Derbyshire Healthcare NHS
NHS Foundation Trust

Meeting of the Board of Directors

7 December 2016

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

Better together

Derbyshire Healthcare NHS
NHS Foundation Trust

NOTICE OF BOARD MEETING - WEDNESDAY 7 DECEMBER 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 2 November 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	Chief Executive's Verbal Update	**-**	Ifti Majid
OPERATIONAL PERFORMANCE, QUALITY AND STRATEGY				
8.	2:00	Integrated Performance and Activity Report	**D**	Mark Powell Claire Wright Amanda Rawlings Carolyn Green
9.	2:15	Position Statement on Quality	**E**	Carolyn Green
10.	2:25	Board Committee Assurance Summaries and Escalations: Safeguarding Committee 4 November, Quality Committee10 November, People & Culture Committee 17 November, Mental Health Act Committee 18 November Ratified Minutes: Quality Committee 13 October, People & Culture Committee19 October, Safeguarding Committee 7 October, Mental Health Act Committee 26 August 2016	**F**	Committee Chairs
11.	2:35	Safeguarding Adults Annual Report	**G**	Carolyn Green
12.	2:45	Annual Looked After Children Report	**H**	Carolyn Green
3:00 B R E A K				
13.	3:15	Deep Dive – Eating Disorders Service	**-**	Mark Powell
14.	3:35	Engagement Programme – ***to follow***	**I**	Amanda Rawlings
GOVERNANCE				
15.	3:45	Governance Improvement Action Plan	**J**	Sam Harrison
16.	3:55	Report from Council of Governors meeting held 24 November 2016	**K**	Sam Harrison
CLOSING MATTERS				
17.	4:00	Any Other Business	**-**	Richard Gregory
18.	4:05	2016/17 Board Forward Plan	**L**	Richard Gregory
19.	4:10	- 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 11 January 2017
in Conference Rooms A & B, Centre for Research and Development, Kingsway, Derby DE22 3LZ
Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.
Participation in meetings is at the Chairman's discretion.

Declaration of Interests Register 2016-17

NAME	INTEREST DISCLOSED	TYPE
Margaret Gildea Non-Executive Director	Director, Organisation Change Solutions Limited Non-Executive Director, Derwent Living	(a, b)
Richard Gregory Interim Trust Chair	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 Senior Independent Director	Director – C D Maley Ltd Trustee – Vocaleyes Ltd.	(a) (a, d)
Barry Mellor Non-Executive Director	Non-Executive Director, Rotherham NHS Foundation Trust Trustee, Rotherham Hospital Charity Mrs Mellor is a befriender with Age UK	(a, d)
Amanda Rawlings Director of People and Organisational Effectiveness (DHCfT)	Director of People and Organisational Effectiveness, Derbyshire Community Healthcare Services (DCHS) Co-optee Cross Keys Homes, Peterborough	(a, d)
Dr John Sykes Medical Director	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 Deputy Trust Chair and Non-Executive Director	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 Julia Tabreham is also assisting NICE (National Institute for Health and Care Excellence) to write training programmes for people providing lay advice to its Guideline Development Groups	(a, d)
Maura Teager Non-Executive Director	Non-Executive Director – Ripplez social enterprise and NHS provider of the Family Nurse Partnership	(a)
Richard Wright Non-Executive Director	Director, Sheffield Chamber of Commerce Chair, The Sheffield College Chair Sheffield University Technical College Member of Advisory Board of Sheffield National Centre for Sport and Exercise Medicine	(a)

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

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

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Wednesday, 2 November 2016

MEETING HELD IN PUBLIC	
Commenced: 1pm	Closed: 4:45pm

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PRESENT:	Richard Gregory	Interim Chairman
	Caroline Maley	Senior Independent Director
	Maura Teager	Non-Executive Director
	Margaret Gildea	Non-Executive Director
	Dr Julia Tabreham	Deputy Trust Chair and Non-Executive Director
For items DHCFT 2016/169 to 174	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:	Barry Mellor	Incoming Non-Executive Director
	Richard Wright	Incoming Non-Executive Director
	Lynn Wilmott-Shepherd	Acting Director of Strategic Development
	Anna Shaw	Deputy Director of Communications & Involvement
	Sue Turner	Board Secretary and Minute Taker
	Karen Wheeler	Acting Divisional Lead Occupational Therapist
Item DHCFT 2016/169	Andrew	Service Receiver
Item DHCFT 2016/169	Bev Green	Service Improvement
Item DHCFT 2016/169	David Hurn	Area Service Manager for Substance Misuse
Item DHCFT 2016/169	Clem Nicholls	Lead Nurse, Substance Misuse
Item DHCFT 2016/180	Rais Ahmed	Clinical Director, Neighbourhoods
Item DHCFT 2016/180	Sarah Butt	Assistant Director Clinical Practice and Nursing
Item DHCFT 2016/180	Peter Charlton	General Manager, Information Management
Item DHCFT 2016/180	Anne Munnien	Clinical Lead, FSR Project
Item DHCFT 2016/180	John Staley	FSR Programme Manager
APOLOGIES:	Jim Dixon	Non-Executive Director
VISITORS:	John Morrissey	Lead Governor
	Gillian Gough	Public Governor, Erewash North
	Ruth Greaves	Public Governor, Derbyshire Dales
	Sarah Waite	Account Development Manager, Vodafone Limited

DHCFT 2016/168	**INTERIM CHAIRMAN'S WELCOME, OPENING REMARKS AND APOLOGIES** Interim Chairman, Richard Gregory, opened the meeting and welcomed everyone. Apologies were noted as above.

	Richard Gregory was pleased to welcome and introduce the two incoming Non-Executive Directors, Barry Mellor and Richard Wright. Lynn Wilmott-Shepherd was introduced in her role as Acting Director of Strategic Development. Karen Wheeler, Acting Divisional Lead Occupational Therapist who was shadowing Carolyn Green, Director of Nursing and Patient Experience was welcomed to the meeting.
DHCFT 2016/169	**SERVICE RECEIVER STORY** Bev Green, introduced Service Line Manager for Substance Misuse, David Hurn and Lead Nurse, Clem Nichols, who accompanied service receiver Andrew who kindly agreed to speak to the Board about his recovery from heroin addiction through the charity, and one of the Trust's partners, Phoenix Futures which helps people overcome drug and alcohol problems. Andrew tried many times to stop taking heroin and was only successful when he went into rehabilitation with Phoenix Futures in Sheffield after leaving prison. Andrew explained that since leaving rehab Andrew has remained involved with Phoenix Futures supporting other service users in their recovery. His work involves encouraging service users to become more involved in the services Phoenix Futures offers particularly through recreational activities, and sport, mainly boxersize as this was the activity that especially helped him in his recovery. Andrew is now a Phoenix Futures service user representative and encourages people to take part in physical exercise to keep them motivated and to feel good about themselves as he believes that improving your physical fitness improves your physical wellbeing. The Board was interested to know if there was anything the Trust could do to help people like Andrew who have been in very challenging situations. Andrew replied that each individual has to be ready to face the process for overcoming their drug and alcohol problems. He felt connected to Phoenix Futures whilst he was in rehab and while he was there he was prescribed medication for people addicted to heroin. His criticism was that prescriptions were given out too easily and people are not supervised when they visit the pharmacist which may result in service users selling their prescribed medication. Andrew was asked if he was treated with respect while he was in the Trust's care especially as there is a lot of stigma associated with mental health issues allied to recovery from substance misuse addiction. Andrew replied that he received respect once he had decided he wanted to recover from his heroin addiction. Andrew also explained that whilst he was taking part in his recovery he became involved in an education programme called Intuitive Thinking Skills which helps people to progress with life skills while promoting abstinence. This scheme also provides people with the tools and knowledge to write CVs, attend interviews and gives people the confidence to demonstrate they are ready and have the right attitude for work. He hoped to progress with this and work with Phoenix Futures to develop intuitive thinking skills with children and young people. When asked by Ifti Majid if the national drug strategy differentiated between maintenance, reduction and abstinence and whether this made it difficult for people using our services, David Hurn responded that people need to feel stabilised when they are in recovery. He thought that people need to understand that all the different aspects of recovery are inextricably linked. It is important to help people's ability to be challenged so they can use their intuitive thinking skills and the Trust's staff are trained in these skills. He agreed with Andrew that the physical activities that Phoenix Futures offer in gym facilities are good ideas that can be offered to service users. Phoenix Futures also have very good care workers and have people like Andrew working with them who have gone through the same experience. Clem Nichols, lead nurse in substance misuse explained that he and his colleagues give

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	people the intuitive thinking skills to deal with their recovery. Being in partnership with Pheonix Futures also means resources are there in the community such as boxercise facilities. Carolyn Green informed the Board that Andrew had recently applied for a job in our organisation but had been unsuccessful because he has a criminal record. She believes policies need to reflect more flexibility to address these challenges and allow people who have had substance misuse problems and have a criminal record to work with us as they have real life experience and are in the best position to help us. Richard Gregory thanked Andrew for talking to the Board and sharing his insights into recovery and support issues and hoped he would continue to be well and find fulfilling opportunities in the future. **RESOLVED: The Board of Directors expressed thanks to Andrew for sharing his experiences and appreciated the opportunity to hear his feedback first hand.**
DHCFT 2016/170	**DECLARATIONS OF INTEREST** An additional declaration of interest was recorded in respect of Julia Tabreham who is assisting NICE (National Institute for Health and Care Excellence) to write training programmes for people providing lay advice to its Guideline Development Groups.
DHCFT 2016/171	**MINUTES OF THE MEETING DATED 5 OCTOBER 2016** The minutes of the meeting held on 5 October were accepted and agreed as an accurate record of the meeting subject to paragraph 3 of item DHCFT 2016/154 being amended to read that although there was no longer a requirement for the Trust to carry out emergency planning measures regarding staffing levels, challenges remain at the Hartington Unit and Radbourne Unit.
DHCFT 2016/172	**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 2016/173	**INTERIM CHAIRMAN'S VERBAL REPORT** Richard Gregory referred to the Care Quality Commission (CQC) inspection that took place in June and the subsequent warning notices and explained that an update on the organisation's compliance ratings was shown in the Quality Position Statement under agenda item 9. Recruitment to reduce vacancy rates and the breach in agency spend has been an issue for some time now. The Trust is entering into a new era of inspection by NHS Improvement (NHSI) and there are significant process issues that need to be corrected regarding the Trust's procurement of agency and locum staff and this will be monitored by the Finance and Performance Committee and Audit and Risk Committee. The proposed merger of the Trust with Derbyshire Community Health Services (DCHS) is referred to in the Chief Executive's Report. Richard Gregory wished it to be recorded that these are very sensitive and emotionally charged times for the Trust. The Board is doing everything possible to ensure any anxieties are alleviated as much as possible for service receivers and staff and the Board will engage and communicate effectively with staff and will work closely with governors to work through the transaction. **RESOLVED: The Board of Directors noted the Interim Chairman's report.**
DHCFT 2016/174	**ACTING CHIEF EXECUTIVE'S REPORT**

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	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 highlighted key points from his report: 1. The CQC's State of Health and Adult Social Care in England 2015/16 was released during October. The report gave a detailed view of the trends, influences and pressures in care across England. Some of the key messages included that 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 'requires improvement' trusts who do rapidly improve. These points were highlighted by Ifti Majid as they have some resonance for the Trust. 2. The Derbyshire STP (Sustainability Transformation Plan) footprint was submitted on 21 October. This is not the final plan and we are now awaiting clarification from NHS England as to when the Trust can commence local engagement and communications with stakeholders and the public. It is hoped that a document will be presented to the next public Board meeting that clarifies the direction of travel identified within the STP submissions. 3. The Strategic Options Case was presented to the confidential meeting of the Board of Directors on 27 October and the recommendations were discussed immediately afterwards with the Council of Governors. The Board's decision has been to continue to the next stage. Ifti Majid emphasised that he felt that this was the right decision to make on behalf of the Trust's service users, staff and stakeholders and governors will be kept informed regularly to enable them to consider the recommendation from the Board. Julia Tabreham referred to the CQC report and sought additional information on the social care and clinical care pathways in Derbyshire. Ifti Majid assured her that some initiatives of the STP would involve placing healthcare support into social care homes and looking at other models that can be developed to have a similar output and be less susceptible to market changes. Ifti Majid attached the NHS Providers' BREXIT briefing for October as an appendix to his report and this was noted by the Board. At this point Ifti Majid left the meeting. **RESOLVED: The Board of Directors noted the contents of the Acting Chief Executive's report.**
DHCFT 2016/175	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT** The Board received the integrated overview of performance as at the end of September 2016 with regard to workforce, finance, operational delivery and quality performance and additional verbal updates were provided by Board Directors. Mark Powell, Acting Chief Operating Officer, gave Board members an overview of the process he has initiated to review performance of key areas to ensure that adequate mitigation plans are in place to enable the Trust to deliver against the expectations it has set itself, and to fully understand the reasons why performance, may at times, fall below set thresholds. This work will inform how assurance is provided to Board members

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	through the Integrated Performance report over the course of the coming months. The Board noted the joint effort of all staff teams and the work that is taking place to complete actions from the CQC inspection which has enabled an integrated approach to managing competing priorities across all service lines to focus on environmental, clinical, policy and organisational governance priorities. Amanda Rawlings, Director of People & Organisational Effectiveness, gave an update on staff vacancies. She was pleased to report that two posts have been approved for the Human Resources team which would improve efficiencies in the recruitment process. Work was also taking place to improve staff sickness rates. She also informed the Board that a piece of work has now commenced to improve the rate of non-medical staff appraisals. Staff will soon be targeted through a tracker system and will be urged to complete their appraisals with their line managers. It is hoped that this work will ensure an upward trend will be seen in the near future. Staff sickness rates were challenged by the Board. It was understood that one of the reasons for staff sickness is stress and anxiety and this correlates with staff shortages and the Board hoped that the work on recruitment will have a positive effect on staff sickness rates. Amanda Rawlings advised she is working on ways of improving staff sickness levels. Clear guidelines will be set up to enable line managers to manage sickness absence more efficiently. Director of Finance, Claire Wright reported that the half year financial position is ahead of plan. She pointed out that now the Strategic Options Case had been approved the transactional costs and the timing of the transaction will need to be assessed further and the Trust was anticipating costs to be in the region of £650k and this would be shared with DCHS. Claire Wright reminded the Board that NHSI's new regime for agency expenditure will be discussed further at the Board Development Session on 16 November and she hoped this would result in the Trust meeting its control total. She planned to discuss this in more detail at the Finance and Performance Committee at the end of November. Carolyn Green, Director of Nursing and Patient Experience, drew attention to the extended quality dashboard that was included in the report. The Board noted that this arose as request from the Quality Committee and thanks were given to Carolyn Green and Rachel Kempster for their work in producing this data. Carolyn Green was pleased to report a reduction in the duration of resolving outstanding actions from complaints at a local level. The Patient Experience Team are on track with their work but extra resource is sometimes required for complex cases. The Board recognised the challenges staff are facing when they are working on these investigations and understood that anything that is seen as a risk to patient safety is always prioritised. **RESOLVED: The Board of Directors scrutinised the content of the report and obtained assurance on the current performance across the areas presented.**
DHCFT 2016/176	**POSITION STATEMENT ON QUALITY** 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. Carolyn Green was pleased to report that 86 out of 156 actions resulting from the action plan developed from CQC visit have now been completed. She felt the amount of work that has been carried out since the inspection has been a significant achievement. A substantial increase in fire warden training, and safeguarding training has been seen and the Quality Committee will continue to receive reports on compliance.

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	The Trust continues to brief clinical staff on the learning and expectations of clinical practice with regard to the Mental Capacity Act. Carolyn Green was pleased to report that there has been a significant improvement in compliance levels and it is hoped to reach 88% compliance level in the near future. The Board appreciated that the key to this result has been through engagement with staff to confirm the essential actions required by staff. This has been led by the Medical Director and is being reported to the Mental Health Act Committee. The Board was pleased to note the good progress of compliance and quality of service as well as an improvement in the professional code of practice. Mark Powell wished to point out to the Board the operational issues within the Kedleston Unit regarding fire evacuation. Carolyn Green assured the Board that she was working with the Fire Service to ensure the Trust's fire procedures are in line with CQC requirements. Carolyn Green reminded the Board that the CQC Quality Summit was due to take place next week and she would provide a briefing pack before the meeting so that Board members can be prepared in advance of this event. **RESOLVED: The Board of Directors:** **1) Received the Quality Position Statement** **2) Received assurance on its content**
DHCFT 2016/177	**BOARD COMMITTEE ESCALATIONS** Assurance summaries were received from the meetings of the Quality Committee held on 13 October, Audit and Risk Committee held on 11 October and Safeguarding Committee held on 4 November which identified key risks, assurance and decisions made. The following points were noted: **Quality Committee:** • The Equality Impact Assessment Policy is out of date and requires review and immediate attention and will be further progressed by the Quality Committee. • The Committee noted the death rate contained in the Serious Incident Report. Additional scrutiny will now take place due to limited confidence in NRLS (National Reporting and Learning System) data, plus the Trust now includes substance misuse deaths in the report. **Audit & Risk Committee:** • Control over agency spend matters raised by the Committee were addressed by the Board in the confidential session • Review of all GIAP actions to date to ensure they satisfy the original recommendations will form part of the wider GIAP report to the Board covered later in the agenda **Safeguarding Committee:** • Chief Executive support is required to prioritise PREVENT and CHANEL Gold Group for Complex Case Enquiries Ratified minutes of the meeting of the Audit and Risk Committee held on 19 July, Quality Committee on 8 September, People and Culture Committee on 20 September and

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	Safeguarding Committee held on 15 April were included for information. **RESOLVED: The Board of Directors received the Board Committee escalations.**
DHCFT 2016/178	**<u>SAFEGUARDING CHILDREN ANNUAL REPORT</u>** This annual report summarised the year 2016 to 2017 and included the Safeguarding Children's Board Strategic plans. The Board obtained assurance with the strong performance of the Safeguarding Children's service especially in areas associated with child exploitation and approved the report and its recommendations. **RESOLVED: The Board of Directors:** **1) Noted the Safeguarding Children Annual Report and received assurance on the Trust's annual activity and agreed that the Trust's Safeguarding Committee would lead and set the future direction for Safeguarding Children in the Trust.** **2) Approved this Annual report and its recommendations.**
DHCFT 2016/179	**<u>EMERGENCY PREPAREDNESS, RESILIENCE, RESPONSE (EPPR) ANNUAL REPORT</u>** The Board received Mark Powell's report on the Trust's emergency preparedness structure to meet the requirements of the Civil Contingencies Act 2004 (CCA 2004) and NHS Commissioning Board, Emergency Preparedness Framework 2015. The report outlined a single framework for dealing with major incidents and business continuity issues and evaluated the Trust's level of compliance as 'Partial compliance'. However, since writing the report Mark Powell had received a letter from commissioners indicating that the Trust's evaluation had been incorporated within last year's rating and not this year's and this now indicates that the Trust is 'not compliant'. The Board was disappointed to hear that despite the work carried out this was not enough for the Trust to reach the required level of compliance. Mark Powell informed the Board that as there is not enough resource to deliver our obligations he was working with DCHS to assess a business impact analysis, put in place robust continuity plans, as well as a training programme for major incidents to improve the Trust's position. The Board noted the organisation's lack of appropriate expertise to ensure there is a formal EPPR process in place and agreed that this issue would be included in the BAF (Board Assurance Framework). In response, Mark Powell undertook to establish new criteria for EPPR and will ensure that a monthly update on the EPPR action plan is received by the Quality Committee. The Board also noted Mark Powell's intentions to provide the Board with assurance that a plan is in place to ensure the Trust delivers its obligations and improves its level of compliance. **ACTION: Monthly updates on the EPPR action plan to be received by the Quality Committee.** **ACTION: Lack of expertise to deliver EPPR requirements to be included in the BAF** **RESOLVED: The Board of Directors** **1) Reviewed the update provided in this annual report** **2) Received the Trust's self-assessment and subsequent outcome of 'non-compliance'** **3) Agreed that the Quality Committee would receive monthly progress reports on EPPR compliance and the EPPR action plan**

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DHCFT 2016/180	**DEEP DIVE – FULL SERVICE RECORD** The Board received the Deep Dive report and presentation which gave an overview of the Full Single Patient Record Project (FSR). The report also showed examples of functionality that the system provides and examples of compliance reports based on information recorded in the system. The report also set out the role of the Clinical Reference Group in shaping future developments and highlighted the advantages identified by clinical representatives. Board members noted the difficulties staff were experiencing in using the FSR system that were impacting progress in the inpatient areas. These challenges included difficulties in allocating time to release staff for PARIS training, as well as Bank staff not having undertaken training. It was also clear that some staff do not feel comfortable working with technology. Other issues were not having sufficient laptop devices to access the system and not having a Project Support Officer in post to support the project. Caroline Maley accepted that full compliance with FSR was a difficult challenge as she had observed during quality visits that some teams were still using paper records. She also noticed there was a lack of access to laptops and teams were finding it difficult to adapt to using technology and was urged to inform people during quality visits that if they feel they did not have access to the technology they must ask for the equipment they needed. The Board recognised the importance of implementing electronic recording and moving towards an electronic process and the work that has taken place to engage staff in this procedure. It was also understood that the FSR team had looked at different solutions that would work with clinicians off-line but this had not been progressed further as the team considered that should the collaboration with DCHS progress there may be a need to work to a different system, System One. The Board considered this to be a very insightful Deep Dive and acknowledged that the Trust will continue to focus on implementing the PARIS system to ensure the benefits of the FSR system are delivered. **RESOLVED: The Board of Directors received the Deep Dive report of the Full Single Patient Record Project and recognised the work which has been completed towards delivery of a Full Service Record.**
DHCFT 2016/181	**GOVERNANCE IMPROVEMENT ACTION PLAN** The Board received the Governance Improvement Action Plan (GIAP) report which gave an update on the progress of delivering the GIAP. The report also provided an overview of performance against all 53 recommendations, set against each respective core area. Mark Powell drew attention to the GIAP Blue Completion Form which related to GIAP task Core 9 – Fit and Proper Persons - which had already been approved by the Remuneration & Appointments Committee. The form enabled the Board to obtain assurance that implementation of the fit and proper person test policy will be part of ongoing work within the Trust and allowed the Board to confirm it was satisfied that this task was complete. It was noted that the accountability framework had been received during the Board's confidential meeting and it was agreed that Core 7 and Core 9 could progress to the status of being on track. The Board reviewed the areas rated as 'off track' and with 'some issues' contained in the report. These comments were noted as follows and would be captured in the GIAP:

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	1. Core 6 (Roles and Responsibilities of Board members) was discussed by the Remuneration & Appointments Committee. The Board agreed this action will remain off track as there is further work to be done with regard to the finalisation of succession planning. 2. Core 7 WOD3 (HR and OD): It was considered that sufficient work has taken place within the HR function to assure the Board that this action is now on track. 3. Core 7 WOD6 (HR and OD): It was agreed that due to monthly pulse checks taking place this action is now on track. 4. Core 10 (CQC2): The Board agreed that although work to fill vacancies has been extremely proactive this action will be monitored further by the People & Culture Committee and the action will remain off track. 5. Core 2 (People & Culture): It was considered that the exercise to revise the Trust values would be refreshed as a result of work taking place with DCHS. This action remains rated as still having issues to resolve. 6. Core 3 (Clinical Governance): This action remains rated as still having issues to resolve and will be brought back to the Remuneration & Appointments Committee. 7. Core 7 (HR and OD): It was agreed that the adherence to the grievance, disciplinary, whistleblowing policies and current backlog of cases would be further reviewed by the People & Culture Committee. In addition to this the Audit & Risk Committee will commission a further update of this action in 6 months' time once new policies and training have had the chance to be embedded within the organisation. Assurance can then be given to the Board regarding effectiveness of this action. It was agreed that this action was now rated as on track. **RESOLVED: The Board of Directors** **1) Noted the progress made against GIAP** **2) Discussed the areas rated as 'off track' and 'some issues', seeking assurance where necessary on the mitigation provided** **3) Approved the blue completion form for Core 9 – Fit and Proper Persons** **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 2016/182	**Board Assurance Framework** This report details the third issue of the BAF for 2016/17 and was presented to the Audit & Risk Committee on 11 October. Sam Harrison drew the Board's attention to the three additional risks that have been added to the BAF this quarter which were noted as follows: 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 Board members could adversely affect delivery of the organisational strategy due to loss of specialist organisational knowledge,

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	capacity and stability. (Currently assessed as moderate risk.) The Board considered the updated BAF and reflected on the challenges the organisation is focussing on and agreed that emergency planning will be added to the BAF. In addition to this, Claire Wright felt that back office collaboration and business continuity should be included as an additional risk to reflect how support functions will be affected by the collaboration with DCHS. **ACTION: BAF to be updated to capture emergency planning (EPPR) and back office collaboration/business continuity** **RESOLVED: The Board of Directors approved this third issue of the BAF for 2016/17**
DHCFT 2016/183	**MEASURING THE TRUST STRATEGY** The Trust Strategy 2016-21 was approved by the Board in May 2016. Since that time work has been ongoing to commence the implementation of the strategy in line with the system-wide Sustainability and Transformation Plan (STP). Lynn Willmott-Shepherd's report presented the Board with a method for providing assurance that the strategy is delivering the required outcomes and performance targets. Lynn Willmott-Shepherd explained that the Board already receives a monthly integrated performance report which enables regular monitoring of the strategy. She proposed that on an annual basis a dashboard would be presented to provide high level assurance of how the Trust is performing against its strategic objectives. The Board noted that the dashboard in Appendix A gave an overall picture of how the Trust is progressing and that the dashboard will be adjusted to capture changed trajectories for each measure for the five year period. The Board also noted that the Strategic Objectives set out in Appendix B will provide assurance on a monthly basis that the strategy is being delivered. The Board discussed the need to demonstrate that the progress of the strategy is being satisfactorily measured and agreed that this approach and a success criteria would be discussed further by the Executive Leadership Team (ELT). **ACTION: The agreed approach for measuring the progress of the strategy and success criteria will be reviewed by ELT.** **RESOLVED: The Board of Directors** **1) Noted the suggested performance measures for the Trust strategy and provided feedback** **2) Approved the use of the integrated performance report for on-going monitoring of the strategy**
DHCFT 2016/184	**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 2016/185	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK OR GIAP** The following risks will be added to the BAF: • Lack of appropriate expertise to ensure the Trust's emergency preparedness

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	structure meets EPPR requirements i.e. the requirements of the Civil Contingencies Act 2004 (CCA 2004) and NHS Commissioning Board, Emergency Preparedness Framework 2015 • Business continuity will be included as an additional risk to reflect how support functions will be affected by the collaboration with DCHS All matters relating the GIAP were recorded in item DHCFT 2016/181 above.
DHCFT 2016/186	**<u>BOARD PERFORMANCE AND CONTENT OF MEETING</u>** The meeting was well chaired but ran over time as there were so many items to discuss. Richard Gregory introduced Sarah Waite to the Board who had observed the meeting as the Trust's account manager from Vodafone. She explained that Vodafone was working closely with the Trust and DCHS to establish a solution for improved productivity and invited members of the Board to attend the Vodafone customer event entitled Transitioning to the Modern Workplace.

