Services	1900	1835	65	96.58%
Operations Support	80	80	0	100.00%
Workforce, OD & Culture	33	30	3	90.91%



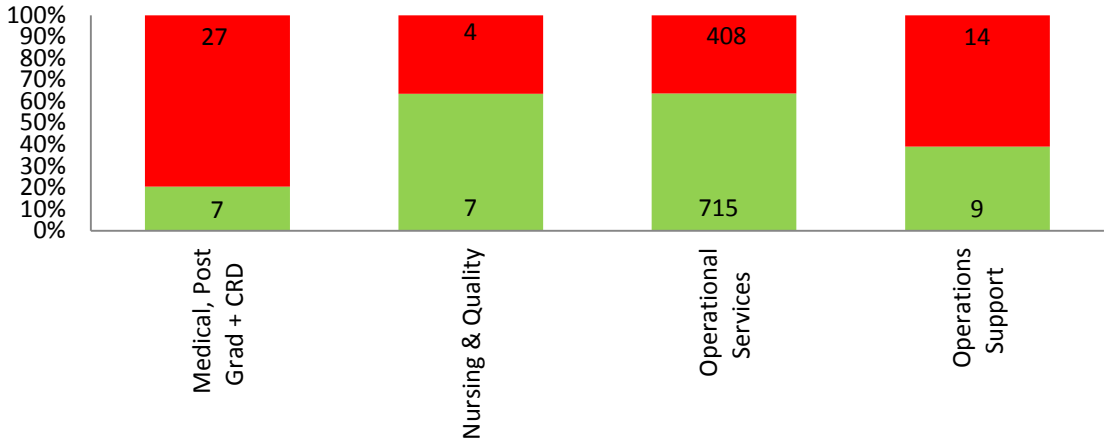
Safeguarding Children Level 2 - Divisional Compliance

Training Name	Target Group	Compliant	Non Compliant	Compliant %
Medical, Post Grad + CRD	38	15	23	39.47%
Nursing & Quality	16	15	1	93.75%
Operational Services	1744	1558	186	89.33%
Operations Support	39	28	11	71.79%



Safeguarding Children Level 3 (3 Yearly) - Divisional Compliance

Training Name	Target Group	Compliant	Non Compliant	Compliant %
Medical, Post Grad + CRD	34	7	27	20.59%
Nursing & Quality	11	7	4	63.64%
Operational Services	1123	715	408	63.67%
Operations Support	23	9	14	39.13%

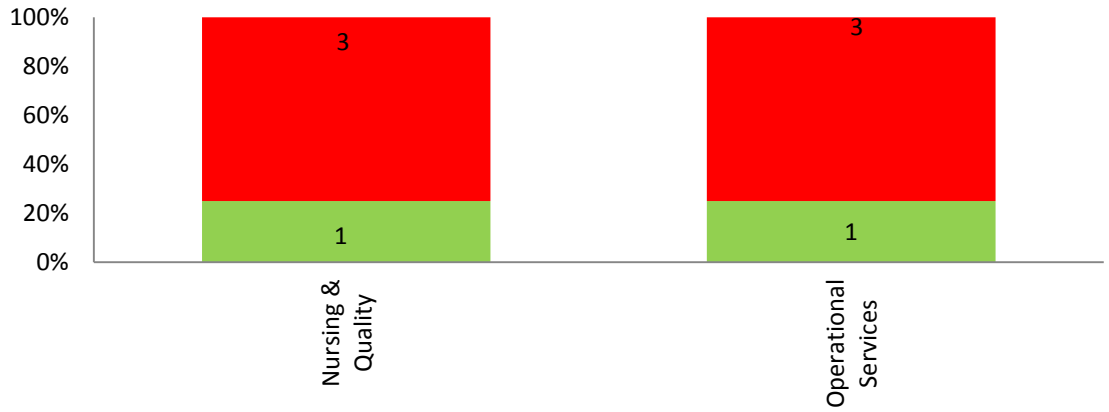


Safeguarding Children Level 3 (Annual) - Divisional Compliance

Training Name	Target Group	Compliant	Non Compliant	Compliant %
Nursing & Quality	4	3	1	75.00%
Operational Services	316	210	106	66.46%

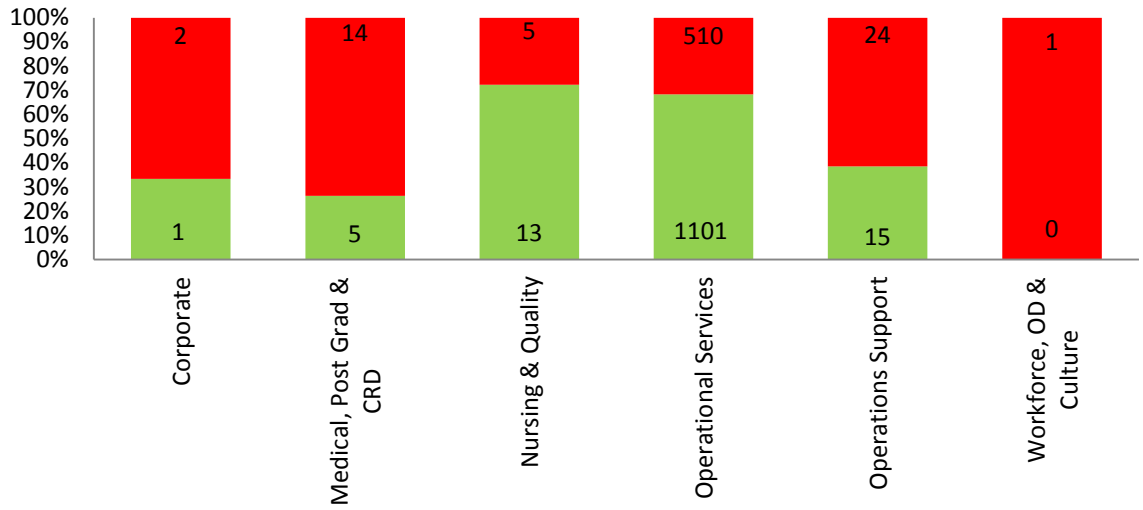
Safeguarding Children Level 4 - Divisional Compliance

Training Name	Target Group	Compliant	Non Compliant	Compliant %
Nursing & Quality	4	1	3	25.00%
Operational Services	4	1	3	25.00%



Think Family - Divisional Compliance

Training Name	Target Group	Compliant	Non Compliant	Compliant %
Corporate	3	1	2	33.33%
Medical, Post Grad & CRD	19	5	14	26.32%
Nursing & Quality	18	13	5	72.22%
Operational Services	1611	1101	510	68.34%
Operations Support	39	15	24	38.46%
Workforce, OD & Culture	1	0	1	0.00%



Current Safeguarding Provision

- **Level 1 taught programme.** This is delivered on the monthly induction programme for ALL new starters as delivered by one of the named nurses.
- **Level 1 e-learning**
- **Level 2 taught programme.** This is delivered on the bi monthly clinical induction block training by (mostly) one of the named nurses. Some additional level 2 courses are delivered by the safeguarding children trainer.
- **Think Family** is delivered in house by the safeguarding children trainer. This has been running since January 2015 with the anticipated expectation that all staff (approx. 1700) would have been trained by December 2016. However it is not likely to achieve this due to training non-attendance (around 30-40% at times and some courses cancelled in June due to illness, annual leave and courses not been organised and advertised for august / early September. As at August there are 578 non-compliant staff with Think Family training (not including new starters in the autumn). 236 places are available.
- **Level 3** is predominantly delivered by the safeguarding children's boards (exception being Think Family internally)
- **Level 3 paediatricians** include training and supervision. The responsibility of monitoring this lies with the consultant and copies of evidence are forwarded to the admin staff in Education for updating onto training passports.
- **Level 4 external training**

DHCFT current resources include a short term 2 day per week safeguarding children trainer and additional training from the named nurses as required. It should be noted that the contract expires in December 2016. Consideration and planning needs to be made for the ongoing internal delivery to meet national and local requirements.

Training Framework / Training Pathway

The Training Framework is the structure for all mandatory and role specific training within the trust. It is the framework for training passports. This year's training framework is due to be ratified shortly. In the last year there have been some amendments to this in that clinical registered staff in adult services have moved from level 2 to level 3. Also administration staff in children services are now required to undertake a taught level 2 training on a three yearly basis.

Furthermore the training pathway has been developed in conjunction with the safeguarding children's training board. This has been updated (slightly) and has been sent for amending on the DSCB website.

All operational managers and leads should be familiar with the training requirements of their departments and ensure a proactive approach to ensuring staff are (and stay) in date with training. The challenges with Training compliance is raised with managers and general managers via team meetings including senior management team meetings.

(Please see Appendix 1 for complete Training Framework and Pathway)

A key aspects of good governance is in ensuring a proactive approach to data collection and ensuring on-going assurance of training data and its accuracy

Recommendations

- The Head of Safeguarding will continue to monitor training compliance closely via the Safeguarding Children Operational Meeting and action as appropriate from each meeting.
- Managers and leads to support training booking as per the training framework and training pathway and ensure an equitable distribution of resources and bookings.
- Consideration and planning needs to be made for the on-going internal safeguarding children training delivery to meet trust and national requirements to take effect from January 2017. The Head of Safeguarding will ensure this has been addressed and presented at the Committee in November 2016.

Current challenges as related to the CQC comprehensive inspection findings

1. Safeguarding training:

Clinical staff who have direct contact with children and young people need to undertake Level 2 & 3 safeguarding training as identified through the "Safeguarding Children and Young people: roles and competences for health care staff

Intercollegiate document (March 2014, v3)" . The Trust's uptake is below the Trust Target. This is clearly identified within the Training report.

The Head of Safeguarding has developed an action plan to achieve the target by December 2016, however the trajectory shows that there will be approximately 130 staff outstanding unless more training is commissioned. The Head of Safeguarding and the General Manager of Children's Services have commissioned extra 8 Level 3 training up to the end of October 2016 to meet a more rapid trajectory of training in line with CQC comprehensive inspection feedback.

2. Supervision:

Staff who have contact with children must receive safeguarding children supervision. The Head of safeguarding has amended the Trust Supervision policy to highlight the requirement for safeguarding supervision within management supervision and added guidance to what might be covered. The policy also clearly explains the different types of safeguarding supervision and how it can be accessed. The recording of supervision has remained a challenge in order to provide assurance to the Safeguarding committee that supervision is happening and is being recorded diligently in line with Trust standards. The requirement and method of recording supervision via Connect supervision monitoring tool has also been made explicit within the policy and will be briefed to teams throughout the year.

All managers have been updated to ensure that the new policy is adhered to. It is an expectation that once the recording of data is recorded that compliance will increase substantially. This will be monitored by the operational group to ensure sustained improvement in this area.

Advice Themes

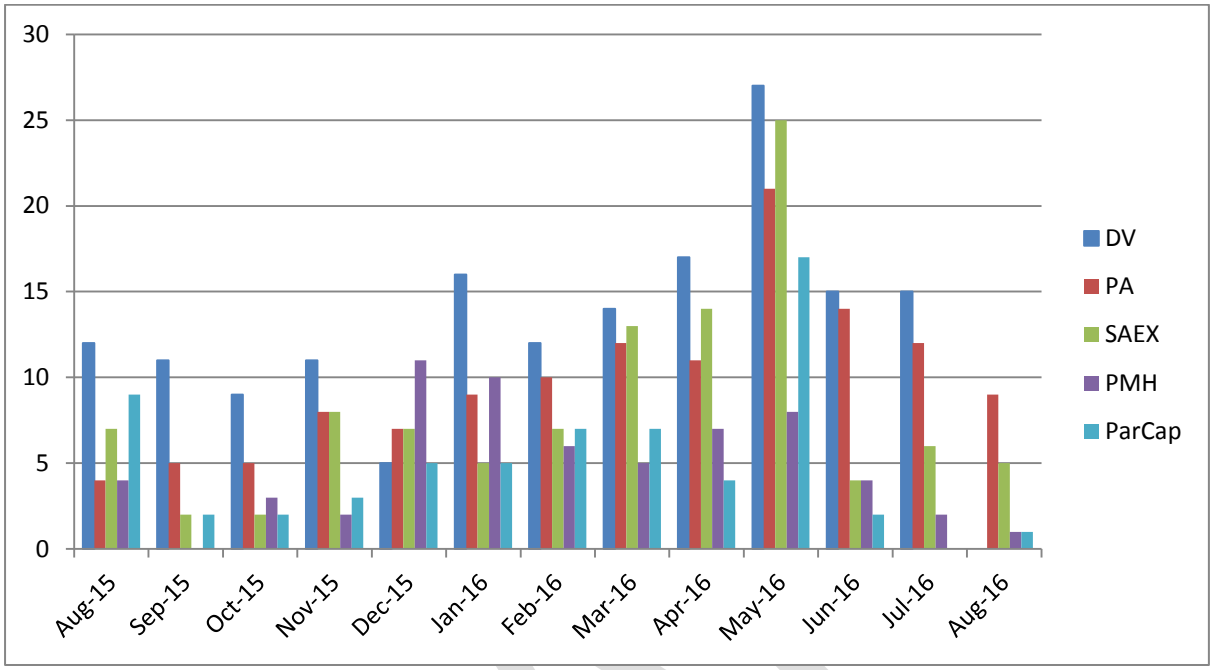
The Head of Safeguarding has reviewed advice calls taken from August 2015 to August 2016 to establish and consider the themes of these calls. During this time 974 advice calls were answered and advice given.

The CQC comprehensive visit gave the opportunity to review practice and what supervision was recorded and whether clinical supervision and advice through the helpline was being recorded routinely. This has resulted in a review of this system and a change to practice to ensure that all advice and supervision calls are also recorded/ This clinical supervision is now recorded in the electronic performance dashboards on Connect under supervision so we will expect to see this reflected in performance data in future, and again this will be monitored at the operational management group.

Our figures also include S47 discussions with Social Care as within our clinical advice themes.

The graph below demonstrates the top five themes that have emerged over the last 12 months:

Key: DV = Domestic Violence; PA = Physical Abuse/Injuries ; SAEX = Sexual Abuse / Exploitation; PMH = Parental Mental Health; ParCap = Parental Skills / Capacity / Basic Care



The findings are as follows that the significant areas remain stable with Domestic Abuse continuing to be an extensive theme of calls to the clinical advice line. This is also linked to the number of plans of children on a safeguarding plan….:

Domestic Abuse is the theme of the joint inspection and a mock inspection is taking place in October 2016 for interagency inspection which will enable the Safeguarding team to reflect upon practice and lead the commissioning or provision of any additional learning or direction in this area of safeguarding practice. The revised Think Family training will have Domestic Abuse strongly featuring as a key learning objective.

Think Family Training is successful in the fact that professionals are recognising abuse, safeguarding issues and contacting the unit for advice. Evaluations of the training are on the whole positive with some anecdotal feedback that the training is still very broad and may benefit from additional theming for clinical pathway areas.

We are more actively monitoring the following themes over the coming year due to Trust-wide initiatives in these areas:

- Suicide / Self Harm
- Terrorism / Radicalisation
- Female Genital Mutilation

Bradbury (link to staffing and Complex enquiry l):

The Independent Enquiry into Childhood Abuse is ongoing despite changes in its Chairmanship. It was set up in response to a number of high profile abuse cases involving those in the public eye and public office. While the focus has often been on high profile celebrities such as Savile and Staff in Education and Social Care there have been concerning cases in the NHS. In addition we have the current internal investigation into a complex enquiry into Aston Hall where allegations of abuse and improper treatment of children have been made against a named Medic and further enquiry into wider issues are being explored. This is now being managed directly by a Gold group of the Derbyshire Safeguarding Children Board.

Myles Bradbury, a Consultant in Paediatric Haematology at Addenbrookes was successfully prosecuted and jailed for multiple sexual offences against his child patients. The subsequent Independent enquiry highlighted Bradbury acted alone and under the radar, so that no-one suspected him of acting unprofessionally, let alone criminally. Flexibility in the appointments process contributed to Myles Bradbury's behaviour going unnoticed and him being commended for going the extra mile when in fact he was creating opportunities to isolate and abuse his patients. There are many lessons to consider for our own services not least that we need to consider that some people seek out employment in organisations to gain access to the vulnerable. Therefore DHCFT must ensure:

The Head of Safeguarding will ensure the following to reassure the Trust fully that

- A Trust action plan in place in conjunction with Adult Safeguarding.
- Our polices have an effective enforced chaperone policy, and policy for children transitioning to adult services, will be implemented and audited
- The Trust briefs and sets expectations with Service Users and Carers as to what to expect at appointments so they are alert to deviations from expected examinations and behaviour of staff and feel able to recognise and query unusual behaviour. This needs to be developed in such a way that it doesn't undermine the trust and confidence in the relationship between health professionals and patients but enables individuals to be aware of risks associated with blurred boundaries.
- Flexibility in the appointments process should be managed and monitored to reduce the risk that some staff might be creating opportunities conducive to grooming and abuse of their patients.
- Safeguarding training continues to raise awareness of the potential for professionals to be perpetrators of abuse. This is currently included in our internal training and this national learning will be considered in our Trust policies and practices.

Safeguarding Children – PREVENT and CHANNEL:

The Trust are active members at local PREVENT groups and the head of safeguarding has oversight, awareness and understanding of how to recognise and respond to the increasing threat of children and young people being radicalised. This work is supported by a Trust clinical policy and although it is at a relatively early

stage of maturity, the system and process are in place to undertake this work safely. The Head of Safeguarding and the Safeguarding Adults Professional Lead are members of the monthly CHANNEL meetings. These are multi-agency forums where referrals are scrutinised in light of potential radicalisation. The purpose of the meeting is to share information from each agency, assess risk and develop action plans to support individuals in a positive and inclusive manner.

Three main areas of concern have been identified for initial attention in developing the process:

- Increasing understanding of radicalisation and the various forms it might potentially take, and develop staff with the skills and abilities to recognise signs and indicators for all staff working with children and young people. This is currently covered in internal Safeguarding Children Training.
- Identifying a range of interventions – universal, targeted and specialist - and the expertise to apply these proportionately and appropriately. This requires a multi-agency approach to provide the necessary specialist expertise, and the incorporation of existing projects and interventions (e.g. Channel).
- Taking appropriate measures to safeguard the wellbeing of children living with or in direct contact with known people who may have extremist views by following DSCB policies and procedures.

Children and young people can be drawn into violence or they can be exposed to the messages of extremist individuals or groups by many means. These can include family members or friends, direct contact with members groups and organisations or, increasingly, through the internet. This can put a young person at risk of being drawn into criminal activity and has the potential to cause significant harm and would also meet the threshold for safeguarding intervention.

Potential diagnostic indicators identified in the Channel Guidance include:

- Use of inappropriate language.
- Possession of violent extremist literature.
- Behavioural changes.
- The expression of the required service and or extend access to psychological therapies for victims of a crime both in childhood and into adulthood.

Female Genital Mutilation (FGM):

FGM is referenced in the multi-agency policies and our Trust work to these requirements and it is covered within internal Safeguarding Children training.

What is Female genital mutilation

Female genital mutilation (sometimes referred to as female circumcision) refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. Female Genital Mutilation is a form of ABUSE and the practice is ILLEGAL in the UK.

It has been estimated that over 20,000 girls under the age of 15 are at risk of female genital mutilation (FGM) in the UK each year, and that 66,000 women in the UK are living with the consequences of FGM. However, the true extent is unknown, due to the "hidden" nature of the crime.

From 31st October 2015, all regulated professionals (health, teachers, social workers) were required to report known case of FGM or disclosed cases of FGM direct to Police.

Regulated health and social care professionals and teachers are required now to report cases of FGM in girls under 18s which they identify in the course of their professional work direct to the police.

This is a personal duty; it cannot be transferred to anyone else.

Once concerns have been raised about FGM, there should also be a consideration of potential risk to other girls in the family and practising community. Professionals should be alert to the fact that any one of the girl children amongst these groups could be identified as being at risk of FGM and will need to be responded to as a ‘child in need’ or a ‘child in need of protection’.

Professionals within the trust need to be mindful of the potential growth of the problem within the unaccompanied asylum seekers.

Female genital mutilation data sets

From 1st October 2015 it will become mandatory for all Health Trusts to collect and submit data in regards to FGM. This process is in place and data is recorded on the female’s health record, either TPP System One or PARIS.

HSCIC is collecting data on FGM within England on behalf of the Department of Health (DH) and NHS England (NHSE). This is to support the DH and NHSE FGM Prevention Programme. The data is collected to improve the NHS response to FGM and to help commission the services to support women who have experienced FGM as well as safeguarding women and girls at risk of FGM.

The FGM Enhanced Information Standard instructs all clinicians to record into clinical notes when a patient with FGM is identified, and what type it is.

Data is submitted every time the woman or girl has treatment related to her FGM or gives birth to a baby girl, and every time FGM is identified (by a clinician or self-reported), not just the first time. This area will be monitored by the Safeguarding operational group.

Domestic Abuse:

Between September 2016 and March 2017 there is to be joint targeted area inspection by the Joint Targeted Area Inspection's teams , OFSTED , HMIC (police), HMI (probation) and CQC. This will involve a multi-agency 'deep dive' into the experiences of children and young people living with domestic abuse. In preparation for this a Health Derby City/County action plan will be prepared and Derbyshire SCB is undertaking a mock inspection during October 16 in readiness. I have familiarised the Safeguarding Children team in preparation.

This action plan is to monitor the integrated health response to the evaluation criteria by the inspection body (Ofsted, CQC, HMIC and HMIP) to provide assurance across the local Safeguarding Children Board partnership and to external inspection.