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

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

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				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - DECEMBER 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 January 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	A wider piece of engagement work is being undertaken and is covered in the Engagement Programme paper under December agenda item	Green
27.7.2016	DHCFT 2016/113	Integrated Performance And Activity Report	~~Carolyn Gilby~~ Amanda Rawlings	~~Carolyn Gilby~~ Amanda Rawlings to check whether the Trust is an outlier with regard to grievances/dignity at work/disciplinaries	2.11.2016	Amanda Rawlings has carried out a detailed review and will make comparisons with other organisations and will provide a verbal update on progress at the December meeting.	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	Sam Harrison will obtain agreement and 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	DNA Report will be received at the November meeting of the Finance & Performance Committee. DNA is now highlighted in Integrated Performance and Activity reports.	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	All these subjects are now being worked into the programme of Recovery Stories which commenced in November.	Green
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 work with each Committee to ensure a consistent approach is applied throughout the year.	2.11.2016	Assurance on this month's review undertaken by Board Committees and will be addresed in GIAP report for December.	Green
02-Nov-16	**DHCFT 2016/179**	Emergency Preparedness, Resilience, Response (EPPR)	Mark Powell	Lack of expertise to deliver EPPR requirements to be included in the BAF	11.1.17	EPPR requirements captured in the BAF and will be evidenced in the updated version submitted to the Board in February 2017	Green
02-Nov-16	**DHCFT 2016/179**	Emergency Preparedness, Resilience, Response (EPPR)	Mark Powell Carolyn Green	**ACTION TRANSFERRED TO QUALITY COMMITTEE** Quality Committee would receive monthly progress reports on EPPR compliance and the EPPR action plan	11.1.17	EPPR Compliance progress will be escalated to the Board through the Quality Commmittee's assurance summary report	Green
02-Nov-16	**DHCFT 2016/182**	Board Assurance Framework	Sam Harrison	BAF to be updated to capture emergency planning (EPPR) and back office collaboration/business continuity	7.12.16	Captured in the BAF and will be evidenced in the updated version submitted to the Board in February 2017	Amber
02-Nov-16	**DHCFT 2016/183**	Measuring The Trust Strategy	Lynn Willmott-Shepherd	The agreed approach for measuring the progress of the strategy and success criteria will be reviewed by ELT	7.12.16	Verbal update to be provided at December Board meeting	Amber

Key:

Action Ongoing/Update Required	**AMBER**	3	22%
Resolved	**GREEN**	10	72%
Action Overdue	**RED**	0	0%
Agenda item for future meeting	**YELLOW**	1	7%
		14	100%

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

Integrated Performance Report Month 7

Purpose of Report

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

Executive Summary

The Trust continued to deliver good performance against many of its key indicators across October. 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.

<u>Quality Performance</u>

During the month focus has remained on addressing the issues arising from the Trust's recent Care Quality Commission (CQC) inspection report. Clinical and operational teams, led by the Director of Nursing and Patient Experience have been working on 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:

- Maintaining Fire warden training compliance in Campus teams which has seen a sustained improvement despite a significantly larger target group and is referenced in the quality dashboard
- Safeguarding children's training at Level 3, resulting in increased improvement and now over 70 percent+. 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 has commenced and works are or have commenced on the new extension to build the new seclusion suite with new roof to meet the CQC revised height specifications.
- Ensuring that supervision and appraisals are recorded. This continues to be challenging with the Deputy Director of Operations taking oversight of the mitigation plan. Quality teams and other services have offered supervision and support time to the campus areas to provide more time to support staff.
- Developing reports on the capacity of teams such as Care co-ordination, Psychology, Paediatrician access/ waiting time and Speech and Language waiting list, management. A detailed Paediatrician access/ waiting time was also reviewed at the Quality Committee

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. Significant progress is being made and a substantial quantity of information has been shared with the CQC. These data requests are already being used in assurance reports to reflect upon clinical practice and develop and or redefine improvement plans.

The quality dashboard reports that the number of moderate to catastrophic incidents has increased compared to the previous quarter. Incidents need to be reviewed over a long period to fully understand their impact; however, Board can be assured that these incidents are being carefully monitored by the Heads of Nursing and the quality team.

The number of prone restraints has increased; this is not unusual to have changes in this area when considering a high use of restraint and some key incidents relating to patient profiles.

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

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.

In summary, the Trust's Performance, Contract and Operational Group (PCOG) has received and approved actions plans in a number of key performance areas.

October and November's PCOG received and approved written actions plans for the following;

- 18 Week Referral to Treatment
- Outpatient Clinic Trust Cancellations
- Outpatient Clinic Do Not attend (DNA's)
- PbR Clustering
- Breastfeeding rates
- Emergency Planning, Resilience and Response (EPRR)

It is expected that these actions will continue to be delivered within their respective division(s). All of the action plans have been scheduled to be reviewed again at PCOG (or Trust Management Team as part of its remit to take oversight of Trust performance) over the next few months to ensure that action is leading to either sustained or improved performance where necessary.

In addition, November's Finance and Performance Committee received and

discussed the action plan for Outpatient Clinic Trust Cancellations, Outpatient Clinic Do Not attend (DNA's) and PbR Clustering.

Financial Performance

This month the finance dashboard includes our performance against the Use of Resources (UoR) metrics that took effect 1st October. (Rankings mean a score of 1 is best and 4 is worst).

On *year to date* financial performance, our overall UoR is a 3. Four of the five metrics are relatively strong at 2, 1, 1 and 1, but the fifth metric, agency spend against ceiling, is a 4, and that triggers an override that restricts the overall rating to a 3, at best.

The *forecast* UoR is a 2, driven by improvement in the agency metric to a 3 (that removes the trigger and allows the overall rating to be a 2). However, the tolerance is very slim and only a marginal increase in agency expenditure in quarter 4 will tip us over the threshold where the year-end rating would be restricted to 3, as currently.

Our shadow NHS segment is 3.

In surplus terms, the Trust remains ahead of plan cumulatively for the year to date, with a trajectory to return to plan by year end as costs increase and income reduces. In forecasting the achievement of the control total surplus, the Board are aware that it assumes the mitigation of some significant risks, that have not yet been mitigated; the unmet CIP and cost avoidance requirements, the risk of income clawback by commissioners, the as-yet unquantified potential for backdated pay (related to outstanding job evaluations), ongoing pressures in agency costs and out of area Psychiatric Intensive Care Unit costs.

People Performance

Whilst a number of indicators in the People and Workforce dashboard remain off track, there continues to be progress in a number of areas that are intended to impact on Trust performance in the short and medium term.

In November, the People and Culture Committee received and challenged plans which provided assurance in the following areas:

- Recruitment review and action plan, including the outcome of the recent recruitment fair which resulted in over 10 appointments being offered on the day, with further appointments planned early December
- Draft mindful, health and well-being strategy, with the key principles being agreed pending a more detailed set of actions being proposed to seek to address issues such as sickness absence rates
- Delivery of specific GIAP actions

In addition, Finance and Performance Committee received a report providing assurance on the progress being made to control agency spend, which also

included the actions being taken to provide solutions in some of the more recruitment challenged service areas.

The Executive led weekly agency meeting continues to focus on agency controls and financial forecasting, but with a greater emphasis now being placed on developing plans to address some of the underlying issues. Specific projects have been commissioned by this group to focus on non-medical prescribing and E-rostering, building on the work already undertaken by the Trust, but seeking to approach this in a much more strategic way.

Board members should note that January's Integrated Performance Report will include the indicators contained within the single oversight framework.

Strategic considerations

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

Board Assurances

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

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

Consultation

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

Governance of 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.

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

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

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<u>Highlights</u>

- Surplus better than plan in month and YTD. Forecast to achieve plan at year end
- Cash better than plan

<u>Challenges</u>

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

<u>Highlights</u>

- % 10-14 day and 6-8 Week Breastfeeding coverage has been addressed

<u>Challenges</u>

- 10/15 day outpatient letter target has been breached due to a software upgrade
- Clustering of patients
- 5 patients have not been followed up within 7 days of discharge
- Outpatient Cancellations and DNAs

<u>Highlights</u>

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

<u>Challenges</u>

- Monthly and annual sickness absence rates remain high.
- Budgeted Fte vacancies remain high.
- Appraisal compliance rates remain low.

<u>Highlights</u>

- Incidents of physical restraint has decreased compared with the previous month.
- No of recorded compliments is continuing to increase
- 95% of policies are now in date
- No of incidents to which Duty of Candour applies, remains low
- No of seclusion forms received by MHA office has increased
- % of patients with a recorded capacity assessment has increased
- CQC actions continue to progress, with strong assurance checks on evidence (RED rating)

<u>Challenges</u>

- No of incidents of moderate to catastrophic incidents has increased compared to the previous quarter.
- No of prone restraints has increased
- % of compliance with fire warden training has decreased due to threefold increase in identified cohort
- No of concerns has increased
- No of outstanding actions following serious incidents had increased at end of Oct, but since reduced

FINANCIAL OVERVIEW – OCTOBER 2016

Category	Sub-set	Metric	Period	Actual	Rating	Trend
Governance	Use of Resources (UoR) Metric	Overall Use of Resources Metric	YTD	3	A	→
			Forecast	2	Y	→
		Capital Service Cover	YTD	2	Y	→
			Forecast	2	Y	→
		Liquidity	YTD	1	G	→
			Forecast	1	G	→
		Income and Expenditure Margin	YTD	1	G	→
			Forecast	1	G	→
		Income and Expenditure variance to plan	YTD	1	G	→
			Forecast	1	G	→
		Agency variance to ceiling	YTD	4	R	→
			Forecast	3	A	→
	Single Oversight Framework	NHS I Segment	YTD	3	n/a	n/a

Key Points: This month sees the change from the Risk Assessment Framework Ratings to the new Single Oversight Framework ratings. As at the end of October the Rating is 3 and is forecast to be a 2 at the end of the year.
We have been shadow segmented in segment 3.

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend
I&E and profitability	Income and Expenditure	Control Total position £'000	In-Month	295	330	G	↑
			YTD	1,271	1,976	G	↑
			Forecast	2,531	2,531	G	→
		Underlying Income and Expenditure position £'000	In-Month	225	261	G	↑
			YTD	787	1,492	G	↑
			Forecast	1,701	1,701	G	→
		Normalised Income and Expenditure position £'000	In-Month	225	299	G	↑
			YTD	787	1,355	G	↑
			Forecast	1,701	1,797	G	↓
	Profitability	Profitability - EBITDA £'000	In-Month	898	909	G	↑
			YTD	5,531	6,071	G	↑
			Forecast	9,806	9,700	R	→
		Profitability - EBITDA %	In-Month	7.8%	8.1%	G	↗
			YTD	6.9%	7.8%	G	→
			Forecast	7.1%	7.2%	G	→
Liquidity	Cash	Cash £m	YTD	10.657	13.606	G	↑
			Forecast	13.153	12.711	R	→
	Net Current Assets	Net Current Assets £m	YTD	5.536	7.829	G	↑
			Forecast	7.570	6.504	R	↑
	Capex	Capital expenditure £m	YTD	1.717	1.335	R	↑
			Forecast	3.450	3.450	G	→
Efficiency	CIP	CIP achievement £m	In-Month	0.358	0.184	R	→
			YTD	2.508	1.295	R	↓
			Forecast	4.300	2.929	R	↑
			Recurrent	4.300	1.598	R	↓

Key Points (I&E and profitability): 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.

Key Points (Liquidity): 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.

Key Points (Efficiency): 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.

Key:

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

Plan In-month or Year end Trust plan

(green) Achieving plan
(red) Not achieving plan

↑ ↗ ↓ Trend comparing current month against previous month actual/YTD/Forecast

OPERATIONAL OVERVIEW – OCTOBER 2016

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Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	NHSI	CPA 7 Day Follow-up	Month	95.00%	96.88%	G	↑	Compliant with all NHSI targets.
			Quarter	95.00%	96.88%	G	→	
		CPA Reviews in Last 12 months	Month	95.00%	95.35%	G	→	
			Quarter	95.00%	95.35%	G	→	
		Delayed Transfers of Care	Month	7.50%	2.39%	G	→	
			Quarter	7.50%	2.18%	G	→	
		Data completeness - Identifiers	Month	97.00%	99.40%	G	→	
			Quarter	97.00%	99.40%	G	→	
		Data completeness - Outcomes	Month	50.00%	93.50%	G	→	
			Quarter	50.00%	93.50%	G	→	
		Community Care Data Activity - Completeness	Month	50.00%	94.46%	G	→	
			Quarter	50.00%	94.26%	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%	75.53%	G	→	
			Quarter	50.00%	75.28%	G	↓	
		18 Week RTT incomplete	Month	92.00%	94.43%	G	→	
			Quarter	92.00%	94.54%	G	→	
		Early Interventions New Caseload	Month	95.00%	152.50%	G	↓	
			Quarter	95.00%	152.50%	G	↓	
		Clostridium Difficile Incidents	Month	7	0	G	→	
			Quarter	7	0	G	→	
		Crisis Gatekeeping	Month	95.00%	96.97%	G	↓	
			Quarter	95.00%	97.06%	G	↓	
		IAPT RTT within 18 weeks	Month	95.00%	99.44%	G	→	
			Quarter	95.00%	99.64%	G	→	
		IAPT RTT within 6 weeks	Month	75.00%	86.65%	G	↓	
			Quarter	75.00%	86.62%	G	↓	
		Early Intervention in Psychosis RTT Within 14 Days	Month	50.00%	51.28%	G	↓	
			Quarter	50.00%	60.32%	G	↑	

Key:

Period Month Current Month

Quarter Current Quarter

Achieving target

Not achieving target

Trend compared to previous month/quarter

OPERATIONAL OVERVIEW – OCTOBER 2016

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Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Locally Agreed	CPA Settled Accommodation	Month	90.00%	96.39%	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 October.
			Quarter	90.00%	96.39%	G	→	
		CPA Employment Status	Month	90.00%	97.32%	G	→	
			Quarter	90.00%	97.32%	G	→	
		Data completeness - Identifiers	Month	99.00%	99.40%	G	→	
			Quarter	99.00%	99.40%	G	→	
		Data completeness - Outcomes	Month	90.00%	93.50%	G	→	
			Quarter	90.00%	93.50%	G	→	
		Patients Clustered not Breaching Today	Month	80.00%	78.10%	R	↓	
			Quarter	80.00%	78.06%	R	↓	
		Patients Clustered regardless of review dates	Month	96.00%	94.86%	R	→	
			Quarter	96.00%	94.75%	R	→	
		7 Day Follow-up - all inpatients	Month	95.00%	93.15%	R	↓	
			Quarter	95.00%	93.91%	R	↓	
		Ethnicity coding	Month	90.00%	91.24%	G	→	
			Quarter	90.00%	91.24%	G	→	
		NHS Number	Month	99.00%	99.98%	G	→	
			Quarter	99.00%	99.98%	G	→	
	Schedule 4	Consultant Outpatient Trust Cancellations	Month	5.00%	5.28%	R	↑	The main reasons given for cancellation were consultants being absent from work and clinics booked in error. 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. There was some disruption to service whilst the digital dictation software was upgraded. Normal service has now been resumed.
			Quarter	5.00%	5.86%	R	→	
		Consultant Outpatient DNAs	Month	15.00%	15.86%	R	↑	
			Quarter	15.00%	15.58%	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%	85.25%	R	→	
			Quarter	90.00%	86.99%	R	↓	
		Outpatient letters sent in 15 working days	Month	95.00%	93.21%	R	↓	
			Quarter	95.00%	94.73%	R	→	
		Inpatient 28 day readmissions	Month	10.00%	5.17%	G	↑	
			Quarter	10.00%	5.49%	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%	98.90%	G	↓	
			Quarter	98.00%	99.29%	G	→	

OPERATIONAL OVERVIEW – OCTOBER 2016

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Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Fixed Submitted Returns	18 weeks RTT greater than 52 weeks	Month	0	0	G		Compliant with Fixed Targets
			Quarter	0	0	G		
		18 Week RTT incomplete	Month	92.00%	94.66%	G		
			Quarter	92.00%	94.66%	G		
		Mixed Sex accommodation breaches	Month	0	0	G		
			Quarter	0	0	G		
		Completion of IAPT Data Outcomes	Month	90.00%	95.49%	G		
			Quarter	90.00%	95.49%	G		
		Ethnicity coding	Month	90.00%	91.18%	G		
			Quarter	90.00%	91.18%	G		
		NHS Number	Month	99.00%	99.99%	G		
			Quarter	99.00%	99.99%	G		
Other Dashboards	Health Visiting	% 10-14 Day Breastfeeding coverage	Month	98.00%	98.52%	G		Compliant with Health Visiting Targets
			Quarter	98.00%	98.52%	G		
		% 6-8 Week Breastfeeding coverage	Month	98.00%	98.70%	G		
			Quarter	98.00%	98.70%	G		
	IAPT	Recovery Rates	Month	50.00%	52.18%	G		Compliant with IAPT Targets
			Quarter	50.00%	52.18%	G		
		Reliable & Recovery Rates	Month	65.00%	70.02%	G		
			Quarter	65.00%	70.02%	G		
	Safer Staffing	Inpatient Safer Staffing Fill Rates	Month	90.00%	100.9%	G		Detailed ward level information shows specific variances
			Quarter	90.00%	100.9%	G		

WORKFORCE OVERVIEW – OCTOBER 2016

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Category	Sub-set	Metric	Period	Plan	Actual	Variance		Trend	Key Points
Workforce Dashboard	NHSI Key Performance Indicator (KPI)	**Turnover** (annual)	**Oct-16**	10%	**11.79%**	↗	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 0.04% lower compared to the previous month and it is also 0.67% lower than in the same period last year (October 2015). The annual sickness absence rate has decreased by 0.15%, to 5.62%. The regional average annual sickness absence rate for Mental Health & Learning Disability Trusts is 5.09% (as at July 2016 latest available data). Anxiety/stress/depression/other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 28.42% of all sickness absence, followed by other musculoskeletal problem at 10.73%, Surgery at 10.13% and cold, cough, flu - infuenza at 7.46%. Vacancy rates have decreased slightly by 0.10% compared to the previous month. The number of employees who have received an appraisal within the last 12 months has increased by 2.78% to 68.66%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £1.194m of which £675k related to Medical staff. Compulsory training compliance has decreased this month by 1.04% but still remains above the 85% main contract non CQUIN.
			Sep-16		11.25%		G		
		Sickness Absence (monthly)	**Oct-16**	5.04%	**5.85%**	↘	R	↓	
			Sep-16		5.89%		R		
		Vacancies (including 10% funded fte cover)	**Oct-16**	10%	**16.82%**	↘	A	↓	
			Sep-16		16.92%		A		
		Vacancies (actual)	**Oct-16**	0%	**6.82%**	↘	A	↓	
			Sep-16		6.92%		A		
		Appraisals (all staff - number of employees who have received an appraisal in the previous 12 months)	**Oct-16**	90%	**68.66%**	↗	R	↑	
			Sep-16		65.88%		R		
		Appraisals (medical staff only - number of employees who have received an appraisal in the previous 12 months)	**Oct-16**	90%	**87.74%**	↗	R	↑	
			Sep-16		80.73%		R		
		Qualified Nurses (to total nurses, midwives, health visitors and healthcare assistants)	**Oct-16**	65%	**68.75%**	↗	G	↑	
			Sep-16		68.07%		G		
		Agency Usage (£ year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Oct-16**	£0	**£1.194m**	↗	R	↑	
			Sep-16		£992k		R		
		Agency Usage (% year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Oct-16**	0%	**67.40%**	↗	R	↑	
			Sep-16		65.30%		R		
	Other KPI	**Compulsory Training** (staff in-date)	**Oct-16**	90%	**88.22%**	↘	G	↓	
			Sep-16		89.26%		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 – OCTOBER 2016

Enc D

Category	Sub-set	Metric	Period	Plan	Actua	Varianc	Trend	Key Points
Quality	Safe	No of incidents of moderate to catastrophic actual harm	Month	24	34			Plan: average last fin yr. Actual: Q2. Inclusion of trend data to commence Q3
			Quarter	73	83		NA	Plan: average last fin yr. Actual: Q2. Inclusion of trend data to commence Q3
		No of episodes of patients held in seclusion	Month	8	8			Plan: previous month. Actual: Current month.
			Quarter	35	59			Plan: Q1 data. Actual: Q2 data
		No of incidents involving patients held in seclusion	Month	20	8			
			Quarter	61	60			
		No of incidents involving physical restraint	Month	55	25			
			Quarter	165	211			
		No of incidents involving prone restraint	Month	5	11			Plan: Mth Qtr, average from 1/4/16 when prone restraint collected on Datix as defined field.
			Quarter	15	30			
		No of incidents of physical assault - patient on patient	Month	15	8			
			Quarter	44	42		NA	
		No of incidents of physical assault - patient on staff	Month	20	8			
			Quarter	61	81		NA	
		No of falls on in-patient wards	Month	38	25			
			Quarter	113	84		NA	
		No of incidents of absconsion	Month	43	31		NA	
			Quarter	130	85		NA	
		No of patients with a clinical risk plan (FACE or Safety Plan)	Month	100%	80.50%			
			Quarter	100%	80.20%			
		Of above, no of patients with a Safety Plan	Month	90%	0.70%			Early stage of implementation. Go live from 1/11/16.
			Quarter	90%	0.80%			
		% of staff compliant with Level 3 Safeguarding Children training	Month	95%	72.04%			
			Quarter	95%	NA			Qtr comparison not available
		% of staff compliant with Think Family training	Month	95%	71.38%			
			Quarter	95%	NA			Qtr comparison not available
		% of staff compliant with Clinical Safety Planning eLearning	Month	95%	93.07%			
			Quarter	95%	NA			Qtr comparison not available
		% of staff compliant with Fire Warden training	Month	90%	72.70%			As of 31/10/16 cohort increased 3x due to change in policy.
			Quarter	90%	NA			Qtr comparison not available
		No of people with LD or Autism admitted without a CTR (Care & Treatment Review)	Month	0	1			
			Quarter	0	7			

QUALITY OVERVIEW – OCTOBER 2016

Enc D

Category	Sub-set	Metric	Period	Plan	Actua	Varianc	Trend	Key Points
Quality	Caring	No of complaints received	Month	9	8			
			Quarter	26	39			
		No of concerns received	Month	18	31			
			Quarter	53	121			
		No of compliments received	Month	72	87			
			Quarter	217	292			
		No of incidents requiring Duty of Candour	Month	2	1		NA	These figures will fluctuate based on the outcome of investigations.
			Quarter	8	1		NA	
	Effective	% of in-patients with a recorded capacity assessment	Month	100%	82.62%			
			Quarter	100%	NA	NA	NA	Qtr comparison not available
		% of patients who have had their care plan reviewed and have been on CPA >12months	Month	90%	95.06%			
			Quarter	90%	95.79%			
		No of seclusion forms not received by MHA Office	Month	0	1			All seclusion forms now xref with Datix. 1 outstanding. Significant improvement
			Quarter	0	10		NA	Relates to Q2 data only.
		% of CTO rights forms received by MHA Office	Month	100%	84%			Relates to whole cohort of patients
			Quarter	NA	NA	NA	NA	
		% of in patient older adults rights forms received by MHA Office	Month	100%	70%			Previous data Cubley Ct only. Now includes Wards 1&2 data
			Quarter	100%	100%		NA	Relates to Cubley Ct only
	Responsive	% of staff uptake of Flu Jabs	Month	45%	17.3%			The figure represent the period between 29/09/2016 and 31/10/2016.
			Year	45%	22.7%			Relates to 2015.16 compaign
		% of policies in date	Month	95%	95.0%			
			Quarter	95%	99.3%		NA	
	Well Led	% of staff who have received Clinical Supervision, within defined timescales	Month	90%	31.74%			
			Quarter	90%	NA	NA	NA	
		% of staff who have received Management Supervision, within defined timescales	Month	90%	50.07%			
			Quarter	90%	NA	NA	NA	
		No of outstanding actions following serious Incident investigations	Month	0	27			To end Oct 16. As of 10/11/016, 9 remain overdue
			Quarter	0	7		NA	Average for Q2. Comparison to Q1 not analysed
		No of outstanding actions following complaint investigations	Month	0	46			With operational teams to resolve
			Quarter	0	NA	NA	NA	
		No of outstanding actions following CQC comprehensive review report	Month	0	170			82% of all the actions are either complete or in progress and on target

Financial Section

FINANCIAL OVERVIEW – OCTOBER 2016

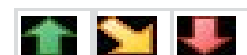
Category	Sub-set	Metric	Period	Plan	Actual	Rating	Trend	Key Points
Governance	Use of Resources (UoR) Metric	Overall Use of Resources Metric	YTD		3	A		This month sees the change from the Risk Assessment Framework Ratings to the new Single Oversight Framework ratings. As at the end of October the Rating is 3 and is forecast to be a 2 at the end of the year. We have been shadow segmented in segment 3.
			Forecast		2	Y		
		Capital Service Cover	YTD		2	Y		
			Forecast		2	Y		
		Liquidity	YTD		1	G		
			Forecast		1	G		
		Income and Expenditure Margin	YTD		1	G		
			Forecast		1	G		
		Income and Expenditure variance to plan	YTD		1	G		
			Forecast		1	G		
		Agency variance to ceiling	YTD		4	R		
			Forecast		3	A		
	Single Oversight Framework	NHS I Segment	YTD		3	n/a	n/a	
				Plan	**Actual**	**Variance**	**Trend**	
I&E and profitability	Income and Expenditure	Control Total position £'000	In-Month	295	330	G		The Control Total shows the position including the Sustainability Transformation Fund (STF) and the Underlying Income and Expenditure position excludes the STF. Surplus is better than plan in the month and due to changes in the run rate is forecast to achieve plan at the end of the financial year. The Normalised Income and Expenditure shows the financial performance adjusting for any non-recurrent costs or benefits that will not continue.
			YTD	1,271	1,976	G		
			Forecast	2,531	2,531	G		
		Underlying Income and Expenditure position £'000	In-Month	225	261	G		
			YTD	787	1,492	G		
			Forecast	1,701	1,701	G		
		Normalised Income and Expenditure position £'000	In-Month	225	299	G		
			YTD	787	1,355	G		
			Forecast	1,701	1,797	G		
	Profitability	Profitability - EBITDA £'000	In-Month	898	909	G		
			YTD	5,531	6,071	G		
			Forecast	9,806	9,700	R		
		Profitability - EBITDA %	In-Month	7.8%	8.1%	G		
			YTD	6.9%	7.8%	G		
			Forecast	7.1%	7.2%	G		
Liquidity	Cash	Cash £m	YTD	10.657	13.606	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	5.536	7.829	G		
			Forecast	7.570	6.504	R		
	Capex	Capital expenditure £m	YTD	1.717	1.335	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	2.508	1.295	R		
			Forecast	4.300	2.929	R		
			Recurrent	4.300	1.598	R		

Key:

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

Achieving plan
Not achieving plan

Plan In-month or Year end Trust plan


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

Governance – Use of Resources (UoR) Rating

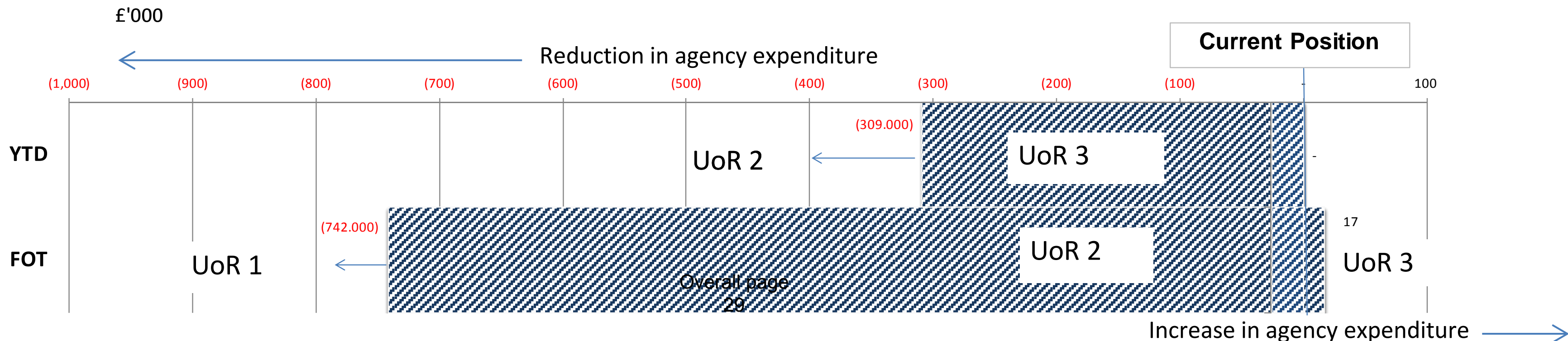
Enc D

The new Single Oversight Framework has come into effect this month and the new Use of Resources Rating and individual metrics are shown below. The Use of Resources rating at the end of October is a 3 which is due to triggering a 4 on the agency metric. The forecast is to achieve a Use of Resources rating of 2 at the end of the financial year due to the forecast improvement on the agency metric. 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:

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

To note some of the metrics including the overall rating does not have a plan set by NHS Improvement, so the plan on the Distance from Plan and the overall rating is based on an internal plan.

As four of the metrics are in a healthy position and it is the agency metric that is driving the lower rating and the trigger this is the area of focus from a headroom perspective, which is shown in he chart below. YTD if agency expenditure was £0.3m less we would have not triggered an override and remained at a rating of 2. From a forecast perspective we would only need to incur further expenditure of £17k in order to trigger an override and drop from a rating of 2 to a rating of 3.



Enc D

Income and Expenditure

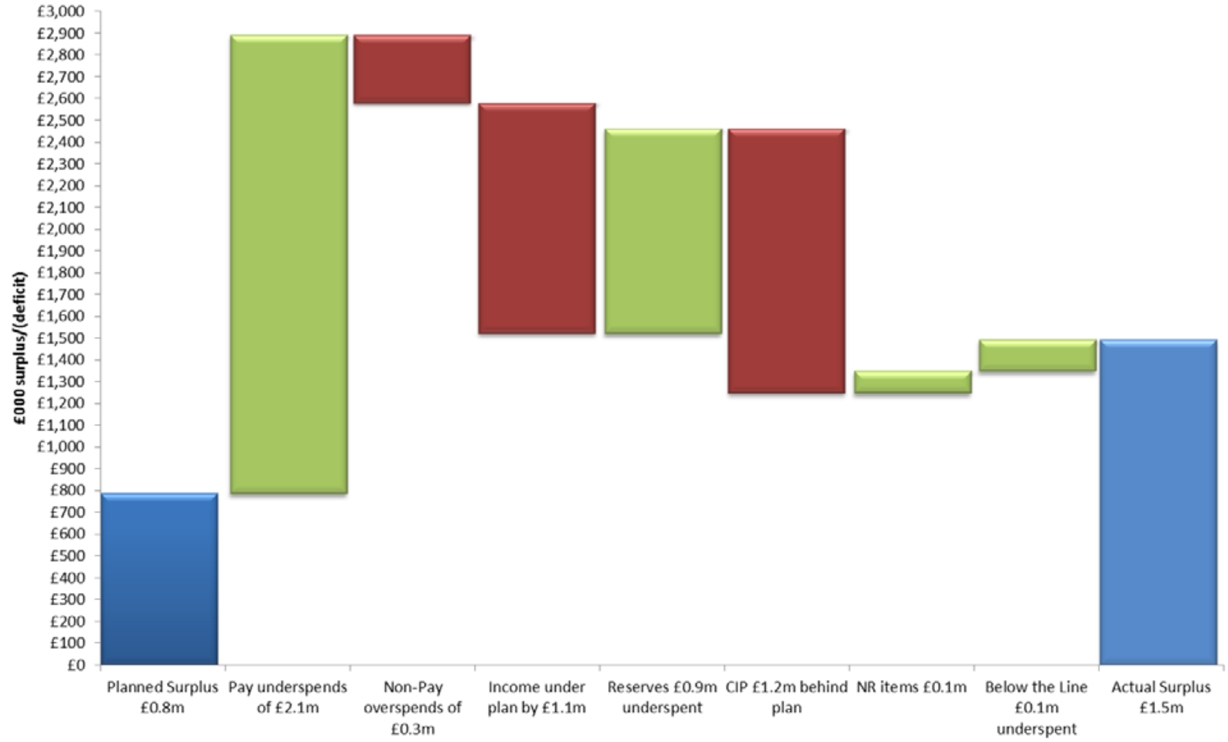
Statement of Comprehensive Income **October 2016**

	Current Month			Year to Date			Forecast		
	Plan £000	Actual £000	Variance *Fav (+) / Adv (-)* £000	Plan £000	Actual £000	Variance *Fav (+) / Adv (-)* £000	Plan £000	Actual £000	Variance *Fav (+) / Adv (-)* £000
Clinical Income	10,654	10,424	(230)	74,212	72,402	(1,811)	127,406	124,422	(2,984)
Non Clinical Income	849	835	(14)	5,944	5,486	(458)	10,190	9,438	(752)
Employee Expenses	(8,426)	(8,039)	387	(59,374)	(56,204)	3,170	(101,492)	(96,794)	4,699
Non Pay	(2,179)	(2,311)	(132)	(15,251)	(15,613)	(361)	(26,298)	(27,366)	(1,068)
EBITDA	**898**	**909**	**11**	**5,531**	**6,071**	**539**	**9,806**	**9,700**	**(106)**
Depreciation	(295)	(271)	24	(2,062)	(1,902)	160	(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)	(175)	(0)	(1,265)	(1,246)	19	(2,141)	(2,105)	36
Dividend	(133)	(133)	(0)	(933)	(946)	(13)	(1,600)	(1,613)	(13)
Net Surplus / (Deficit)	**295**	**330**	**35**	**1,271**	**1,941**	**669**	**2,231**	**2,231**	**0**
Technical adjustment - Impairment	0	0	0	0	(36)	(36)	(300)	(300)	0
Control Total Surplus / (Deficit)	**295**	**330**	**35**	**1,271**	**1,976**	**705**	**2,531**	**2,531**	**(0)**
Technical adjustment - STF Allocation	69	69	0	484	484	0	830	830	0
Underlying Net Surplus / (Deficit)	**225**	**261**	**35**	**787**	**1,492**	**705**	**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 £0.2m less than plan in month and is forecast to be £3m 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 £14k 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 £0.4m 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 £132k and has a forecast outturn of £1m behind plan which mainly relates to Drugs and PICU expenditure.



Summary of key points

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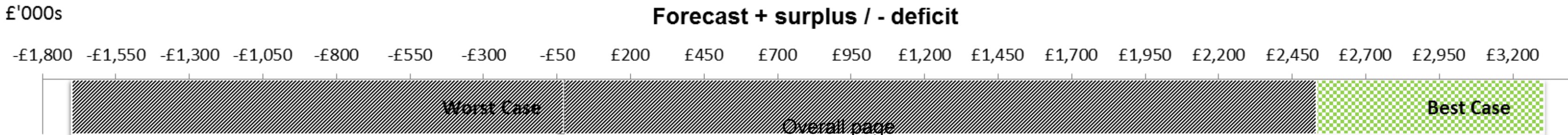
Overall favourable variance to plan year to date which is driven by the following:

- 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
£3.3m Surplus	£2.5m surplus	£1.7m deficit



Normalised Income and Expenditure position

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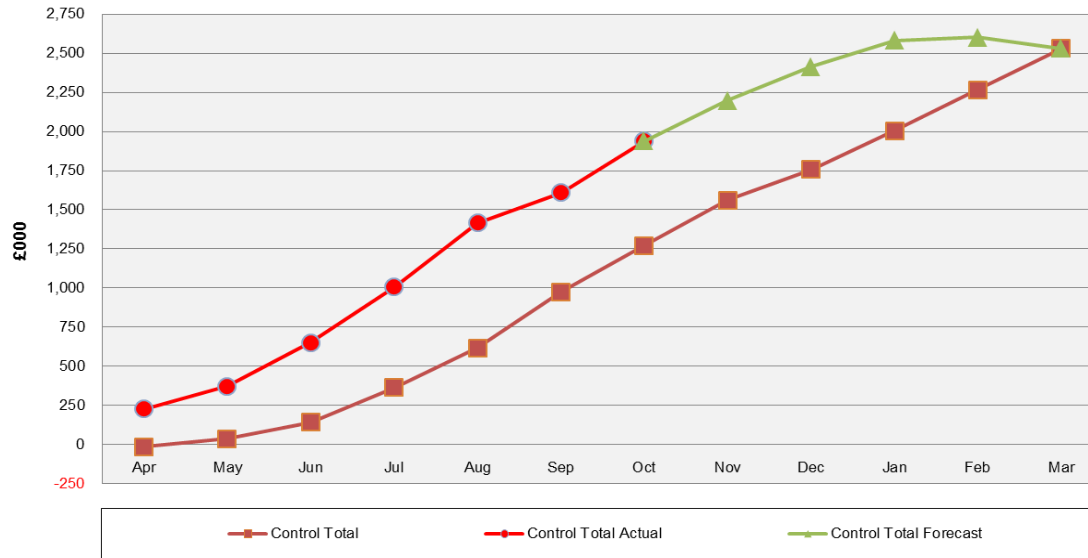
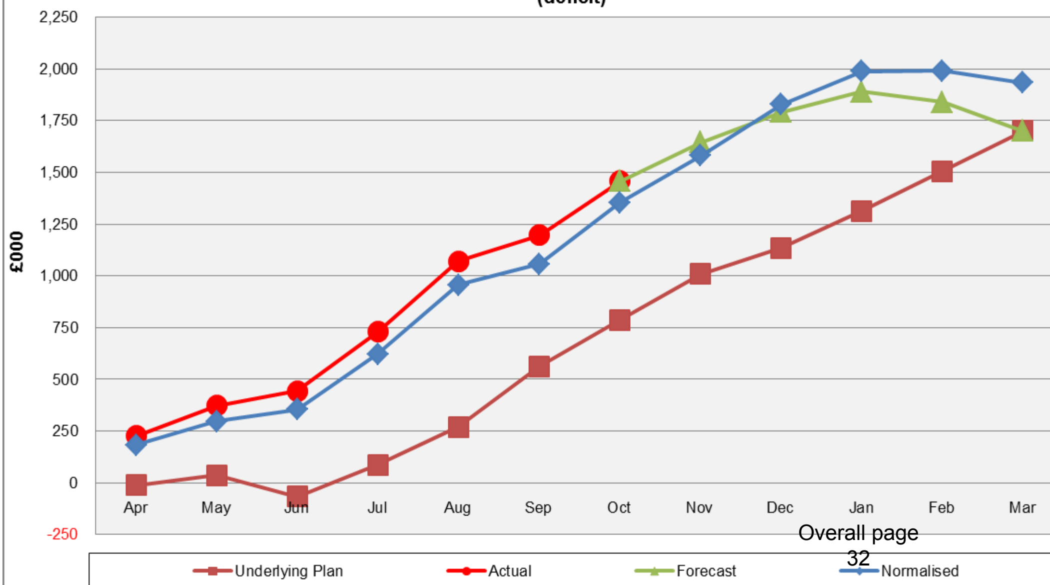




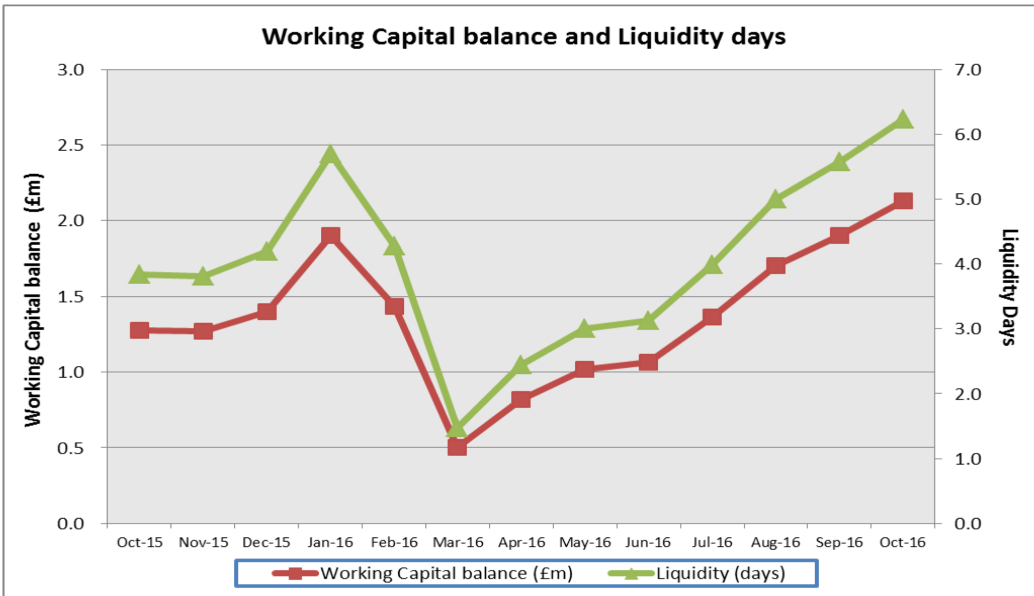
The first graph shows the actual and forecast cumulative surplus against the control total (including the Sustainability Transformation Fund (STF). The surplus is forecast to remain ahead of plan in the first part of the financial year and then slowly reduce back down to the planned control total.

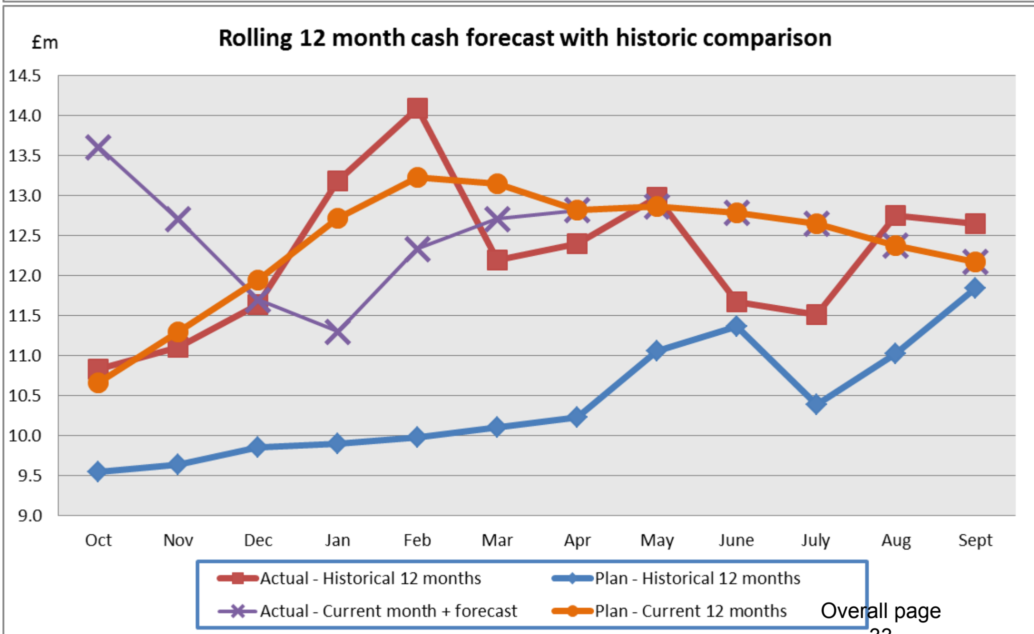
The second graph shows the underlying actual and forecast surplus against the underlying plan excluding the STF.

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





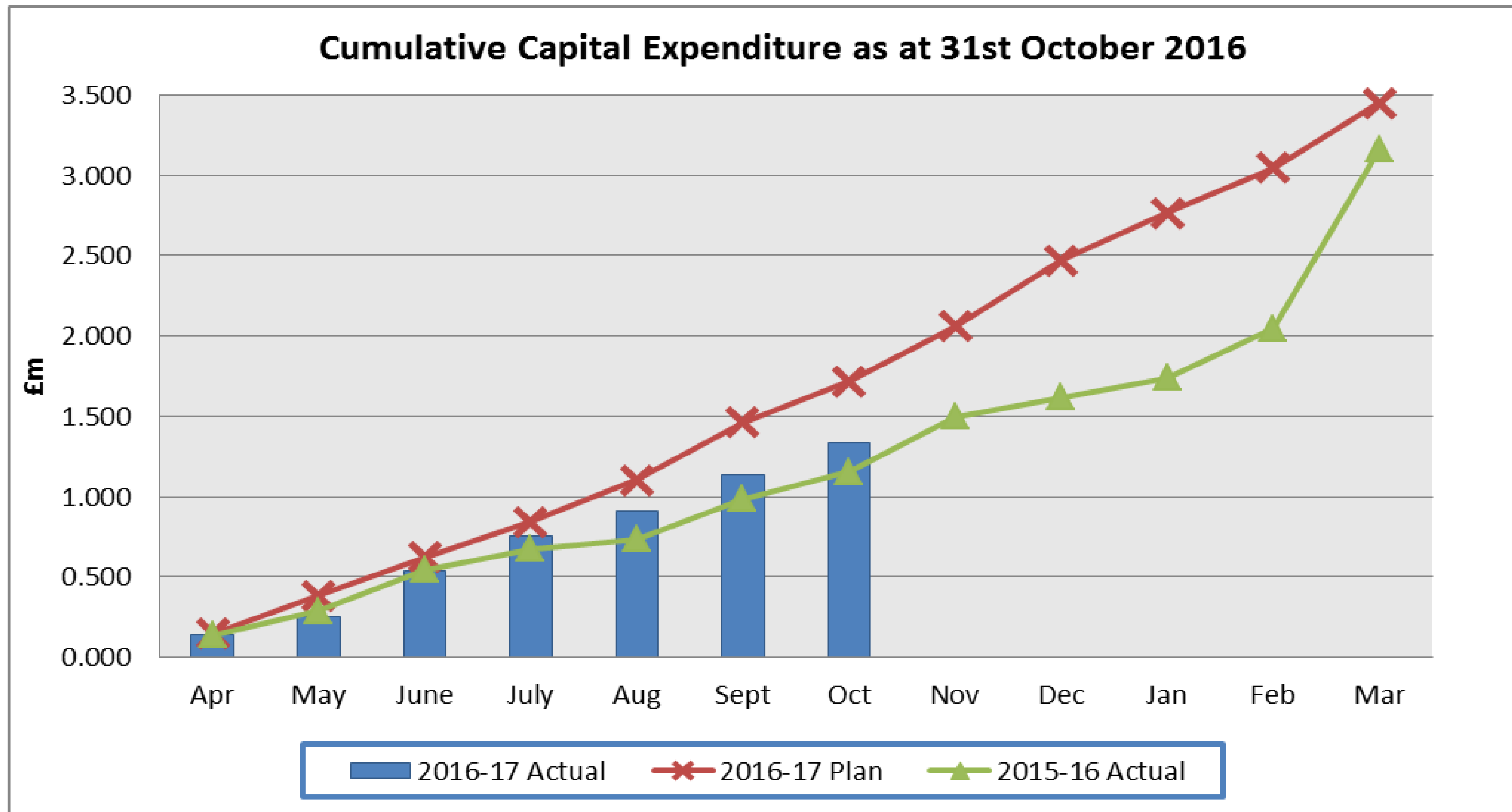
The first graph shows the working capital balance (net current assets less net current liabilities adjusted for assets held for sale and inventories) and how many days of operating expenses that balance provides.