The Evaluation Criteria is:

- Professionals and support staff see incidents of domestic abuse through the eyes of the child. They are well trained, confident and knowledgeable and they understand the impact of domestic abuse. This enables them to identify how to help and protect children and to take action to do so
- Children who live with domestic abuse experience a child-centred approach from all professionals and the risks to them and their needs are assessed effectively and responded to appropriately
- Risks to children living with domestic abuse are prevented and reduced. The needs of the child, their non-abusive parent and the perpetrator are met at an early stage through timely access to effective help
- Children living with domestic abuse receive the right help and protection because application of appropriate thresholds, effective information sharing and timely intervention takes place. (This includes thresholds for early help, children in need, child protection processes, children becoming looked after and MARAC)
- Risk of harm to children is reduced through the identification and assessment of the risks that perpetrators and adult offenders pose. This leads to appropriate and targeted interventions by all professionals
- Children's welfare is promoted and protected through effective and timely identification, assessment and response to the risks to, and needs of, adult victims of domestic abuse. Professionals recognise that the abuse does not necessarily end when people stop living together and may in fact escalate
- Multi-agency risk assessment conferences support the protection of children through timely sharing of information, assessment of risks to children and through developing effective action plans

- Children and their families living with domestic abuse benefit from evidence-based approaches, tools and services that reduce risks and meet their needs
- The police force investigates cases of domestic abuse in families with children effectively
- Cafcass identifies, responds to and works with children living with domestic abuse effectively and provides effective advice to the family court.
- Children and their families feel that their views have been heard. This leads to improvements in the help and support that they receive
- The impact of domestic abuse on children is reduced because they, their families and the perpetrators can access a sufficient range of commissioned local services. For example, community and voluntary services, including therapeutic help that improves children's and adult family members' emotional well-being and safety
- Leaders and managers understand the experiences of children living with domestic abuse and the prevalence of this issue in their area. This leads to effective action to meet children's needs and improve the help and support provided to children and their families
- Leaders and managers recognise the challenges in working with domestic abuse and provide appropriate support, training and challenge to practitioners so that effective practice can flourish
- The LSCB actively monitors, promotes, coordinates and evaluates the work of the statutory partners that help and protect children at risk of domestic abuse, including working effectively with other multi-agency groups that have responsibility for responding to domestic abuse

As the table of advice themes highlights domestic abuse continues to be the main focus of safeguarding concerns across children and adult services. The Head of Safeguarding children can assure the Board that the Safeguarding Children Team are totally engaged with all formal process and the MASH to cover domestic abuse to date. Further briefings on findings and outcomes will be provided to the operational group and to the Safeguarding committee in next year's annual report

Child Sexual Exploitation (including unaccompanied minors and increase number and links to CSE, Slavery, missing and FGM):

Following on from National and local investigations Child Sexual Exploitation remains a high priority for both City and County Safeguarding Boards. Each area has considered this from a slightly different focus with an eye on future Joint Targeted Area Inspection of safeguarding children. In April a Child Sexual Exploitation, Children Missing from Home, Care or Education was the focus of a "Deep Dive" in the County. This resulted in an Action Plan that is currently being disseminated via the Named and Designated Professional Group with a distinct Health focus. In July a Local Government Association Diagnostic of Derby City's Child Sexual Exploitation

(CSE) Services was undertaken found that Derby is compliant with its statutory responsibilities relating to CSE and CSE remains a high priority. Investment in CSE has been maintained and is reflected in the high level of awareness and commitment across partners and practitioners. Policies and procedures are in place to support front line staff are evident in relation to CSE. All agencies are represented on the DSCB with exception of NHS England. There were areas for development that particularly highlighted partnership working. It has been advised that Derby City Council and its partners should:

1. Agree a narrative in relation to CSE activity across the city in relation to the downward trajectory of numbers at risk
2. Review the number of multi-agency CSE meetings and strengthen the focus on evidencing impact
3. Outline the CSE pathway or CSE offer and disseminate this across the partnership and to children and families
4. Develop one problem profile that partnership works to and is shared with front line practitioners
5. Develop a data set that informs partners on impact and outcomes of the strategy

The Head of safeguarding will await further information from the Safeguarding Boards regarding the review and will collaborate with them on an Action Plan. There is membership from our trust on the CSE multi-agency meetings and the work will be monitored via the operational meeting. Electronic data will be recorded to ensure data collection around CSE is in place for provision to Commissioners when required. DHCFT continues to highlight the use of the CSE Safeguarding Toolkit and others such as the Brooke Tool Kit and Spotting the Signs which are being trialled in the County. An audit is to be undertaken by the team to ensure robust staff knowledge and usage of the CSE toolkit.

Both assessments considered the needs of vulnerable groups particularly boys, young people that go missing or are missing from education, young people from BME populations and unaccompanied asylum seekers all of whom are often under reported as being victims of CSE.

As highlighted previously as our population changes the complexity of Safeguarding aspects may increase. This is a concern with the dispersal of Unaccompanied asylum seekers who may have been subject or at risk of FGM or actually trafficked for the purposes of Modern Slavery, who may have had abusive experiences as part of their journey to the UK and experienced trauma in their country of origin. This will require ongoing monitoring over 2017 to ensure the needs of young people are being identified and met.

To mitigate against health and safeguarding risks prior and during the transfer process, Unaccompanied Asylum Seeking Children will be registered with a Kent GP and have an NHS number allocated. They will need to re-register with a GP in their new area as soon as they move and the new GP will then request the existing GP record. The Young People will be provided with a Health Passport which will contain details of their NHS number, GP registration, a copy of their Fitness to Travel screen and some relevant health information leaflets.

Health needs for consideration by DHCFT Trust services will be

- Poor nutrition and anaemia.
- Screening for TB and Hepatitis B
- Poor dental health and visual problems
- Lack of immunisations
- Psychological/mental health issues which may be delayed
- Sexual health concerns, pregnancy, STI's and need for contraception.
- Rashes, scars and fungal infections.
- Parasitic infection, lice and scabies.
- Musculoskeletal complaints.
- Smoking, drugs and alcohol dependency.

Safeguarding Issue

Unaccompanied Asylum Seeking Children are at higher risk of being trafficked for CSE or modern slavery. These children are at a high risk of going missing. Girls may have been the victim of FGM and rape.
All of these safeguarding issues need to be considered at the time of the Initial Health Assessment or at any other health contact and will be highly pertinent to the Services DHCFT in both City and County. There are no additional identified funds to help support the health needs of UASC. Training and supervision is key to ensure professional awareness and good practice. The Head of Safeguarding will ensure that this is covered at professional and team meetings by the Safeguarding Children team.

Trauma Informed Service

This report highlights a number of key areas (Child sexual abuse, CSE, domestic abuse and sexual violence, UASC) where in addition to Safeguarding there is a need to address the trauma experienced by individuals. Some examples are the requirement of SARCS to provide access to therapeutic services and the treatment needs of Adult Survivors of Aston Hall. . This raises significant questions for DHCFT regarding development of an understanding and an expertise in Trauma Therapies and Trauma informed Services. Adverse Childhood experiences including all forms of abuse and living with domestic abuse is increasingly linked to a wide range of chronic

health problems including cancer, substance misuse, mental health problems including psychosis and increased self-harm. Only by equipping and developing our workforce with the psychological, social and medical skills to work effectively with trauma at all stages will we have services fit for purpose. This is a challenge to the organisation that needs to be considered widely and beyond Safeguarding MASH (multi agency safeguarding hub):

The core functions of the Derby MASH:

The intention of the MASH is to bring together partner agencies on a permanent basis in one location to share information relating to vulnerable children and Young people. This will enable the sharing of vital information across agencies in order to make better informed and timely decisions about the referrals being made regarding children and young people.

Legislative and Procedural Context

Children Act 1989 and 2004
Working Together 2015
Derby Local Safeguarding Children Board (LSCB) procedures, including thresholds document and escalation process.
Information Sharing advice for Practitioners providing Safeguarding Services. Department of Education (2015)

The MASH will bring the following benefits:

- Faster, more co-ordinated and consistent responses to new safeguarding concerns about vulnerable children and young people. .
- An improved 'journey' for the child with a greater emphasis on early intervention and better-informed services provided at the right time.
- Greater ability to identify potential vulnerability, enabling more preventative action to be taken, dealing with cases before they escalate.
- A more straightforward and responsive process for the professional or citizen raising a concern, with clear guidance and support.
- Closer partnership working, clearer accountability and less duplication of effort.
- A reduction in the number of children and young people inappropriately accessing costly services from social care, the Police and others.
- A reduction in the number of inappropriate referrals and re-referrals.

CURRENT MULTI-AGENCY ARRANGEMENTS FOR SAFEGUARDING CHILDREN FOR DERBYSHIRE AND DERBY CITY

In June 2015, Starting Point was based in Ripley and was designed to act as the first point of contact for all Derbyshire Children Social Care Services including safeguarding and child protection concerns and children's wellbeing. It was agreed that the service would include staffing from Children's Social Care, Local Authority Children Services, Police and Health working together at a central location with virtual links to other services and agencies including Education, Probation, and Housing, with a long-term vision of co-locating all services in one central location once the service has been established.

Derbyshire Starting Point handles all child protection and safeguarding referrals from professionals as well as from members of the public and family members.

A number of the contacts or referrals made to Starting Point are managed under the Early Help and Child in Need arrangements and where there are Child Protection concerns the health team has an essential role to play in gathering information from relevant health organisations including GPs to analyse and share the information with professionals who are attending the on-site statutory Strategy Meeting in line with Working Together to safeguard Children (2015)

Derbyshire Starting Point handles approximately 520 calls per week; of these, the health team are handling on average 182 cases of children/young people and their families for assessment. These figures are more than initially anticipated. 50% of these cases result in child protection work and 50% results in child in need and early help arrangements being put in place.

Derby City arrangements

The Derby City Multiagency Safeguarding Hub (MASH) has been formally agreed by both Derby City Safeguarding Children and Adult Boards. The decision was made to develop a different model to the one that has been set up covering the Derbyshire area called **Starting Point**.

In Derby City, the MASH Model covers both Children and Adults and processes all domestic violence referrals, Child protection section 47 enquires and Adult safeguarding referrals.

The Derby City MASH aims to include representatives from Children's Social Care, Adult Social Care, Police and Health all working together in a central location. Virtual links will exist with other services and agencies such as Education, Probation, and Housing. The location of the MASH that commenced in June 2016 (from a children perspective) is based in the Derby City Council House. There was a slight delay with the adult team in the MASH who joined the teams from Social Care in September 2016.

The intention of the Derby City MASH is to bring together partner agencies on a permanent basis in one location to share information relating to vulnerable children and adults. This will enable the sharing of vital information across agencies in order to make better informed and timely decisions about the referrals being made regarding vulnerable children, young people and adults.

In Derby City, the MASH is not a 'front door' service for children Social Care. The 'front door' of Derby City Children, Social Care will remain the unchanged. This remains at Ashtree House in Derby City. All initial referrals, contacts, enquiries will continue to go to First Contact Point in Derby City, who will determine which cases need to be forwarded to the Derby City MASH to undertake the relevant information checks, analysis, strategy discussion and meetings.

Currently the Derby City MASH is significantly under resourced from a health perspective and the current health contribution is not a long-term solution. The current arrangement is that Derbyshire HealthCare Foundation Trust have agreed to provide a Safeguarding Named Nurse to cover half a day every day (Monday to Friday). Additionally temporary funding until March 2017 has been agreed and 2 full time MASH Advisor posts have been advertised.

An options paper was submitted requesting additional funding to cover the health contribution to the Derby City MASH. This has been successful in the short term and two full time health worker job vacancies will be advertised and appointed September 2016 for a six month period and then reviewed.

This post will work across children and adult to provide the Health component. The post will be managed and supervised across the Adult and Children Safeguarding Team.

Learning from Serious Case Reviews and Thematic Reviews:

Thematic Review 1. Neglect

Derby City Safeguarding Children Board currently does not have any Serious Case Reviews or Learning Reviews but have undertaken a multi-agency audit around Neglect. As a result of this the Derby Safeguarding Children Strategy and Action Plan has been developed.

The executive summary outlines the main issues and the learning and recommendations below are also detailed within the multi–agency action plan. The action plan will be operationalised by the Head of Safeguarding Children via the Safeguarding Children operational meeting and via professional and team meetings. There was training for staff arranged in October 2016. Learning is also captured within our internal level 2 and 3 training.

Executive Summary

The findings of this thematic audit of neglect present a mixed picture of the quality of the work being undertaken in Derby at an early stage and as concerns about neglect increase. It is apparent that at the point where the cases were considered at risk of significant harm there were substantial levels of multi-agency activity seeking to prevent further escalation.

There was good evidence of the extensive and persistent work being carried out by practitioners seeking to engage with children and parents within child protection plans. There was evidence of good multi-agency work through core groups and work with parents to effect change to prioritise the needs of the children. There was evidence that the plans were being reviewed.

However the robust systematic assessment of neglect, specifically informed by the Neglect Graded Care Profile, was absent in all but one of the cases audited. The use of assessment tools to gather objective judgements about neglect and demonstrate the impact of change over time was poor. Chronologies were not systemically used. Practitioners frequently experienced non-engagement by parents or disguised compliance.

Working with cases of neglect has been recognised as complex requiring skills, knowledge and support to provide practitioners with the tools to remain focussed on the needs of the child and rise to the challenges presented by parental needs. “Think Family” approaches are essential to ensure the needs of parents are addressed. The cases audited highlighted the high prevalence of domestic violence, substance misuse, parental mental ill health and learning difficulty. All factors presenting significant complexity within the family and increasing the importance of a “Think Family” approach.

A sample of practitioners working with the families demonstrated little evidence that they had received appropriate training to work with complex cases of neglect.
Management oversight and supervision of staff was insufficiently robust to ensure that staff had received training on neglect, appropriate assessment tools were used to inform judgements and that effective reviewing of cases (at Early Help and Children in Need level) ensured that drift was avoided.

Currently a multi-agency strategy is being developed to drive forward the effectiveness of arrangements to prevent and respond to neglect.

Whilst noting that the audit sample was small, the findings are sufficiently consistent to inform key areas for inclusion in the Derby Neglect Strategy.

The audit did not include the examination of a selection of cases where early help intervention had successfully achieved sustained progress to prevent neglect.

Key Findings

Agencies are working together well at a child protection level and progress is being made to achieve improvements. Liaison between agencies is generally good and the coordination and effectiveness of inter-agency work has led to improved planning and focus on individual needs.

There were examples of the effective engagement with parents over time that, for example, had led to important disclosures of domestic violence or the development of practical skills that improved children’s hygiene and attendance at school.
There were examples of direct work and good engagement with children leading to improvement in social and interpersonal skills and general happiness evident in school.

Multi-agency work through the Core Group was noted as having a positive impact on the wellbeing of a child and had prevented the deterioration of the family situation.
The absence of structured assessments at an early stage, used to inform multi-agency work, such as the Early Help Assessment and Graded Care Profile, meant

that there was limited evidence that there was effective planning on an objective basis, informed by a framework specifically focussing on neglect.

Where early concerns were emerging there was sometimes a lack of clarity about the role of different agencies to “monitor” and review progress and this was compounded by lack of clear assessments and plans. This contributed to drift and extended the time the children experienced neglect.
Chronologies were not present in most cases and therefore not systematically used to inform judgements about the seriousness of ongoing concerns, the relevant history of previous involvement leading to increased risk of “start again” syndrome.
Domestic violence was a factor in five of the six cases. The Domestic Violence Risk Identification Matrix is a key assessment tool that was not being used to inform assessments of the impact on the children and the victim, identify risk factors and quantify the level of risk within the family.

It would be expected that in cases of neglect where the level of concern was increasing that records would indicate clearly what needed to change, what steps had been taken to achieve change within timescales and the parents engagement in the process. There was little information indicating that cases had been effectively and consistently reviewed by agencies prior to becoming subject of child protection plans.

The lack of management scrutiny of the use of assessment tools upon which to base planning and provide a benchmark upon which sustained progress can be judged is an area of significant importance and one that should be the focus for improvement.
Management oversight is not consistently ensuring that practitioners have the skills, training and support to ensure that complex cases of neglect avoid drift and that appropriate escalation occurs.

“Think Family” approaches seek to ensure that there is effective coordination between children’s and adults’ services. This becomes more critical when the difficulties and needs of parents are impacting on the neglect of their children. There was insufficiently consistent practice to ensure effective join up between services.
Written agreements with parents can be an effective tool however where non-engagement or disguised compliance occurred robust contingency plans were not consistently in place. Where used as part of ongoing monitoring, the use of a written agreement was not always clearly understood by agencies that had an ongoing role with the family.

Recommendations

A Neglect Strategy is implemented in Derby to ensure effective and consistent action is taken to identify and respond to neglect at an early stage by all agencies.

Agencies report on how they have implemented the strategy and its impact. I will be fully engaged with the process and implementation on behalf of the Trust and ensure that the Committee is kept up to date with progress.

Agencies report on how they know management practice is ensuring that key practitioners are:

- Obtaining the necessary skills and knowledge to work with cases of neglect and with families where there is poor engagement, resistance or disguised compliance;
- Using assessment tools such as the Early Help Assessment, Graded Care Profile, DVRIM and chronologies to inform planning and decision making in cases of neglect;

Thematic Review 2. Intra-Familial Child Sexual Abuse

As a result of SCR SM13 (which was reported on in last year's annual report) the Derby City Safeguarding Children's Board held a Learning Review of Intra-Familial Child Sexual Abuse. The overview report is still in draft but once finalised the learning will be disseminated. Workshops will run in October alongside the neglect workshops referred to earlier as early neglect was a common theme in cases that was overlooked. The Draft reported areas of good practice including effective Communication between the Police and paediatrician, good interagency and information sharing which led to improving the cooperation of family members and effective planning. The SCR and this audit highlighted the effectiveness of the New and Emerging Communities Team which unfortunately has now been dissolved, despite me highlighting the safeguarding and Think Family benefits of this team. There is further work including updating the Multiagency Training, robustness of strategy discussions improving effective plans, appropriate arrangements in case of the alleged perpetrator being a child. Explicit consideration of other hidden factors under Think Family including domestic abuse, neglect, mental ill health and substance abuse. Consideration of support to the child and the non-abusing carer/parent.

Learning from Serious Case Reviews

There are currently 3 serious case reviews within the county of which DHCFT had minimal involvement with each case.

- ADS15 and KN15 have not yet been signed off by the Derbyshire Safeguarding Children Board but the learning for DHCFT has been identified.
- ADS14 the original review was commissioned by the Derbyshire Safeguarding children's Board on 13th June 2014 but a subsequent review

was recommended to reflect the information and convictions of the mother and mother's partner.
Additional questions were added to the original TOR as on outcome of the criminal trial the mother being convicted of murder and child cruelty; her partner being convicted of causing or allowing the death of a child. All IMR were audited by an external agency and the chair of the Panel. There were no significant issues raised and the report has been resubmitted.

- Actions for Health Professionals from KN15, ADS15 and ADS14 have been identified by Derbyshire Safeguarding Children Board as follows and action plans are in place and are being progressed – whilst not all recommendations directly apply to DHCFT the learning is always transferrable.

KN15 : Serious Case Review to look into the circumstances around the death of a 14 year old from hanging although KN15's death is not considered as suspicious and the post mortem supports that she died from hanging , concerns have been raised regarding the parenting she was receiving from her mother and stepfather and possible emotional abuse.

Recommendations:

- All professionals involved with Family members should be part of any multi-agency safeguarding process in order to identify any impact on children and young people.
- To continue with the implementation of the electronic patient record.
- All patient discussion and action from multi-disciplinary meetings to be entered into the record.
- To investigate the issue of locking down of patient records on PARIS within the organisation and to issue a recommendation.
- To clarify the use of process notes by psychology teams and the impact for record keeping.
- To ensure that all clinical staff are trained in Think Family.
- To audit staff awareness /knowledge of the historical sexual abuse policy.
- For the Trust to consider/review the availability/allocation of a CPA care co-ordinator in all community based care where patients have complex needs.

ADS15: Serious Case Review to investigate the circumstances surrounding the death of a 4 month old baby boy. Initially his death appeared to be due to SIDS but post mortem examination revealed unexplained injuries to the baby. The mother has been arrested and charged with manslaughter. Siblings are being cared for by family members while the case is progressed and tried.

Recommendations

- Assessments: When a child/children in a family are already receiving services (such as from the MAT) and there are significant changes, for example the mother becomes pregnant, then the Assessment should be updated taking into account multi-agency views and should consider holistically other issues within the wider family. DSCB should conduct an audit of a range of multi-agency assessments to ensure such a 'Think Family' approach is being applied.

- The need for a formalised research based Neglect Assessment Tool (for example Graded Care Profile) - The DSCB should review the neglect assessment tool currently available and formally launch the tool to enhance practice and provide consistency regarding assessment of neglect, and for the implementation of the tool to be supported by appropriate multi- disciplinary training and information across all partner agencies.

- Policies on growth and/ or weight gain - agencies who have existing policies in relation to growth or weight gain should review their policies. It is important such polices have sufficient emphasis on the need to consider neglect as part of the differential diagnosis for the possible cause of poor weight gain in children and to refer to children's social care if there are any indicators of neglect in parallel to addressing other issues.

- Training for assessing families where there are concerns of contact with adults who pose a risk to children -_The DSCB with partners, should re-examine multi agency training regarding sexual abuse investigation to ensure course content is robust and includes risk assessments relating to contact between children and adults who pose a risk to them.

- Auditing cases of known sexualised behaviour between children - the DSCB through its Quality and Performance framework should audit a sample of cases where sexualised behaviour between children has been a presenting concern, to examine whether the circumstances have been appropriately and holistically assessed.

- Assessing referrals on open cases - the DSCB through its Quality and Performance framework should conduct an audit of cases open to MAT to ensure new information or concerns relating to open cases are properly assessed and categorised with appropriate action taken.

- Discharge planning meetings - before a child is discharged from hospital it should be documented that a discharge planning meeting was considered and

the rationale for the decision is recorded. This is especially required where there is already multi-disciplinary involvement with the child or family.

ADS14: Serious Case Review in to the death of a 19 month old child – pronounced dead on arrival at A&E. Mother's partner attempted cardiac massage as the child was reported floppy and had stopped breathing. The post mortem revealed a number of injuries which were considered to be non-accidental. Mother had a history of substance misuse, parental mental health and violent behaviour. Both mother and partner were arrested and made subject of police bail.

Recommendations:

- Professionals working with difficult/non engagement and disguised compliance within service users / families. Preventing work being effectively carried out.
- Professionals need to be :
  - aware of their responsibilities
  - the importance of prompt information sharing with partner agencies that children and young people are registered with when families move across geographical areas.
- All professionals who form part of a core group when working with families where a child/YP is on a protection plan, Children In Need Plan and/or a Supervision Order, are fully aware of their role and their specific action / expected outcome is.
- Importance / need to involve birth fathers if they do not live with birth mother but take an active role in the care of the child / YP.

Our key relationships with our Safeguarding Board our attendance and our work:

Summary of agency representation at DSCB meetings 2015 - 2016
Draft 1

Agency	DSCB		SCR Panel	CDOP (Main meeting)	QA Group	P & P	Workforce Group	Training Provider Group	VYP Group	CSE Group	Education Hub
	Percentage of total number of meetings where agency was represented (Figure in brackets indicates where a substitute for named member attended from the total number of meetings)										
	4 Meetings	Development Day (1 Meeting)	4 Meetings	7 Meetings (1 meeting held with P/ Health Vacancy)	4 Meetings	4 Meetings	4 Meetings	3 Meetings	4 Meetings	5 Meetings	3 Meetings
Derbyshire Healthcare NHS Foundation Trust											
Chief Nurse	100%(25%)	Y									
DHCFT Representative			75%	40%	100%(25%)	100%(25%)	75%(25%)	0%	50%	40%	

DHCFT are committed and continue to work in partnership with Derby City and Derbyshire safeguarding children's boards. There is a member from the organisation on each sub group of the Board; attendance is monitored as is shown in the chart above. There has been difficulty in ensuring membership and full attendance due to staff sickness and changes in role. However, I have now ensured that staff is now

represented and attendance has to improve - this will be monitored and assured by the Safeguarding Children Operational Meeting.