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. October continues to show a further improvement up to 6.2 days which still gives a rating of 1 (the best) on that metric (-7days drops to a rating of 2).

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

Cash is currently at £13.6m which was £3m better than the plan at the end of October. This is mainly driven by the Income and Expenditure surplus and capital slightly behind plan.

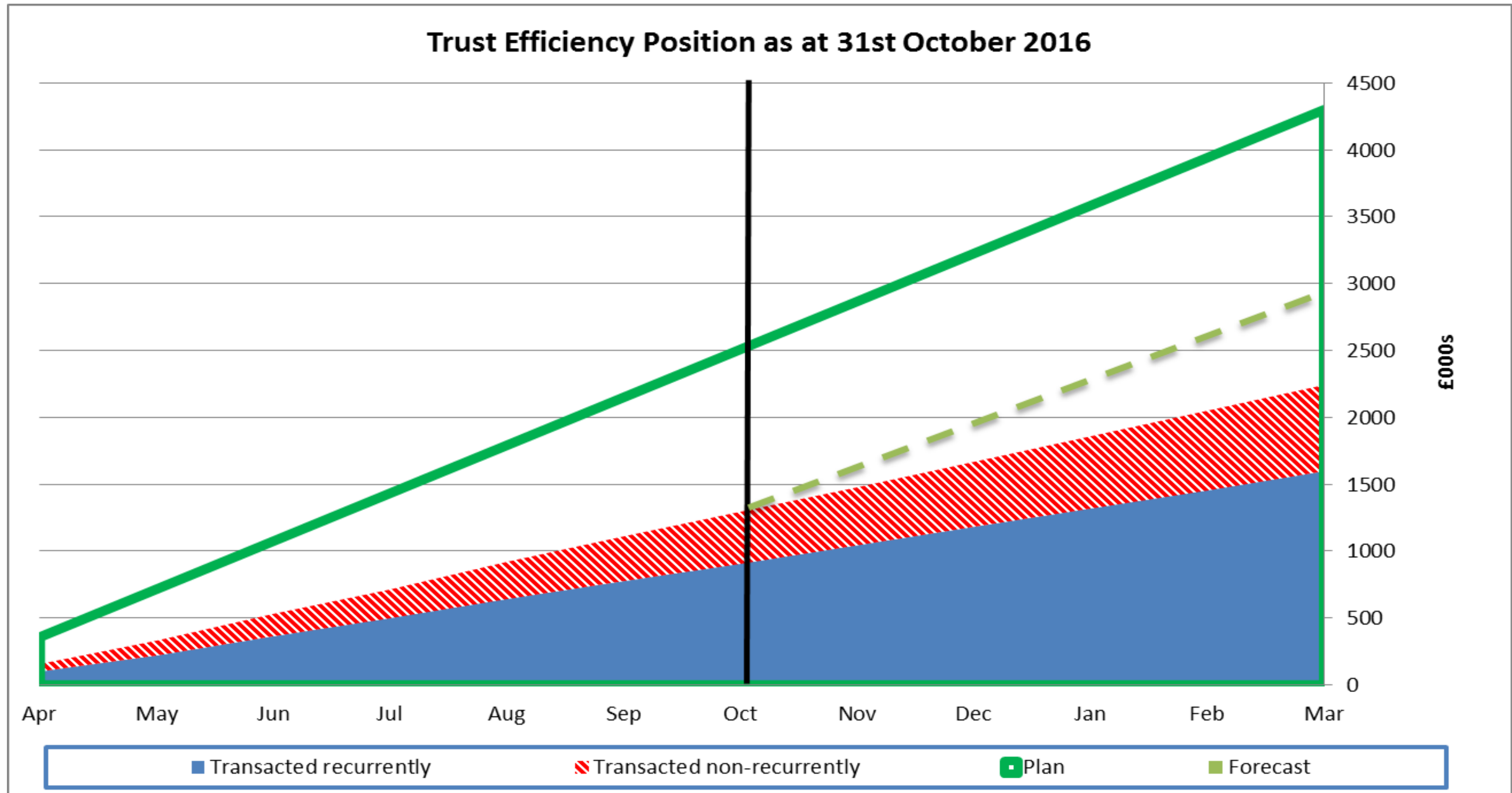
Capital Expenditure



Capital Expenditure is £382k 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)



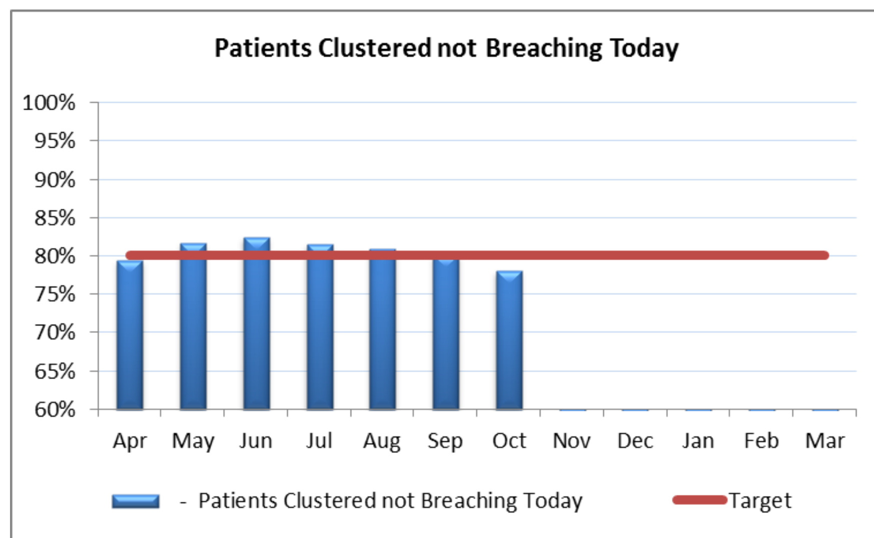
At the end of October there was a shortfall against the year to date plan of £1.214m. The full year amount of savings identified at the end of October reporting is £2.2m leaving a gap of £2.1m.

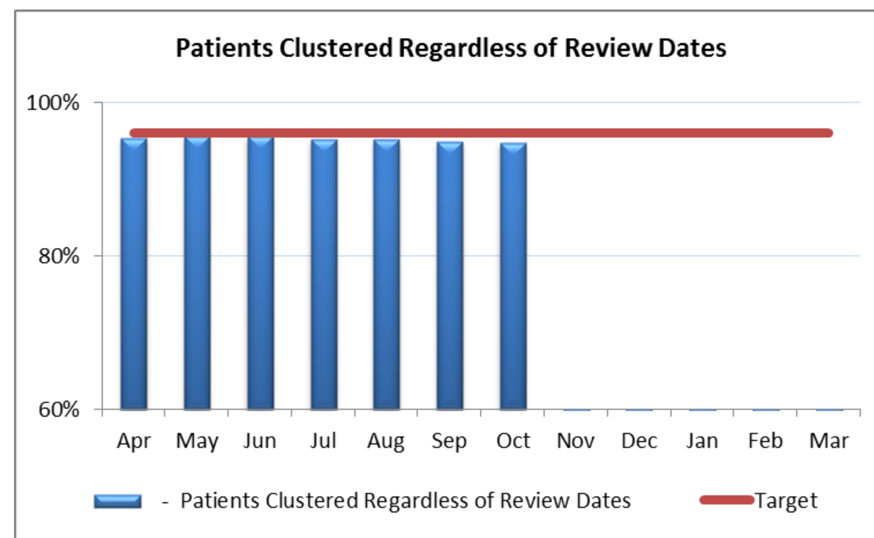
The forecast assumes that a further £0.7m will be achieved by the end of the financial year leaving unfound CIP of £1.4m. This underachievement is compensated for by cost avoidance and other underspends in the overall position.

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

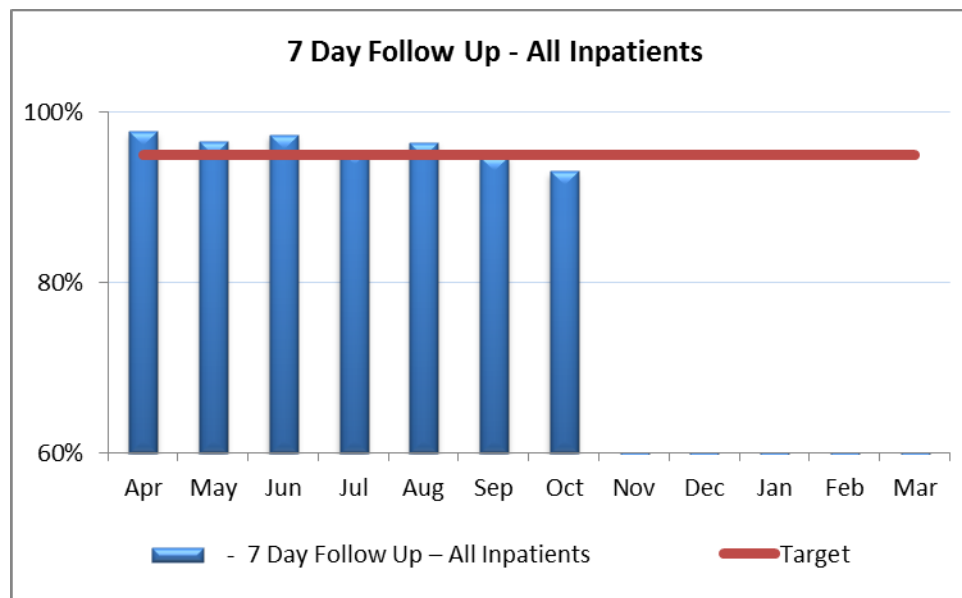




The Trust's Performance, Contract and Operational Group (PCOG) approved a clustering action plan, which was subsequently provided to Finance and Performance Committee for assurance that actions have been agreed to seek to improve performance in this KPI.

The plan includes 10 specific actions which will be overseen by PCOG or the newly formed Trust Management Team as part of its remit to review Trust wide performance.

7 Day Follow Up - All Inpatients



The underperformance this month is associated with 5 patients. 3 of the 5 patients were followed up, with 1 on day 8 and 2 others confirmed as followed up but with no clear record of this. This is being addressed with the wards to which this relates to. 2 patients were not able to be contacted, both of which did not attend their follow up appointment. The team managed to make contact with other agencies working with 1 of the patients to confirm that they were safe and well. The 5th patient is currently being followed up via other agencies who are known to work with them

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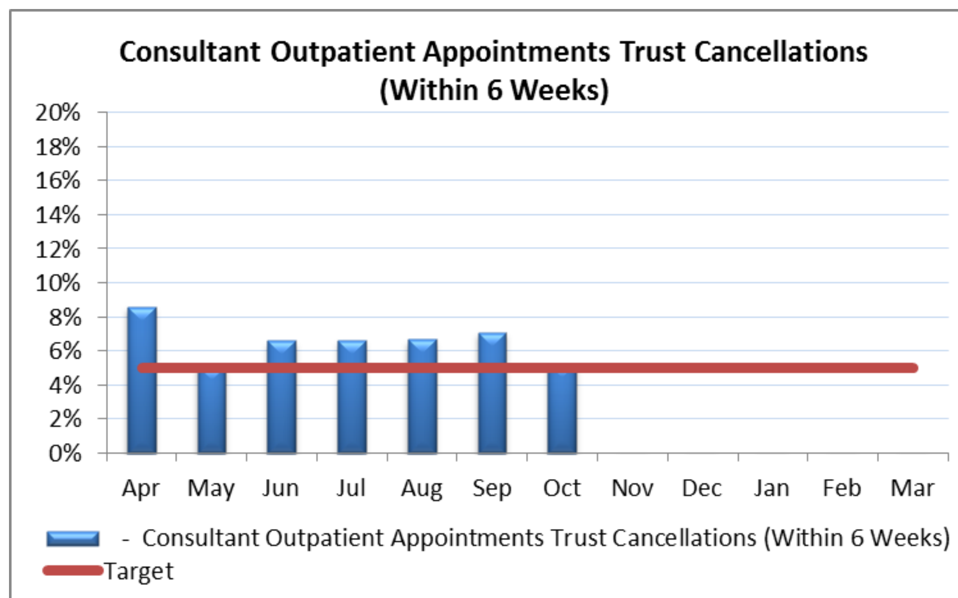
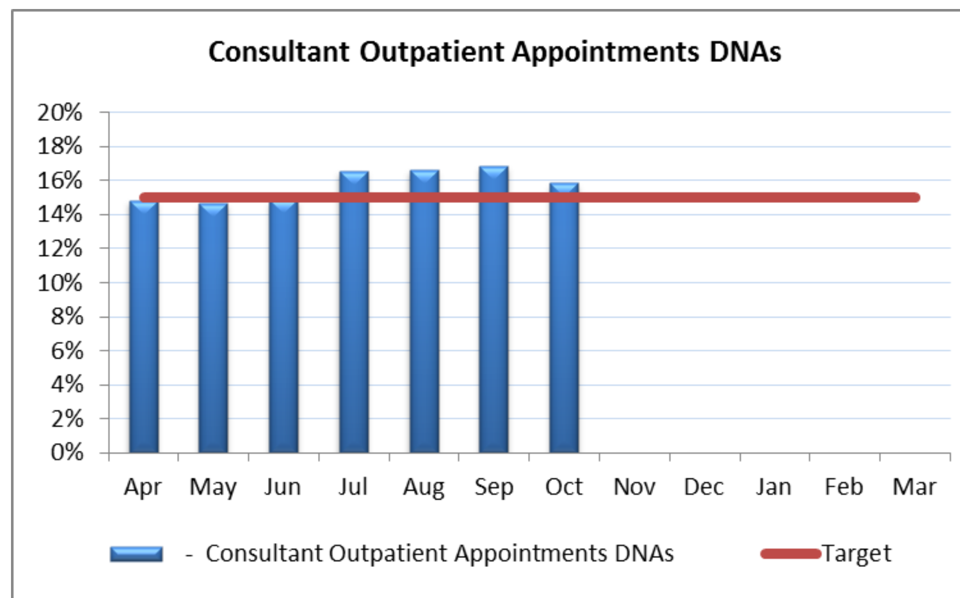
Consultant Outpatient Appointments Trust Cancellations (within 6 weeks)



The Trust's Performance, Contract and Operational Group (PCOG) approved an action plan aimed at understanding the issues for cancellation and actions to address them. This was subsequently provided to Finance and Performance Committee for assurance that actions have been agreed to seek to improve performance in this KPI.

The plan will be overseen by PCOG or the newly formed Trust Management Team as part of its remit to review Trust wide performance.

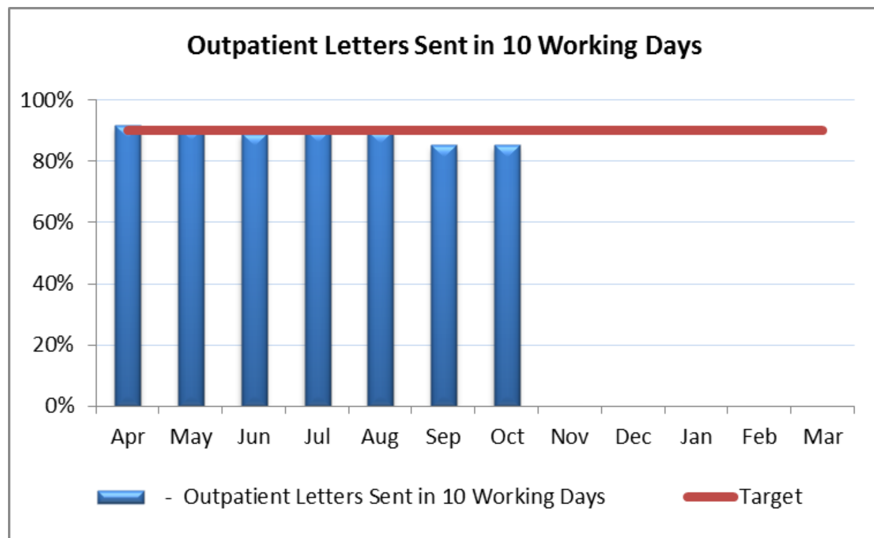
Consultant Outpatient Appointments DNAs

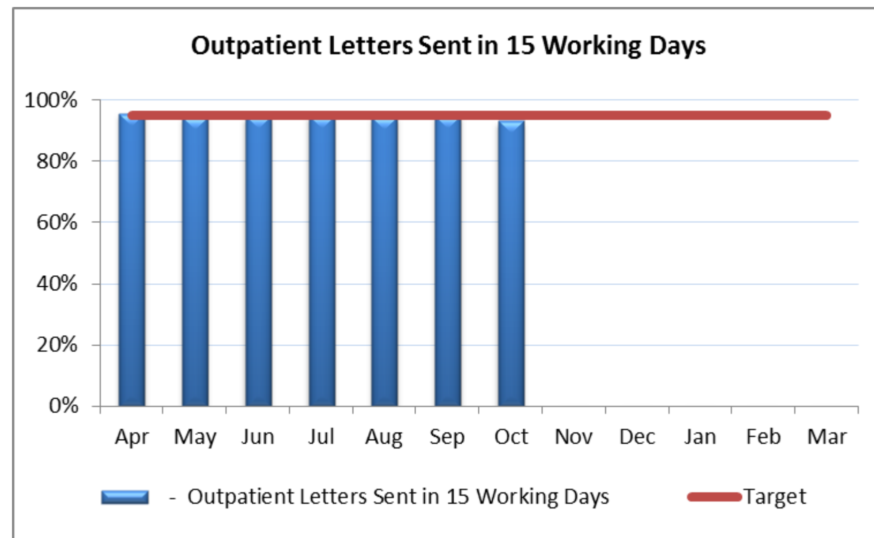


The Trust's Performance, Contract and Operational Group (PCOG) approved a plan which set out actions to address issues associated with DNA's. This was subsequently provided to Finance and Performance Committee for assurance that actions have been agreed to seek to improve performance in this KPI.

The plan will be overseen by PCOG or the newly formed Trust Management Team as part of its remit to review Trust wide performance.

Outpatient Letters Sent in 10 & 15 Working Days





There was some disruption to service whilst the digital dictation software was upgraded. Normal service has now been resumed, however, this will continue to be closely monitored.

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WARD STAFFING

Ward name	Occupancy % Rate	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
		Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
AUDREY HOUSE RESIDENTIAL REHABILITATION	75.00%	149.1%	73.3%	193.5%	16.1%	Yes	The Ward currently has two RN posts unfilled.
CHILD BEARING INPATIENT	79.44%	120.0%	159.2%	100.0%	287.1%	Yes	Current fill rate tolerances for care staff have been broken in October due to backfill for 0.8 WTE vacancy, long term sickness absence and high engagement levels particularly in relation to providing infant care.
CTC RESIDENTIAL REHABILITATION	86.81%	111.5%	91.5%	100.0%	100.0%	No	
ENHANCED CARE WARD	84.67%	78.0%	109.0%	56.5%	138.7%	Yes	No comment received
HARTINGTON UNIT - MORTON WARD ADULT	93.33%	99.5%	112.0%	56.4%	168.1%	Yes	On Morton ward we are still carrying a high number of vacancies at Band 5 – some are recruited into and staff awaiting start dates, thus it is not always possible to allocate x2 Band 5 nurses to night duty.
HARTINGTON UNIT - PLEASLEY WARD ADULT	103.33%	110.2%	84.4%	78.0%	142.9%	Yes	Short term HCA sickness over October and the removal of a HCA from clinical duty at short notice are responsible for the 84% cited for care staff on days. The ward is also carrying x1 Registered nurse vacancy (identified staff member to commence at start of January 2017), and has a new starter who is still supernumerary at this time, this shortfall with the usual pressures of A/L, training, sickness etc. have meant the ward has not been able to place x2 registered nurses on every night shift, this has inevitably been covered by the use of HCA staff resulting in the breach of night figures.

Enc D

WARD STAFFING

Ward name	Occupancy % Rate	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
		Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
HARTINGTON UNIT - TANSLEY WARD ADULT	90.56%	96.2%	112.6%	50.0%	193.8%	Yes	Between the 19th of September and the 3rd of October a further 3.8 wte registered nurses commenced post on Tansley Ward and were all given a supernumary period of 2 weeks for induction and insight visits to enable them to integrate effectively into the ward team. This leaves a further 4.4 wte vacancies at Band 5 and 1 x Band 5 currently on special leave with no provisional date for return. All posts are open to the rolling recruitment programme and also the recruitment Fayre on the 11th of November where we are hopeful that we will be able to recruit more nurses for the ward. Current experienced nurses on the ward are still working Bank shifts in addition to their regular shifts to bring the skill mix up to the desired level where possible and Band 6 nurses are also working clinical shifts when not on bleep. All other shifts with a shortfall from basic numbers are being covered with Band 2 Bank nurses. All of the new starters are newly qualified and under preceptorship so have not yet been allocated any night duty, they are due to commence night duty from December onwards so I anticipate that for November and possibly December the safer staffing returns will still identify deficits in registered nurse night duty cover where some nights have only 1 registered nurse as opposed to the funded 2. The figures for October identify a marked improvement in the skill mix for day duty due to the commencement of the long awaited new starters, hopefully we will continue to recruit and by rostering the preceptorship staff as second registered on night duty we should begin to meet our required skill mix on night duty too.

Enc D

WARD STAFFING

Ward name	Occupancy % Rate	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
		Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
KEDLESTON LOW SECURE UNIT	89.67%	109.6%	87.2%	100.0%	100.8%	Yes	We have had a number of staffing changes which have included the need for new starters staff to undertake super-numerary shifts. This has also included a return from a long term sickness as a phased return. We has had a depletion of Nurse Assistance in which we have advertised and are in the process of recruiting staff, This has left Unqualified shifts unable to cover with experienced and C and R staff as a result for the safety of the ward environment Qualified have backfilled at times for N/As this is reflected in the 87.2 deficit of care staff, against the 109.6 fill tolerance from qualified.
KINGSWAY CUBLEY COURT - FEMALE	74.81%	78.4%	107.4%	79.0%	117.2%	Yes	The reasons for breaking the current fill rate tolerance are: 1) we currently have 5 Registered Nurses vacancies. 2) There are 12 shifts where only one Registered nurse was on duty and a care staff was used to backfill the other Registered Nurse hence the reason for the surplus of care staff on the night shifts. 3) Data collected on the 22/10/16 indicates that only one Registered Nurse was on the early shift however the bleep holder was working in numbers, which equate to the 2 Registered Nurses planned for that shift. 4) 3 care staff on long term sick.5) 3 care staff on short tem sick.
KINGSWAY CUBLEY COURT - MALE	88.89%	75.2%	107.8%	50.0%	135.5%	Yes	The reason for us not having 2 RN's on shift in the night is due to having 5 vacant RN posts and one RN on long term sick meaning that the days have been prioritised for having 2 RN's per shift. Recruitment has been a struggle – 4 adverts have been out and we have not appointed. Hence NA rate being higher to cover. We are attempting to ensure over both Cubley wards that there are 3 RN's on nights to offer support.

Enc D

WARD STAFFING

Ward name	Occupancy % Rate	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
		Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP	99.79%	125.7%	62.9%	74.2%	154.8%	Yes	We have supported mandatory training needs The sickness rate was 6.6% but there were also staff on phased RTW on shorter hours There were 2 leavers end of October WTE We have supported 2 escorts for pts transferred to RDH and levels of observation Plan for 2 R/N's on Night duty on 7 occasions R/N's N/A's were redeployed to other wards as a short term measure Band 6 & 7 staff are required to hold the bleep on the Kingsway site on 8 occasions and are also involved in Investigations/meetings away from clinical area on 6 occasions
LONDON ROAD COMMUNITY HOSPITAL - WARD 2 OP	87.08%	115.3%	87.0%	100.0%	140.3%	Yes	We have been fully staffed on all shifts on days we had a higher proportion of registered staff on nights we increased staffing numbers due to having patients on observation levels
RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT	92.00%	83.9%	96.8%	58.1%	98.7%	Yes	The Radbourne unit continues to experience significant staffing pressures, particularly in regard to registered staff. Ward 33 is currently, marginally, the most severely impacted area. We continue to make concerted efforts to robustly manage rosters and direct resource to the areas of highest clinical need within the unit at appropriate times. In addition we try to ensure, when using bank staff that they are familiar with our environments and trained to the appropriate skill level as far as possible. We have local and organisational recruitment drives in operation, however recruitment and retention remain a challenge.
RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT	94.83%	96.2%	112.3%	53.2%	185.4%	Yes	Ward 34 continues to carry 5.2 band 5 vacancies ,recruitment is an on going issue, which has increased the use of bank staff
RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT	88.17%	97.3%	110.0%	66.1%	115.8%	Yes	We have broken current fill rates due to long term sickness and unfilled vacancies
RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT	97.33%	96.8%	102.2%	56.5%	188.1%	Yes	Ward 36 has had to employ an uplift in bank staff particularly on nights where a second qualified nurse hasn't been available, also clinical activity has demanded extra staff

Workforce Section

Enc D

WORKFORCE DASHBOARD

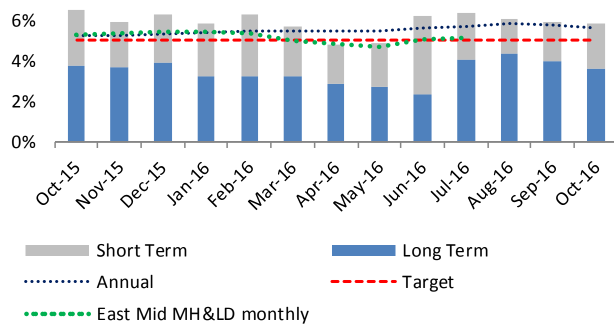
Wellbeing

Sickness Absence

(Monthly)

	Aug-16	Sep-16	Oct-16
	6.08%	5.89%	**5.85%**

Target 5.04%



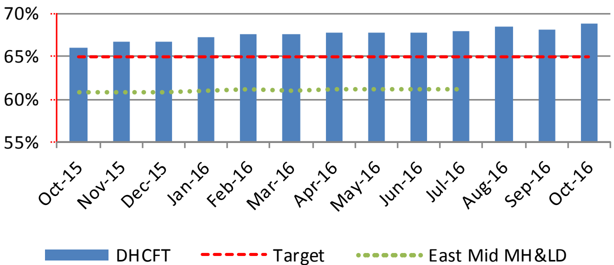
The Trust annual sickness absence rate is currently 5.62%. Monthly sickness absence is 0.04% lower than the previous month and is 0.67% lower than the same period last year. In June 2016 there was a large increase in short term absence caused by traditional long term absence reasons which developed into long term sickness. Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 28.42% of all sickness absence, followed by other musculoskeletal problem at 10.73%, Surgery at 10.13% and cold, cough, flu - influenza at 7.46%.

Qualified Nurses

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

	Aug-16	Sep-16	Oct-16
	68.36%	68.07%	**68.75%**

Target 65%



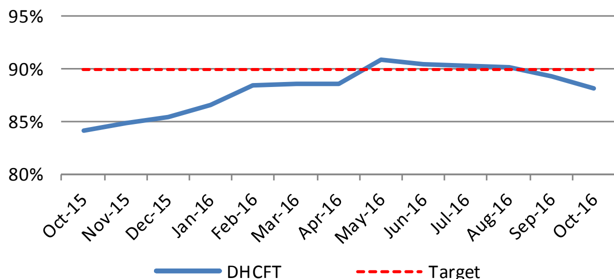
Contracted staff in post qualified nurses to total nurses, midwives, health visitors and healthcare assistants is running at 68.75%. Vacancy rates can impact on this measure. The average for East Midlands Mental Health & Learning Disability Trusts is 61.19%. Health Visitors represent 5.39% of the Trust total and are not included in the Qualified Nurses calculation. Healthcare Assistants and Nursing Support staff represent 25.86% of the total.

Compulsory Training

(Staff in-date)

	Aug-16	Sep-16	Oct-16
	90.23%	89.26%	**88.22%**

90%



Compulsory training compliance continues to remain high running at 88.22%, although a decrease of 1.04% compared to the previous month. Compared to the same period last year compliance rates are 4.47% higher. Compulsory training compliance remains above the 85% main contract commissioning for quality and innovation (CQUIN) target and is slightly below the Trust target.

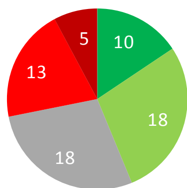
Enc D

WORKFORCE DASHBOARD

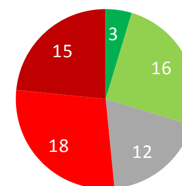
Motivation

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

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



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



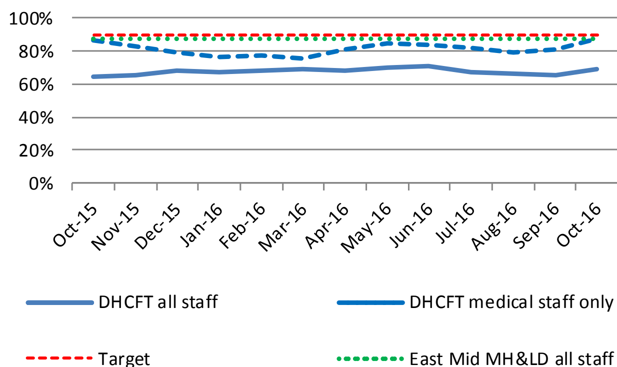
- 1 - Extremely Likely
- 2 - Likely
- 3 - Neither likely nor unlikely
- 4 - Unlikely
- 5 - Extremely unlikely
- 6 - Don't Know
- 7 - No Response

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

Appraisals

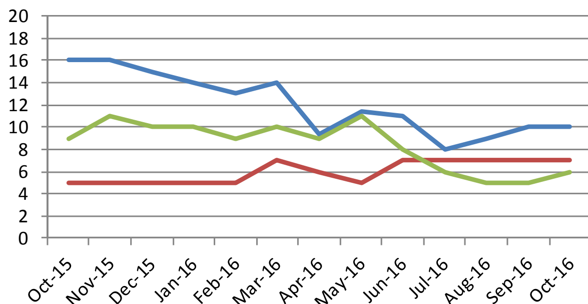
	Aug-16	Sep-16	**Oct-16**
(All staff)	66.29%	65.88%	**68.66%**

Target 90%

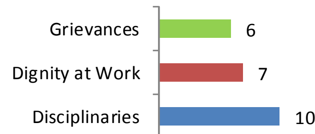


The number of employees who have received an appraisal within the last 12 months has increased by 2.78% during October 2016 to 68.66%. Compared to the same period last year, compliance rates are 3.93% higher. Medical staff appraisal compliance rates are running at 87.74%. According to the latest staff 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 78.44%.

Grievances/Dignity at Work/Disciplinaries as at 31/10/16



There are 6 grievances currently lodged at the formal stage, 1 new grievance has 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 2 new cases have been received.



WORKFORCE DASHBOARD

Attendance

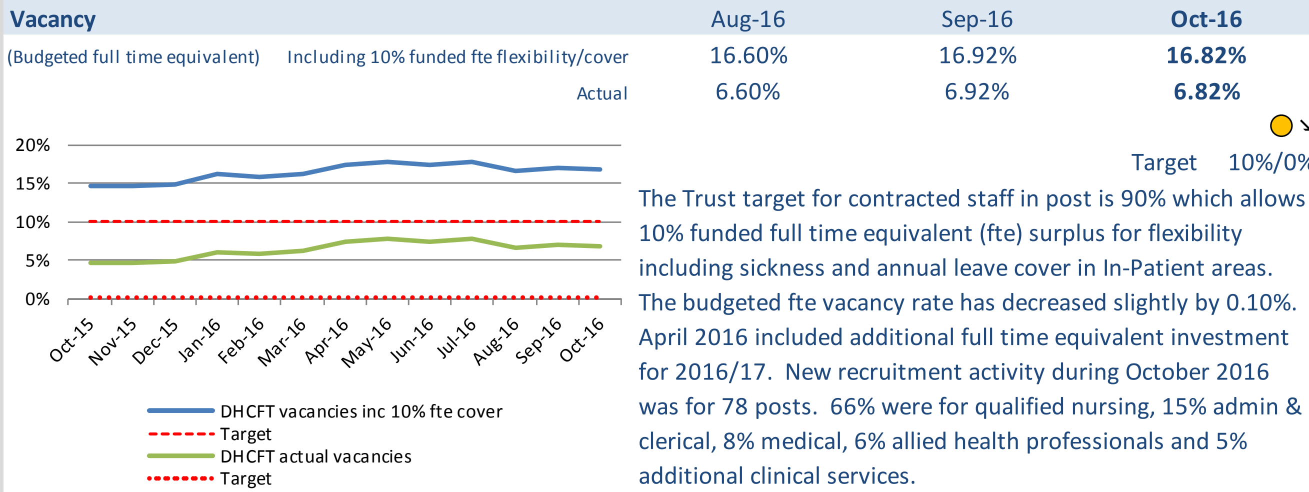
Enc D

Vacancy

(Budgeted full time equivalent)		Aug-16	Sep-16	**Oct-16**
	Including 10% funded fte flexibility/cover	16.60%	16.92%	**16.82%**
	Actual	6.60%	6.92%	**6.82%**

↘

Target 10%/0%



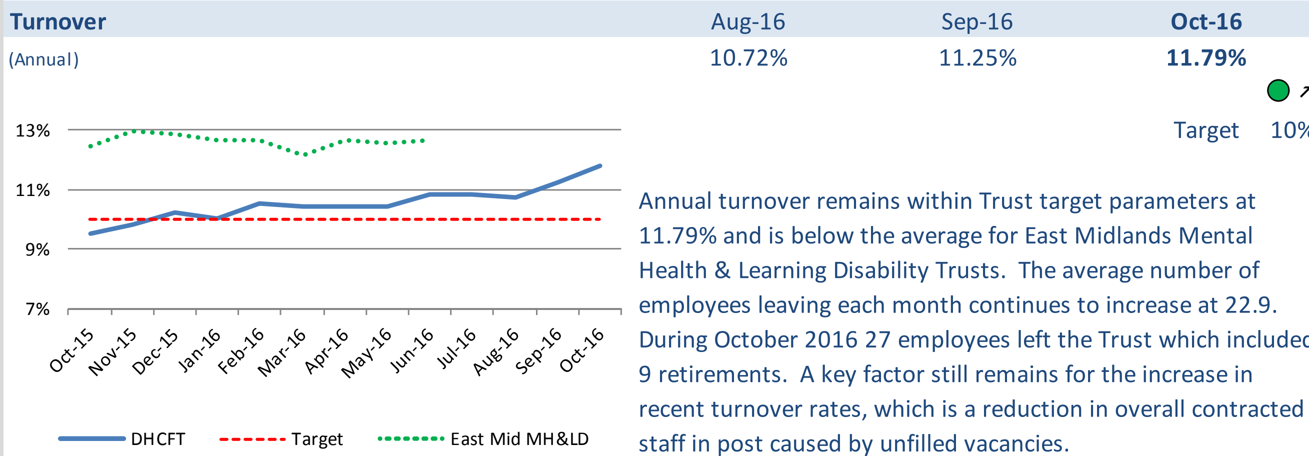
The Trust target for contracted staff in post is 90% which allows 10% funded full time equivalent (fte) surplus for flexibility including sickness and annual leave cover in In-Patient areas. The budgeted fte vacancy rate has decreased slightly by 0.10%. April 2016 included additional full time equivalent investment for 2016/17. New recruitment activity during October 2016 was for 78 posts. 66% were for qualified nursing, 15% admin & clerical, 8% medical, 6% allied health professionals and 5% additional clinical services.

Turnover

	Aug-16	Sep-16	**Oct-16**
(Annual)	10.72%	11.25%	**11.79%**

↗

Target 10%

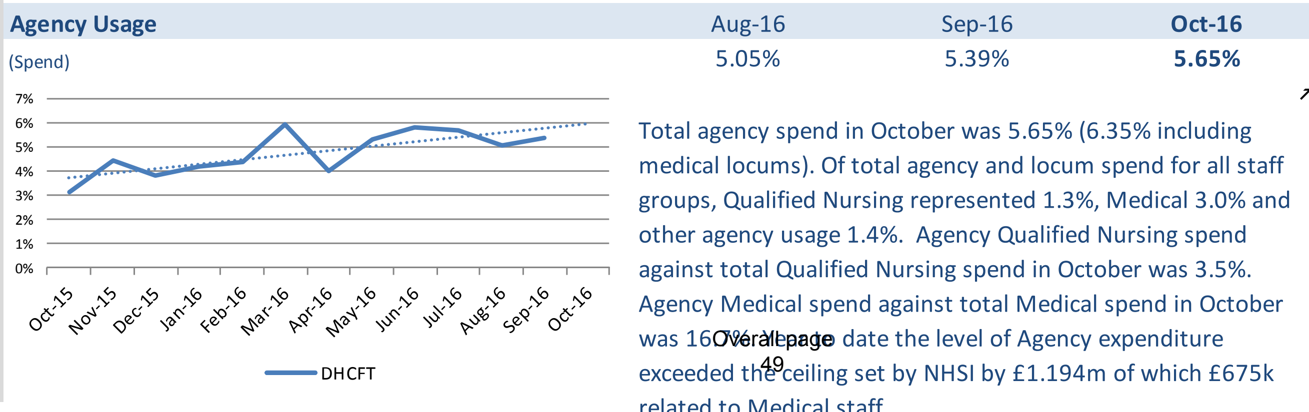


Annual turnover remains within Trust target parameters at 11.79% and is below the average for East Midlands Mental Health & Learning Disability Trusts. The average number of employees leaving each month continues to increase at 22.9. During October 2016 27 employees left the Trust which included 9 retirements. 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

	Aug-16	Sep-16	**Oct-16**
(Spend)	5.05%	5.39%	**5.65%**

↗



Total agency spend in October was 5.65% (6.35% including medical locums). Of total agency and locum spend for all staff groups, Qualified Nursing represented 1.3%, Medical 3.0% and other agency usage 1.4%. Agency Qualified Nursing spend against total Qualified Nursing spend in October was 3.5%. Agency Medical spend against total Medical spend in October was 16.7%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £1.194m of which £675k related to Medical staff.

Quality Section

Strategic Risks (Board Assurance Framework)

Enc D

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	HIGH	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	↔

No significant change. V4 of BAF in process of update for Audit and Risk Committee Jan 2017.

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., Memory Assessment Service Since last reported Children in Care have identified a high staffing level risk . A number of risks associated remain with exceeding of the agency cap for reasons of patient safety	HIGH	↔
Associated with the number of staff vacancies, risks related to work related stress and increased risks of violence and aggression on the Radbourne Wards remain	HIGH	↔
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	↔
Risks with respect to discharge from the DRH and transfer across neighbourhood boundaries. remain	HIGH	↔
New high level risks have been identified in relation: patient transport; out of area beds; and access to e-learning within the Trust.	HIGH	NEW

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

Quality Position Statement

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

Executive Summary

This position statement sets out:

1. **Safety**
   Learning from homicides and suicides, our response to security, increasing our capacity in safeguarding services to support interagency models.
2. **Caring**
   Learning from Healthwatch Derby City and Derbyshire and benchmarking with other mental health organisations for the patient experience.
3. **Effectiveness**
   Improving access to psychological therapies, annual report and benchmarking.
4. **Responsiveness**
   Developing the Mental Health Act Committee and learning from monitoring the Mental Health Act in 2015/2016 CQC national report.
5. **Well- led**
   Quality leadership.
   The first new model of a learning event for staff following a very serious incident in 2013. Learning from our staff support and recommendations.
   Transparency.
   CQC regulatory management.

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
December 2016

1. SAFE SERVICES

1.1 Safety

The Appleby Homicide and Suicide study has been reported in a number of national publications. It reveals that the number of Mental Health homicides by patients being treated for mental health problems is falling and it is formulated and proposed that this is probably as a result of improved NHS care. The number of suicides has increased across the UK since 2008 – except in Scotland – with middle-aged men the most likely group to take their own life. There are concerns that every year, dozens of patients may be completing suicide after they have been wrongly released from hospital and it has been proposed that this is due to mental health units having too few beds. Patients with schizophrenia, psychosis or other disorders, committed a total of 870 homicides across the UK between 2004 and 2014, representing 11% of all deaths in this this group killings in that time, but the total number of homicides carried out by service users fell by 27% over the 11 years covered by the National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (NCISH). However, homicides by mental health patients are not falling as fast as the overall drop in homicides and the NCISH researchers recommend that the NHS needs to undertake "specific clinical measures" to close the gap, such as improving services for those with mental health problems who are also addicted to drugs or alcohol.

The Appleby Homicide and Suicide study provides a benchmarking report, it will be received in January 2017 and we will publish this scorecard in the public domain. As a Trust, we have not experienced a mental health homicide since 2013. We continually monitor risk management and our changes in risk and safety planning is a key quality priority.

We are carefully monitoring our drug related deaths related to co-injecting incidents which require multi-agency working with public health and police to understand the nature and degree of these incidents and whether additional learning for focus can be given to our substance misuse integrated workforce. Our Family Liaison Officer who has a background in substance misuse is working with the Derbyshire Drug related deaths group to understand any learning from this interagency lead.

Our integrated report focuses upon the roll out of this training, which as a quality priority and a CQUIN we are working on this year is our safety plan in regard to suicide reduction programmes.

We have seen an increase over the last two months in our serious incident. We are undertaking further analysis at the Quality Committee to understand this data and put in

place risk mitigation plans and proactive strategies to manage clinical risk. At this time, no team has any immediate patterns. We continually monitor the Crisis team, due to the high risk nature of this team's clinical work. We continue to look for themes and we are currently monitoring potential contributory factors such as pain or the number of clinical workers and increasing stability. We are looking for electronic solutions to support clinical stability and case allocation.

The Quality Committee will lead on this work and seek advice from the Suicide Prevention Group and Quality Leadership Teams on what clinical support they require to proactively prevent and mitigate risks.

Safeguarding Adults work and embedding the Assurance framework review continues to be a focus of our work. All security incidents are continually reviewed by our Safeguarding leads to focus upon proactive action and learning from incidents. At the end of November, our local Security Management Specialist and the lead Director submitted the self-assessment against the NHS protect required standards. In this submission, the Trust downgraded itself on two indicators due to security management that we require further assurances that the Trust has learnt from security incidents.

This did not, however, downgrade the whole self-assessment, but commentary has been included to NHS protect the feedback form the CQC on learning from safety and security incidents to seek additional security analysis and assurance on what the trust is undertaking.

Safeguarding Adults work and having capacity to meet demand was raised by our Quality Regulator and in an earlier Quality position statement, the Trust received additional pilot monies from Southern Derbyshire CCG for the Multi-agency Safeguarding hub (MASH). Derby city partners in the local authority and Police have invested in a Safeguarding Childrens and Adults hub in the Council House. This MASH development in Derby City is service development and investment provided by Southern Derbyshire CCG for a six month pilot of two additional Band 7 workers in the team have been successfully recruited to and will be operational in December.

2. CARING SERVICES

2.1 Complaints and Compliments

In December, the Quality Committee will receive two reports from Healthwatch.

- One report from Healthwatch Derby on a December 2015 complaints survey with a small sample size which was submitted to the CQC prior to inspection in June 2016.

- One report form Healthwatch Derbyshire from Summer / Autumn 2016 showed the live experience of health and social care responses to a crisis in north and south Derbyshire - sample size 40 complaints survey with a small sample size.

Both reports will be reviewed by the Quality Committee and will be included in the Trust's Quality account and have both learning and recommendations that have been submitted.

The first report changed the design of the 'My Care' leaflet to expressly focus on how to complain and how to escalate a concern if you are not fully satisfied with the Trust's response. In addition, it has led to the Mental Health alliance developing in-reach services to the wards to explore the patient experience working in partnership with the Patient Experience team to listen to early feedback. This has correlated with an increase in concerns to be rectified at an earlier stage and an overall reduction in complaints. In addition, the Executive Director of Nursing met with complainants at the Council House to listen directly to concerns, individuals attended and gave direct feedback on what they wanted to happen next with the learning and feedback.

The second report is being submitted for the first time to the Quality Committee and has both Trust and systems learning. A key theme is defining what you can expect from the Crisis team and what the voluntary sector social care offers is key learning. The dedicated Consultant Nurse for the Crisis team has been tasked with developing information to be placed both on the Trust website, but also on Healthwatch Derbyshire's website and exploring a externally focused response to this report and ensuring that our involvement groups and Mental Health alliance are co-producing our response.

Our CQC Community Mental Health Survey

The Community survey was released and the findings were from a sample size 850 people with 234 respondents. Our direct feedback and overall rating was solid.

The results of the 2016 Community Mental Health survey have been published and our Trust has bucked the trend in terms of satisfaction with our services.

Nationally, the survey suggests that people's experiences have not improved since last year's publication. Dr Paul Lelliott, CQC's Deputy Chief Inspector of Hospitals has written a letter to the providers identified as performing worse than others in the survey, asking them to take action.

We are not one of these Trusts as our performance has overall remained solid and we have comparable scores to Trusts rated 'good'. Our rating was 7.0. Overall this is above average. Our nearest performers were East London Mental Health Trust at 6.9 for care overall and we were just behind Northumberland, Tyne and Wear NHS Foundation Trust at 7.2.

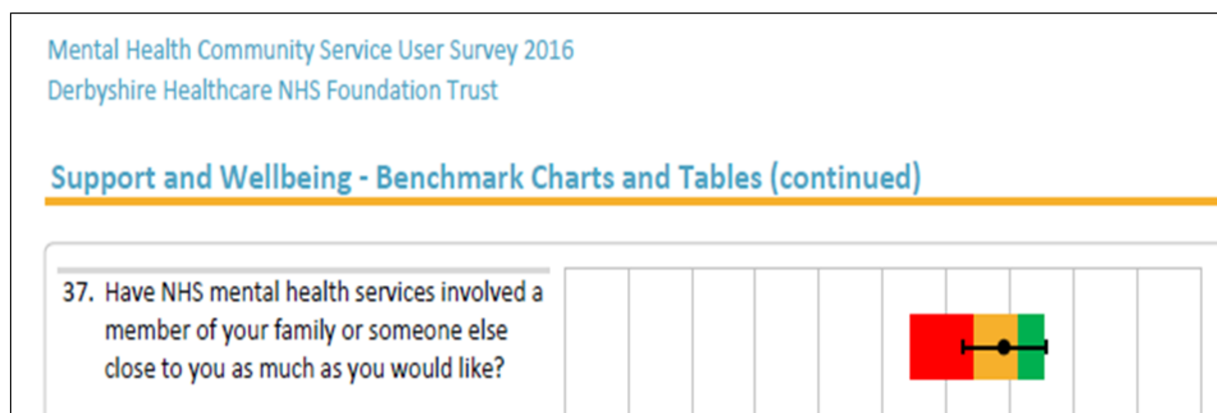
"This is a credit to the continued work of our teams," says Carolyn Green, Executive Director of Nursing and Patient Experience. "We have had a big year of change in the neighbourhoods and had new difficult targets for early intervention which we are staying on top of. Thank you to you all for your continued work in this area. Although we clearly have areas for improvement, this doesn't change my view that we mainly do a very good job and just sometimes lack consistency and that is our area to improve."

2.2 Triangle of Care - Think Family and Family Inclusive Practice, a Trust Quality Priority

The Triangle of Care (ToC) project is an initiative run by the Carers Trust to support a therapeutic alliance between service receivers, staff and carers, promoting safety, recovery and a sustainable well-being. Having rolled out this piece of good practice within our campus areas, we are now ready to introduce ToC throughout our neighbourhood services.

Staff working in neighbourhood, campus or specialist services are invited to find out more about the ToC and learn practical ways to support families and carers in your work workshops in November, December and January across the county to really embrace our developments in Family inclusive practice.

This preventative safeguarding families work is monitored by the Safeguarding Committee to ensure the Trust is putting into practice development opportunities to embed the newly ratified Families and Carers strategy agreed by the Safeguarding Committee in November.