The multi-agency work in focus currently covers;

- Reviewing the effectiveness of early help.
- MASH arrangements.
- Monitoring the impact of the local Domestic and Sexual Violence Policy and its implementation.
- The ongoing impact, via audit, of the Pre-birth Assessment.
- Obtaining the voice and views of children and young people and how it drives forward improvements.
- Audit around engagement with men.
- Audit the quality of child protection plans.

Derbyshire Health Care Foundation Trust Safeguarding Children Strategic Plan:

Our overall aim through the implementation of this strategy is to provide outstanding Safeguarding Services in Derby and Derbyshire for children, young people and their families. To safeguard, protect and promote the welfare of children and young people whilst supporting families to flourish and to achieve optimum wellbeing, health and development with the best possible outcomes.

This will be achieved through the accomplishment of the following key goals:

- Working with our partner agencies to focus services on Early Intervention and Prevention – taking a team around the family approach in light of limited and diminishing resources.
- Providing safeguarding services of excellent quality to Children, Young people and their families
- Improving the experience of vulnerable children, young people and families through the development and delivery of Services and the integrated delivery of collaborative care with our partner agencies.
- Ensure that all staff are well trained, competent and equipped to support children, young people and their families.
- Ensuring that we work to a holistic family based approach with the needs of the child being ‘paramount’ and at the centre of our care.
- The implementation of the actions with the Safeguarding Children Work plan 2016/17 to achieve the set outcomes.

This Safeguarding Strategy is enacting and empowering strategy which describes the priorities for continual improvement of the culture, workforce, quality of practice, leadership and performance management and quality assurance within our Trust to

achieve the strategic impact priorities that have been set by ourselves within the work plan, alongside the Derby City and Derbyshire Safeguarding Boards.

Our Vision

Our vision is "to work together with children, young people and their families in order to keep them safe, achieve their full potential and continuously improve their outcomes". We will respect and encourage the participation of children, young people, their carers and their families in service development and delivery. We need to value and respect the staff working with families and to learn from our mistakes when things go wrong in an environment which promotes 'Think Family' – this should be a 'golden thread' throughout the Trust's work and recognised as integral to the Trust's strategy and not merely an element of Safeguarding. The Trust's aim is to promote a culture of respectful challenge, curiosity and transparency and ensures that our workforce is highly trained, competent, motivated, effectively supported and supervised to safeguard and promote resilience.

1. **What we want to achieve:** This strategy highlights the 5 key priority areas which are critical for Safeguarding Children, young people and their families.

2. **Our Priorities:** The Safeguarding Children Work plan 2015/2016 details the actions required to achieve these priorities. These priorities have been grouped into five key themes that will assist in making this strategy achievable. These are:-
   - Culture
   - Workforce
   - Leadership
   - Quality of Practice
   - Performance management and quality assurance

The above key themes are integrated into the required outcomes as documented within the work plan.

Culture

A change in the culture of the organisation is critical to achieve our aims. It is important that there is a clear understanding within the organisation that safeguarding is everyone's responsibility, and that this function is not something separate from their everyday practice. Key to this is the 'Think Family Principles'. A closer stronger working relationship built on trust, is needed internally across Adult and Children's Services and externally with partner agencies with openness to sharing information, joint assessments and care plans to achieve better outcomes for children and families. We need to work together to support safeguarding through the effective implementation of early intervention and prevention strategies and joint

identification of risk through assessment and Care Planning. Person centred care planning and listening to the voice of the child is essential so they feel listened to, valued, respected and supported. Similarly we need to ensure the Workforce feels empowered, listened to, valued, respected and supported at all levels of the organisation. We require the development of a culture that supports openness, enquiry and an appropriate level of challenge where learning, including learning from Serious Incidents, is welcomed. Ensuring the workforce takes ownership for continuous learning and self-development is essential. Staff need a clear understanding of their roles and responsibilities within 'Safeguarding Families' ensuring that everyone who works with children, young people and their families understands how safeguarding links to their everyday practice and how their work builds resilience within families, for example, through support for parenting. Safeguarding depends on strong partnerships within and with other agencies and the Safeguarding Board and a culture of consistent, respectful cooperation and representation to the Board and its subgroups across the City and Shire is essential. The work plan outcomes focus on ensuring that resources within the Safeguarding team are sufficient and creatively operationalised. For systems and process to be in place to ensure that supervision, advice and training is in place to support the cultural change/ transformational change process needed with frontline staff and services. Audit programmes are in place and designed to monitor improvement and effective change in practice to improve outcomes for children.

Workforce

Workforce refers to everyone who works with children, young people and their families within DHCFT. This includes all staff both Clinical and non-clinical including Adult Mental Health Services, Substance Misuse, Child and Family Services and Volunteers at all levels. We need to ensure our workforce is competent and that staff understands safeguarding pathways, policies and procedures and their role in implementing them. We want to develop a workforce by ensuring the delivery and attendance of both internal and multiagency wide training and development programmes and from the findings and actions of local and National Serious Case Reviews, Learning Reviews and Internal Serious Untoward Incidents in order to improve practice and achieve best outcomes for Children and their families. We need to give assurance to the Trust Board and the Safeguarding Board that staff are trained and the impact on practice of all learning and actions from recommendation's are fully embedded across the organisation. We require diligence in recruiting safe staff who do not pose a risk to Children and vulnerable adults and effective, prompt management to ensure minimisation of risk to children if a member of the workforce or Volunteer at any level of the organisation appears to pose a risk to others. The capacity of the workforce will be monitored and analysis of risk/impact in line with issues of resources will be undertaken to ensure safe and effective practice. An outcome of the Safeguarding Children Work plan is for the Safeguarding Team to engage with any transformational change projects to ensure safeguarding children

practice is a fundamental part of the planning and delivery of services and to identify any related risks. Capacity and resource issues of and within the workforce that potentially may impact on services and practice will form part of this assessment and analysis of the impact of this will be reported on to the committee and Derby/Derbyshire Safeguarding Children Board. This will also include the assurance that staff are supported and empowered and know how to access support when required promoting a support fostering environment that is equitable across both adults and children's services. This will be shared with our partner agencies in order to highlight potential/actual risk.

Leadership

One of the main priority areas for improving safeguarding is Leadership. By Leadership we mean senior staff within the organisation that lead and motivate the Workforce, to work together to gain the skills, knowledge and expertise, to deliver safe and effective services for children, young people and their families, and to ensure that a clear vision and values that are embedded within the workforce.
The leadership teams across the organisation

- Needs to be visible and available to support and advise staff and to facilitate a culture of mentoring and support to be adopted and embedded in delivering better safeguarding outcomes for families.
- Need to have a "grip" on Safeguarding within the organisation jointly.
- Need to ensure effective working arrangements between the Safeguarding Boards, the Trust and key partners as identified within the safeguarding children work plan by ensuring these systems and structures are in place.
- Need to ensure a clear and effective governance structure and quality assurance framework that confirms evidence of leadership of Safeguarding via the Safeguarding Operational Groups and the Safeguarding Vulnerable Adults and Children Committee.
- Needs to develop and embed a clear system for communicating with practitioners at all levels within the Trust and with partners that is open, honest and reliable – this should empower staff and ensures a no blame culture.
- Needs to develop an effective framework to ensure the voices and views of the child, young people and their families are listened to and acted on. Similarly Leaders are required to listen to and value the workforce.
- need to engage with any transformational projects to ensure that Safeguarding is a fundamental part of delivery and planning of services
- needs to understands their responsibilities within Section 11 of the Children Act , Markers of Good Practice, CQC and Ofsted and ensure effective scrutiny and respectful challenge of Safeguarding Practice within the organisation

- Needs to interpret and ensure operationalization of Local and National Policy Guidance and Legislation. For example :
    - New domestic violence NICE guidance (out February 2016)
    - Serious crime act (2015) in relation to female genital mutilation and domestic abuse being strengthened
    - The prevent duty (2015)
    - Care act (2014) and the key changes (2015)
- Needs to ensure and provide evidence of their own professional development in order to be compliant with the 'Roles & Competences for Healthcare Staff, Intercollegiate Document 2014" whilst identifying and developing talent in order to identify future Safeguarding Professionals and Leaders.

A major challenge for all organisations including DHCFT is talent spotting and the development of our next Leaders in Safeguarding. Named roles are no longer ones that can be stepped into with no prior development or training given the breadth of experience and knowledge required to fulfil the roles. Development plans, additional training and shadowing need to be developed before a Named Professional commences in a Safeguarding role to ensure there is no "knowledge gap" in key strategic roles particularly that of the Named Doctor.

Quality of Practice

Quality of practice, relates to improving the quality and consistency of assessments, information sharing, partnership working, interventions, person centred care planning, record keeping and documentation, professional management and supervision all within a timely manner with clear SMART targets. Our aim is to develop and ensure consistent interpretation and implementation of lessons learnt, recommendations, guidance, policies and procedures across the Trust, to improve the quality of safeguarding practice by all staff. Audits provide evidence of and evaluate continued improvement of clinical practice, as part of the Safeguarding Children work plan. A comprehensive yearly audit plan will be develop in line with outcomes of serious case reviews, serious incident learning reviews and serious incidents. Further learning and recommendations from audit will inform the training needs analysis and deliver of the Trust training programme. To improve the quality of practice the trust also needs to ensure the organisation captures user feedback and involvement in order to capture and embed the voice of children, young people and their families and carers. The evidence of what is captured and collated will be used and embedded into services. NICE guidance informs practice in order to ensure quality and safe practice – the guidance is adhered to at all times. There are a number of new issues on the horizon for DHCFT to be mindful of and staff need to have an awareness of these and of the challenges they present. The internal training strategy and programme include outcomes for all of the list below and all clinical staff.

These new and existing challenges include:-

- ✓ New and Emerging Communities
- ✓ Sexual Exploitation
- ✓ Trafficking and Human Slavery
- ✓ FGM
- ✓ Substance Misuse including New Psychoactive Substances
- ✓ Domestic Abuse
- ✓ Safe Sleeping,
- ✓ Suicide and Self Harm
- ✓ Missing Children
- ✓ E-safety
- ✓ Radicalisation and Extremism
- ✓ The needs of those more vulnerable in our society including children with disabilities
- ✓ Looked After Children
- ✓ Priority Families

Performance Management and Quality Assurance

Performance management relates to the reporting systems and data by which the Trust can ensure the quality and effectiveness of safeguarding within the organisation. Quality Assurance provides the Trust, the Safeguarding Boards, Commissioners and regulatory bodies with an understanding of the standard and consistency of our services to ensure that they are delivered to the highest possible standard for children, young people and their families. Data is collated and evidence provided to assure the above of the quality of our services. Assurance internally within the Trust is provided through the Safeguarding Operational Groups via evidence on the delivery of the various action plans from Serious Case Reviews, CQC, MOGP (section 11), Think Family and the Safeguarding Children Work plan. Analysis of the themes and issues arising from the advice system and safeguarding referrals will serve to inform training, policy, guidance and professional development. Decision making processes, thresholds and the need for escalation of cases will be monitored via the above channels to ensure that the organisation is part of the multi-agency quality framework and feeds into the 'Health Quality Assurance Group' and the Safeguarding Boards' quality assurance processes, providing assurance that performance indicators in relation to Safeguarding Children are met.

Making it Happen

The Trust has made a strong commitment to Safeguarding by reviewing its Safeguarding Governance structures in line with the "Safeguarding Children : 'Roles

& Competences for Healthcare Staff, Intercollegiate Document 2014" which states that the Safeguarding Named Nurses and Doctors directly reports to the Executive Lead for Safeguarding Children. The 'Safeguarding Vulnerable Adults and Children Committee' now directly reports to the 'Trust Board'. We need now to ensure the implementation and action for each priority within the strategy, and in line with the actions and timescales outlined within the Safeguarding Children Work plan 2016/17 will be communicated throughout the Trust and reviewed yearly.

The recommendations at the year end of the Safeguarding Committee and are endorsed for the Trusts Children Annual report are:

1. The Head of Safeguarding will ensure that systems and structures for Safeguarding Children are maintained in conjunction with the wider team. It will include a review of the Health contribution into the MASH both from a children's and adults perspective .The safeguarding team has invested in the recruitment of extra staff on both a permanent and fixed term contract basis .
2. The Safeguarding Children team and myself will continue to maintain the profile and analyse the Safeguarding Children's advice and to monitor the types of enquiries and advice given, monitoring the number of calls and activities. This will include a review of enquiries and directly linking this learning into the Training plan for professionals learning requirements.
3. The Head of Safeguarding will work with the Training Manager and the Safeguarding Children Trainer to revise the training offer in line with any statutory changes to the Safeguarding Children's procedures and review that all changes associated with intercollegiate guidance issued in specifically gaining assurance that all health staff must have the competences to recognize child maltreatment and to take effective action as appropriate to their role. Staff must also clearly understand their responsibilities, and should be supported by their manager to fulfill their duties.
4. The Head of Safeguarding will continue to work closely with the training Manager to ensure Safeguarding Children training compliance is achieved by ensuring provision and access to Safeguarding Training on all levels.
5. The Head of Safeguarding will ensure that the newly amended supervision policy, containing detail and guidance on Safeguarding Children supervision is visible and operationalised to ensure that Safeguarding Children supervision is equitable across all services via varied options and that recording shows compliance.
6. The Head of Safeguarding will continue to ensure audits are completed to show the impact on practice, the changes of historical serious case and learning reviews to ensure that clinical practice recommendation have been subject to sustained change and that any risks still found are mitigated and restorative actions are put in place associated to full compliance with Safeguarding Children's procedures in quarter 3 and quarter 4 of this year,

learning from their findings and readjusting procedures and or practice to learn from cultural or persistent service improvement issues.

7. To understand and embed the collaborative requirements of making the 'Think Family' agenda and move the service from a reactive service to continual in reach into clinical services to make sustained impact on preventative measures in Children's and Adult services.
8. To fully contribute to the Derby City and Derbyshire Safeguarding agendas within the Trust resources.
9. To develop a Safeguarding Children's monitoring system to spot early warning signs of professional or organisational abuse, acting swiftly to prevent harm to Children in our care.
10. To review the new soon to be published CQC standards for Safeguarding Children and ensure full compliance and in addition, although there are specific standards that relate to safeguarding and safety, effective safeguarding also requires compliance with a range of other standards as well. For example, robust recruitment and vetting processes for staff; having enough well-trained, competent and supported staff; providing effective and appropriate treatment; having systems in place to enable people who use services and their representatives to feedback concerns; and ensuring that people using the service are respected and as fully involved as possible in their care and support.
11. The Head of Safeguarding will ensure the whole organisation Think Family audit is repeated and analysed to capture the change in practice as a result of the Think Family CQUINN. From the audit hotspots, challenges will be highlighted. This will enable a gap analysis to be completed informing further areas for improvement and training.
12. The Head of Safeguarding will ensure that the Safeguarding Children strategy and work plan are implemented operationalised and progress and challenges reported back in to the Committee as requested.
13. The Safeguarding Teams across children and adults will develop an action plan in line with the Bradbury enquiry and ensure compliance and report back on any challenges to the Committee.
14. The Head of Safeguarding will ensure action plans are implemented, updates and reported into the Committee to give reassurance and assurance to the Trust Board that actions are completed or they are in progress. This includes all SCR/ Learning review Action Plans, CQC Action Plans, the Safeguarding Children Work plan, The Markers of Good Practice Action Plan, Neglect Action Plan.

Tina Ndili
Head of Safeguarding for Children

Appendix 1

Training Framework- Safeguarding Children Training

Courses	Duration / method	Frequency	Target group
An Introduction to Safeguarding Children Level 1	45 mins Taught programme OR E-learning programme	**3 yearly non clinical staff** **Once for clinical staff as part of incremental training**	**All** staff at induction Clinical staff once only before completing level 2 training
Safeguarding Children: Level 2 **Recognising and Responding to Abuse / Everybody's Business**	Half a day taught internal (DHCFT) programme	**3 yearly depending on staff role.** **OR** **Once as part of an incremental training programme (all clinical staff)**	**3 yearly requirement:** • Admin staff (non -clinical staff) in : Universal children's services, CAMHS, Perinatal, Safeguarding Team Support clinical staff in adult mental health teams: community and Inpatient i.e. healthcare workers, OT assistants • Junior Dr's as part of rotation placement • Pharmacy clinical staff **Once as part of an incremental training programme for clinical staff needing to complete level 3 or 4.** **All clinical staff need to undertake this.** **Need to have completed level 1 training prior to attendance of level 2.** To be completed in the first 3 months of employment.

Safeguarding Children Level 3 Training pathway identifies relevant courses for completion	Level 3 course External training via safeguarding boards DSCB City and Count / conferences / seminars OR Internal training needs led	**Annual**	**Need to have completed level 1 and 2 prior to attending level 3 training** <u>All clinical staff - qualified and unqualified in</u>: • CAMHS • Children's Universal Services- health Visitors, School Nurses, Nursery Nurses, Children's Specialist Services • Perinatal Services • Safeguarding Team Clinicians
Safeguarding Children Level 3 Training pathway identifies relevant courses for completion	Level 3 course External training via safeguarding boards DSCB City and Count / conferences / seminars OR Internal training needs led	**3 yearly**	**Need to have completed level 1 and 2 prior to completing level 3 training** Clinical registered staff in adult mental health teams, community and inpatient. IAPT / CBT / Liaison / Therapy Teams / psychology / psychological wellbeing.
Think Family **Level 3**	1 day once only	**Once only**	**<u>All</u> clinical staff** **This will also count as level 2 and / or 3 as part of training passport**
Safeguarding Children Level 3 **(Community Paediatric Child Safeguarding)**	<u>10 hours total per year.</u> 50% attendance at NAI peer review 50% attendance at CSA peer review Minimum of 6 hours external / multi-agency training over a 3 year period	**Annual** Evidence of training and reviews to be kept with Consultant Community Paediatrician in the event of an audit	All community paediatricians. Sign off sheets to be forwarded to Education and Development.

Safeguarding children Level 4	External training level 4 via safeguarding boards DSCB City and County. Conferences, seminars, workshops.	Annual Named Safeguarding Lead to validate level of training at level 4 and maintain evidence for audit trail	Role specific for those with management or supervisory responsibility for safeguarding children i.e. named nurses. **Need to have completed level 1, 2 and 3 prior to level 4 training** **Annual level 3 training requirement in addition** External Training

Appendix 2

Training Pathway for the DHCFT – Derbyshire Healthcare Foundation Version 3

Team Composition:

In accordance with the Derby/Derbyshire SCB training strategy this pathway relates to the following staff groups. The terminology is different to that outlined in the inter-collegiate document and is outlined below.

Level 1 staff: Non-clinical staff such as reception staff and those without direct contact with children.

Level 2 staff: Those who have contact with children but will not carry safeguarding responsibility i.e. admin staff in CAMHS, children services. Unregistered staff in adult services

Level 3 staff: (Annual): Those with particular specialised responsibility for safeguarding children contributing to safeguarding assessments and plans. This will include: Health Visitors, School Nurses, Perinatal staff, CAMHS, Children in Care nurses, Occupational Therapists / Physiotherapists in children's services, Safeguarding Team

Level 3 staff (three yearly), Clinical registered staff in adult services including Substance Misuse services, Learning Disability teams, In-patient areas, Community Teams, Therapy Services

Level 4 staff: Managers and supervisors of Level 3 staff i.e. those with responsibility for supervising or guiding staff in safeguarding processes such as designated or named professionals.