3.0 RESPONSIVE AND EFFECTIVENESS OF OUR SERVICES

Monitoring the Mental Health Act was published and this work has been initially reviewed by the Mental Health Act Committee and will be reviewed formally with an action plan for learning by the Medical Director and the Mental Health Act team for learning to be implemented in the Trust.

4. WELL LED

4.1 Quality Leadership

The Executive Director of Nursing and Patient Experience attending the Campus and Neighbourhood. This is part of the quality priorities of supporting and developing the Quality Leadership Team and their clinical leadership. The group had representation from its areas but attendance could be improved. It was positive to hear clinical risks and mitigations being reviewed and escalation of issues and the use of the risk register in raising concerns re clinical practice and opportunities to reduce risks. Further work needs to be invested in the QLT to develop its clinical reference groups to ensure they are working effectively.

The Neighbourhood and Campus Quality leadership team will be a priority area for the new Deputy Director of Nursing and Quality Governance to pay attention and investment in the teams.

4.2 Quality Visit Feedback

We will reflect on the quality visit feedback to date that some staff would like to re-visit the Quality visit model and would like to consider revisions to the operating model this year. A review of the model will be completed after the end of this season and is being scheduled.

The Trust Awards Ceremonies have been held on 29th November 2016 and 15th December 2016 to recognise staff for their commitments and hard work throughout the year.

This year has seen the re-setting of the clock for all awards to develop a level playing field for all teams, therefore no platinum scores have been awarded this year. At this year's moderation panel, the majority of teams were downgraded for their appeal, supervision rates of compliance throughout the year. This has resulted in a number of teams raising their disappointment and sometimes anger that they have not received a platinum award and/or not agreeing with the impact of moderation on significant inconsistency in supervision and appraisal rates. This will continue into the next season and all teams will be briefed in advance that this will be required both at the visit and must be maintained throughout the year and teams may be downgraded at moderation.

4.3 Learning From Feedback

The first new model of a learning event for staff followed a very serious incident in 2013. Learning is key from our staff in terms of both support and recommendations.

A common practice in Safeguarding Childrens practice is to develop and foster a culture of "no blame." This is undertaken by reflective learning accounts held with all parties to learn from serious case reviews. In November 2016, our new Safeguarding Leads, Karen Billyeald and Deep Sirrur, with the expert advice of Tina Ndili held its first Safeguarding Adults learning review of a very serious incident. Key staff attended and were able to share their often painful experiences of the serious incident and contribute on how the Trust should respond to draft recommendations.

On behalf of the Executive in 2013, Carolyn Green apologised to staff that their experience of staff support and how they were briefed after the incident did not always feel supportive and she confirmed that the executive team would learn and have and would continue to put in place measures of how they would respond and provide support now. Carolyn Green has issued a personal apology letter to all staff for the Trust response in 2013 and onwards.

The Safeguarding Committee will receive feedback on the learning event and the recommendations and oversee the recommendations and action plan when submitted into the public domain.

4.4 Shaping Clinical Practice and Learning from Mental Health Nurse Academics and International Nursing Practice

The Trust Joint Negotiating Committee have received in November 2016 two reports on the future of mental health nursing and the use or RGN's and Associate Nurses in the Trust and a position paper in professional standards authority and regulation.

These reports will be received by the Unions for both feedback and for challenge and will be included in developments at both The People and Culture and the Quality Committees and sub reporting groups for further actions and developments based upon this feedback.

4.5 Care Quality Commission Comprehensive Inspection

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

Some high level actions that have been progressed since receiving the comprehensive report and immediate feedback on areas of improvement already in progress or completed have been submitted to the CQC. The integrated report contains some key aspects for improvements.

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. This report has been produced monthly for the Quality Committee and a report was sent to the CQC to initially provide reassurance and assurance on the Trust implementing all learning and recommendations.

In addition, the Trust will be providing a monthly provider report to the CQC on information. This data will used by the CQC to inform them of provider intelligence and this intelligence will be used to consider unannounced visits to the service, focus inspection visits and wider issues for probing or analysis. This was submitted in November 2016.

In addition, a site visit by the CQC was undertaken and Amanda Rawlings was interviewed with regard to the Equality and Diversity Standards and requirements to provide evidence on the Trust's progress.

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

Safeguarding Committee Summary Report to Trust Board meeting held on 4 November 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)
Minutes and action log	Received and reviewed.	Assurance on the minutes	Ensuring key escalation from Safeguarding Children's Operations and to Safeguarding Committee	An action for the Executive lead for safeguarding, to in-reach to the safeguarding operations meeting. To review the system of escalation and ensuring a golden thread.	None
Safeguarding Children work plan	Accepted Received and reviewed.	Solid and improved performance Partial Assurance due in part that the safeguarding agenda is emerging and developing both nationally and locally Trust detailed information was provided giving increased confidence National benchmarking	Lack of national benchmarking	Adding the potential system risk to the BAF with regard to systems leadership of the Prevent agenda	None
Update Report on Safeguarding Children	Received and ratified	Significant improvement and a higher level assurance received on	Continued uptake of PREVENT training.	Information received	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)
Training Report and WRAP		Level 1 and Level 2 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 by 2017/18	Actions For Dr Sirur, to raise with the medical workforce, the need to be compliant	
CQC Safeguarding Children	Received and ratified	Accepted Partial assurance Some issues of actions that are retractable problems Agreed, the care Co-ordination allocation is still a risk and problem.	None	Accepted and partial assurance RED risk for the allocation of care co-ordination, remains unresolved Mark Powell to raise with CMDG in this commissioning gap.	None
CQC actions, comprehensive reviews	Action plan and improvements to-date	Accepted Significant improvement in level 3 annual training Supervision policy, supervision recording, advice on how to record and dates for new support and nursery nurses group supervision model. Partial assurance	None Specialist support to children service to improve 10 supervision groups have been offered to supplement the safeguarding offer.	Challenge on how we can demonstrate sustained change.	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)
Summary of SCR ADS14 **15/ KN15**	Assurance and summary on reopened of another areas incident with the Trust having peripheral improvement Review of capacity and demand of the impact of social care and learning from SCR, by the designated nurse and Director of nursing KNI5/ AMH involvement.	Director of nursing to feedback on KNI5 and the risks of stigmatising mental health problems			None
Safeguarding Adults	Safeguarding adult annual report	Partial and assurance and increasing level of assurance	Continued progress on the safeguarding issues related to Safeguarding and the Mental Capacity Act.		No escalations. Report to be recommended to Trust Board.
The Trust Carers Strategy	Was agreed and ratified	Feedback was one of the best carers strategies Young carers being detailed, was a positive aspect For each QLT, to submit a dashboard of how they will meet the strategy for their areas, per Neighbourhood, Ward area and Campus to then provide evidence	Young carers a strategic alliance.	To develop a young carers strategy, as a section for children's services over the medium term development piece of work, to add to this as a carer Wendy Slater and Young	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)
		every 6 months to the Safeguarding committee.		carers agencies to be explored for in-reach training to the Trust	
Triangle of Care	Report was received and accepted	Hosted the regional Triangle of Care forum A thorough and comprehensive report was provided including assessments	Continual to share information and resources	For the carers champions, events, scheduled North and South, who are writing their self-assessments and staff training has commenced.	None
Safeguarding Adults Work Plan	Report was presented	Information feedback on the MASH and positive early experiences under the new model Significant activity and improvement	Positive outcomes are appearing Lack of national information on safeguarding adults in board papers to benchmark against		None
Chaperone Policy & Procedure	Supervision Policy and Procedure	Good policy, assured	None identified	Ratified	None
Supervision Policy and Procedure	Amendments and agreed	Refinements to policy to ensure supervision	Policy agreed and with further minor amendments form the Designated nurse	Ratified	None
SAAF review and letter	Received and accepted	Partial assurance and an action plan for improvement	Capacity of the Safeguarding team.		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)
Forward Plan **Meeting dates 2016/17**	Agreed and ratified				None
Any Other Business	None				-
Meeting Effectiveness	Very good meeting Well briefed Improving level of assurance obtained				-

Board Committee Summary Report to Trust Board
Quality Committee - meeting held on 10 November 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)
Clinical policy management **Policy status matrix**	Significant improvement in policy governance	Good assurance	Maintaining performance, one outstanding policy EIA, a draft has been seen and is being commented on.	Assurance received	None
Quality Dashboard	Significant improvement	Good assurance	Clinical and management performance of supervision	Additional weekly monitoring by COO Additional report in Jan top 15 worst performers	
CQC **Action Plan**	Significant improvement and good assurance on progress Terms of reference reviewed with review and challenge.	Good assurance	None currently identified.	Evidence presented and agreed. Quality Committee Group to have additional detail and agreed.	None
Community Paediatrics performance report	Significant improvement, but not impacting on the full waiting list.	Partial assurance	Remains a high risk area	A future report in February 2017 on solution and assurance in improvement	
Patient Experience report	Reviewed patient experience report. Paper reviewed Assurance on key areas and improvement in the	Strategy – clinical priority area Significant work in person centre care and care planning.	Significant improvement in person centred care planning	Assurance of evidence and mitigations	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
	strategy Safer staffing and filling vacancies Care planning and clinical record audit and personalised work measures of performance				
Safety plan as a quality priority	Report received Significant training as part of roll out	Increasing assurance, in patient experience	Remains a high risk area	Assurance received	
Ligature risk reduction	Report received	Increasing assurance, and report to be included in the February Health and Safety	Reminds a medium risk	Assurance received	
Physical Healthcare	Paper presented and discussed Significant and substantial information received	Increasing assurance, in this quality priority area.	Meeting and care planning.	Assurance received	
Serious incident monthly report	Paper presented and discussed 71/38 investigations overdue, additional resources being explored Over 6000 incidents as an average remain stable and unchanged. The number of serious incidents remains stable.	Explanation appears to be the national changes and impacting on framework The serious incident framework of what is investigated has changed substantially. Significant level actions requiring completion, the ability proactively plan	Remains a medium risk	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)
	27 overdue actions at the end of October and then reviewed and achieved down to 10, with actions.				
Care planning person centred care	Copies and issued for next meeting.	Tabled so issued for next month	For December meeting		
Annual Clinical research plan	Report presented Significant research activity and the positive impacts of being involved in research.	Increasing assurance.	None at this time.	None	
Governance Improvement Action plan	Verbal report received and	Increasing assurance.	None at this time.		
Neighbourhood and Campus QLT	A report was presented	Increasing assurance.	Concerns re risks of the medical workforce for Cubley, immediate		
Quality and Assurance Group	The quality assurance and review	Increasing assurance. Evidence of flow.	None at this time. Risks and associated		
Any other business and effectiveness	Group discussion Lively Quality dashboard received well Sharp and effective				

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	Reflection on the meeting Minutes agreed				

Board Committee Summary Report to Trust Board

People & Culture Committee - meeting held on 17 November 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)
Matters Arising	Completed/December due dates	N/A	N/A	N/A	N/A
Staff Story	Feedback on Black History Month event and catering on 24 October 2016	History, event and catering coming together to celebrate our cultural diversity	Involving a broad range of staff in the programme	Developing a calendar of cultural focus areas each month	N/A
Strategic Workforce Report	NHS Employers evidence to the 2017/2018 Pay Review Body Tier 2 Immigration route changes announced East Midlands Streamlining project update Flu Vaccination Programme Staff Survey Participation Leadership Training Appraisal refresh Equalities Update	Ongoing focus on flu vaccination Ongoing focus on Staff survey participation Leadership training launched Appraisal process refresh underway	Ongoing challenge to meet the flu vaccination target Staff survey participation rate of 30% - 15% to achieve the target	To add to the 2017/2018 audit schedule to review the quality of appraisals	N/A
GIAP - Reconciliation Report/Exercise	Complete review of all the people related GIAP actions to update the	Noted complete actions and timetable to close the remaining ones	Progress noted, still some key areas to close by April 2017	To approve closure of a number of actions	Blue forms to be completed for close off
GIAP - WOD7 – Monitoring of adherence to the Grievance,	PWC findings and progressed was reviewed.	Noted actions taken to close the findings identified in the report	Improvements made that now need to be embedded and consistently followed	To schedule a review in the 2017/2018 audit schedule	Note progress

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Disciplinary, Whistleblowing Policies – PWC Audit Report					
GIAP WOD 7 – Tracker for backlog of cases monthly overview	Tracker is in place, reviewed monthly by Executives and bi weekly by HRD and will engage with staff side for monthly case reviews	Progress noted. PCC receive the number of cases via with the workforce performance report Staff side to engage in regular case reviews to unlock issues	A number of cases require ongoing support and focus	N/A	To take assurance of the focus and scrutiny that is in place
Recruitment Review and Action Plan	High level review of vacancy data for nursing and medical staff Review of process changes planned	New approval to appointment process has been developed to increase speed and slow Trust to invest in the TRAC system to speed up the recruitment process Review of all our medical vacancy numbers Focus onboarding for recent recruits	Loss of new hires before joining the trust	Appointed two additional resources to support a review of temporary staffing and permanent posts	N/A
HR Metrics	Deep dive into turnover and reasons and areas Review of reasons for sickness	Trust to tackle retention of staff whilst focusing on recruitment	Sickness absence is not reducing and the tackling of recruitment issues has to be a key priority for the trust	40% of the reasons for people leaving are due to workplace issues that we can resolve	N/A
Development of Apprenticeships	Update on the readiness for the Apprenticeship levy from 1/4/17 £450,000 plus 10% from the government	Progress noted and agreed that PCC will oversee the implementation of the programme	The timeliness of the standards being ready	PCC to receive a further update on state of readiness for April 2017 in January 2017	N/A
Staff Health and Wellbeing	Refreshed strategy presented with the current things the	Strategy requires further work to develop an improved offer that will support that is target		To increase the range of people engaged in the health and wellbeing working group	Revised strategy for April 2017

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Strategy	trust provides	to the needs of our staff		to review this again to bring back a revised version	
Forward Plan	To be revised to align to the refreshed People refreshed				
Items escalated to the Board or other Committees	To note that GIAP actions are starting to close down				

Board Committee Summary Report to Trust Board
Mental Health Act Committee - meeting held on 18 November2016

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Re-audit Consent to Treatment Section 58 Presentation	Recently completed audit to be presented but doctor not available. Presentation to be deferred.	Audit action plan to be completed and ratified by QLT. Audit department to assure completion of action plan and flag exceptions to Quality Committee.	N/A	Defer presentation. Action plan to be agreed by QLT.	N/A
Findings of the Audit for Capacity and Consent to Treatment for CTO Patients	Audit presentation. Partial assurance on compliance and quality of documentation. Further action required.	Assurance from audit investigation that clinicians are covering relevant bases but poor assurance that they are documenting this is a acceptable way.	Documentation of capacity assessments and related information needs to be improved in order to give assurance.	To rationalise documentation in line with S58 model and develop compliance stream from electronic records. To supplement with training and the champion model.	Development of compliance reports from PARIS may be restricted by reduced capacity in IT development.
Framework to improve performance regarding the Mental Health Act and Mental Capacity Act	Framework of compliance islands and best practice audit bridges accepted.	To populate the forward plan with audit programme. Compliance checks to run in real time as systems develop.	Pace of IT developed compliance checks could be compromised by lack of capacity in IT department.	To populate forward plan.	As above.
Mental Health Act Committee Report	Assurance received around activity levels with no significant variance.	Equality data is being collated on a roling basis and wil be benchmarked against population profile.	Lack of clarity in reporting of seclusion/segregation/isolati on data.	To clarify difference between the 3 types of restrictive practice and report separately.	N/A
PWC Internal Audit Report 2016/2017 Mental Capacity Act – A review	PWC audit September 2016 suggested further assurance required re paper records.	Audit of paper notes and electronic Best Interest forms gives assurance on clinical approach but not recording/documentation.	Action point from original audit “in progress” rather than complete.	JRS to meet with CM to give further assurance re original PWC audits action points.	N/A

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
of Patient Notes					
Section 5(2) Audit Summer 2016	Audit of compliance with S5(2) policy.	Low compliance with policy noted (but safe practice overall supported by MHA report).	Documentation of rationale for detention needs to be improved.	Recommendation re junior doctor training accepted. Earlier re-audit suggested.	N/A
Seclusion Review – Service Improvement Project – Summer 2016	Project to ascertain confidence of doctors in reviewing seclusion and documentation of reviews.	Doctors who were surveyed expressed low confidence in their first experience of review and although this improved with practice documentation did not.	Doctors new to the Trust may not have confidence in their competency.	Seclusion reviews to be included in induction training and EPR proforma to be developed.	N/A
The Seclusion Pathway and revised Seclusion and Long Term Segregation Policy	To provide assurance that changes to policy and documentation have improved quality of reporting data.	Lack of assurance with apparent lack of understanding of definitions and reporting.	Segregation/isolation may be under reported compared to seclusion.	JRS to brief staff re "frequently asked questions". Seclusion/segregation/isolation reports to be sense checked/validated and reported separately.	N/A
Section 136 Group Annual Report	Paper not submitted due to sick leave.			To clarify when Annual Report/Annual Plan is required to ensure fidelity to reporting schedule.	N/A
Section 12 Doctors Pilot	Pilot has been completed in October but results not available.	AMHPs have recently submitted their report to pilot lead.	S12 doctors' availability remains a problem.	To clarify with pilot lead when report will be completed.	N/A
Update – CQC Compliance Checking Model October 2016	Further resources have been allocated, ie: * clinical skills tutor * clinical practice leads x 2 - restrictive practices - MCA/DOLS	Recruitment has commenced.	Filling posts given skill set required.	To confirm appointments at Quality Committee.	N/A
Update on	Progress noted re learning	Need to quantify progress	E-learning has developed	To prioritise registered staff	To clarify resolution of E-

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Mental Health Act/Mental Capacity Act Training Mental Capacity Policy	materials/ongoing training.	and confirm trajectory for completing training.	technical problems so that completion cannot be confirmed by individuals.	for first pass training and then move to non registered staff. Move to a 3 yearly cycle.	learning IT problem.
Derby City AMHP Update including quarterly DOLS report Derbyshire County Council AMHP Update	First joint report received. No exceptions identified. Increase in DOLS activity noted.	To clarify that inpatients subject to DOLS applications are being assessed in a timely way and not illegally detained.	DOLS applications may outstrip LA resources leading to delayed assessments.	To monitor DOLS response times through MHA Manager's report.	N/A
Any other business	None				
Issues escalated to Board, Audit Committee or other Board Committees	1. Development of compliance reports from PARIS may be restricted by reduced capacity in IT department 2. To clarify resolution of E-learning IT problem	Escalated to Board following recent Deep Dive.	Lack f compliance checks necessary to improve performance around MCA/MHA.	To re-open discussion following recent Deep Dive.	Board
Meeting effectiveness	1. One paper not submitted due to illness 2. One paper submitted without front sheet due to paternity leave 3. Many apologies not given 4. Agenda overran 5. Compliance reports developing in MHA Manager's report.	Executive lead to confirm forward plan and reporting to Quality Committee avoiding congestion at MHAC.	Congestion of agenda at MHAC.	Executive lead to review.	N/A

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE QUALITY COMMITTEE

HELD ON THURSDAY 13 OCTOBER 2016
MEETING ROOM 1, ALBANY HOUSE

PRESENT	Julia Tabreham	Chair and Non-Executive Director
	Maura Teager	Non-Executive Director
	Carolyn Green	Director of Nursing & Patient Experience
	Mark Powell	Director of Operations
IN ATTENDANCE	Sam Harrison	Director of Corporate Affairs & Trust Secretary
	Rachel Kempster	Risk & Assurance Manager
	Emma Flanders	Lead Professional for Patient Safety
	Richard Morrow	Head of Nursing, Central & Children's Services
	Rubina Reza	Research & Clinical Audit Manager
	Donna Cameron	Corporate Services Officer
	Sandra Austin	Carer Representative, Derby City & South Derbyshire Mental Health Carers Forum
APOLOGIES	Margaret Gildea	Non-Executive Director
	John Sykes	Executive Medical Director
	Deepak Sirur	Deputy for the Executive Medical Director

QC/2016/165	**WELCOME AND APOLOGIES FOR ABSENCE** The Chair, Julia Tabreham welcomed all present to the meeting. Apologies from Board members/representatives were noted as above.
QC/2016/166	**MINUTES OF THE MEETING HELD ON 8 SEPTEMBER 2016** The minutes of the previous meeting, held on 8 September 2016, were accepted as a correct record with the following amendment: **QC/2016/156 – QUALITY LEADERSHIP TEAM (QLT)** QLT Chairs or named representative to be requested to attend ALL meetings.
QC/2016/167	**ACTIONS MATRIX & MATTERS ARISING** The Committee reviewed the Actions Matrix and agreed updates and amendments. **ACTION: It was agreed that a new standing item will be added to the Agenda – Carer & Service User Representative Feedback.**
QC/2016/168	**POLICY STATUS MATRIX** The Committee noted that of the two out of date policies listed on the matrix, the Declaration of Interests, Hospitality and Sponsorship Policy & Procedure is to be presented for approval today. Carolyn Green advised that Amanda Rawlings is aware of the out of date Equality Impact Risk Analysis (EIRA) Policy and Procedure. The Board had received an action plan to address this. The Committee expressed concern at the out of date EIRA Policy and

	agreed to escalate this item to the Board. Rachel Kempster added that this is also referred to in the Policy Governance Report. **ACTION: Concern regarding the out of date EIRA policy and procedure to be escalated to the Board.**
QC/2016/169	**ANNUAL HEALTH & SAFETY REPORT** Carolyn Green presented the report on behalf of Carrina Gaunt. Apologies were offered on behalf of Carrina Gaunt who was unable to attend due to a funeral. Carolyn Green apologised for the late presentation of this report; it had been available to present as per the forward plan in August but had been deferred due to the need to prioritise risk based and other regulatory reporting matters. The report provides the Quality Committee with an annual Health & Safety Report, outlining the activities and achievements in fire, health & safety, moving & handling and security management for 2015/16. In summarising key points to note Carolyn Green highlighted compliance rates for Fire Training and Fire Wardens are of a higher compliance rate than reported in the annual report (produced in August). Moving & Handling is a key risk area of required focus but the Health & Safety Committee gives substantial amount of reassurance regarding statutory duties and ensuring that they are discharged. Good work and engagement continues with Police and Fire Service representatives in our shared work in ensuring a safe service. No major RIDDORs have occurred during the reporting year for specific harm. Fire risk assessments are good. Following the CQC inspection, work continues to increase fire warden training compliance. Carolyn Green advised the report offers the board good assurance, with the understanding that further work is required on fire wardens and security management. Stress management and support for employees was highlighted by Maura Teager; Carolyn Green suggested that uptake of this service be reviewed, as well as its offering. NHS England has issued a new cultural barometer to measure, amongst other things, staff wellbeing which Carolyn Green has requested whether this will be implemented with Amanda Rawlings. Maura Teager requested data on the use of the service provided by the Staff Liaison Manager in supporting staff wellbeing to be provided to gain assurance that the services described were being used, it was confirmed that on the next report in 6 months an analysis of use and up-take will be provided. Maura Teager sought an update on Schwartz Rounds in the Trust. Carolyn Green reported she was aware that a previous Schwartz round session had been planned but she was not aware of a new programme of activity and agreed to escalate to Carrina Gaunt and Human Resources to request an update on any blocks to implementation or on reactivation of the Rounds. Maura Teager queried the categories used in Causes of Fire Alarms (page 18 of the report), specifically Malicious Patient category. Carolyn Green confirmed that categories are set by NHS Protect but agreed to refine and review the language in the Trust report rather than use the NHS Protect recommended language. Julia Tabreham observed that the word “etc” appears throughout the report and requested that it should be removed or replaced with the relevant

	information. It was also suggested that the report would benefit from tables and less descriptive text for the next report in six months. Children's Services were noted to have achieved 100% on their Health & Safety Assessments; Carrina Gaunt will pass on congratulations from the Quality Committee. Maura Teager requested further information on the non-attendance on the Moving & Handling Induction course, seeking assurance that this was not related to service capacity issues. A further discussion ensued with regard to the Quality Dashboard and where this will be reported. The Non-Executive Directors would like the revised quality dashboard to be reviewed at the Quality committee and then the same report to be presented in the Public domain at the Trust Board. Julia Tabreham would like to revisit the dashboard and review the dataset that is contained within and expressed that this overarching dashboard ins key to driving quality awareness at a Board level. **ACTION: Data on use of service provided by the Staff Liaison Manager requested by Carolyn Green to Carrina Gaunt for the next 6monthly report.** **ACTION: Update on Schwartz Rounds to be sought by Carolyn Green with the Human Resources team** **ACTION: Language used in categories defining patients in Causes of Fire Alarm to be reviewed and refined.** **ACTION: The use of the word "etc" in the report to be removed and addressed for future reports.** **ACTION: Key data on attendance at Moving & Handling Induction Course to be provided to assure that capacity is not a barrier to attendance. To be confirmed by Carina Gaunt and confirm any mitigating actions.** **RESOLVED: The Quality Committee received substantial assurance and approved the content of the report.**
QC/2016/170	**SERIOUS INCIDENT REPORT** Emma Flanders presented the report to provide the Quality Committee with information relating to all Serious Incidents (SIs) that had occurred during September 2016. Emma Flanders highlighted that the latest NRLS data had been received and an increase had been observed in levels of harm for deaths. The NRLS data is significantly affected by two key aspects, our Trust manages substance misuse services and we report all drug g related deaths if dual diagnosis is a factor. We are aware that many other Trusts no longer manage substance misuse services and therefore do not contain the data. The Trust is generally a very good reporter of incidents and has made significant headway in reporting deaths, we are aware that other Trusts have significant gaps in whether they report all deaths. In addition the occupied bed days against 100,000 populations in addition may be impacting upon the data analysis,

	due to the batch data approach undertaken by the NRLS team. Additional scrutiny of the Trust ONS data, NRLS and the Appleby suicide and homicide data can only provide a range of benchmarking This is being analysed but the Committee is warned this increase may trigger a concern to the regulator. This will be shared with the Board and a detailed analysis of our data and the risks will be continually revisited until we are fully assured that the NRLS data is a secure data source. Julia Tabreham suggested obtaining a data quality indicator and will be giving feedback on a potential solution In noting the externally reported incident of the death of an eating disorder patient who died at the RDH while waiting for an inpatient bed, Maura Teager reminded colleagues of a similar death around five years ago and suggesting flagging this with Commissioners. Carolyn Green confirmed she was aware of the previous case and had flagged this to commissioners and advised that NHSE may be concerned with this recent death with regard to access. The patient was from another city where the relationship had broken down and the Trust was hosting this patient as a supportive measure to another organisation. The legal team had been briefed to support the clinical service in this process. Sam Harrison is asked to keep a monitoring brief on this matter. Julia Tabreham thanked Emma Flanders for the report. **RESOLVED: Quality Committee received assurance from the report and noted the awareness of the emergency and current issues under a monitoring brief in the SIG Group under the leadership of Dr John Sykes.**
QC/2016/171	**POSITIVE & SAFE MONTHLY PROGRESS REPORT** Carolyn Green delivered the verbal update on behalf of Sarah Butt, who had not been able to attend the meeting. The Committee was advised the Trust had been performing well against strategy but following the CQC inspection there were aspects of performance which were downgraded to red, as some areas of practice were not articulated by staff and some aspects of practice were not be fully recorded in all instances. Reassurance is given that improvements are in development and additional assurance on a confirmed action plan with follow up compliance and assurance checks. Carolyn Green is pressing for confirmation that seclusion pathway record and forms are fully embedded into practice. These forms will become electronic once transferred to Paris, when live data will be secured when the remaining wards roll out Electronic patient records. Maura Teager sought to understand the obstacles to achieving sustained performance in these areas. Richard Morrow advised that this is due to an unclear pathway and cross referencing multiple forms of data, such as paper records, DATIX and the seclusion pathway which will be resolved when the source of data becomes a singular electronic source. The main obstacle is capacity/resource to develop and implement the forms and then moving all ward areas onto Electronic patient records. Until this is resolved paper recording is receiving a high focus of scrutiny, however this is not an efficient solution. Mark Powell agreed to look into the capacity issue in the IT

	development team and report back to Quality Committee in November. **ACTION: Capacity update on development and implementation of the electronic form(s) to be fed back to Quality Committee in November.** **RESOLVED: Quality Committee noted the update.**
QC/2016/172	**<u>PHARMACY UPDATE</u>** Carolyn Green presented the report on behalf of Sangeeta Bassi who had not been able to attend the meeting. The report updates the Quality Committee regarding medicines management related actions and progress made in line with regulatory (CQC) feedback within the last three months following the CQC visit in June. Julia Tabreham gave feedback that the report would benefit from improved clarity on scale and scope of the actions required. Carolyn Green assured the committee that this was an interim Quality position statement post CQC comprehensive inspection to provide assurance on progress to date that the that the main report, expected in January, will provide quantitative detail **RESOLVED: Quality Committee noted the report in line with CQC feedback and provision of partial assurance but evidence of substantial improvement at this stage.**
QC/2016/173	**<u>NICE GUIDELINES UPDATE REPORT</u>** Rachel Kempster presented the NICE Guidelines Update Report to update the Quality Committee with progress and plans for improving the Trust systems and processes for monitoring the effectiveness of implementation of NICE guidance and advice. In summarising the status of the project Rachel Kempster highlighted that all Carolyn Green added that the status of NICE guidelines will be presented in a similar listing view as with Policies & Procedures, via a Connect Sharepoint site. Over 100 guidelines have been assessed as relevant and they will be addressed on a risk-based priority. However, resource to deliver and implement the system fully is required. Mark Powell agreed to discuss the resource requirement with Rachel Kempster outside the meeting. Oversight of the NICE Dashboard will be via the Quality subcommittee pending confirmation and integration of the accountability framework and it is integrated. **ACTION: Mark Powell and Rachel Kempster to discuss resource requirements to support the NICE Guidelines project and feedback to the Committee.** **RESOLVED: The Quality Committee agreed the progress reported and plans to improve monitoring and reporting on progress against NICE guidance. A further progress report will be received in three months' time.**
QC/2016/174	**<u>POLICY GOVERNANCE REPORT</u>** Rachel Kempster presented the report to update the Quality Committee on progress to ensure policies are reviewed, ratified and uploaded to Connect in a timely manner and also to report on progress against the actions on the

	Governance Improvement Action Plan –ClinG2. The out of date Equality Impact Risk Assessment Policy. It is felt to not be fit for purpose. Quality Committee agreed to escalate this to the Board for completion (as per item QC/2016/168). As the Committee knows, the Job Evaluation Policy became overdue for review in 2014. An interim solution has now been reached with a suggested 12 month revision to be ratified imminently. Fluctuations in compliance can be dramatic; for example 16 policies went out of date on one day, taking compliance below required thresholds. One of the actions in the GIAP had been to reduce the number of policies. Rachel Kempster advised that this is unlikely to be an outcome. In comparison with other Trusts we appear to have less or similar amounts of policies. **ACTIONS: Policies to be reassigned for attention of Mark Powell as interim Director of Operations to replace Carolyn Gilbys as policy lead and or sponsor.** **RESOLVED: Quality Committee noted the status of policies overdue for review and agreed the progress outlined in the report. A further update will be presented in three months' time, as agreed on the forward plan.**
QC/2016/175	**DECLARATION OF INTERESTS, HOSPITALITY AND SPONSORSHIP POLICY AND PROCEDURE** Sam Harrison presented the revised policy for review and approval. The policy had been through a general review, including updates to reflect key legislation. Input has been received from Counter Fraud on required standards. Awareness will be promoted through publication on Connect and the Policy Bulletin to ensure staff are aware and the Trust is capturing declarations. **RESOLVED: The Quality Committee approved the updated policy, noting the amendments made.**
QC/2016/176	**RISK REGISTER ESCALATION** Rachel Kempster presented the report to summarise the current 'Top Risks' to ensure the Committee is aware of the Trust's most significant risks on its risk register at both a strategic and operational level. The report identifies risks currently rated as high or extreme on the Trusts risk register. These have been identified through the strategic and operational risk processes and escalation. A summary of risks rated as high or extreme on the trusts risk register is presented to the Board as part of the Integrated Performance Report. Three new risks have been added to the Board Assurance Framework (BAF), bringing the total number of risks to nine. This was presented to Audit & Risk earlier in the week and will be presented to Board in November. There remains a significant number of operational risks. There remains a significant risk around staffing levels. Mark Powell confirmed he had initiated actions to better understand the staff risks and the causation and will provide additional assurance on these risks and their mitigation plans.

	ACTION: The next quarterly report will include mitigating factors for the risks. However, should anything significant arise, Mark Powell will advise the Quality Committee at its November meeting to provide additional assurance on these risks and their mitigation plans. **RESOLVED: Quality Committee approved the report and agreed to continue to receive a bimonthly report, providing a summary of the 'top risks' and a summary of emerging themes.**
QC/2016/177	**QUALITY LEADERSHIP TEAM UPDATE** Richard Morrow presented the update to appraise Quality Committee of the activities within Central and Children's Services QLT. Richard raised the issue that the timing of the QLT meeting makes it a significant challenge for the minutes to be submitted in time for inclusion in the Quality Committee pack as it is scheduled for the same week. It was agreed that a meeting summary should be submitted to the Quality Committee with the full minutes of the meeting to the following month. QLT is reminded of the need to make the required updates, including using the escalation template. Richard added that meetings are quorate except during the summer months when some staff due to child care and other caring responsibilities impact on attendance. Maura Teager suggested using the summer meeting session as a Development Session. Overall, the QLT meetings have benefited from a review of terms of reference and injection of purpose. The group continues to revise its action plan, consider its function and how it escalates and also cascades information. Quality priorities and CQUINS have clear priority and monitored actions. Maura Teager sought further information on the under-reporting of incidents in Children's Services. Carolyn reported that she had met with the Team earlier in the day as part of their development day and she had feedback on some key questions the team had following their inspection and the impression is that there is confusion between concerns and patient experience and actual patient safety incidents and or near misses. Carolyn Green advised she had talked through NRLS criteria with the team and further follow up will be undertaken by Richard Morrow and Rachel Kempster to clarify the key differences. The Chair took the opportunity to ask colleagues if they had any matters to raise in relation to the QLT Minutes from Children's & Central Services and Neighbourhoods & Campus Services in general. Maura Teager commented that she felt the minutes were much improved. Carolyn Green reported she had attended Children's & Central Services QLT meeting as an assurance visit and confirmed they were noting and doing actions, that there was good attendance and she was assured that things had improved from earlier reports earlier in the year that the meeting had not been well attended. **RESOLVED: Quality Committee noted the report and agreed that a summary of the QLT meeting will be provided in the month of the meeting, with the full minutes to be received the following month.**
QC/2016/178	**GOVERNANCE IMPROVEMENT ACTION PLAN (GIAP)** Mark Powell presented the report, updating the Quality Committee with

	updates against Core 3 of the GIAP, Clinical Governance. The paper sets out three main recommendations that the Committee has oversight for. As agreed at the October Trust Board meeting, and following some feedback from Deloittes on progress on the GIAP, each Committee is tasked with a six month review on oversight of those actions. ***ClinG 1 – Refresh the role of the Quality Leadership Teams to increase their effectiveness as core quality governance forums (4 actions).*** In reflecting upon the narrative from Deloitte's report, the Chair did not feel assured that attendance and reporting of QLT meetings had been sufficiently embedded. Carolyn Green considered that with current trajectory would expect sustained effectiveness around January/February. Mark Powell pointed out that the GIAP had agreed these would be in place around October and asked the Committee to clarify what it was it hoped to see sustained and the end point. The Chair requested to see evidence of escalation templates in active and sustained use, minutes of meetings, work plans linked to the QLT forward plan, attendance embedded on the minutes and risk register. QLT leads could attend on a rotational monthly basis but QLT updates from each Team should be provided monthly. When the Committee has received all this information from each QLT consistently on a monthly basis for four months the Chair indicated she would be prepared to sign off this task. Carolyn Green added that she has attended QLT Meetings to provide coaching and address the need for clinical governance but the Executive Medical Director has not,due to the timing of the quality meetings and clinical commitments which Julia Tabreham flagged as an issue to log with the executive leadership team. **ACTION: Rotational QLT attendance with monthly updates as standard.** **ClinG 2 – The Trust would benefit from a robust and thorough policy review programme (1 action)** There is recognition that a good system with underpinning processes is firmly in place. The Committee was asked to consider what would make this task complete. Rachel Kempster reminded colleagues that 95% is supposed to be required but the percentage can change rapidly, for example, if a number of policies go out of date in the same month. It was agreed that this this aspect had been achieved and the wider policy governance had been achieved. An additional review of the original Well Led feedback would be conducted to ensure this had been achieved. **ACTION: It was agreed that this action had been achieved. Rachel Kempster would bring broader evidence of completion of the original outcome to the next Quality Committee to clarify the whether the totality of the task had been achieved prior to a recommendation to the Board.** **ClinG 3 – 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** Both the Chair and Maura Teager agreed that challenge from Non-Executive Directors is in place and has directly affected the content of reports presented to Quality Committee. Further benefit will be derived from the

	soon to be implemented Quality Dashboard. The Action Log requires richer narrative when capturing actions and accountabilities. Overall, the Committee expects to sign off this task by the end of the calendar year. **ACTION: Action log to have broader descriptive narrative on actions and accountabilities.** **RESOLVED: Quality Committee noted the report and will continue to develop the associated actions to evidence assurance that recommendations have been embedded.**
QC/2016/179	**REVIEW OF QUALITY STRATEGY & QUALITY FRAMEWORK** Carolyn Green presented the Quality Committee with a revised and updated Quality Strategy and Framework with updates on the continuing work to improve the quality services provided in line with the Trust's strategy and strategic objectives. Maura Teager observed formatting/bookmark errors. There was a reference to Monitor on page 6 of the report. **ACTION: It was agreed to revise the section on Risk, with Rachel Kempster to confirm revised content to Carolyn Green.** **RESOLVED: Quality Committee resolved to receive the Quality Strategy and framework. Assurance was received by the report.**
QC/2016/180	**DRUGS AND THERAPEUTICS COMMITTEE MINUTES** The minutes of the meeting held on 28 July 2016 were noted and assurance received on cross-triangulation.
QC/2016/181	**ALLIED HEALTH PROFESSIONS AND MEDICAL SCIENTISTS STRATEGY** The Committee welcomed Karen Wheeler, Acting Divisional Lead Occupational Therapist to the meeting to present the Allied Health Professions and Medical Scientists Strategy. The strategy replaces the previous multi-professional care strategy. The strategy represents a coordinated approach from the AHP group to the Trust's strategy and outlines how its aims will be achieved. Carolyn Green alerted Quality Committee to the impending advert for the AHP Lead, to backfill a one year secondment of the post holder to Erewash CCG. If the post is not successfully filled further consideration will be given to a solution to ensure AHP leadership is present in the Trust. **ACTION: An annual report against the professional strategy will be added to the forward plan for the Quality Committee.** **RESOLVED: The Chair thanked Karen Wheeler and the AHP group and Quality Committee noted and accepted the strategy.**
QC/2016/182	**Carer & Service User Representative Feedback** The Chair invited feedback from Sandra Austin, Carer Representative from Derby City and South Derbyshire Mental Health Carers' Forum.

	Sandra Austin reported that she had been advised of patient related correspondence for the attention of a carer being posted incorrectly. Carolyn Green confirmed she was aware of this issue, which is being investigated and treated as a complaint. A 'Blue Light' has been issued by the Patient Safety Team on how to improve patient and carer info on electronic patient records. Rachel Kempster added that this is referred to and followed through by the Information Governance Committee. Sandra also shared the concerns across the voluntary sector regarding the lack of funding for mental health groups, which was shared by Committee members.
QC/2016/183	**ANY OTHER BUSINESS** Maura Teager requested an update on environmental handovers from Richard Morrow as escalated by the Health and Safety team. Richard advised that this is being piloted on ECW and the environmental handover encompasses were risks as well as awareness of the potential of ligature areas on wards As a proof of concept and effectiveness the handover process is being piloted on ECW. Will continue to embed and analyse this practice before expanding to all areas.
QC/2016/184	**ITEMS ESCALATED TO THE BOARD OR OTHER COMMITTEES** • Concern regarding the out of date Equality Impact Risk Analysis Policy & Procedure. • Receipt and approval of the content of the Annual Health & Safety Report.
QC/2016/185	**FORWARD PLAN 2016/17** The forward plan was noted.
QC/2016/186	**MEETING EFFECTIVENESS** Maura Teager commented that some good decisions had been made and progress identified. Attendance was noted to be lower than expected, which can reduce debate and challenge. Mark Powell observed the good quality of the papers and the updates received. Good progress is being made with the wider QLT and the quality dashboard. The meeting closed at 16.30 and a confidential meeting with Board members only followed.

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF PEOPLE & CULTURE COMMITTEE

HELD ON WEDNESDAY 19 OCTOBER 2016 AT 2.00 PM
MEETING ROOM 1, ALBANY HOUSE, KINGSWAY

PRESENT	Margaret Gildea	Chair of Committee & Non-Executive Director
	Julia Tabreham	Non-Executive Director
	Mark Powell	Acting Chief Operating Officer
	Amanda Rawlings	Director of People and Organisational Effectiveness
IN ATTENDANCE	Sam Harrison	Director of Corporate Affairs & Trust Secretary
	Liam Carrier	Workforce Systems & Information Manager
	Anna Shaw	Deputy Director of Communications & Involvement
	Owen Fulton	Principal Employee Relations Manager
	Garry Southall	Principal Workforce & Organisational Development Manager
	Susan Spray	Principal Workforce & Organisational Development Manager
	Kelly Sims	Staff Governor
	Lee Fretwell	Chair, Staff Side
	Donna Cameron	Corporate Services Officer (minute taker)
	Tracy Shaw	Training Manager (for item P&C/2016/106)
APOLOGIES	John Sykes	Executive Medical Director
	Richard Gregory	Trust Chair & Non-Executive Director

P&C/2016/101	**WELCOME AND APOLOGIES** Margaret Gildea opened the meeting, welcomed attendees and led introductions. Kelly Sims was welcomed to her first meeting as Staff Governor representative. It was noted that governors will be represented on a rotation basis shared between Kelly Sims Staff Governor for Administration and Allied Support Staff and April Saunders Staff Governor for Nursing and Allied Professions.
P&C/2016/102	**MINUTES OF THE MEETING HELD ON 20 SEPTEMBER 2016** Julia Tabreham noted that her apologies had been recorded at last meeting. As she is not a member of the Committee she asked that they be removed. **P&C/2016/088 – STAFF FRIENDS AND FAMILY TEST REPORT** The Action status to be amended to show that the communication to staff had been developed by Anna Shaw with Amanda Rawlings and Lee Fretwell. With those amendments, the minutes were accepted as a correct record of the meeting.

P&C/2016/103	**ACTIONS MATRIX** Updates were provided and noted directly on the actions matrix.
P&C/2016/104	**MESSAGE TO STAFF** The Committee noted the email that had been sent to staff following the September meeting. Margaret Gildea asked if any reactions had been received. Lee Farewell confirmed this message had been discussed with staff.
P&C/2016/105	**ADOPTION OF REVISED PEOPLE & CULTURE COMMITTEE TERMS OF REFERENCE** Sam Harrison and Amanda Rawlings presented the amended terms of reference, reflecting inclusion of Equalities Forums and BME Network as a sub-committee of the People & Culture Committee; and the responsibility for the Committee to oversee compliance with equality and diversity legislation. The chairs of those sub-committees will also be required to attend the People & Culture Committee. Sub-committee terms of reference will reflect the duties and responsibilities of the People & Culture Committee and quarterly update reports will be submitted to the People & Culture Committee. The following errors were noted - the terms of reference will be amended as follows: • Director of Operations – should be Chief Operating Officer • Title of Workforce Director to be amended to Director of People and Organisational Effectiveness • JNCC (Joint Negotiative and Consultative Committee) to be typed in full (page 17) • Organisation chart to be reformatted **RESOLVED: Subject to the changes noted above, the Terms of Reference were approved.**
P&C/2016/106	**STAFF STORY** Tracy Shaw, Training Manager, presented the Staff Story, outlining the recent experience of recruitment and staff support of an occupational therapist (OT) in Mental Health. In summary, KB was recruited by a panel without OT representation, into a role which she did not meet the essential criteria for, received minimal supervision and had with no access to preceptorship or induction. The role was temporary and part time. More suitable full time roles had arisen during KB's appointment but she had felt it would be unfair to apply for those roles. KB has since left the Trust for another OT role. An exit interview was conducted and feedback given to the recruiting manager. Four main areas of concerns were discussed: The absence of reference to or use of the tools available to Recruiting

	Managers (New Employee Policy, Recruitment Checklist, Inductions). Inconsistency in the approach to representation on interview panels, which both Liam Carrier and Kelly Sims shared they were aware of. Thirdly, as raised by Julia Tabreham, how a Band 5, who did not meet essential criteria, was recruited to fill a vacancy left by a Band 6. The concern being the recruitment would appear to have been led by available budget rather than operational/patient need. Lee Fretwell also suggested that career progression for OTs should be an area for concern as the Trust has just one Band 7 OT out of the 80 or so employed. **ACTION: Kelly Sims to investigate, with Susan Spray, the procedures for composition of interview panels.** **ACTION: Mark Powell to look further into this story to identify areas/gaps for future improvements.** **ACTION: Mark Powell to discuss opportunities and infrastructure for OTs with Carolyn Green.** **RESOLVED: The Committee noted the report.**
P&C/2016/107	**STRATEGIC WORKFORCE REPORT** Amanda Rawlings presented the report to provide People & Culture Committee with a monthly update on key national and local workforce projects and highlighted: **Implementing the Junior Doctor Contract** Guarding of Safe Working has been appointed. Out of hours rotas are being redesigned. The Medical Staffing Manager is focusing on rostering and exception reporting. **Staff Survey** Historically there had been low response rates in the Trust, below the national average. The survey is being actively promoted with the additional support of Sue Walters, Engagement Project Manager. Amanda Rawlings had, earlier in the day, attended the Spotlight on Leaders session and took the opportunity to promote the survey, asking leaders to take responsibility for their staff to participate in the survey. The anonymity of the survey was reiterated. Teams with less than 12 people will not receive a report in order to protect anonymity. Julia Tabreham sought views on why the survey was received with scepticism. Kelly Sims felt it was a historical view held mainly by longer serving staff, supported by lack of confidence and faith in the Trust to make any changes based on the results of previous surveys. However, the podcast, shared in Connect, by Lee Fretwell, had been positively received. Amanda Rawlings assured the Committee that the data will be used to identify priorities that will make a difference to staff. **Flu vaccination programme** The Trust's target for this year is 45%. Amanda Rawlings advised that two weeks into the programme, the Trust has achieved 24%, which is 2%

	higher than the previous year's achievement. **ACTION: The staff survey will be tracked through the People & Culture Committee from results, through to actions and making recommendations to the Board.** **ACTION: Amanda Rawlings to arrange a vaccination session for the Board meeting in November to be organised and promoted.** **RESOLVED: The Committee noted the report.**
P&C/2016/108	**<u>WORKFORCE KPI DASHBOARD</u>** Liam Carrier presented the report to provide the latest key workforce KPI results, as at the end of September 2016, with 12 months of historic data. An update was given on hotspots and a triangulation focus list for key metrics identifying the top 20 teams in need of attention and support was also presented. The Committee was also apprised with the latest month end open case tracker regarding employee relations cases. Liam Carrier highlighted the deep dive into reasons for leaving the Trust over the last 12 months, as requested by the Committee. The main reason was retirement, followed by voluntary resignation/unknown. The main destination is no employment (retirees) followed by other NHS Organisations at 28%. Destination of leavers is also noted in the report. Other analysis, not included in the report, demonstrated that of the 77 leaving the Trust for other NHS organisations, 32 were nurses (9 health visitors, 23 nurses) 83% were here for less than five years and 16% less than two years. Kelly Sims requested benchmarking information from DCHS and Derby Teaching Hospitals, which Liam Carrier undertook to add to the next report. Amanda Rawlings informed the Committee that research had shown that many trusts are seeing Generation X, Y, Z changing employment frequently. Some trusts have changed how they recruit newly qualified staff, offering them rotations and preceptorships. This can lead to improved recruitment and retention. Amanda Rawlings reported that she had secured funding from NHS England to review how a joined up approach with local trusts working with Generation X, Y, Z could benefit recruitment and selection; this is supported by Chief Nurses. The report also contained initial reporting on internal turnover. In September 2016 33 employees transferred internally, which is an annual figure of 17% turnover. Mark Powell requested a 12 month analysis of internal turnover, expressing his concern at the time spent on internal moves. The analysis may provide information on moves to provide a greater understanding around why it is occurring so much. Owen Fulton asked if data collected in exit interviews could also be analysed. Sarah Spray confirmed it could and assured the Committee that any significant points are raised with managers. In reviewing sickness/absence, Julia Tabreham noted the high level of injuries recorded as fractures. Clarification on whether these are work related will be provided as figures presented to Quality Committee recently showed a low level of RIDDORs (Reporting of Injuries, Diseases and

	Dangerous Occurrences Regulations) in the Trust. Amanda Rawlings assured the Committee that recruitment and agency spend are the top priority, followed by understanding sickness/absence. **ACTION: Liam Carrier to provide age range of staff leaving in less than two years for analysis.** **ACTION: Liam Carrier to providing benchmarking destination of leavers with DCHS and Derby Royal.** **ACTION: Liam Carrier to conduct exit interview analysis for further analysis of reasons for leaving.** **ACTION: Liam Carrier to review fracture injuries to ascertain if work based injuries and cross-reference with RIDDORs reported in the 2015/16 Health & Safety Annual Report.** **RESOLVED: The Committee noted the report. The Committee is not yet assured but welcomed the process and focus of work.**
P&C/2016/109	**HUMAN RESOURCES STATUS REPORT** Amanda Rawlings presented the report to provide the People & Culture Committee with an update on how the HR team is delivering against its core functions and meeting the requirements of the GIAP (Governance Improvement Action Plan) and CQC (Care Quality Commission) findings. Since joining the Trust six weeks ago Amanda Rawlings had carried out a review of the status of the function against the expectations from within the Trust and of external bodies has been undertaken. The report presented a position statement and requested support for proposals to move forward. The proposals are: • To restructure the HR team and appoint substantive resources in the key areas outlined. This will provide a solution to some of the current issues in the team but would not meet the long term national requirement to consolidate back office functions. • To develop a joint structure with the DCHS team with joint leadership posts and teams. Due to the fragility of the team it is proposed that this is enacted as soon as possible and move to early integration in the areas that can move quickly, i.e. recruitment. Mark Powell indicated his support for the proposals and drew attention to the GIAP actions narrative and emphasised that the proposals must be delivered upon to resolve enforcement undertakings on the Trust's licence. In addition to this, the Committee must be absolutely assured that the proposal has the mechanisms in place to deliver on the 22 recommendations required by the licence enforcement action. Margaret Gildea asked members to consider how the proposal may be aligned to the actions. It was agreed that a subset of the People & Culture Committee would review each GIAP action against the proposal to ensure correct mapping before returning the results to Committee to provide assurance.