	Mandatory Training	Comments	Target Group	Frequency
1	**Level 1 staff** to complete ¾ hour on adult safeguarding and ¾ hour on safeguarding children. E-	The in-house training would take place during staff	**All** staff at induction Most non-clinical staff	3 yearly non clinical staff Once for clinical staff as they will be required to

	learning is undertaken via OLM E-learning is via the OLM site Staff could also access the DSCB E learning package 'An Introduction to Safeguarding' found on www.derbyscb.org website. This is a free course designed by Derby and Derbyshire SCB an assessment leads to a certificate. Undertaking this course will not result in training passport being amended unless the staff forwards a copy of their certificate to the Education Team.	induction.	Clinical staff once only before completing group 2 training	undertake additional training
2	**Level 2 staff** will receive a half day, in house safeguarding children course. **Everybody's Business**	The in-house training would take place during clinical induction block (currently available on a rolling basis every 2 months) Level 2 training in 2015-2016 is delivered on refresher clinical block training and some stand-alone sessions	Admin staff in universal children's services, CAMHS, Perinatal, Forensic Services, Learning Disability Services, Substance Misuse services. Junior Dr's on rotation placement Unregistered support staff in adult clinical teams i.e. healthcare worker, OT assistant	3 yearly depending on staff role. **OR** **Once as part of an incremental training programme.**

		In house from Bon Ndili To be completed in the first 3 months of employment		
3	**Think Family**	Counts as a level 2 / 3 course	All clinical staff This is a requirement that **ALL** clinical staff (registered and unregistered) need to undertake this once	Once
3	**Level 3 – Annual** **All Level 3 staff must complete ONE Level 3 course on the subject of children's safeguarding every year.** Aim to undertake a different course each year **Mandatory courses for all Level 3 staff include:** • **Safeguarding children from BME and N Communities** • **Parents with a Learning Disability** • **Domestic Abuse** • **Working with reluctant and resistant families**	Via DSCB	Clinical, registered and support staff, medics from: • CAMHS • Children's universal services • Health visitors • School nurses • Perinatal services • Safeguarding Children's team	Annual Need to have completed level 1 and 2 (both once only) prior to attending level 3 training

	• **Alcohol and substance misuse by parents** • **Child Protection Conferences and Core Group** • **Parental Mental Health** – for CAMHS, School Nurses, Children in Care Nurses • **Suicide and Self- harm** – for CAMHS, School Nurses, Children in Care Nurses, Health Visitors			
3	**Level 3 three yearly** **<u>Mandatory courses for all Level 3 staff include:</u>** **Think Family has to be completed first:** • Safeguarding children from BME and New Communities • Parents with a Learning Disability • Domestic Abuse • Working with reluctant and resistant families • Alcohol and substance misuse by parents • Child Protection Conferences and Core Group • Internal courses as appropriate	Via DSCB	**Clinical registered staff** in adult mental health teams, medics, community, inpatient, IAPT / CBT / Liaison / Therapy Teams / psychology / psychological wellbeing / Substance misuse services / Learning Disability services/	3 yearly Need to have completed level 1 and 2 (both once only) prior to attending level 3 training
3	**Safeguarding Children Level 3** **(Community Paediatric Child Safeguarding)**	Training and Peer Reviews	<u>10 hours total per year.</u> 50% attendance at NAI peer review 50% attendance at CSA peer review Minimum of 6 hours external / multi agency training over a 3 year period	Annual Copy of evidence sheet to be forwarded to the Education Team. Evidence of training and reviews to be kept with

				Consultant Community Paediatrician in the event of an audit
4	**FGM training** is mandatory all for staff and is included within current training level 2 and level 3	Reference is L 2 and Think Family training	Reference only	Ongoing
5	**PREVENT WRAP** training is mandatory for all clinical staff and is provided in house.	Via safeguarding adults level 2 training in house	All new staff receive PREVENT awareness at corporate induction via safeguarding adults level 1. Clinical staff will undertake WRAP 3 via safeguarding adults level 2 training or as stand-alone courses in Learning Disability services.	3 yearly
6	**Once staff have attended all mandatory training they can access <u>up to one day</u> of the following specialist level 3 courses every year:** • Assessment and Analysis, • MAPPA foundation, • Child Sexual Exploitation, • Child Sexual Abuse, • Neglect,	Via DSCB		

	• Improving the Health of Children in Care (half day), • Court Skills (half day), • Chairing Safeguarding meetings (half day), • Suicide and Self Harm (for non- for CAMHS, School Nurses, Children in Care Nurses, Health Visitors)			
7	**Level 4 Staff –** to access the: • Effective Support and Supervision 2 day course • Managing Allegations course (half day). • Additional conferences etc of a specialist nature	Via DSCB	Names nurses due to the supervisory responsibility and safeguarding children trainer	Annual <u>In addition</u> to level 3 annually

APPENDIX 3

Annual Report 2016-17 – Recommendations Action Plan – this will form part of the Safeguarding Children Workplan

	Recommendation	Action agreed	Evidence	Responsible Person	Progress and time scale for completion	
1	The Head of Safeguarding will ensure that systems and structures for Safeguarding Children are maintained in conjunction with the wider team. It will include a review of the Health contribution into the MASH both from a children's and adults perspective .The safeguarding team has invested in the recruitment of extra staff on both a permanent and fixed term contract basis.	• interviews to be held in conjunction with MASH manager – Children & Adult Safeguarding Team for MASH advisors Band 7 x 2 fixed term contact March 2017.	Appointment	Tina Ndili Jane Elliott Karen Billyeald Shirley Parker	Interviews - Oct 2016 Appointment – Nov/Dec 2016	
		• Head of Safeguarding attends MASH project meetings. Appointment	Attendance at meetings	Tina Ndili	Complete to date (September 2016)	
2	The Safeguarding Children team and myself will continue to maintain the profile and analyse the Safeguarding Children's advice and to monitor the types of enquiries and advice given, monitoring the number of calls and activities. This will include a review of enquiries and directly linking this learning into the Training plan for professionals learning requirements.	•analysis to be presented within the annual report • quarterly data to be collated and analysed and fed into Operational Meeting, Committee and training	Annual Report	Tina Ndili Ruth Thomason	Complete to date – next submission November 2016	
3	The Head of Safeguarding will work with the Training Manager and the Safeguarding Children Trainer to revise the training offer in line with any statutory changes to the	• meeting to be arranged for Oct 2016 between Head of Safeguarding and Training Manager and Named Doctor		Tina Ndili Tracy Shaw Jo Kennedy	October 2016	

	Safeguarding Children's procedures and review that all changes associated with intercollegiate guidance issued in specifically gaining assurance that all health staff must have the competences to recognize child maltreatment and to take effective action as appropriate to their role. Staff must also clearly understand their responsibilities, and should be supported by their manager to fulfill their duties.					
4	The Head of Safeguarding will continue to work closely with the training Manager to ensure Safeguarding Children training compliance is achieved by ensuring provision and access to Safeguarding Training on all levels.	• analysis of compliance data at Operational meetings	Compliance data		Complete to date – meetings monthly and bi-monthly	
		• to work closely with Operational Managers, SLMs and General Managers to evaluate non compliance	Compliance data on meeting agenda	Tina Ndili Tracy Shaw		
5	The Head of Safeguarding will ensure that the newly amended supervision policy, containing detail and guidance on Safeguarding Children supervision is visible and operationalised to ensure that Safeguarding Children supervision is equitable across all services via varied options and that recording shows compliance.	• once ratified policy will be circulated and advertised on Connect and at team meetings Connect	Policy Alerts Meetings Agenda	Tina Ndili Ruth Thomason Operational / Clinical Managers	Policy on Safeguarding Children Committee Agenda 2016 Complete October 2016	
		• new appointments within the Safeguarding team who will provide supervision within CAMHS and Adults			In post September 2016	

6	The Head of Safeguarding will continue to ensure audits are completed to show the impact on practice, the changes of historical serious case and learning reviews to ensure that clinical practice recommendation have been subject to sustained change and that any risks still found are mitigated and restorative actions are put in place associated to full compliance with Safeguarding Children's procedures in quarter 3 and quarter 4 of this year, learning from their findings and readjusting procedures and or practice to learn from cultural or persistent service improvement issues.	• SCR Action plans to be developed from completed SCR and to be operationalised within the Safeguarding Children Operational meeting • submission of the action plans to the Health QA and the DSCB QA meetings • quality Assured by the Committee quarterly • to link with Safeguarding Children Trainer to ensure learning within internal training.	Audit Plan SCR Amalgamated Action Plan	Tina Ndili Jo Kennedy Jane Elliott Liz Holmes Shirley Parker		
		• yearly audit plan to be developed in line with local and national SCR and learning reviews		Tina Ndili Jo Kennedy Jane Elliott Liz Holmes Shirley Parker	Some outstanding audits from 2015/16 due to staff movement Audit 2016/17 on target	
7	To understand and embed the collaborative requirements of making the 'Think Family' agenda and move the service from a reactive service to continual in reach into clinical services to make sustained impact on preventative measures in Children's and Adult services.	• continue with Think Family Training until December 2016 • to look at option paper submitted to continue beyond 2016 •new training designed for Children's services to be delivered out • continue within supervision	Data on compliance Option paper Training content	Tina Ndili Tracy Shaw Bon Ndili	Complete to date September 2016	
8	To fully contribute to the Derby City and Derbyshire Safeguarding agendas within the Trust resources.	• to ensure membership from DHCFT • clarify DSCB data • raise non attendance at Safeguarding Operational meeting and Committee	DSCB data	Tina Ndili	Complete to date September 2016	

9	To develop a Safeguarding Children's monitoring system to spot early warning signs of professional or organisational abuse, acting swiftly to prevent harm to Children in our care.	• to work closely with DSCB's • to ensure discussed in training and supervision • ensure staff are aware of Polices and procedures • analysis of advice and DATIX		Tina Ndili Jo Kennedy Jane Elliott Liz Holmes Shirley Parker	Complete to date September 2016	
10	To review the new soon to be published CQC standards for Safeguarding Children and ensure full compliance and in addition, although there are specific standards that relate to safeguarding and safety, effective safeguarding also requires compliance with a range of other standards as well. For example, robust recruitment and vetting processes for staff; having enough well-trained, competent and supported staff; providing effective and appropriate treatment; having systems in place to enable people who use services and their representatives to feedback concerns; and ensuring that people using the service are respected and as fully involved as possible in their care and support.	• Organisational CQC 2016 Action Plan to be developed • Plan to be actioned as directed	Action Plan	Tina Ndili Ruth Thomason		
		• Children's and LAC Action Plan 2015 actioned monthly and submitted to Designated Nurse on a monthly basis.		Tina Ndili Ruth Thomason	Complete to date September 2016 2 outstanding actions to date	
11	The Head of Safeguarding will ensure the whole organisation Think Family audit is repeated and analysed to capture the change in practice as a result of the Think Family CQUINN. From the audit hotspots, challenges will be highlighted. This will enable a gap analysis to be completed informing	• re audit of organisation of Think Family self-assessment questionnaire	Audit completion	Liz Holmes	Audit Returns October 2016 Completion November 2016	

	further areas for improvement and training.					
12	The Head of Safeguarding will ensure that the Safeguarding Children strategy and work plan are implemented operationalised and progress and challenges reported back in to the Committee as requested.	• operationalised via Safeguarding Children Operational meeting and SMT • exception reports via committee	Minutes and updated work plan	Tina Ndili Jo Kennedy Jane Elliott Liz Holmes Shirley Parker	Work plan updated to date September 2016	
13	The Safeguarding Teams across children and adults will develop an action plan in line with the Bradbury enquiry and ensure compliance and report back on any challenges to the Committee.	• action plan to be developed	Action plan	Jo Kennedy Tracey Holtom	Not yet complete. Conference attended by Tracey Holtom and Jo Kennedy	
14	The Head of Safeguarding will ensure action plans are implemented, updates and reported into the Committee to give reassurance and assurance to the Trust Board that actions are completed or they are in progress. This includes all SCR/ Learning review Action Plans, CQC Action Plans, the Safeguarding Children Work plan, The Markers of Good Practice Action Plan, Neglect Action Plan.	• development of action plans as required • update plans monthly and bi-monthly • operationalised via Operational meetings • assure committee quarterly of progress and challenge	Action plans	Tina Ndili Jo Kennedy	Complete to date September 2016	

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors 2 November 2016

Annual Report - Emergency Planning, Resilience and Response (EPRR)

Purpose of Report

The Trust is required to provide an annual report on its Emergency Planning, Resilience and Response (EPRR) activities.

Executive Summary

This paper provides a report on the Trust's emergency preparedness in order to meet the requirements of the Civil Contingencies Act 2004 (CCA 2004) and NHS Commissioning Board, Emergency Preparedness Framework 2015.

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

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

Set against this context the Trust is required to self-assess against key standards and submit this assessment to NHS Hardwick CCG (on behalf of Commissioners and NHS England) as part of a confirm and challenge process. The confirm and challenge process was held in October 2016.

The outcome letter received from this process from Hardwick CCG and NHS England on the organisation's evaluated level of compliance was Partial compliance.

Strategic considerations

Extra resource will be required to deliver the actions to improve the Trust's position from being partially to substantially compliant

Assurances

An action plan has been developed to address feedback following self- assessment submission and to ensure staged progression to greater compliance.

Governance or Legal issues

The Trust is required to deliver the requirements set out in the Civil Contingencies Act 2004 (CCA 2004) and NHS Commissioning Board, Emergency Preparedness Framework 2015.

Recommendations

The Board is requested to:

1) Review the update provided in this annual report
2) Receive the Trust's self-assessment and subsequent outcome of 'Partial Compliance' from the confirm and challenge session with Commissioners
3) Accept and approve the action plan

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

Report prepared by: **Tracey Holtom, Interim General Manager and Karen Billyeald, Interim Safeguarding Lead**

Emergency Preparedness, Resilience and Response (EPRR) Annual Report - November 2016

1. Introduction

This paper provides a report on the Trust's emergency preparedness in order to meet the requirements of the Civil Contingencies Act 2004 (CCA 2004) and the NHS Commissioning Board, Emergency Preparedness Framework 2015.

The Trust has plans to deal with Major Incidents and Business Continuity issues, which are currently being refreshed. These will conform to the CCA (2004), ISO 22301 and current NHS-wide guidance. All plans are being developed for consultation with regional stakeholders to ensure cohesion with their plans. They will reflect our status as a Category 2 responder, in line with the CCA (2004).

The paper reports on the training and exercising program which is being planned and details the developments of the emergency planning arrangements and plans. The report gives a summary of instances in which the Trust has had to respond to circumstances where the major incident approach has been utilised.

It also discusses the participation in the local 'self- assessment' exercise against the required standards, the 'peer review' by Commissioners and the next steps which will be taken from the review.

2. Background

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

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

3. Leadership & Governance Responsibilities

The overall organisational responsibility for EPRR lies with the Chief Executive Officer (CEO). Delegated Director responsibility is currently held by the Interim

Chief Operating Officer, since October 2016. Prior to this the Acting Director of Operations held Board level accountability.

Emergency Planning at an operational level is currently in the portfolio of the Safeguarding Adults lead. There is a manager who currently undertakes EPRR functions in post in the organisation.

The Infection Control lead also contributes to key aspects of planning and policy / guidance development.

Emergency planning and EPRR reports to the Health & Safety Committee.

4. Risk Assessment

The Civil Contingencies Act 2004 places a legal duty on responders to undertake risk assessments and publish risks in a Community Risk Register. This is facilitated locally in Derbyshire by the local Health Emergency Planning Operational Group (HEPOG) and this work to align risk assessments is underway.

DHcFT is represented at the working group, and we anticipate the risk assessments will be completed by HEPOG by early 2017.

The following sections provide an area-by-area report on developments over the past year and planning for next year.

The self -assessment against key standards was completed and submitted to NHS Hardwick CCG (on behalf of Commissioners and NHS England) in October 2016.

A 'confirm and challenge' session was held in October 2016. The outcome letter received from Hardwick CCG and NHS England on the organisation's evaluated level of compliance was **Partial**.

Compliance Level	Evaluation and Testing Conclusion
Full	The plans and work programme in place appropriately address all the core standards that the organisation is expected to achieve.
Substantial	The plans and work programme in place do not appropriately address one or more the core standard that the organisation is expected to achieve.
Partial	The plans and work programme in place do not adequately address multiple core standard that the organisation is expected to achieve.
Non-compliant	The plans and work programme in place do not appropriately address several core standard that the organisation is expected to achieve.

The feedback identified key areas which the Trust needs to further develop and an action plan has been developed to address them in the coming 6-12 months. The plan is appended at the end of this report. Key areas include:

- Duty to assess risk
- Governance
- Training and exercising
- Duty to maintain plans
- Preparedness
- Improve co-operation with partners
- Information sharing
- Command and control
- HAZMAT

5. Major Incident Policy

This Policy details the Trust's actions in the event of an external major incident (e.g. transport crash, floods, or a terrorist attack). Such an event requires the Trust to employ a different method of working in order to manage the situation. The Policy is supplemented with unit-level plans (held locally) that detail the actions required of individual units to ensure that the corporate plan is achieved. In addition to conventional incidents, the policy details how the Trust will manage Chemical, Biological, Radiological and Nuclear (and Explosive) incidents.

The Major Incident Plan was revised and updated in December 2015.

6. Business Continuity Management Policy

Business Continuity Management is a management process that helps to manage the risks to the smooth running of an organisation or delivery of a service, ensuring that the business can continue in the event of a disruption. These risks can be from the external environment (e.g., power failures or severe weather) or from within an organisation (e.g., systems failures or loss of key staff).

A business continuity event is any incident requiring the implementation of special arrangements within an NHS organisation in order to maintain or restore services. For NHS organisations, there may be a long 'tail' to an emergency event, e.g., loss of facilities, provision of services to patients injured or affected in the event, etc.

The Business Continuity Policy is part of the Major Incident Plan. Further work is needed to address consistency and currency of Business Continuity Plans across the organisation.

The Trust needs to undertake training and exercises on major Incident response and business continuity issues. To enable this, a training needs analysis has been commissioned to look at requirements and to inform a training plan.

The Health & Safety Committee will receive and review the plans at its next meeting on 13 December 2016.

7. Pandemic Influenza and Outbreak of Infection Policies

The Trust has a policy to manage an outbreak of pandemic influenza. It also offers the annual flu vaccination to staff and in-patients who fulfill the 'at risk' criteria as defined by the Chief Medical Officers letter.

There is also a staff health CQUIN this year (NHS England) which focusses in part on the staff flu vaccination. The Trust Pandemic Flu Policy was last revised in August 2015.

There is a policy to deal with the response required to Diarrhoea and Vomiting, both in local cases and the larger response required should an outbreak occur.

Outbreaks of infection and matters of infection prevention and control are governed by the work of the Trust Infection Control Committee

8. Testing and Exercising

The Trust EPRR Lead took part as an observer on the 16th March 2016 in the Exercise Mercian Shield which was a family and friends reception centre live exercise.

The Trust has invested in training 7 Loggists, with 2 staff being trained as trainers to ensure that Loggists are available for major incident recording within the organisation.

9. Live Events

The Trust has implemented the Major Incident plan for 3 events in the year 2015/2016

- Junior Doctors Industrial Action
- Outage of Paris clinical care record
- Staffing difficulties at the Radbourne Unit

The success of these incident management plans was outlined in the confirm and challenge session with Commissioners and they serve as a template for further development.

10. Debriefing from Live Events and Exercises

Following the Junior Doctors Industrial action a feedback survey was made available to staff for comment to provide information and learning that could be taken forward and inform future operations.

11. Partnership Working

The Trust attends Formal committees and is a member of the Local Health Resilience Partnership (LHRP) for Derbyshire and Derbyshire & Nottinghamshire Health Emergency Planning Operational Group.

DHcFT is also an active member of the Humanitarian Assistance Sub Group and contributes to the Major incident plan for Derbyshire, by screening for Post -Traumatic Stress Disorder following a major incident occurring. The purpose of these groups is to ensure that effective and coordinated arrangements are in place for multi - agency emergency preparedness and response in accordance with national policy and direction from NHS England.

12. Summary

The past year has seen some developments in the Trust's resilience arrangements; however, more work is required at the service level to achieve greater compliance against core standards.

The Trust should be undertaking a more detailed and comprehensive training and exercising program.

The Trust should review and update risk assessments and ensure business continuity plans are consistent across the organisation

13. Recommendations

The Board is asked to receive the annual report on Emergency Preparedness, Resilience and Response.

	Recommendation	Action and Lead Person	Timescale	Progress	
1	**Duty to assess risk** – development of Business Continuity Plans including Business Impact Assessments with MTODs and Risk Assessments	Organisation-wide review and update of Business Continuity Planning process, with plans developed in key areas. Develop a task and finish group to implement and oversee the achievement of this action plan. EPRR Professional and Task and Finish Group Members.	Feb 2017		
2	**Governance** – ensuring plans and work programmes are up to date. **Training and Exercising** **Command and Control**	Training Needs Analysis to be completed. - EPRR Lead Trust-wide Training Plan to be developed. - EPRR Professional and Head of Learning and Development.	Feb 2017		
3	**Training and Exercising** **Command and Control**	Exercise Plan to be developed. Table top exercise to be completed around scenario base. EPRR Professional and Head of Learning and Development.	Feb 2017		
4	**Duty to maintain plans**	Revision of HAZMAT plan; Update to Fuel plan; Addition of VIP plan [see Action 8] Stakeholder engagement; Debrief process	Feb 2017		

	Recommendation	Action and Lead Person	Timescale	Progress	
		EPRR Lead and Estates Lead.			
5	**Preparedness**	Identified staff to be reminded of portfolio requirements. Audit and training needs analysis.	Feb 2017		
6	**Information Sharing** – maintain and improve links with partner organisations.	Attain consistent attendance at LHRP and HEPOG meetings and review need for DHCFT attendance at sub groups. Lead Professional and Acting COO.	Feb 2017		
7	**Maintain and improve links with partner organisations.**	Develop Mutual Aid agreements through participation in meetings and exercises. EPRR Lead and Lead Professional.	Feb 2017		
8	**Improve co-operation with partners.**	Participation in humanitarian assistance – further development of MIST. Further expansion of de-brief procedures to be included in the EPRR policy. EPRR Professional and Psychology Leads.	Feb 2017		
9	**Preparedness** - Arrangements explain how VIP and/or high profile patients will be managed.	SOP and action card to be developed and added to the Major Incident Policy. EPRR Lead.	Feb 2017		

	Recommendation	**Action and Lead Person**	**Timescale**	**Progress**	
10	**HAZMAT** **Preparedness** – plans to be developed	Processes to be further developed in line with partner services and communicated effectively. EPRR Lead Professional.	Feb 2017		

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 2 November 2016

Full Single Electronic Patient Record Project

Purpose of Report:
This paper provides the Trust Board with an overview of the Full Single Patient Record Project (FSR).

Executive Summary

- Overview of the progress that the Trust has made towards completion of the Full Single Patient Record Project
- Examples of Functionality the system provides
- Examples of compliance reports available based on information recorded in the system
- The role of the Clinical Reference Group in shaping future developments
- Advantages identified by clinical representatives

Strategic considerations

- A fully electronic patient record is seen as an enabler of the Trust's Transformation Programme

(Board) Assurances

- This report should be considered as an update on progress towards completion of the Full Single Record Project

Consultation

- This paper has not been considered elsewhere however papers and aspects of detailed content supporting the overview presented are reviewed at the monthly Full Single Patient Record Project Board

Governance or Legal Issues

- None

Equality Delivery System

- There is no specific impact on members of the REGARDS groups in the report itself

Recommendations

The Board of Directors is requested to:

1) Consider the content of the paper and recognise the work which has been completed towards delivery of a Full Single Patient Record.

Report prepared and presented by:

Rais Ahmed, Associate Clinical Director, Neighbourhoods

Sarah Butt, Assistant Director Clinical Practice and Nursing

Peter Charlton, General Manager, Information Management

Anne Munnien, Clinical Lead, FSR Project

John Staley, FSR Programme Manager

Derbyshire Healthcare NHS
NHS Foundation Trust

Full Single Electronic Patient Record Project

2nd November 2016

Better together

Participants

- Rais Ahmed, Associate Clinical Director, Neighbourhoods
- Sarah Butt, Assistant Director Clinical Practice and Nursing
- Peter Charlton, General Manager IM&T and Records
- Anne Munnien, Clinical Lead, FSR Project
- John Staley, FSR Programme Manager

Agenda

- Full Single Record Project (FSR)– overview
  - Current status
  - Forward programme of work into inpatient wards
  - Financial Scorecard
- Examples of Paris functionality
- Examples of compliance reports that can be pulled off the system to show how data is being used
- Examples of how the Clinical Reference Group is working with IT and others to develop systems and processes.
- Advantages/ benefits of the system.

FSR - Overview

Current status

- Electronic Patient Record
  - CareNotes to Paris
  - “Like for like”
  - Three roll-outs during 2014
  - Fully live on Paris in November 2014
  - CareNotes system retained for reference only
  - Combination of electronic and paper records

- Full Single Record Project
  - Project Initiated Sep 2015
  - Project Objective was to establish a single electronic repository for all patient records
  - Phase One – Community (including Crisis teams, CAMHS and LD) - Oct 2015
  - Phase Two - Day Hospitals - Nov 2015
  - Phase Three - Inpatients - currently in progress

FSR - Overview

Issues impacting progress in Inpatient wards :-

- Staffing issues have lead to inpatient wards being put into emergency measures :-
  - Difficult for ward staff to allocate time to spend with project team on the wards
  - Wards have difficulty in releasing staff for Paris training
  - Bank staff have not yet undertaken Paris training – but training programme now underway
  - Staff have access to Paris only after receiving full Paris training
- The approach of reviewing existing processes and introducing more efficient and effective ways of working has stimulated the engagement of staff
- Problems with GEM to configure (build) laptop devices
- Project Support Officer on the project has left. Delays in releasing her seconded replacement.
- Project team members have needed to spend time on other EPR related work.
- Potential withdrawal of project clinical lead – risk assessment submitted

FSR - Overview

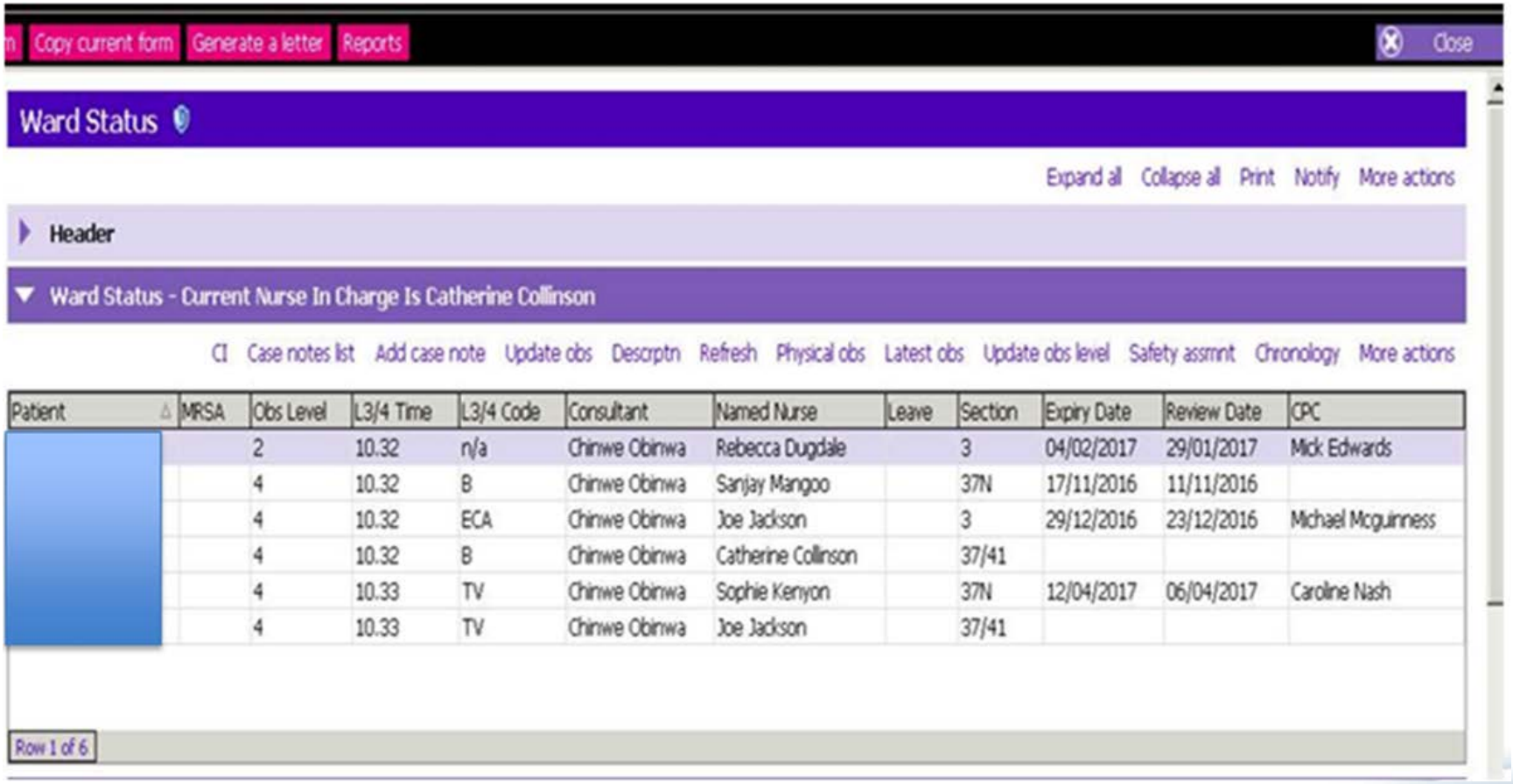
Forward programme of work into inpatient wards

Campus	Core Recording (Admissions, Discharges, Risk Assessment, Careplan, MDM)	Casenotes	Observations	Current Status	Target Fully Live
Audrey House	Live	Live	Live	Live	Fully Live
Kedleston Unit	Live	Live	Live	Live	Fully Live
Cherry Tree Close	Live	Live	Live	Live	Fully Live
Cubley Court	Live	Live	Awaiting Bank Staff Training	Live	Awaiting Bank Staff Training
London Road	Live	Live	Awaiting Bank Staff Training	Live	Awaiting Bank Staff Training
Hartington Unit	Admissions/Discharges and Patient Details. Target full core - end of Nov	End of November	End of December	Part Live	End of December
Radbourne Unit	Admissions/Discharges and Patient Details. Target full core - end of Dec	End of December	End of January	Part Live	End of January
Child Bearing (Perinatal)	Admissions/Discharges and Patient Details. Target full core – mid Nov	End of November	End of November	Part Live	End of November
ECT	Live	Live	Live	Live	Live

FSR Financial Scorecard
April 2016 – March 2017

	Budget April - Sept	Actual April - Sept	Act-Bud	Budget April – March 2017	Projected Actual to March 2017	Projected Act-Bud
Capital	27,500	13,756	13,744	27,500	27,500	0
Revenue	68,767	68,767	0	134,322	134,322	0

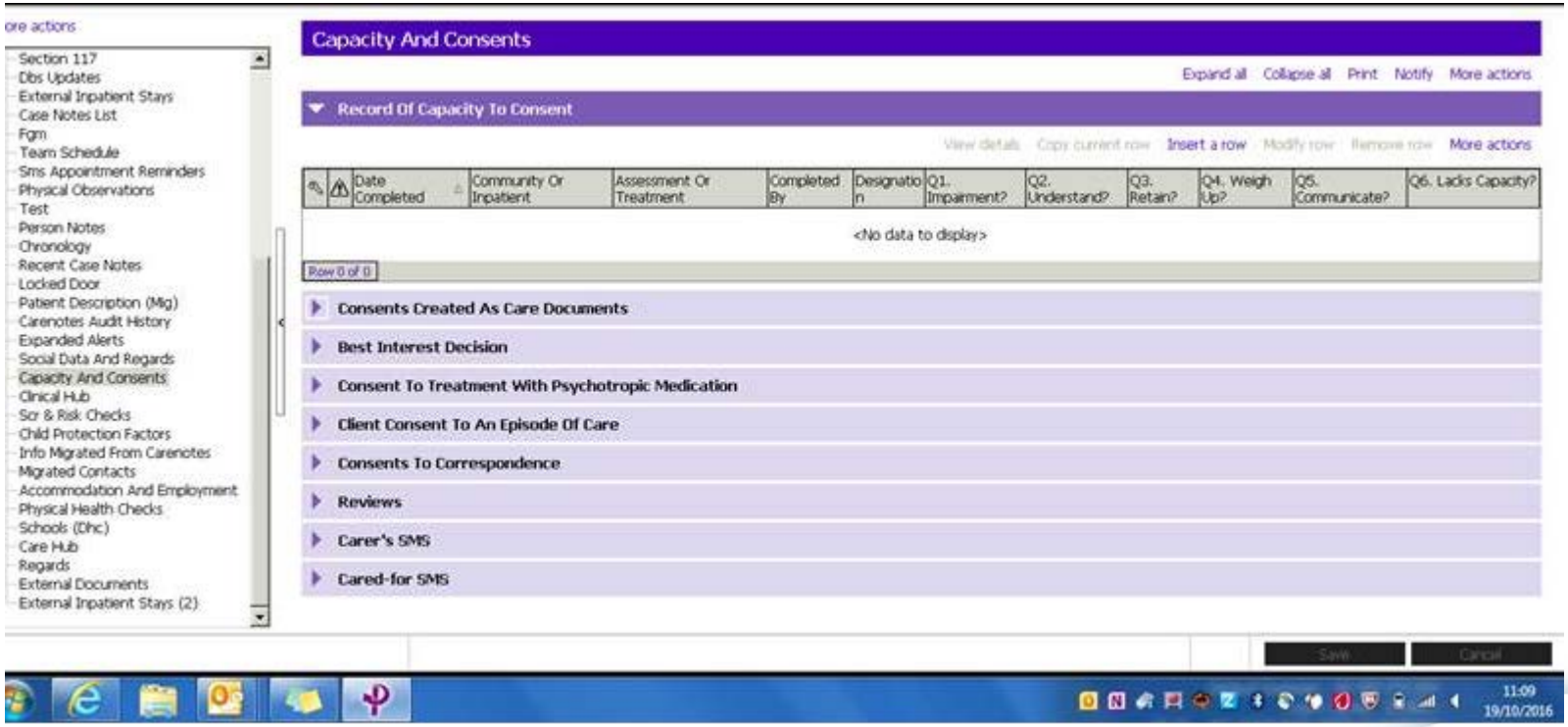
Ward Status



Patient	MRSA	Obs Level	L3/4 Time	L3/4 Code	Consultant	Named Nurse	Leave	Section	Expiry Date	Review Date	CPC
		2	10.32	n/a	Chinwe Obinwa	Rebecca Dugdale		3	04/02/2017	29/01/2017	Mick Edwards
		4	10.32	B	Chinwe Obinwa	Sanjay Mangoo		37N	17/11/2016	11/11/2016	
		4	10.32	ECA	Chinwe Obinwa	Joe Jackson		3	29/12/2016	23/12/2016	Michael Mcguinness
		4	10.32	B	Chinwe Obinwa	Catherine Collinson		37/41			
		4	10.33	TV	Chinwe Obinwa	Sophie Kenyon		37N	12/04/2017	06/04/2017	Caroline Nash
		4	10.33	TV	Chinwe Obinwa	Joe Jackson		37/41			

Capacity and Consent Recording

- Person Based
- Can be recorded stand alone or as part of Inpatient Admission Form



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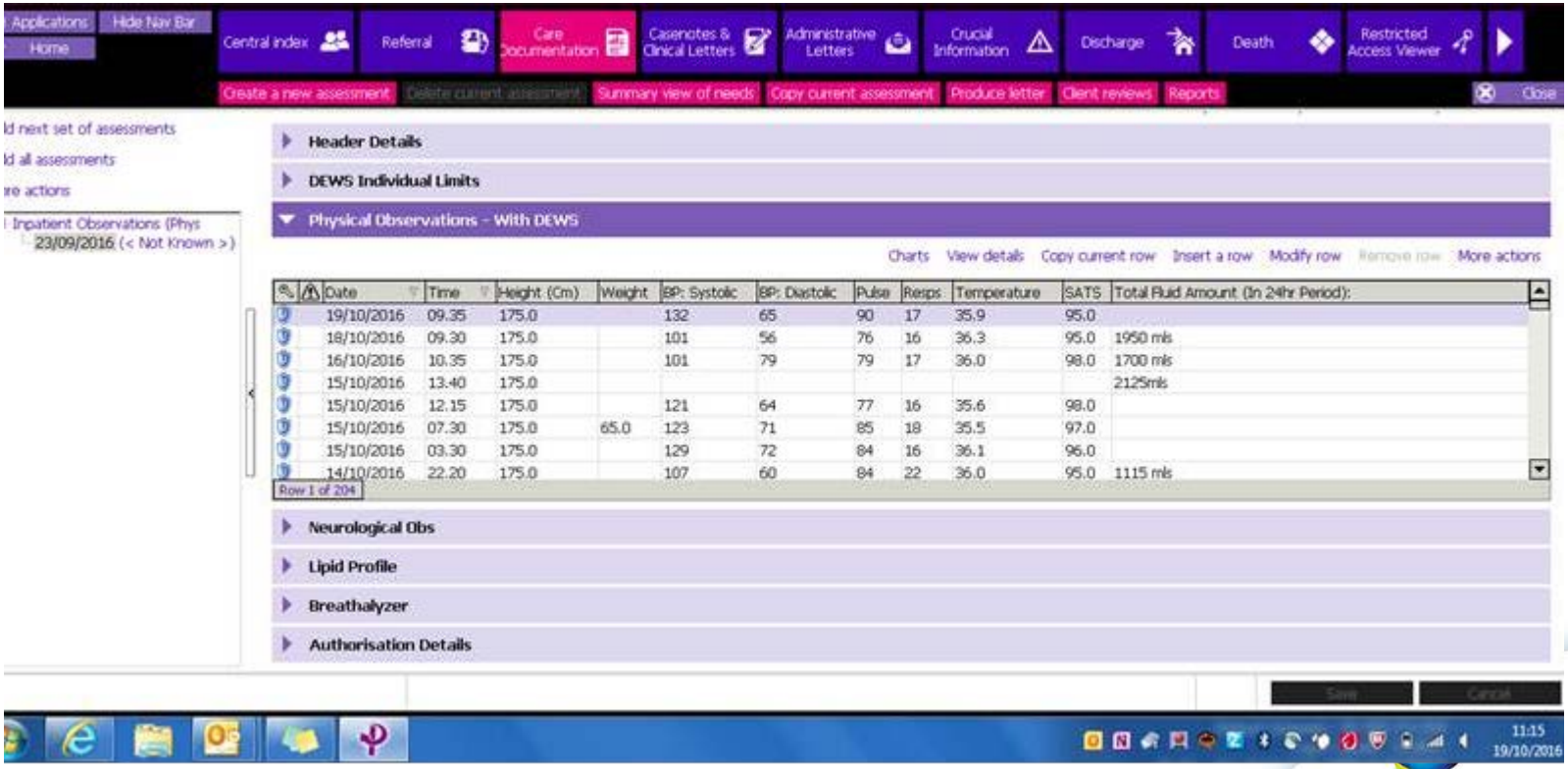
Physical Obs

- Person Based
- Record stand alone or as part of Inpatient Admission Form or via Ward Status
- Displayed on Multi Disciplinary Meeting (MDM) form

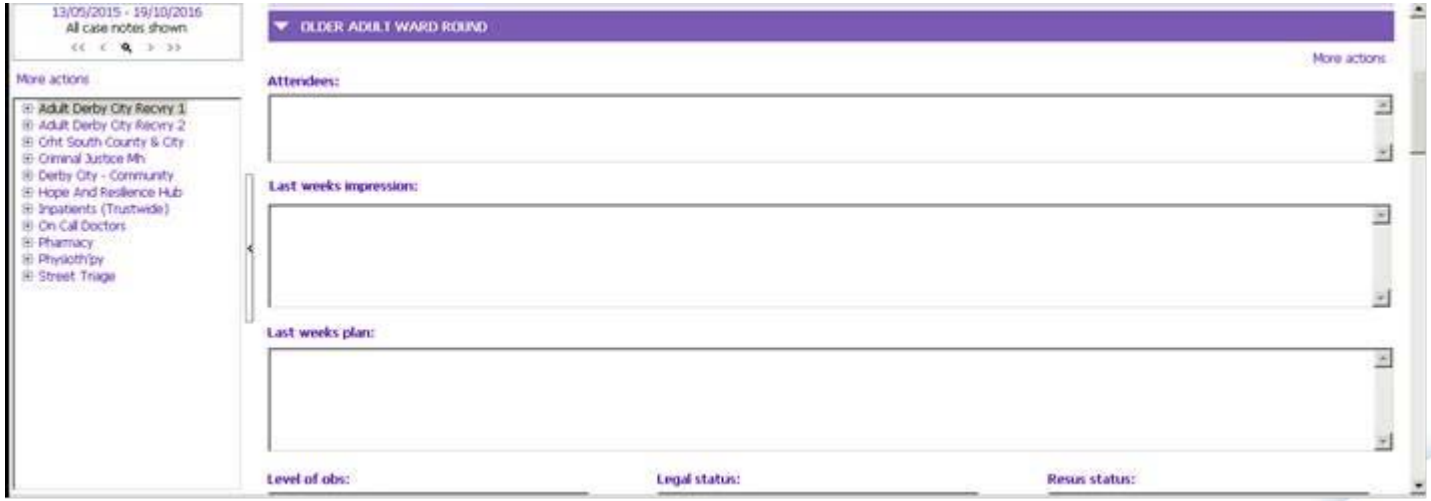


Date	Time	Height (Cm)	Weight	BP: Systolic	BP: Diastolic	Pulse	Resps	Temperature	SATS	Total Fluid Amount (In 24hr Period):
19/10/2016	09.35	175.0		132	65	90	17	35.9	95.0	
18/10/2016	09.30	175.0		101	56	76	16	36.3	95.0	1950 mls
16/10/2016	10.35	175.0		101	79	79	17	36.0	98.0	1700 mls
15/10/2016	13.40	175.0								2125mls
15/10/2016	12.15	175.0		121	64	77	16	35.6	98.0	
15/10/2016	07.30	175.0	65.0	123	71	85	18	35.5	97.0	
15/10/2016	03.30	175.0		129	72	84	16	36.1	96.0	
14/10/2016	22.20	175.0		107	60	84	22	36.0	95.0	1115 mls

Row 1 of 204

Multi Disciplinary Meeting (MDM) form

- Shared with all participants
- This is the start of the form. Other data recorded includes :-
  - Multi disciplinary reports
  - Physical Health Issues including Physical Obs
  - Review of Capacity to Consent
  - Medication Issues
  - Safeguarding issues



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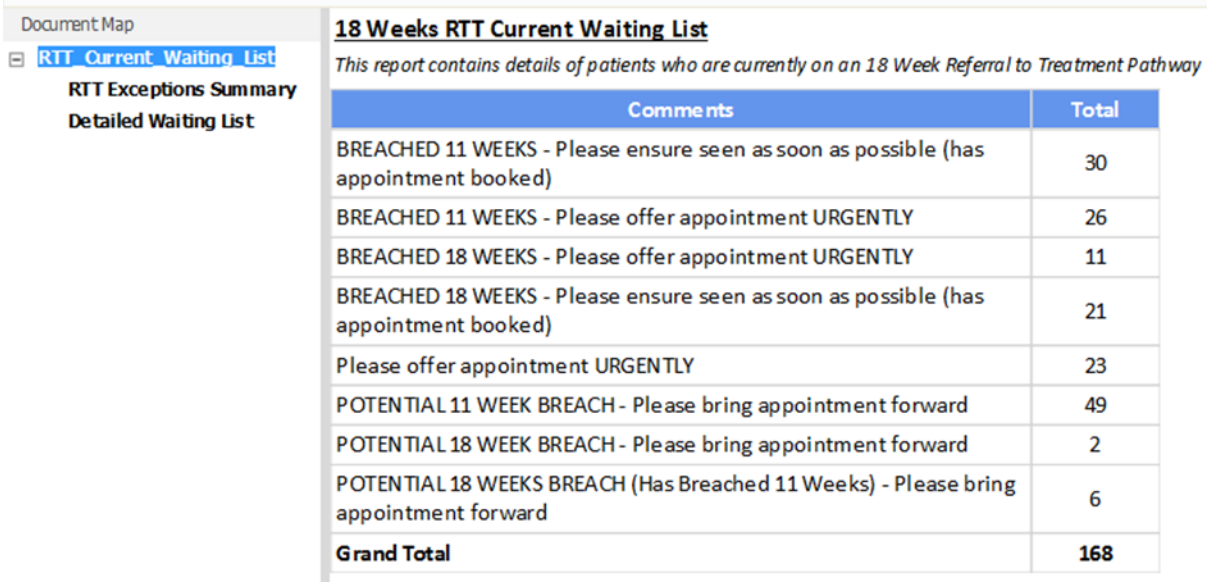
RTT (Referral to Treatment) Compliance



18 Weeks RTT Current Waiting List

This report contains details of patients who are currently on an 18 Week Referral to Treatment Pathway

Comments	Total
BREACHED 11 WEEKS - Please ensure seen as soon as possible (has appointment booked)	30
BREACHED 11 WEEKS - Please offer appointment URGENTLY	26
BREACHED 18 WEEKS - Please offer appointment URGENTLY	11
BREACHED 18 WEEKS - Please ensure seen as soon as possible (has appointment booked)	21
Please offer appointment URGENTLY	23
POTENTIAL 11 WEEK BREACH - Please bring appointment forward	49
POTENTIAL 18 WEEK BREACH - Please bring appointment forward	2
POTENTIAL 18 WEEKS BREACH (Has Breached 11 Weeks) - Please bring appointment forward	6
Grand Total	**168**

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Record of Consent Compliance (Inpatients)

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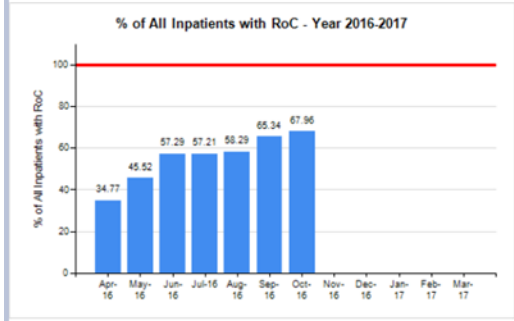
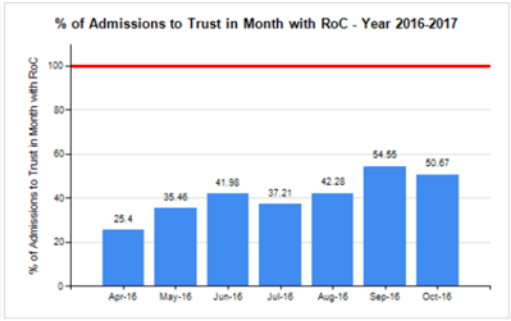
Inpatient Admissions Record of Consent Compliance





Ward Admission Campus (All Inpatients Open in Month with RoC) - allocation based on IP Admission Ward	Apr-16			May-16			Jun-16			Jul-16			Aug-16			Sep-16			Oct-16		
	n	%	Trend from Previous	n	%	Trend from Previous	n	%	Trend from Previous	n	%	Trend from Previous	n	%	Trend from Previous	n	%	Trend from Previous	n	%	Trend from Previous
Hartington Campus	48	42.86	▲	71	63.39	▲	101	82.79	▲	96	74.42	▼	88	72.73	▼	83	74.11	▲	75	82.42	▲
Kingsway Campus	45	67.16	▲	53	82.81	▲	59	95.16	▲	61	96.83	▲	62	93.94	▼	54	94.74	▲	45	88.24	▼
Perinatal	0	0.00		0	0.00		0	0.00		0	0.00		0	0.00		0	0.00		0	0.00	
Radbourne Campus	44	21.57	▲	59	27.83	▲	68	33.50	▲	77	37.20	▲	89	41.01	▲	110	55.28	▲	107	58.47	▲

Ward Admission Campus (All Inpatients Open in Month with RoC) - allocation based on IP Admission Ward	Apr-16			May-16			Jun-16			Jul-16			Aug-16			Sep-16			Oct-16		
	n	%	Trend from Previous	n	%	Trend from Previous	n	%	Trend from Previous	n	%	Trend from Previous	n	%	Trend from Previous	n	%	Trend from Previous	n	%	Trend from Previous
Audrey House Residential Rehabilitation	2	66.67	▼	2	100.00	▲	2	100.00	●	2	100.00	●	1	100.00	●	1	100.00	●	1	100.00	●
Cherry Tree Close	1	20.00		1	100.00	▲	1	100.00	●	1	100.00	●	1	50.00	▼	1	50.00		1	50.00	
Enhanced Care Ward	1	7.14		2	15.38	▲	8	44.44	▲	11	73.33	▲	12	60.00	▼	16	84.21	▲	13	76.47	▼
Hartington Unit Morton Ward Adult	19	44.19	▲	26	63.41	▲	35	81.40	▲	23	52.27	▼	19	42.22	▼	17	50.00	▲	20	68.97	▲
Hartington Unit Reasley Ward Adult	17	51.52	▲	19	63.33	▲	28	87.50	▲	31	86.11	▼	30	96.77	▲	26	89.66	▼	24	92.31	▲
Hartington Unit Tansley Ward Adult	12	33.33	▲	26	63.41	▲	38	80.85	▲	42	85.71	▲	39	86.67	▲	40	81.63	▼	31	86.11	▲
Kedleston Unit	1	100.00	●	1	100.00	●	1	100.00	●	1	100.00	●	1	100.00	●	1	100.00	●	1	100.00	●
Kedleston Unit – Curzon Ward	16	88.89	▲	16	88.89		16	88.89		16	94.12	▲	16	94.12		16	100.00	▲	14	100.00	●
Kedleston Unit – Scarsdale Ward	3	100.00	●	3	100.00	●	3	100.00	●	3	100.00	●	3	100.00	●	3	75.00	▼	3	75.00	

Better together

Out of Area Placements (Inpatients)

Out of Area Placements

Placement Type	PARISID	Forename	Surname	NHSNumber	Start Date	End Date	Location	Location Gender	Planned Duration Days	CTR YN	LoS
ACUTE					01/05/2016	02/05/2016	Royal derby Hospital	Male			1
					20/05/2016		Royal Derby Hospital	Male			153
					Total						154
PICU					09/02/2016	19/09/2016	ST ANDREWS ESSEX	MIX		Yes	223
					07/04/2016	01/08/2016	ST ANDREWS ESSEX	MIX			116
					13/05/2016	03/08/2016	CYGNET HOSPITAL KEWSTOKE	MALE			82
					19/08/2016		THE PRIORY HOSPITAL THORNFORD PARK	MALE			62
					14/07/2016	11/08/2016	ST ANDREWS NORTHAMPTON	MALE			28
					15/07/2016	02/08/2016	CYGNET HOSPITAL BIERLEY	FEMALE			18
					20/07/2016	30/08/2016	CYGNET HOSPITAL BECKTON	FEMALE			41
					25/07/2016	11/08/2016	THE PRIORY HOSPITAL THORNFORD PARK	MALE			17
					26/07/2016	15/08/2016	CYGNET HOSPITAL	MALE		Yes	20
					26/07/2016	18/08/2016	CYGNET HOSPITAL	MALE			23
					03/08/2016	06/09/2016	THE PRIORY HOSPITAL THORNFORD PARK	MALE		No	34
					04/08/2016	16/09/2016	CYGNET HOSPITAL	MALE		No	43
					10/08/2016	22/09/2016	THE PRIORY HOSPITAL THORNFORD PARK	MALE			43
					25/08/2016	06/09/2016	ST ANDREWS NORTHAMPTON	MALE			12
					30/08/2016	28/09/2016	CYGNET HOSPITAL	MALE		No	29
					30/08/2016	09/09/2016	THE SPINNEY	MALE		No	10
					05/09/2016	21/09/2016	THE PRIORY HOSPITAL THORNFORD PARK	MALE			16
					07/09/2016	03/10/2016	CYGNET HOSPITAL BECKTON	FEMALE		No	26
					09/09/2016	27/09/2016	THE PRIORY HOSPITAL [illegible]	MALE		No	18

Better together

Leavers (staff) with System Caseloads

Clear Selection | Export Staff To Excel | Export All Allocations To Excel

Staff Name	Paris Staff Code	ESR Number	Months Since Last AD Login	Managers Email	ESR Assignment Status	Patients on Caseload	Single Allocations
Select A	STAF000315	24827529				1	Yes
Select A	STFS574720	22115538				1	
Select B	STF8942068	24113162				4	Yes
Select B	STF9344193	24474214				5	
Select D	STAF101062		8	Lisa.Kenny@derbyshcft.nhs.uk		1	
Select D	STF69957	24701423				1	
Select E	STFS571290	10755660				1	
Select E	STFS571478	10753606				37	
Select F	STAF000276		10	Abbas.Ramji@derbyshcft.nhs.uk		3	Yes
Select G	STFS571880	10756311				8	
Select G	STFS571703	10756239				4	
Select H	STAF101788	25792939				4	Yes
Select H	STAF101157		8	Kerry.Zyngiel@derbyshcft.nhs.uk		1	
Select I	STFS574622	10754422				2	
Select J	STFS572038	10756641				2	Yes
Select J	STFS573228	10754446				1	
Select J	STF9750657	24367060				4	
Select K	STFS573358	10754232				12	Yes
Select K	STF8895512	24113361				1	Yes
Select L	STAF000297					9	Yes
Select M	STFS573868	10755604				3	
Select N	STAF000367	25502478				1	Yes
Select O	STAF101799		7	Paul.Willis@derbyshcft.nhs.uk		4	Yes
Select R	STFS571388	23362070				24	Yes
Select S	STFS573844	10754322				8	Yes
Select S	STFS572122	22805090				9	
Select S	STFS574532	10754475				2	
Select S	STF9329311	24422873				36	Yes
Select S	STAF000210		6	Laura.McAra@derbyshcft.nhs.uk		3	Yes
Select S	STAF000324	25398597				51	
Select T	STFS573633	10753156	12		Maternity & Adoption	1	
Select T	STAF101850		6	Jon.Scattergood@derbyshcft.nhs.uk		1	Yes
Select T	STF9951849	24598193				1	
Select V	STFS573729	10753322				3	

Deceased Patient Updates

Deceased Patients Not Marked as Deceased on PARIS

These patients have an alert on PARIS where a DBS trace indicates that they are deceased, however the process around updating the electronic record has not been completed.

Total Patients: 36

PARIS ID	Responsible Team	Responsible Clinician	Alert Desc	Date Alert Added to PARIS	Documented Date Of Death on PARIS	Referral Date	Discharge Date
[redacted]			DBS TRACE INDICATES DECEASED : DBS Trace:Patient died on 2016-10-07 00:00:00	14/10/2016		13/05/2015	
			DBS TRACE INDICATES DECEASED : DBS Trace:Patient died on 2016-09-23 00:00:00	07/10/2016		18/07/2016	
			DBS TRACE INDICATES DECEASED : DBS Trace:Patient died on 2016-09-23 00:00:00	07/10/2016		15/09/2016	
			DBS TRACE INDICATES DECEASED : DBS Trace:Patient died on 2016-09-13 00:00:00	16/09/2016		27/08/2008	
			DBS TRACE INDICATES DECEASED : DBS Trace:Patient died on 2016-10-09 00:00:00	14/10/2016		04/12/2013	
			DBS TRACE INDICATES DECEASED : DBS Trace:Patient died on 2016-09-20 00:00:00	07/10/2016		15/07/2004	
			DBS TRACE INDICATES DECEASED : DBS Trace:Patient died on 2016-09-05 00:00:00	09/09/2016		13/09/1995	
			DBS TRACE INDICATES DECEASED : DBS Trace:Patient died on 2016-08-03 00:00:00	12/08/2016		14/04/2016	
			DBS TRACE INDICATES DECEASED : DBS Trace:Patient died on 2016-10-05 00:00:00	07/10/2016		24/09/2013	
			DBS TRACE INDICATES DECEASED : DBS Trace:Patient died on 2016-08-24 00:00:00	02/09/2016		03/08/2012	
			DBS TRACE INDICATES DECEASED : DBS Trace:Patient died on 2016-10-12 00:00:00	14/10/2016		26/06/2014	
			DBS TRACE INDICATES DECEASED :				

Clinical Reference Group

- Terms of Reference established by Medical Director
- Chaired jointly by :-
  - Sarah Butt, Assistant Director Clinical Practice and Nursing
  - Rais Ahmed, Associate Clinical Director, Neighbourhoods
- Members include consultants, and nurses, IM&T and Records
- Members represent all services and professional groups
- Focal point for Paris enhancement/improvement
- Meets Bi-weekly
- Current topics
  - Uniformity, Consistency and Rationalisation
  - Capacity and Consent
  - Safety Forms
  - Care Plans
  - Assessments
  - Seclusion
  - Mental Health Act forms

Paris – a Consultant's View

- **Current Situation**
  - Better IT system than CareNotes
  - Captures information nicely compared to previous system.
  - Facilitates nicely to notify information between professionals within team or different teams.
  - Signing letter is easy and fast.
- **Draw Backs**
  - Lay out is not user friendly
  - Is not integrated with other IT systems
  - Too many clicks to search for information
  - Information lost with too many assessment forms "care documentation" which belong and feels like information is owned by relevant teams.
  - Difficult to search for specific information.
  - Duplication of information and repeated assessments

Paris – advantages of use

- 24/7 access
- The ability to share safety planning and risk management information across teams at any time of day or night.
- Clinical care & risk management - 24/7 access of information across the platforms allows making informed decisions about clinical care & risk management.
- Being able to have control over assessment planning and review processes through an electronic system, means that we reduce clinical variance and reduce deviation away from clinical recording standards.
- Recent developments will bring clinical improvements to the reporting and audit functions. This will allow improved assurance and monitoring.
- Having one set of casenotes that are multidisciplinary instead of nursing and medical.
- Casenotes that follow the patients journey, not having disjointed service by service perspective.

Paris – advantages of use

- Quality Improvement: Analyses of data to improve quality of care i.e. Evidence of best practices and where we need to change it. By compare & contrast we can identify the activities which are not proving beneficial.
- Quality assurance aspect of EPR - It keeps a log of events regarding a patient with the time stamp to facilitate audit of who did what and when (plus who didn't do what & when).
- Documents cannot be lost or changed retrospectively. This increases accuracy and aids in investigations.

Any Questions?

Better together

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 2 November 2016

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

Core	Number of Recommendations	Off Track	Some Issues	On track	Completed
Core 1 - HR and associated Functions	5	0	0	4	1
Core 2 - People and Culture	6	0	1	4	1
Core 3 - Clinical Governance	3	0	2	1	0
Core 4 - Corporate Governance	13	2	0	10	1
Core 5 - Council of Governors	3	0	0	3	0
Core 6 - Roles and Responsibilities of Board Members	5	1	3	1	0
Core 7 - HR and OD	8	2	1	5	0
Core 8 - Raising concerns at work	1	0	0	1	0
Core 9 - Fit and Proper	1	0	0	0	1
Core 10 - CQC	2	1	0	1	0
Core 11 - NHS improvement undertakings	6	0	0	3	3
Total	53	6	7	33	7

Since the last Board meeting there has been 1 change in Board RAG ratings for the overall recommendations. This relates to Core 9 – Fit and Proper person.

Remuneration and Nominations Committee reviewed the evidence underpinning this recommendation at its meeting on the 5th October and recommended to the Board of Directors that this was now complete. The blue form is provided at the end of this report for full Board approval.

Following receipt of Deloitte's phase 1 report, it was agreed at October's Board meeting that the GIAP would be reviewed in full, with this responsibility sitting with each of the Board's Committees. An update on progress to date for each Committee is provided in the paper.

Whilst overall Board Rag ratings have remained the same, progress has been made in the areas that are currently rated as 'off track' or 'some issues. The body of the report provides more detail on this.

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 namely:

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

3b: Risk of a fundamental loss of confidence by staff in the leadership of the organisation at all levels

Consultation

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) Discuss the areas rated as 'off track' and 'some issues', seeking assurance where necessary on the mitigation provided
3) Approve blue completion form for Core 9 – Fit and Proper Persons
4) Agree 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

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

Report prepared by: Mark Powell (Acting Chief Operating Officer)

1. Introduction

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

Since the last Board meeting there has been 1 change in Board RAG ratings for the overall recommendations. This relates to Core 9 – Fit and Proper person.

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Core 4 - Corporate Governance	13	2	0	10	1
Core 5 - Council of Governors	3	0	0	3	0
Core 6 - Roles and Responsibilities of Board Members	5	1	3	1	0
Core 7 - HR and OD	8	2	1	5	0
Core 8 - Raising concerns at work	1	0	0	1	0
Core 9 - Fit and Proper	1	0	0	1	0
Core 10 - CQC	2	1	0	1	0
Core 11 - NHS improvement undertakings	6	0	0	3	3
Total	53	6	7	33	7

2. Red Rated 'Off Track' recommendations

There are 6 recommendations rated as Red as detailed in the table below:

Core Area	Recommendation	Action(s)	Mitigation
Core 4 - Corporate Governance	CorpG7 - In light of the changing governance and accountability structures (such as neighbourhoods, campuses and QLTs), an accountability framework should be designed to fully engage staff in how these changes will affect ways of working, performance management structures and desired behaviours moving forward	1. Aligned to the Corporate Governance Framework develop and approve an organisational accountability framework 2. Develop and fully engage senior staff in an accountability framework	Trust Board agenda item for November
	CorpG9 - Formalise the role of PCOG as a key forum in the Trust's governance structure	1. As part of the Governance Framework review the Trust will formalise the role of PCOG 2. Clarifying the role of PCOG in light of the move to neighbourhoods and campuses	See above
Core 6 - Roles and Responsibilities of Board Members	RR1 - Implement proposals to improve succession planning at Board level, including ensuring that Governors are adequately engaged in this process. Alongside this, develop processes for succession planning for Senior Leader positions	Develop and approve Board level, key divisional and corporate leaders succession plan	A mitigation plan was agreed at October's Remuneration & Appointments Committee, with succession planning process being led by Amanda Rawlings and Ifti Majid.
Core 7 - HR and OD	WOD3 - Address the relationship issues identified within the function, and alongside this agree a development programme for HR and its related functions that starts by building relationships at a senior level before seeking to develop an effective and efficient function	Develop and implement a HR and related function Development programme, which includes building good working relationships	Full integrated team meetings have now been put in place by the Director of Workforce, HR and OD and will continue to be held, with the expectation that this recommendation will be progressed very quickly to being on track.

Core Area	Recommendation	Action(s)	Mitigation
	WOD 6 - Consider mechanisms to regularly seek feedback from the HR function on the extent to which the candour, openness, honesty, transparency and challenge to poor performance are the norm, e.g. through monthly pulse checks	Implement Integrated Team meeting	See above
Core 10 - CQC	CQC 2 - The trust should continue to proactively recruit staff to fill operational vacancies	Implement the recruitment plan and monitor effectiveness against an agreed vacancy rate trajectory	A revised recruitment plan has not yet been fully developed; however, P&CC agreed at its meeting on 19 October that all recommendations that it is responsible for need to be reviewed in full by a sub-group of P&CC. This exercise will be led by Amanda Rawlings, Sam Harrison and Mark Powell and will take place on 11 November with the wider HR team, reporting back to November's P&CC.

3. Amber rated 'some issues' rated recommendations

There are 7 recommendations rated as Amber as detailed below:

Core Area	Recommendation	Action(s)	Mitigation
Core 2 - People and Culture	PC5 - Undertake an exercise to refresh the Trust values. As part of this exercise engage with staff to ensure that values are meaningful and expected behaviours are clear. Relaunch revised values across the Trust.	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 3 - Clinical Governance	ClinG1 - Refresh the role of Quality Leadership Teams to increase their effectiveness as core quality governance forums	1) Agree and implement a QLT forward plan process to ensure all required papers are received at each meeting 2) Develop and implement a standard escalation template to be used by	QC agreed that in order to progress this recommendation to completion it would need to see evidence of escalation templates, minutes of meetings, work plans linked to the Quality Committee forward plan, attendance embedded on the minutes and risk register. QLT leads will need

Core Area	Recommendation	Action(s)	Mitigation
		QLT's 3) For a 6 month period Don and MD to attend QLTs to provide coaching and oversight of meeting effectiveness	to attend QC on a rotational monthly basis but detailed QLT updates from each Team will be provided monthly. When the Committee has received all this information from each QLT consistently on a monthly basis for four months the Committee indicated she would be prepared to sign off this recommendation.
	ClinG3 - Increase the effectiveness of the Quality Committee by ensuring clear alignment of the committee with the quality strategy and associated objectives, and ensuring a clear focus on seeking assurance	Ensure that Quality Committee agenda is structured so that it focuses on topics to deliver quality strategy and goals	QC agreed that there needed to be more focus on revising the agenda template to confirm how papers supported delivery of the Trust strategy, in ensuring completion of actions and having a clear forward plan At October's meeting QC agreed that the Action Log required richer narrative when capturing actions and accountabilities. Overall, the Committee expects to sign off this recommendation off by the end of the calendar year.
Core 6 - Roles and Responsibilities of Board Members	RR2 - Agree a programme of Board development work which includes a mix of internal and externally facilitated sessions, is clearly aligned to the combined governance action plan	Implement Board Development programme which will include Board effectiveness sessions to address team dynamics and agreed ways of working including • clarity of purpose and vision; • effective challenge and leadership; and • individual coaching.	Board development programme to be reviewed in light of new Board recruits and priorities and challenges for the Trust
	RR3 - Complete the full process of 360 feedback for all BMs and utilise the outcome to set clear objectives in relation to portfolio areas (for EDs) as well as in relation to the role of the corporate director and contribution	Implement 360 degree feedback for all BM's	A mitigation plan was agreed at October's Remuneration Committee, with succession planning process being led by Amanda Rawlings and Ifti Majid.

Core Area	Recommendation	Action(s)	Mitigation
	to the Board		
	RR5 - The trust should ensure that training passports for directors reflect development required for their corporate roles	Provide BM and NED training update reports to Rem Com to demonstrate completion in line with mandatory and CPD requirements	This report is delayed. It will be provided to December's Remuneration and Nominations Committee
Core 7 - HR and OD	WOD7 - The trust should monitor the adherence to the grievance, disciplinary, whistle-blowing policies and the current backlog of cases concluded.	The backlog of cases made known to the CQC at the time of the inspection are concluded	Progress continues to made resolving all cases in line with Trust policy

4. Six month review of GIAP progress update

Following receipt of Deloitte's phase 1 report, it was agreed at October's Board meeting that the GIAP would be reviewed in full, with this responsibility sitting with each of the Board's Committees. An update on progress to date for each Committee is provided below.

4.1 Audit and Risk Committee

The Audit and Risk Committee received an update on progress against actions to address recommendations, including a preliminary review of the embeddedness and robustness of work already undertaken. Given the volume of recommendations for oversight by the Committee it was agreed that Sam Harrison would complete the full review against the original context of the recommendations outside of the meeting and following liaison with the Committee chair, present to the December meeting.

4.2 Remuneration and Nominations Committee

The Committee has not met since the last Board meeting and therefore has not been able to review all of its recommendations. An update on progress against actions is to be reported to the next meeting where the Committee will be asked to review all recommendations and associated actions and/or evidence for assurance that will give the Committee assurance that the recommendations have been fully addressed and embedded.

4.3 Quality Committee

The Quality Committee reviewed all of the recommendations that it is responsible for at its October meeting. The 3 recommendations were discussed in detail alongside the underpinning narrative for each recommendation from Deloitte's original report. This resulted in the Committee being much clearer on what assurance it is expecting to receive, and in what format, so that it can provide assurance to the Board when it believes recommendations have bene delivered and are complete.

4.4 People and Culture Committee

The People and Culture Committee discussed how it would review the significant number of recommendations that it is responsible for. It agreed that a sub group of the Committee would be best placed to undertake this role on behalf of the Committee. This has been planned for 11 November and will then report back to November's Committee meeting.

Recommendation **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.	**Current BRAG Rating** **Completed**	**Recommended BRAG rating** **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', 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	Ratified by Board of Directors March 2016, published May 2016, review scheduled for May 2019
Annual Declaration of fit and proper	Declaration to Public Trust Board, 25 May 2016
CQC Inspection report confirming requirement met	CQC Inspection Report, published 29/09/2016, page 47,

Ongoing monitoring arrangements:

Monitored on an annual basis by the Remuneration Committee, supported by the Fit and proper filing system that is now in place

Executive Director Responsible:	**Director of Corporate Affairs**	**Responsible Assurance Committee:**	**Remuneration & Appointments Committee**

Blue Action Form - Board of Directors

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 2 November 2016

Board Assurance Framework (BAF) update for 2016/17 (Issue 3)

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

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. The BAF provides a central basis to support the Board's disclosure requirements with regard to the Annual Governance Statement (AGS), which the Chief Executive signs on behalf of the Board of Directors, as part of the statutory accounts and annual report.

This is the third formal presentation of the Board Assurance Framework to the Audit & Risk Committee for 2016/17.

Executive Summary

- There has continued to be significant review and update of each risk during the last quarter

- Since Issue 2 of the BAF for 2016/17 three further risks have been added to the BAF. These are:

    - 1b) The Trust is not compliant with equality legislation. There is therefore a risk that the Trust does not operate inclusivity and may be unable to deliver equity of outcomes for staff and service users. Currently assessed as high risk.
    - 1c) Risk to delivery of safe, effective and person centred care due to the Trust being unable to source sufficient permanent and temporary clinical staff. Currently assessed as high risk.
    - 3c) There is a risk that turnover of the Board members could adversely affect delivery of the organisational strategy due to loss of specialist organisational knowledge, capacity and stability. Currently assessed as moderate risk.

- All other risks identified in the BAF remain graded as either High or Extreme.

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

- Except for the three new risks which are yet to be confirmed, all dates for 'deep dives' of individual BAF risks are planned for the year and are target to be achieved. Deep dives for all risks rated as high or extreme will be undertaken by

the Audit & Risk Committee but this is subject to change dependent upon the current risk rating of each risk.

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

Strategic considerations

All risks identified in the BAF relate to risks to the achievement of strategic outcomes, as this is its main purpose.

(Board) Assurances

This paper provides an update on all Board Assurance Risks

Consultation

Individual Executive Directors – September 2016
Executive Leadership Team (via email) – 19 September 2016
Audit and Risk Committee – 11 October 2016

Governance or Legal issues

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

Equality Delivery System

None

Recommendations

For the Board to approve this third issue of the BAF for 2016/17

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

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

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

There has continued to be significant review and update of each risk since it was last reviewed by the Board in July 2016. Changes since Issue 2 are highlighted in blue text in the detailed spreadsheet attached.

1) New risks

Since Issue 2 (July 2016), three additional risks have been added to the BAF. These are summarised below:

BAF ID	Risk title	Executive Director Lead	Current risk rating	Rationale
1b	The Trust is not compliant with equality legislation. There is therefore a risk that the Trust does not operate inclusivity and may be unable to deliver equity of outcomes for staff and service users.	Interim Director of Workforce, Organisational Development and Culture	**HIGH**	Significant gap in control identified. Concern raised by CQC
1c	Risk to delivery of safe, effective and person centred care due to the Trust being unable to source sufficient permanent and temporary clinical staff	Interim Director of Workforce, Organisational Development and Culture	**HIGH**	Level of impact on staff retention, agency spend and sickness rates
3c	There is a risk that turnover of the Board members could adversely affect delivery of the organisational strategy due to loss of specialist organisational knowledge, capacity and stability.	Director of Corporate Affairs and Trust Secretary	**MEDIUM**	Current changes to Board appointments

2) BAF risks summary

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

BAF ID	Risk title	Director Lead	Risk rating
1a	Failure to achieve clinical quality standards required by our regulators which may lead to harm to service users and/or staff	Executive Director of Nursing and Patient Experience	**HIGH**
1b	The Trust is not compliant with equality legislation. There is therefore a risk that the Trust does not operate inclusivity and may be unable to deliver equity of outcomes for staff and service users.	Director of People & Organisational Effectiveness	**HIGH**
1c	Risk to delivery of safe, effective and person centred care due to the Trust being unable to source sufficient permanent and temporary clinical staff	Director of People & Organisational Effectiveness	**HIGH**
2a	Risk to delivery of national and local system wide change. If not delivered this could cause the Trusts financial position to deteriorate resulting in regulatory action	Acting Director of Strategy	**HIGH**
3a	There is a risk that the NHSI enforcement actions and CQC requirement notice, coupled with adverse media attention may lead to significant loss of public confidence in our services and in the trust of staff as a place to work.	Acting Chief Executive	**HIGH**
3b	Risk of a fundamental loss of confidence by staff in the leadership of the organisation at all levels	Director of People & Organisational Effectiveness	**HIGH**
3c	There is a risk that turnover of the Board members could adversely affect delivery of the organisational strategy due to loss of specialist organisational knowledge, capacity and stability. Furthermore, failure to deliver the governance improvement action plan could lead to a risk of further breaches in licence regulations with Monitor and the CQC and further regulatory action	Director of Corporate Affairs and Trust Secretary	**MEDIUM**
4a	Failure to deliver short term and long term financial plans could adversely affect the financial viability and sustainability of the organisation	Executive Director of Finance	**EXTREME**
4b	Failure to deliver the agreed transformational change, at the required pace could result in reduced outcomes for service users, failure to deliver financial requirements and negative reputational risk	Acting Director of Strategy	**HIGH**

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

4) 'Deep dives'

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

The programme for deep dives for 2016/17 is planned as follows: This is however subject to change dependent upon the current risk rating of each risk. The plan is currently on track.

Risk ID	Subject of risk	Director Lead	Quality Committee	Finance and Performance Committee	People and Culture Committee	Audit & Risk Committee
1a	Clinical Quality	Carolyn Green	(X)	→	→	Dec 2016
1b	Equality	Amanda Rawlings				Date for 'Deep Dive' tbc
1c	Clinical workforce	Amanda Rawlings				Date for 'Deep Dive' tbc
2a	System change	Acting Director of Strategy		(X) →	→	Mar 2017
3a	Regulatory compliance	Ifti Majid				Jan 2017
3b	Loss of confidence in leadership	Amanda Rawlings			(X) →	Dec 2016
3c	Board turnover	Samantha Harrison				BAF review planned for R&AC* 02/11/2016. Deep dive not required unless risk increases.
4a	Financial plan	Claire Wright		(X) →	→	Oct 2016 Completed
4b	Transformation	Acting Director of Strategy		(X) →	→	Jul 2016 Completed

*Remuneration and Appointments Committee

Note: The arrows show when the Audit & Risk Committee will receive the risk 'deep dives' rather than the lead responsible committee.

BOARD ASSURANCE FRAMEWORK 2016/2017 v3.3

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

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

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

	Principal Risk	Director Lead and named responsible Committee	Risk Rating	Impact (1-5)	Likelihood (1-5)	Key Controls	Gaps in control	Assurances on Controls (Internal)	Positive Assurances	Gaps in Assurance	Action plan: To increase effective controls. To gain assurance.	Action: due/review date	Progress on action	Risk Register ID
1a	Failure to achieve clinical quality standards required by our regulators which may lead to harm to service users and/or staff	Executive Director of Nursing and Patient Experience Quality Committee	HIGH	4	4	1) Quality Framework (Strategy) outlining how quality is managed within the trust 2) Board committee structures and processes ensuring escalation of quality issues 3) Quality governance structures and processes in to manage quality related issues 4) Quality visit programme, providing partial evidence of compliance with CQC requirements 5) Incident, complaints and risk investigation and learning, including robust mechanisms for monitoring resulting actions plans 6) Agreed clinical policies and standards, available to all staff via Connect. Reports detailing timely review of policies submitted to Quality Committee. 7) Engagement with clinical audit and research programmes 8) 'Duty of Candour' monitoring and reporting processes 9) Annual skill mix review	Clinical buy in to review of NICE guidelines Embeddedness of QLT's Embedded personalised care planning. Robust compliance monitoring for record keeping, capacity and consent, physical health cheeks and clinical standards Compliance with medicines management policy Including compliance with storage of medicines at the correct temperature), and gaps in capacity of pharmacy team (3302) (3301) (20844) Demands of the Derbyshire population out strips capacity (3260) (20908) (20928), in particular community teams, paediatrics and fast track PREVENT referrals. Ability to recruit and retain adequate numbers of staff to ensure safe practice i.e. inpatient wards at Radbourne and Hartington Units, (3386) (3410) (2675) (2678) (2797) (2801) (2834) (3409) (2669), paediatricians (3262), CMHT (20857) 20819), psychology (20867) (3385), CANHS (20916) Clinical dashboards to monitor early warning signs of service failure (1565) MHA data validation of seclusion and rapid tranquilisation incidents. Inadequate physical environment for seclusion at Kedleston Unit. Ineffective training compliance with restrictive practice requirements of the MHA Code of Practice Non commissioned services for Derbyshire based PICU beds (3314) and a secure and effective forensic pathway, and CAMHS Tier 4 beds Uptake of level 3 safeguarding and fire warden training	Service improvement mapping and contributions i.e. positive and safe, reduction in the use of seclusion Clinical Audit Programme and action plans where gaps identified Audits of compliance with NICE Guidelines National Audits i.e. National Audit of Schizophrenia and POMH UK Audits 'Clinical interest' led audits focused on local resolution of issues	National Community Patient Survey results (above average results) National Inpatient survey (above average results) HealthWatch survey 2014 (significant assurance) Benchmarking data identifies higher than average qualified to unqualified staffing ration on inpatient wards CQC inspection comprehensive review identified good feedback from families, individuals and carers re service experience.	CQC inspection comprehensive review detailed a number of gaps in assurance. Achievement of Quality Framework in relation to care planning and capacity and consent , reconfirmed by audit: 2015/16 Mental Capacity Act and findings from CQC comprehensive inspection June 2016, identifying significant lack of knowledge by staff in recording of capacity and consent. Clinical audits identifying gaps due to inconsistent application of process i.e. capacity and consent, nutritional screening, DNAR, DEWS scoring, recording of allergies. Re-audits of rapid tranquilisation and seclusion identifying gaps in adherence to policy remain Delays in implementing actions i.e. ward admission pack information re restraint and debrief. Supporting staff retention through practice development and embedding uptake of clinical supervision Unfilled clinical vacancies due to lack of available medical staff and recruitment to new investment.	Further engage clinical leadership (though QLT's in particular) in the review and implementation of NICE guidelines.	31/12/2016	Progress update to QC Oct 2016. Connect site fully populated with relevant NICE guidelines, awaiting dashboard function to be added and will then be published.	20830
											Embedding of actions resulting from incidents and complaints into the medium to long term through Quality Leadership Teams. Improve systems and processes to identify links between incidents and learn lessons.	31/12/2016	Redesigned agenda/structure and forward plan in place for QLT's. Demonstration of 'Datix dashboards', configured to ensure local oversight and learning from incidents, planned for 22/9/16. CAT bid submitted.	
											Continue to monitor progress against implementation of the quality strategy in relation to compliance with care planning and capacity and consent requirements, including the implementation of actions resulting from the recent 2015/16 Mental Capacity Act audit and CQC comprehensive inspection. Ensure SOAD (second opinion approved doctors) are requested in a timely manner.	30/11/2016	MCA/MHA Team Leader appointed, to start in post 5/10/16. to develop systems, monitor impact and implement training around capacity and consent and compliance with the MCA Act (DoLS applications). Revised publication of 'Your Care' details personalised care planning issued. Training to develop new model for clinical skills tutors will also support person centred care planning. Working toward solution through PARIS to support SOAD requests.	
											Implement improvement plan for medicines management, as highlighted in Board deep dive into medicines management (Sept 2015) and hence to commissioners. Implement measures to ensure medicines are being stored at the correct temperatures.	31/10/2016 Completed	Report to Quality Committee June 16 reported on progress against pharmacy strategy. Review monthly until further assurance received. Lack of compliance with correct storage temperature of medicines is being managed through portable air conditioning units whilst capital bids to install permanent solutions are being implemented. Medicines trolley position on Kedleston Unit reviewed.	
											Raise risks with commissioners regarding community team capacity and forensic community offer. Recruit to new investment and action planning around 12 hour A&E breaches.	31/10/2016	£1m additional investment received, £2m shortfall remains. Deep dive reports to Quality Committee on plans to safety manage waiting lists for paediatricians and CMHT's considered. People and Culture Committee received plan for recruiting to new investment and existing vacancies.	
											Implementation of clinical dashboards to monitor early warning signs of service failure	Completed	Revised quality monitoring dashboard presented to July 16 Board.	
											Implementation of action plans resulting from gaps identified through clinical audit projects	31/10/2016	Delay in completing actions identified by audit, being escalated through R&D Group. Limited evidence of change identified through re-audit i.e. physical health checks post prescribing, adherence to seclusion and rapid tranquilisation policies. Escalated though practice Development Groups.	
											Increase uptake of clinical and managerial supervision and level 3 safeguarding training	30/11/2016	Revised supervision policy. Performance monitoring though TOMM, reported to Board through Integrated Performance Report. Supervision audit by Radbourne Unit identified actions for trust wide implementation. New Supervision Group, initially covering campus sites, commencing mid Sept 2016. Additional level 3 safeguarding training in place.	
											Reinstate practice development groups	31/12/2016	Commenced with campus teams. Being rolled out to Neighbourhood teams.	
											Recruit to/remodel medical workforce (20918) (20916) (20924) (20966)	31/10/2016	Medial workforce plan to People and Culture Committee July 2016, to reduce vacancies and/lore remodel service. Implementation of new NHSI Medical Workforce Toolkit underway.	
											Ensure consistency of understanding and application by clinical staff and clinical leaders of seclusion, in line with the MHA Code of Practice. Ensure the monitoring of incidents of seclusion is robust and cross referenced between ward, MHA office and Datix held data. Instigate capital programme re improvements to the physical environment of the Kedleston seclusion room.	31/10/2016	Blue Light' issued 17/6/16 regarding care of patients in seclusion and segregation care and reporting of these incidents. Capital programme re improvements to the physical environment of the Kedleston seclusion room underway. A system to improve xchecks between data held by the MHA office and on Datix implemented and data correlated from 1/4/16. A full picture was reported to the MHA Committee in Aug 16, showing improved data collection. Ward visits/training is being instigated.	

										PICU bed manager being appointed to review pathway. Cluster analysis of incidents requested via CCG through STEIS incident reporting.	31/10/2016	PICU manager in post. Staring to make significant headway to reduce inappropriate use of PICU beds. Benchmarking exercise of PICU is being undertaken.	
										Review policies on positive and safe, seclusion , DNAR (Do not attempt resuscitation) and management of capacity and consent	30/11/2016	Progress update at Quality Committee Sept 16. Standing agenda at each MHA Committee to ensure pace.	
										Implement emergency planning measures re staffing on inpatient wards at Radbourne and Hartington.	30/11/2016	Extensive programme of management actions to mitigate risk underway	
										Improve compliance with fire warden training	31/10/2016	Comprehensive plan in place to increase compliance with uptake of fire warden training , including bespoke training delivered as required.	
1b	The Trust is not compliant with equality legislation. There is therefore a risk that the Trust does not operate inclusivity and may be unable to deliver equity of outcomes for staff and service users.	Interim Director of Workforce, Organisational Development and Culture People and Culture Committee (Audit Committee)	Jun-16	4	4	1) Appointment of new joint Director for Workforce, OD and Culture 2) Launch of a new Equalities Forum 3) Additional resource to support development of the equalities agenda 4) Reporting of approach and progress to Board and People and Culture Committee 5) Urgent non compliance addressed and reported to the People and Culture Committee	Organisation wide approach to improving compliance with the national equality programme Lack of robust process for improving and tracking compliance against the Race Equality Scheme				Review of EDS2 across all 4 domains.	31/12/2016	Internal assessment completed. External assessment planned. Progress reported to Board 5/10/16.	20936
										Analysis of gap to meet Race Equality Scheme standard.	31/12/2016	Action plan developed and being implemented.	
1c	Risk to delivery of safe, effective and person centred care due to the Trust being unable to source sufficient permanent and temporary clinical staff	Interim Director of Workforce, Organisational Development and Culture People and Culture Committee (Audit Committee)	Jun-16	4	4	1) Recruitment policies and processes 2) Recruitment campaigns 3) Reporting of numbers of vacancies and time to recruit to People and Culture Committee 4) Weekly senior management review of agency spend	System wide recruitment tracker Detailed recruitment plan for professional groups. Staffing risks identified in operational risks: (3386) (3410) (2675) (2678) (2797) (2801) (2834) (3409) (3262) (20857) 20819) ((20867) (3385) (2669), CAMHS (20916) and consultant agency spend risks (20918) (20916) (20924) (20966) Sufficiently well stocked bank and adequate resource to manage bank office function				Develop system to identify an accurate baseline of vacancies and implement recruitment tracker	31/10/2016	On track to achieve	20976
										Revision of approval to appoint process	31/10/2106	On track to achieve	
										Implementation of resource plan for all professionals	30/11/2016		
										Identify requirements for bank office to function more effectively and implement changes required.	31/12/2016		

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

	Principal Risk	Director Lead and named responsible Committee	Risk Rating	Impact (1-5)	Likelihood (1-5)	Key Controls	Gaps in control	Assurances on Controls (Internal)	Positive Assurances	Gaps in Assurance	Action plan: To increase effective controls. To gain assurance.	Action: due/review date	Progress on action	Risk Register ID
2a	Risk to delivery of national and local system wide change. If not delivered this could cause the Trusts financial position to deteriorate resulting in regulatory action	Acting Director of Strategy Finance and Performance Committee (Audit Committee)	EXTREME	4	4	1) Programme of public consultation to support system wide changes 2) Stakeholder and relationship management in order to develop and maintain partnerships 3) Trust fully involved in Mental Health programme of work for the STP 4) Trust involvement with Strategic Options Case (SOC) for closer collaboration with DCHS 5) Executive to executive and Board to Board discussion with DCHS on opportunities for collaboration in line with national guidance re reviews of 'back office' functions	Unclear system wide governance to oversee delivery of national priorities Lack of clarity around collaboration and competition Issues of communication owing to NHSE directives Long term local strategic partnerships to deliver quality, sustainable services	NHSE agreement of Derbyshire STP short term Regular STP reports to confidential Trust Board Regular system wide service change proposals reported to Trust Board	NHSE 'Checkpoint' undertaken. Assurance received to progress to final plan.		Delivery of NHSI operational plan	Completed	Monitor Plan for 16/17 approved by Trust Board and sent to Monitor within the agree timeframe.	20832
											Agree system wide Sustainability and Transformation Plan (STP)	Completed	STP plan for Derbyshire was submitted on the30/6/16 in line with national expectations.	
											Implementation of Sustainability and Transformation Plan (STP)	From 01/11/2016		
											Engagement with STP business case workstreams to ensure local ownership of DHCFT specific plans	31/10/2016	Final STP business cases at system level due 14/10/16. All information circulated to project managers to ensure alignment and any final comments re: risks etc.	
											Delivery of DHCFT and DCHS strategic options case to confidential Board Oct 2016	31/10/2016	Final DRAFT completed w/c 10th October. Clinical engagement to ensure patient stories are included, reflecting benefits. On track for Board dates	
											Phase 1 (back office functions) business case to be developed	31/10/2016	Four business cases developed and discussed; all progressing as planned	

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

	Principal Risk	Director Lead and named responsible Committee	Rating	Impact (1-5)	Likelihood (1-5)	Key Controls	Gaps in control	Assurances on Controls (Internal)	Positive Assurances	Gaps in Assurance	Action plan: To increase effective controls. To gain assurance.	Action: due/review date	Progress on action	Risk Register ID
3a	There is a risk that the NHSI enforcement actions and CQC requirement notice, coupled with adverse media attention may lead to significant loss of public confidence in our services and in the trust of staff as a place to work. Furthermore, failure to deliver the governance improvement action plan could lead to a risk of further breaches in licence regulations with Monitor and the CQC and further regulatory action	Acting Chief Executive Audit Committee	EXTREME	5	3	1) Governance committees and structures, with clear responsibility to lead on specific GIAP actions 2) People and Culture Committee, with clear responsibility to lead on specific GIAP actions 3) Governance processes to deliver the governance improvement action plan including reporting to ELT and monthly reporting to Board 4) Listen, Lead and Learn - executive visibility plan 5) Formal reporting to regulators on a monthly basis. 6) Ongoing engagement with regulators	Identified in the governance improvement action plan. Deloitte and CQC reports	Well led self assessment Deloitte and CQC reports	NHSI agreement of governance improvement action plan 2016/17 Governance and improvement action plan 2016/17 Performance Management Framework (planned Q3) 2016/17 Committee Effectiveness (planned Q2)	Outcomes from Deloitte and CQC reviews	Implement actions from Governance Improvement Action Plan. To be undertaken via weekly review of the GIAP at the ELT, robust monitoring of progress through identified board committees, monthly monitoring reports to Board, monthly reporting to NHSI and the CQC.	Monthly	Performance Review Meeting with NHSI 2/9/16 noted progress made on GIAP and plans in place to mitigate actions 'off track'.	20834
											Internal audits to be undertaken on key areas identified in the governance improvement action plan, i.e. compliance with policies and procedures	30/11/2016	First audit focusing on specific HR policies in line with GIAP actions completed. Agreed report and associated management actions in place	
											Implement actions identified through CQC comprehensive review, June 2016	31/10/2016	Delivery of actions underway, supported by Trust wide engagement and delivery processes.	
											Agree framework with Deloitte over remaining quarters of the year to undertake a full well led review	31/03/2017	Deloitte Phase 1 review (governance and procedures) completed. Draft discussed at confidential Board 5/10/2016.	
3b	Risk of a fundamental loss of confidence by staff in the leadership of the organisation at all levels	Interim Director of Workforce, Organisational Development and Culture People and Culture Committee (Audit Committee)	EXTREME	5	3	1) Appointment of new joint Director for Workforce, OD and Culture to focus and deliver the immediate requirements of the governance improvement action plan and the HR function and organisational culture going forward 2) Further development of the leadership development programme 3) Engagement Group 4) Increased focus on vacancy management 5) Implementation of the People Plan 6) Trust values outlining expected behaviours of all staff	Robust approach to delivery of the People Plan and GIAP action plan Strong partnership working with staff side Limited informal engagement by Board with staff Review and implementation of HR policies	Staff Values Poll Listen, learn, lead initiative by Executive Team Staff survey action plan, reviewed an supported by Board	HEE annual quality visit 2016/17 Governance and improvement action plan	Gaps in CQC/NHSI governance standards (as identified in GIAP action plan) Safer staffing data identified in 2015/16 HR Processes: Recruitment. Staff survey 2016/17 Compliance with HR policies and procedures (planned Q1)	Implement actions from Governance Improvement Action Plan To be undertaken via weekly review of the GIAP at the ELT, robust monitoring of progress through identified board committees, monthly monitoring reports to Board, monthly reporting to NHS Improvement and the CQC.	Monthly	Performance Review Meeting with NHSI 2/9/16 noted progress made on GIAP and plans in place to mitigate actions 'off track'.	20835
											Facilitated session with ACAS arranged to support staff side partnership agreement.	31/10/2016	Arranged for 12/10/2016	
											Seek resource and support from Derbyshire human resources system to support delivery of People Plan	Completed	Resources secured through external recruitment and now includes support from DCHS	
											Implement actions from internal audit report (2015/16 HR Processes: Recruitment) in relation to safer staffing reports.	Completed	Reported to P&CC	
											Establish a robust action plan to support staff survey outcomes	30/11/2016	Action plan completed. New engagement group in place to monitor progress against the action plan. Mindful, health and Well Being group re-established to support work to reduce work related stress.	
											Revise Workforce Plan and supporting Training Plan	31/12/2016		
3c	There is a risk that turnover of the Board members could adversely affect delivery of the organisational strategy due to loss of specialist organisational knowledge, capacity and stability.	Director of Corporate Affairs and Trust Secretary Remuneration and Appointments Committee	HIGH	4	3	1) Interim arrangements in place for Chief Operating Officer 2) Remuneration Committee agreement to determine future appointments following agreement of Strategic Options Case (SOC) 3) Two new Non Executive Directors appointed Sept 2016 4) Development of the SOC 5) Joint appointment with DCHS re Director of Workforce and OD appointment	Capacity of current executive and non executive to maintain 'business as usual'				Council of Governors considering process for replacement Chair	31/10/2016	To be discussed at extra ordinary Council of Governors meeting 12/10/2016	20970
											Appointment of two further Non Executive Directors underway	30/11/2016		
											Permanent recruitment to Chief Operating Officer	31/01/2017		
											SOC (Strategic Options Case) to be formally presented to Board	31/10/2016	Scheduled for 27/10/2016 at extra ordinary Board meeting.	

	Principal Risk	Director Lead and named responsible Committee	Risk Rating	Impact (1-5)	Likelihood (1-5)	Key Controls	Gaps in control	Assurances on Controls (Internal)	Positive Assurances	Gaps in Assurance	Action plan: To increase effective controls. To gain assurance.	Action: due/review date	Progress on action	Risk Register ID
Strategic Outcome 4. We will transform services to achieve long-term financial sustainability														
4a	Failure to deliver short term and long term financial plans could adversely affect the financial viability and sustainability of the organisation	Executive Director of Finance Finance and Performance Committee (Audit Committee)	20 EXTREME	5	4	1) Monthly Financial Performance Reporting to Public Trust Board meetings providing assurance on financial performance, including integrated performance reporting to enhance triangulation when assessing finance, quality, workforce and operational performance 2) Reporting to Finance and Performance Committee to gain assurance on all aspects of financial (and other resources) management on behalf of the Board, including oversight of CIP delivery and contractual performance 3) Project Assurance processes and systems for in-year monitoring of CIP delivery and escalation procedures 4) System of delegated budgetary responsibility - in line with standing financial instructions and scheme of delegation 5) F&P and PCOG meeting monitoring of contractual performance that impacts on contractual payments including activity levels, CQUIN and contract levers/penalties. 6) Service Line Reporting and other financial reporting systems and action planning at Finance & Performance, Performance and Contracts Overview Group (PCOG), Integrated Services Delivery Group (ISDG), Divisional meetings, IAPT Board and other groups	Future payment systems beyond 1617 not yet defined by Regulators or agreed with commissioners Control Totals for required surplus imposed by Regulator do require stretch levels of CIP delivery Additional regulatory reporting and controls having negative impact on capacity and flexibility in financial planning	Monthly financial reporting systems on current and forecast performance include "challenge and review" each month before reporting Pre-submission scrutiny of annual operational financial plan prepared and submitted to NHSI Delivers FSRR of at least 3 each quarter Pre-submission scrutiny of health system Sustainability and Transformation Plan (STP) (5 year plan) Budget-setting operational requirements are signed-off by those responsible for their delivery (and the Trust Board) In-year financial forecasts are co-owned by finance and the individuals responsible for their delivery Existence of contingency reserve and the contingency reserve access request process Large proportion of income guaranteed through block contract for 1617 .	External Audit: the Audit Findings for DHCFT (year ended 31 March 2016) . Issued with Unqualified Opinion Confirmed NB - VFM assessment and governance (see gap in assurance) External Audit: Bespoke Key Financial Indicators 2015 report show that aside from the gap in assurance for liquidity (as the only red indicator) - the other indicators are amber or green (benchmarked against MH FT peers) . Strongest indicator is EBITDA. Generally improving position on metrics or benchmarked position NHSI: In year compliance reporting: FSRR rating has always been 3 or 4 NHSI: "Green" rating for Trust's current 5 year strategic financial plan (only 30% of Trusts rated as green). Assessment of new health system STP - currently A2 Internal Audit: 2015/16 Cash forecasting and controls (low risk) Internal Audit 2015/16 Contract Assurance Shared Business Services (SBS) (medium risk) Internal Audit 2015/16 Off payroll arrangements (medium risk)	Re: External Audit benchmarking for Financial KPIs and resilience: Main area to improve is liquidity ET/Governance reviews/investigations and subsequent regulatory impact created negative external assurance (e.g. need to develop integrated reporting and update F&P TOR and had negative impact on External Audit VFM Assessment for 1516 annual accounts and report) Residual gaps in assurance related to exceeding agency controls on: % cost ceilings, pay rate caps, use of approved frameworks and high cost off payroll compliance (and gaps identified in Internal Audit Report on off payroll medium risk) ELT 16th May 2016 determined that the remaining CIP gap of c £2m as at that date was significant enough to increase the probability that a significant level of non-delivery of CIP will impact on the ability to achieve the financial plan for 16/17	To minimise control gap around future payment systems: Attendance at events, keeping up to date with current thinking from Regulator, discusssions with commissioners (joint exec ownership between DoF and Director of Strategic Development)	Oct-16	Actions are ongoing and contractual progress is reported to F&P	20833
											To minimise gap in control re control total required by NHSI - continue financial planning and financial control and ensure CIP delivery. Due the worsened level of assurance over CIP delivery as at mid May there have been additional CIP emergency meetings and action planning meetings. Progress is reported to ELT every meeting, and to F&P May and Board. 6. Extraordinary F&P meeting took place in June 2016 to focus on CIP.	Oct-16	April 16 submit final 1617 plan -updated for contract outcomes. also Q1 evidenced performance against 1617 plan and trajectory to deliver control total . Month 4 performance to date is ahead of plan but future run rate worsens. Assured delivery of control total requires the CIP gap to be reduced	
											To minimise control gap for regulatory capacity and inflexibility in planning - ensure long term financial plans are deliverable and effectively monitored, continue to improve liquidity.	October 17 submission	Long term STP submission being developed	
											To improve assurance gap on External Audit benchmarking indicators: continue to improve liquidity and build cash reserves (e.g. through retention of disposal proceeds), maintain tight financial control	31/03/2017	Progress continues - see latest board financial reporting for current metrics	
											To improve assurance gap related to financial components of governance gaps: achieve delivery of the relevant governance improvement actions and compliance with findings recommendations from Deloitte et al	Completed	Papers provided to F&P and Board during the year are being amended as required. E.g. Enhanced financial dashboard reporting actioned from Feb 16 board onwards. Also from March board 16 onwards Trust Board receive a new integrated performance report. PCOG and F&P reports from Feb/March 16 included additional content on forward financial risks and trends.	
											To improve assurance related to agency usage: Internally monitor and manage reduction in use of agency staffing and monitor the delivery of improvement trajectories and also report progress on trends to relevant committees and Trust Board. (Action owner = Ops director) Also achieve further evidence of assurance on rostering and longer term workforce planning to reduce reliance on agency (reported through People committee) (Action owner= Workforce Director)	Oct-16	Increased scrutiny and oversight continues - however agency usage is still in excess of NHSI ceiling. Additional operational processes and procedures have been put in place, and are being further enhanced, to comply with reporting requirements to NHSI and to internally monitor and manage reduction in use of relevant temporary staffing . Progress is reported as part of regular performance reporting to Trust Board, F&P Committee and People and Culture Committee. Internal audit on agency processes being undertaken.	
4b	Failure to deliver the agreed transformational change, at the required pace could result in reduced outcomes for service users, failure to deliver financial requirements and negative reputational risk	Acting Director of Strategy Finance and Performance Committee (Audit Committee)	15 HIGH	5	3	1) New 5 year Strategy 2016 - 2021 outlining strategic direction for Trust 2) Tight plans for implementing transformational change , with clear objectives and metrics for internal and external reporting. 3) Programme of engagement events with staff and stakeholders to consult with and agree the programme for implementing transformational change 4) Commissioner involvement and support of transformational process	Plans have not as yet identified full CIP for year and pipeline going forward. Embedded coaching culture to deliver empowered leadership and accountability Capacity to deliver transformational plan, exacerbated by regulatory actions, alongside other project demands. Sufficient engagement with staff side	Board reporting on strategy implementation with associated board discussion and challenge	2015/16 Transformation 2016/17 Data security and handling (planned Q2). Awaited.	Gaps in assurance on CIP schemes	Develop transformational project plans submitted for current and future years with assurance on cost out in line with Trust strategy and national policy. £600,000 gap in delivery of Trust total control. Current plans being progressed	31/10/2016	£600,000 gap in delivery of Trust total control. Current plans being progressed, Gateway 1 took place on12th and 20th July 2016, Gateway 2 on 16th and 23rd Sept 2016.	20831
											Develop a performance framework to support empowered leadership and accountability to ensure decision making is undertaken at the right level.	31/08/2016	Accountability framework being developed as part of GIAP action. First meeting of senior management team planned for 27/06/2016.	
											Regular engagement with staff side through meetings with Associate Director	31/10/2016		
											Review capacity to deliver transformational agenda	31/10/2016	As part of 'Gateway 2' all teams were asked to identify resource capacity and potential risks to delivery	
											Progress implementation plans via agreed business planning process	30/11/2016	3/10/2016 confirm and challenge planned with general managers and members of senior leadership teams	

Abbreviations

ACAS	Advisory, Conciliation and Arbitration Services
CEO	Chief Executive Officer
CIP	Cost Improvement Programme
COSRR	Continuity of Services Risk Rating
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation payment
CRG	Clinical Reference Group (accountable to QLT's)
DEWS	Derbyshire Early Warning System - tool to identify sharp physical health decline
DCHS	Derbyshire Community Healthcare Services
DNAR	Do Not Attempt Resuscitation order
DoF	Director of Finance
EBITDA	Earnings before interest, taxes, depreciation and amortization
ELT	Executive Leadership Team
F&P	Finance and Performance Committee
FRR	Financial Risk Rating
FSRR	Financial Sustainability Risk Rating
GIAP	Governance Improvement Action Plan
HR	Human Resources
IAPT	Improving Access to Psychological Therapies
NICE	National Institute for Health and Care Excellence
NHSI	NHS Improvement (formally Monitor)
PARIS	Electronic Patient Record solution provided by Civica
PCOG	Performance and Contracts Overview Group
PICU	Psychiatric Intensive Care Unit
POMH-UK	Prescribing Observatory for Mental Health
PYE	Part Year Effect
QAG	Quality Assurance Group (led by Commissioners)
QC	Quality Committee
QIA	Quality Impact Assessment
QLT	Quality Leadership Teams (accountable to Quality Committee)
SLA	Service Level Agreement
STP	Sustainability and Transformation Plan
TOMM	Trust Operational Management Meeting
VFM	Value for Money

Cross reference to ID of related operational high/extreme risk

ID	Directorate	Date of next review	Risk Subtype	Title	Risk level (current)	BAF risk
1565	Campus - Radbourne Unit	31/07/2016	Clinical - Points of Ligature	Risk of death through strangulation	High Risk	1a
2669	Campus - Radbourne Unit	31/08/2016	H&S - Violence and Aggression	Violence and Aggression	High Risk	1a 1c
2675	Campus - Radbourne Unit	31/08/2016	H&S - Work Related Stress	Workplace Stress	High Risk	1a 1c
2678	Campus - Radbourne Unit	31/08/2016	H&S - Lone Working	Lone Working	High Risk	1a 1c
3260	Neighbourhood Services	31/07/2016	Commissioning Risk	Lack of ADHD service for adults	High Risk	1a
3262	Community Paediatrics	30/09/2016	Clinical - Staffing levels	Long waiting lists following reduction in staffing levels	Extreme Risk	1a 1c
3301	Pharmacy	30/09/2016	Clinical - Medication/ Pharmaceutical	Medicines Management - Non-Compliance with Medicines Management standards	High Risk	1a
3302	Pharmacy	30/09/2016	Clinical - Staffing levels	Pharmacy on call services	High Risk	1a
3314	Neighbourhood Services - City	31/07/2016	Commissioning Risk	Lack of pathway for patients discharged from prisons	High Risk	1a
3385	Neighbourhood Services - City	30/04/2016	Clinical risk - Other	Waiting Times for Psychological Assessment and Intervention	High Risk	1a 1c
3386	Campus - Radbourne Unit	06/10/2016	Clinical - Staffing levels	Vacancies, reduced leadership, capacity for succession planning	Extreme Risk	1a 1c
3410	Campus - Radbourne Unit	24/10/2016	Clinical - Staffing levels	Vacancy levels above 30%	High Risk	1a 1c
20819	Neighbourhood Services - City	13/06/2016	Operational - Business Continuity	Waiting lists for assessment and interventions	High Risk	1a 1c
20844	Pharmacy	31/10/2016	Clinical - Medication/ Pharmaceutical	Lack of Facilities to Assure Compliance with Medicines Management Standards - Clinical Areas (Trust-Wide)	High Risk	1a
20857	Neighbourhood Services - North	31/07/2016	Clinical risk - Other	Transfer of patients through the change in neighbourhood boundaries	High Risk	1a 1c
20867	Learning Disabilities Services	07/09/2016	Clinical - Therapeutic activity	Lengthy waiting times for psychological involvement	High Risk	1a 1c
2797	Campus - Radbourne Unit	3.1/12/2016	H&S - Violence and Aggression	Violence and Aggression_Ward 34. Increased due to number of vacancies	High Risk	1a 1c
2801	Campus - Radbourne Unit	18/12/2016	H&S - Fire Safety	Increase risks of fire related to smoking ban Ward 34	High Risk	1a 1c
2834	Campus - Radbourne Unit	27/10/2016	H&S - Fire Safety	Risk of possible fire increasing due to people smoking_Ward 33	High Risk	1a 1c
3409	Campus - Radbourne Unit	03/10/2016	H&S - Work Related Stress	Increased team stress due to vacancy levels Ward 34	High Risk	1a 1c
20908	Substance Misuse Services	06/10/2016	Clinical risk - Other	Communication of information regarding patients on discharge from Royal Derby Hospital	High Risk	1a 1c
20916	CAMHS	26/0/8/2016	Clinical - Staffing levels	Safe service and Team capacity_CAMHS City	High Risk	1a 1c
20918	Neighbourhood Services - North	30/12/2016	Clinical - Staffing levels (exceeding agency cap)	Uncovered consultant Vacancy	High Risk	1a 1c
20924	Campus - Kingsway Site	22/08/2016	Clinical - Staffing levels (exceeding agency cap)	Lack of Medical Cover	High Risk	1a 1c
20928	Neighbourhood Services - North	31/10/2016	Clinical - Staffing levels	Long waiting times for MAS Diagnosis	High Risk	1a
20966	Campus - Radbourne Unit	06/10/2016	Clinical - Staffing levels (exceeding agency cap)	Lack of consultant cover	High Risk	1a

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 2 November 2016

Measuring the Trust Strategy 2016-21

Purpose of Report

The Trust Strategy 2016-21 was approved by the Board in May 2016. Since that time work has been on-going to commence the implementation of the strategy in-line with the system wide Sustainability and Transformation Plan (STP). The purpose of this report is to present the Board with a method for providing assurance that the strategy is delivering the required outcomes and performance targets.

The Board already receive a monthly integrated performance report therefore it is proposed that this, together with other regular reports, provides the necessary assurances. On an annual basis a dashboard would be presented to provide high level assurance of how the Trust is performing against our strategic objectives.

Executive Summary

As reported at the September Board the strategy implementation process is on-track and aligned to the STP. Whilst there will inevitably be system wide dashboards to monitor progress of the STP it is important that as a Trust DHcFT continues to performance manage against its own strategic objectives.

The attached proposed dashboard at Appendix A has been designed to give an overall picture of how we are progressing as a Trust. Key measures for each area have been agreed amongst the Executive Management Team and their respective teams. A trajectory for each measure has then been established for the five year period.

Many of the measures are either annually collected or are presented within the integrated performance report or other regular reports, therefore it is proposed that these form the basis for assurance with a final report at the end of each financial year. Appendix B maps the strategy measures against the integrated performance report and other sources of assurance.

Strategic considerations

The Trust strategy and subsequent strategy implementation process is fully cognisant of the wider system transformation and the emerging STP.

It should be noted that owing to the STP we are working within a dynamic environment and there is the potential that trajectories could change owing to local or national decisions. An example of this would be the control totals, both at an organisation level or system level.

Board Assurances

The Board Assurance Framework for 2016/17 has been updated to reflect the strategy implementation process and the links to the STP.

Consultation

The dashboard has been discussed by the Executive Management Team and their respective teams.

Governance or Legal Issues

There are no governance or legal issues associated with the actual dashboard.

Equality Delivery System

This report has a neutral impact on REGARDS groups.

Recommendations

The Board of Directors is requested to:

1. Note the suggested performance measures for the Trust strategy and provide feedback
2. Approve the use of the integrated performance report for on-going monitoring of the strategy

Report presented by: **Lynn Wilmott-Shepherd**
Acting Director of Strategic Development

Report prepared by: **Lynn Wilmott-Shepherd**
Acting Director of Strategic Development

Appendix A – Measuring the Strategy

Measure	Baseline	2016/17	2017/18	2018/19	2019/20	2020/21
1. Quality – provide good care to our service receivers and families, developing the use of clinical and patient reported outcome measures, to test and measure how effective our services are. Work to achieve at least a ' good' rating with the Care Quality Commission						
Achievement of at least 'good' in CQC ratings	Requires Improvement	Requires Improvement	good	good	good	good
Reduce restrictive practice in services in line with our Positive and Safe Strategy and develop trauma informed services. The number of reported restraint incidents will reduce year on year (data source = Datix)	1133	1020	918	826	743	669
Contribute to a reduction in the mortality gap for people with a serious mental illness compared to the rest of the population through improving annual physical health check numbers and quality (data source = annual national audit)	62%	68%	74%	80%	86%	92%
Increase in the volume of friends and family test feedback received	956	1004	1054	1107	1162	1220
An increase in patient and carer satisfaction	89.75%	90.75%	91.75%	92.75%	93.75%	94.75%
2. People – our people and organisational development strategy will enable us to create the cultural change that is required for the next five years						
90% of people receive an appraisal	80%	85%	90%	90%	90%	90%
Sickness levels are below 4%	6%	6.00%	5.50%	5.00%	4.50%	4.00%
Leaders to receive leadership training	0%	50%	70%	80%	90%	95%
Staff survey response rate to increase	41%	46%	52%	58%	60%	62%
3. Partnerships – develop partnerships which enhance service delivery and foster a system wide approach in line with the STP						
Partnerships result in improved patient care and experience: closer collaboration	Qualitative feedback will be given to update the Board on a regular basis, with an annual update on progress. Quantative measures will be developed as part of any new partnership agreements					
Partnerships result in improved efficiency: successful integration of back office functions						
Partnerships are in place with NHS, voluntary and other public/private bodies: number of joint bids or joint research projects increases						
4. Transformation – our plans will be both internally and externally focused, aimed at ensuring a sustainable long-term future for the organisation and the health and care economy in which we work.						
Achievement of organisational Control total	£2.530m	£2.530m	£2.764m	£3.022m	£3.022m	£3.022m
Achievement of STP system Control total	TBC	TBC	TBC	TBC	TBC	TBC
Full receipt of DHcFT Sustainability and Transformation Funding	£0.830m	£0.830m	£0.794m	£0.794m	£0.794m	£0.794m
Delivery of Capital programme (as proxy for delivery of estate strategy which will be key for supporting transformation)	£3.450m	£3.450m	£3.450m	£3.450m	£3.450m	£3.450m

Appendix B – Strategic Objectives mapped to sources of assurance

Measure	Assurance provided by:
1. Quality – provide good care to our service receivers and families, developing the use of clinical and patient reported outcome measures, to test and measure how effective our services are. Work to achieve at least a ' good' rating with the Care Quality Commission	
Achievement of at least 'good' in CQC ratings	On-going quality reports and action plan updates
Reduce restrictive practice in services in line with our Positive and Safe Strategy and develop trauma informed services. The number of reported restraint incidents will reduce year on year (data source = Datix)	Integrated performance report
Contribute to a reduction in the mortality gap for people with a serious mental illness compared to the rest of the population through improving annual physical health check numbers and quality (data source = annual national audit)	On-going quality reports and action plan updates
Increase in the volume of friends and family test feedback received	
An increase in patient and carer satisfaction	
2. People – our people and organisational development strategy will enable us to create the cultural change that is required for the next five years	
90% of people receive an appraisal	Integrated performance report
Sickness levels are below 4%	Integrated performance report
Leaders to receive leadership training	On-going HR reports and updates
Staff survey response rate to increase	On-going HR reports and updates
3. Partnerships – develop partnerships which enhance service delivery and foster a system wide approach in line with the STP	
Partnerships result in improved patient care and experience: closer collaboration	Updates on new partnerships, updates on closer collaboration, back office functions etc The external Audit Report on Value for Money also provides assurance on the development of partnerships to deliver strategic objectives
Partnerships result in improved efficiency: successful integration of back office functions	
Partnerships are in place with NHS, voluntary and other public/private bodies: number of joint bids or joint research projects increases	
4. Transformation – our plans will be both internally and externally focused, aimed at ensuring a sustainable long-term future for the organisation and the health and care economy in which we work.	
Achievement of organisational Control total	Integrated performance report
Achievement of STP system Control total	Integrated performance report
Full receipt of DHcFT Sustainability and Transformation Funding	Integrated performance report
Delivery of Capital programme (as proxy for delivery of estate strategy which will be key for supporting transformation)	Integrated performance report

2016-17 Board Annual Forward Plan

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	Apr-16	May-16	Jun-16	Jul-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
		Deadline for papers	**18 Apr**	**16 May**	**20 Jun**	**18 Jul**	**26 Aug**	**26 Sep**	**24 Oct**	**28 Nov**	**3 Jan**	**23 Jan**	**20 Feb**
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
CG	Actions and learnings from patient stories.		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	
AR	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	

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	Whistleblowing Policy - annual nomination of NED role (one year rotation)	Francis Report		X									
SH	Committee Assurance Summaries (following every meeting) - Audit & Risk - Finance & Performance (Confidential) - Mental Health Act - Quality Committee - Safeguarding - People & Culture	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	Policy for Engagement between the Board of Directors and Council of Governors							X					
SH	Fit and Proper Person Declaration	Licence Condition FT4		X									X
MP	Emergency Planning Report								X				
SH	Board Effectiveness Survey										X		
SH	Revision of Engagement with the Board of Directors & Council of Governors Policy							X					
OPERATIONAL PERFORMANCE													
CG, CW, AR, CGi	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
AR	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/JS	Safeguarding Children Annual Report	Children Act Mental Health Standard Contract							X				
CG/JS	Safeguarding Adult Annual Report	CQC Mental Health Standard Contract								X			
CG	Control of Infection Report	Health Act Hygiene Code		X									

2016-17 Board Annual Forward Plan

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	Apr-16	May-16	Jun-16	Jul-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
CG/JS	Integrated Clinical Governance Annual Report including MHA/Governance/Complaints and Compliments/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				
JS	Re-validation of Doctors	Strategic Outcome 3			X								
CG	Progress from Quality Visits				X					X			X
CG	Annual Review of Recovery Outcomes							X					
CG	Annual Looked After Children Report									X			