	The Chair asked if the Committee was content with the proposal to develop a joint structure with the DCHS HR Function, with joint leadership posts and teams. Julia Tabreham sought additional information on the trajectory and mechanisms for this proposal. Amanda Rawlings clarified that this proposal is presented as part of the back office work stream of the STP (Sustainability and Transformation Plan) and is therefore not connected to the Strategic Outcome Case (SOC). In seeking assurances around data protection, Amanda Rawlings advised Julia Tabreham that the joint structure is to maximise on shared leadership, expertise and best practice; data sets remain within organisations. Both HR Teams have also indicated their support for this approach. **ACTION: Mark Powell, Kelly Sims, Sam Harrison, Amanda Rawlings and the HR Team to reconcile the proposal with the GIAP and produce a report that outlines to People Committee clear timescales, leads and ownership.** **RESOLVED: The Committee noted the report and endorsed the proposals for restructuring of the HR team and a joint structure with DCHS. A further report, reconciling the proposals to the GIAP actions will be required.**
P&C/2016/110	**GOVERNANCE IMPROVEMENT ACTION PLAN** Mark Powell agreed this item had been superseded by the discussion on the proposals in the Human Resources Status Report (P&C/2016/109).
P&C/2016/111	**OPERATIONAL UPDATE** Further to the comprehensive report from Liam Carrier on Workforce KPI Dashboard, Mark Powell offered no further update.
P&C/2016/112	**PEER SUPPORT – ENGAGEMENT, CULTURE AND COMMUNICATIONS** Mark Powell and Sam Harrison reminded the Committee that NHSI had offered to facilitate peer support to help the Trust deliver its actions on engagement, culture and communications. NHSI see external support as a positive action in organisations with enforcement actions. Preliminary conversations had been held with Dudley and Walsall Mental Health Partnership NHS Foundation Trust (DWMHFT) to develop peer support arrangements. Sue Walters will continue in her Engagement Project Lead role and look at the methodology in the toolkit with Amanda Rawlings. A meeting will be arranged with DWMHFT to explore terms of regulatory action and to knowledge share in preparation for a recommendation to be made to the Committee. **ACTION: Sam Harrison to contact the independent consultant used by DWMHFT.**

	ACTION: Report with recommendations to People Committee at the January meeting.
P&C/2016/112	**REMAINING MEETING DATES FOR 2016/17** The Committee noted that the meeting scheduled for 21 December had moved to 22 December.
P&C/2016/113	**FORWARD PLAN** Sam Harrison will review the Forward Plan with Amanda Rawlings and consider any necessary restructuring. Mark Powell advised that the GIAP should not be on the forward plan – just the component parts for delivery. **ACTION: Sam Harrison to meet with Amanda Rawlings to review.**
P&C/2016/114	**ITEMS ESCALATED TO THE BOARD OR OTHER COMMITTEES** The Committee agreed to escalate the following items to the Board. • Endorsement of the proposal to develop a joint HR structure with DCHS • A sub-set of the Committee will review all 22 GIAP recommendations before the Committee's next meeting • The proposal to restructure the HR Team and appoint some substantive resources will be discussed with JNCC
P&C/2016/115	**IDENTIFIED RISKS** • The Chair remains concerned regarding the risks to recruitment and staffing • The capacity of HR Team is of concern • Mark Powell highlighted wider organisational risk due to capacity • Julia Tabreham identified the timeframe for the delivery of the 22 actions for the People & Culture Committee, as a risk
P&C/2016/116	**MEETING EFFECTIVENESS** The Chair welcomed the broad range of contributions to the meeting and particularly welcomed the representation from HR. With no further business the meeting closed at 4.20 pm.
Date and Time of next meeting: The next meeting of the People & Culture Committee will take place on **Thursday, 17 November 2016 at 1.00 pm in *Meeting Room 1 – Albany House, Kingsway, Derby.***	

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE SAFEGUARDING COMMITTEE

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

Friday, 7 October 2016

MEMBERS PRESENT:	Maura Teager	Chair and Non-Executive Director
	Julia Tabreham	Non-Executive Director
	Carolyn Green	Director of Nursing and Patient Experience
IN ATTENDANCE:	Tina Ndili	Head of Safeguarding Children
For item SC/2016/058	Tracey Holtom	Service Line Manager (part)
	Brenda Rhule	Interim Head of Nursing
	Garry Southall	Principal Workforce & OD Manager
	Bill Nicol	Head of Safeguarding Adults Southern Derbyshire CCG
	Michelina Racioppi	Designated Nurse Southern Derbyshire CCG
	Deep Sirur	Named Doctor for Safeguarding Adults
	Tracy Shaw	Training Manager
For item SC/2016/053	Alison Reynolds	Area Service Manager, Complex Health Needs and Paediatric Therapies (representing David Tucker)
For item SC/2016/057	Shirley Parker	Named Nurse Safeguarding Children
	Sue Turner	Board Secretary
APOLOGIES:	John Sykes	Executive Medical Director

SC/2016/046	**WELCOME AND APOLOGIES** The Chair, Maura Teager welcomed everyone to the meeting and introduced Julia Tabreham as the additional Non-Executive Director for the Committee.
SC/2016/047	**MINUTES OF THE MEETING DATED15 APRIL 2016** The minutes of the meeting, dated 15 April were accepted and agreed as an accurate record of the meeting, subject to the heading of item SC/2016/037 being amended to read Update Report on Safeguarding Adults Training Report and Wrap (Workshop to Raise Awareness of PREVENT).
SC/2016/048	**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/2016/049	**MATTERS ARISING** **SC/2016/037 The Voice of Those With Lived Experience:** A reminder of the Dark Net website in Safeguarding Training. Michelina Racioppi recommended at the April meeting that the Safeguarding Boards should work towards alerting and incorporating training about websites that encourage suicide and self-harm within Safeguarding Training. At today's meeting Julia Tabreham suggested that this could be the subject of a research project. In response, Carolyn Green agreed to raise the matter of these websites at the Safeguarding Boards to include awareness in the training programme. **ACTION: Carolyn Green to work with the Safeguarding Boards to arrange for training on the Dark Net and similar websites to be included within Safeguarding**

	Training if not already included in existing programmes and developments.
SC/2016/050	**<u>SAFEGUARDING CHILDREN WORK PLAN 2016/17</u>** Tina Ndili presented the Safeguarding Committee with an updated version of the Safeguarding Children Workplan for 2016/17 which provided the Committee with a clear strategic direction of timescales of the work to be completed by the Safeguarding Team, SLMs and operational managers in order to deliver the Safeguarding Children strategy and agenda. The Committee reviewed and approved the work plan although it was accepted that improvements were required and requested that the governance template is updated in future work plans to ensure AMBER rated risks include an arrow to indicate an improving or worsening position. The workplan would also be amended to show Amanda Rawlings, Interim Director of People and Organisational Effectiveness as a member of this Safeguarding committee to replace Jane Storey, and Carolyn Green would discuss this membership directly with her. **ACTION: Workplan template to include an arrow to indicate an improving or worsening position and be amended to include Amanda Rawlings, Interim Director of People and Organisational Effectiveness as a member of this committee** **ACTION: Carolyn Green to discuss membership of this committee with Amanda Rawlings** **RESOLVED: The Safeguarding Committee received partial assurance of the Trust's work around safeguarding children and young people and the continued 'Think Family' agenda operational level planning and performance.**
SC/2016/051	**<u>SAFEGUARDING CHILDREN ANNUAL REPORT</u>** Tina Ndili presented this report which set out an overview of the current issues and themes within Safeguarding Children to provide the Committee with assurance on the quality of the services provided. Tina Ndili drew attention to the current level of training compliance to assure the Committee that an improved performance and prioritisation of Level 3 training is taking place to achieve the standards outlined in the intercollegiate guidance. The Committee acknowledged the challenges in achieving the required standard of training compliance and Carolyn Green asked Tina Ndili and Tracy Shaw to develop an alternative training plan taking account of existing resources and capacity and produce a business plan for additional resources if required. Carolyn Green proposed to escalate the matter of training resource and capacity to the People and Culture Committee so that training needs can be addressed in an effective training plan and she would brief Non-Executive Directors on progress between meetings and provide a verbal update at the next meeting in November. The People and Culture Committee would also be asked to consider the development through its sub groups of a training needs analysis for staff competence in trauma and disclosure work. In addition to this, the matter of how to mitigate low attendance of training and DNAs (Did Not Attend) will be discussed outside of the meeting between Tina Ndili and Tracy Shaw. Carolyn Green explained that the Safeguarding Board did not wish the Trust to partake in single organisation Level 3 safeguarding training and proposed to take action to ensure this this particular training is included in the training programme as there is a real need for staff to participate to develop this required skill The Committee recognised that training compliance is a challenge and this would be escalated as an issue to the Board.

	The report also highlighted the main points and recommendations of the Bradbury report and its implications on the Trust and it was agreed that an action plan will be developed and scheduled for subsequent meetings. The overview of the Multi Agency Safeguarding Hub (MASH) arrangements both in Derby City and Derbyshire County were noted and Carolyn Green proposed to confirm with Mark Powell the risk associated with this service not being funded past the pilot stage in Derby city. The Committee received significant assurance from the report and recommended that it be received by the Trust Board in November. **ACTION: Tina Ndili and Tracy Shaw to develop an alternative training plan for existing resources and produce a business plan for additional resource if required.** **ACTION: Training capacity to be escalated to the People and Culture Committee to address. Verbal report on progress will be made at the next meeting in November.** **ACTION: Action Plan for Bradbury report will be provided to be scheduled for a future meeting and it is proposed the November meeting, subject to confirmation from the report authors.** **ACTION: People and Culture Committee to develop a training needs analysis for trauma and disclosure work.** **ACTION: Carolyn Green to obtain confirmation of funding for MASH from Mark Powell as part of the contract and commissioning round.** **RESOLVED: The Safeguarding Committee** **1) Noted the Safeguarding Annual Report received assurance on the Trust's annual activity to enable the Safeguarding Committee to lead and set the future direction for Safeguarding Children in the Trust.** **2) Agreed this Annual report and its recommendations in preparation for submission to the Trust Board**
SC/2016/052	**SAFEGUARDING CHILDREN TRAINING UPDATE** This item was not discussed and would be covered in a report from Tina Ndili at the November meeting. **ACTION: Safeguarding Children Training Update to be received at the November meeting**
SC/2016/053	**ANNUAL HEALTH REPORT FOR LOOKED AFTER CHILDREN** Alison Reynolds presented the annual report for Looked After Children (LAC) written by Lesley Smales who has since left the Trust. The report summarised the annual report for the year 2016-17 and provided the Safeguarding Committee with an overview of the current issues and themes within LAC. The priority actions for LAC contained in the report were noted. Attention was drawn to the role of the LAC Named Nurse and it was agreed that the job description would be redefined by Alison Reynolds and Tina Ndili to ensure clinical professional supervision. The Committee acknowledged the escalations contained in the report and the high level of assurance received on the level of outcomes, clinical outcomes and performance. Concern was raised regarding the level of experience and capacity

	within the team due to staff retiring and leaving the organisation and new staff joining the team and this gap in knowledge and experience would be highlighted to Commissioners and added as a risk to the risk register. It was agreed that a skill mix review would be carried out by David Tucker and additional support or advice would be requested and support given from CAMHS which would provide a key clinical link between LAC and CAMHS. Maura Teager welcomed the cohesive approach with CAMHS and the LAC team and acknowledged the dedication and hard work of all involved in this work on behalf of children and young people in Derby and recommended that the report be submitted to the Trust Board. Thanks were specifically extended to Lesley Smales on behalf of the Committee for the work she has carried out for many years for Looked After Children. **ACTION: LAC Named Nurse job description to be defined by Alison Reynolds and Tina Ndili** **ACTION: David Tucker to carry out a skill mix review of LAC team and Alison Reynolds will include the gap in experience and knowledge as a risk on the risk register** **ACTION: Annual LAC report to be submitted to the Trust Board in December** **RESOLVED: The Safeguarding Committee:** **1) Noted the report and received assurance on the quality of the Trust's LAC service** **2) Accepted the report and its recommendation that the report be submitted to the Trust Board.**
SC/2016/054	**MARKERS OF GOOD PRACTICE** Michelina Raciopi updated the Safeguarding Committee on the outcome of Markers of Good Practice quality visit, the assurance provided to Southern Derbyshire Clinical Commissioning Group (SDCCG) and the Derby City Safeguarding Children Board (DSCB) regarding the Trust's Safeguarding Children arrangements. The report was noted by the Committee and that Tina Ndili was working hard to progress responses on actions that are still outstanding. Michelina Racioppi would update the Committee of all outstanding actions at the next meeting of the Committee in November. **ACTION: Michelina Racioppi to update the Committee of all outstanding Marker of Good Practice actions at the November meeting.** **RESOLVED: The Safeguarding Committee accepted the information contained in the report and agreed to be kept informed by the Designated Nurse of any outstanding actions within the progress report at the next Safeguarding Committee meeting.**
SC/2016/055	**CQC SAFEGUARDING CHILDREN ACTION PLANS** This item was not discussed and would be deferred to the next meeting in November. Michelina Racioppi briefly updated the Safeguarding Committee and requested an update on the detailed actions prior to the next meeting. **ACTION: Tina Ndili and Carolyn Green to update the Committee of all outstanding CQC actions at the November meeting.**
SC/2016/056	**SERIOUS CASE REVIEWS**

	This item was not discussed. It was agreed that Serious Case Reviews KN15 and ADS15 would be deferred to the next meeting.
SC/2016/057	**TRUST'S AUDIT ON QUALITY OF CASE CONFERENCE REPORTS DOCUMENTATION OF ATTENDANCE AND OUTCOMES** The Named Nurse Safeguarding Children, Shirley Parker, provided the Safeguarding Committee with the results of the audit that was carried out to review the quality of case conference reports and documentation of attendance and outcomes of the case conference in the records. The audit focused on the case conference reports from Child and Family, Perinatal, Substance Misuse, Adult Mental Health, Learning Disability and CAMHS services, recognising the health professional's roles and responsibilities in safeguarding children, and the Working Together and Intercollegiate document 2014. The Committee accepted the audit and agreed that an improvement is required in the diligence of completing the correct template for reporting and endorsed the recommendations contained in the report as follows: 1) Support through training - relevant staff to access DSCB (Derbyshire Safeguarding Children Board) training on case conference attendance. 2) All relevant staff to use the Case Conference template as per DSCB, to maximise compliance. 3) A checklist to be incorporated on the records to improve and reinforce compliance in accordance with the DSCB procedures on case conference reports. 4) The Case Conference report template to be made accessible on different electronic systems and if not compatible, a downloadable version to be made available It was also agreed that a communication will be made on CONNECT to enable staff to be aware of the correct process for case conference reporting. Carolyn Green proposed to update Mark Powell as Electronic Patient Record lead on the need to change the PARIS record in line with developments included on System One which will enable the case conference template to be embedded within the system. To provide the Committee with assurance, a report and mitigation plan will be received at the January meeting. **ACTION: Tina Ndili to provide Mark Powell and the PARIS record team with a copy of the report and the template on Case Conference reporting and produce a mitigation plan to be received by the Committee in January.** **ACTION: Timescale for Case Conference Training and attendance tracker to be brought back to the January meeting.** **ACTION: Communication to be issued on CONNECT to make staff aware of the correct process for case conference compliance** **RESOLVED: The Safeguarding Committee endorsed the recommendations from the case conference audit as set out above**
SC/2016/058	**SAFEGUARDING ADULTS ANNUAL REPORT** Tracey Holtom's draft annual report summarised the year 2015/16 and this included Safeguarding Board plans and the Trust's position. The paper also provided an update of progress towards Safeguarding Adults and included a description of our systems and processes to protect adults and plans to strengthen our work in 2016/17. The Committee referred to the Trust's membership of the PREVENT Gold Group for

	Complex Case Enquiries 1 and 2 as outlined in the report. Bill Nicol informed the Committee that PREVENT Gold Group has since disbanded and that this particular aspect of safeguarding is now the responsibility of the CCG Chief Nurse. The Committee acknowledged the need to set up a strategic group for both these complex cases as it considered this to be a risk to the community and to the organisation. This system risk would be escalated to the Board and will also be included in the Board Assurance Framework (BAF). Carolyn Green stressed that the Committee takes systems responsibilities very seriously. She proposed to ask Ifti Majid for his support in prioritising this commitment to our community and will provide him with a briefing and ensure will ensure the Trust is represented at strategic group meetings to address complex cases. The Committee noted that the Datix system requires further realignment with the Care Act 2014 categories and that work is taking place to ensure cases are recorded correctly and will be completed in 2016/17. Tracey Holtom was pleased to report that good reporting practice is now taking place and an increase in reporting levels had been observed when compared to previous years. The Committee discussed the Trust's safeguarding referral rate and data accuracy and considered there should be triangulation of all referrals with the City and County local authorities. It was noted that as the source of referral is hard to detect as the local authority categorise all health referrals from any provider under one category this means that as an organisation we are not able to benchmark referrals within the current system. This has been escalated as an issue by Bill Nichol and Carolyn Green through the Adult Safeguarding Board especially as problems with data accuracy have in the past been acknowledged by the Safeguarding Board. In the meantime Carolyn Green assured the Committee that the Trust has a Datix screening team that scrutinises all incidents and regularly upgrades and downgrades incidents in line with incident reporting framework and data accuracy of recording. Allegations of abuse from staff towards patients was noted as a theme of calls to the Safeguarding Adult advice service. This data may be due to historical and current incidences. It was agreed that the Committee would refer this matter to John Sykes to explore any possible research development in this area. The target to achieve a staggered increase in PREVENT WRAP (Workshop to Raise Awareness of Prevent) training will be included in the final version of the report to show this will be increased from 13% from March with a monthly upgrade to ensure regulators are aware the Trust is working within the national guidelines for trust targets. This incremental training target should be changed on the training framework so that regulators are aware of a staggered in increase and clarity on this incremental trajectory should also be applied to the training work plan. Level 3 Safeguarding Adults Training is nearing completion for multi-agency roll out and it was agreed that the level 3 Safeguarding training target would also have an incremental structured target increased from 50% from March 2017. The application of the Mental Capacity Act within the Trust is inconsistent. This has been identified as a quality priority through audits and as an area for improvement as this gap in clinical practice impacts on the ability to ensure that patients in our care are safeguarded. The Trust has identified the work required to ensure compliance with the Mental Capacity Act. An action plan has been put in place and this is being monitored by the Mental Health Act Committee. Further concerns have been raised in regards to the Trust's application of the Mental Capacity Act following the Care Quality Commission comprehensive inspection in June. A further action plan has been developed and will be reported upon in the Safeguarding Annual Report 2017/18 and will also be reported to the Mental Health Act Committee and cross reported to this Committee.

	The Committee recognised that application of the Mental Capacity Act is as an area of practice that needs to be addressed from a training aspect so that the requirements of the Act are embedded into working practice. The Committee requested that John Sykes and the Mental Capacity Act team take action on the feedback from training and work towards simplifying the recording and monitoring the system on PARIS. Maura Teager reflected on the difficult and busy year experienced by the Safeguarding Adults Team and acknowledged the good reporting and key benchmarking information that had been achieved. Although this clinical area of practice is still in a developmental phase there has been clear organisational progress made against the strategy. She commended the work carried out by Tracey Holtom and recognised the significant complex challenges she has had to face. Maura Teager also thanked Tracey Holtom and her colleagues for their work in supporting survivors of complex enquiries at unnamed institutions. The Committee agreed this was an excellent report and looked forward to receiving the final version of the report at the next meeting in November. **ACTION: Carolyn Green and Bill Nichol to revisit escalate the risks associated with all health providers being grouped into one category in monitoring of referrals to the Safeguarding Board** **ACTION: Carolyn Green would speak to John Sykes to explore research opportunities into specific allegations.** **ACTION: Tracy Shaw to change the Training framework to include an increasing trajectory of compliance for WRAP and for level 3 Safeguarding Adults training target from a staggered percentage starting from an agreed baselines assessment up until achievement at March next year.** **ACTION: Reporting on application of the Mental Capacity Act to be brought to the November meeting of the Committee.** **ACTION: Mental Capacity Act action plan will be reported upon in the Safeguarding Annual Report 2017/18 for specific reference to its relation to safeguarding and reported through the Mental Health Act Committee and cross reported to this Committee.** **ACTION: Mental Health Act Committee and John Sykes and Mental Capacity Act leads to simplifying recording on PARIS and consider training feedback** **ACTION: Final version of the Safeguarding Adults Annual Report to be agenda item at November meeting.** **RESOLVED: The Safeguarding Committee:** **1) Noted the complexity of the Safeguarding Annual Adult report, the higher profile nature of this work, the changing landscape and our organisational progress against the strategy.** **2) Received assurance on the Trust's annual activity and on our work plan and integration with the Safeguarding Board agenda and to enable the Trust Safeguarding committee to lead and set the future direction for Safeguarding Adults in the Trust.** **3) Agreed that a final version of the Annual report would be received at the November meeting subject to comments from CCG partners and committee members.**
SC/2016/059	**UPDATE REPORT ON SAFEGUARDING ADULTS TRAINING AND PREVENT WRAP TRAINING REPORT**

	Tracy Shaw's report provided the Safeguarding Committee with an update on the safeguarding adults training position and PREVENT training. The Committee noted the safeguarding adults training compliance levels and agreed that all clinical staff are required to take part in PREVENT training. Discussion took place regarding the WRAP training and the importance of staff training passports accurately capturing individual training uptake. It was agreed that the training framework would be reviewed by Amanda Rawlings and Faith Sango to provide the Committee with assurance that safeguarding training is correctly recorded in training passports. **ACTION: Amanda Rawlings and Faith Sango to review training framework in regard to WRAP and training passports to assure the Safeguarding Committee that training passports capture safeguarding training correctly.** **RESOLVED: The Safeguarding Committee:** **1) Noted the maintenance of level 1 and 2 training** **2) Noted the ongoing plan for safeguarding adults level 3 training to increase compliance.** **3) Noted the ongoing plan for PREVENT WRAP 3**
SC/2016/060	**TRIANGLE OF CARE** This item was not discussed and would be deferred to the next meeting in November.
SC/2016/061	**CARERS STRATEGY** This item was not discussed and would be deferred to the next meeting in November.
SC/2016/062	**CHAPERONE POLICY** This item was not discussed and would be deferred to the next meeting in November.
SC/2016/063	**SUPERVISION POLICY AND PROCEDURE** This item was not discussed and would be deferred to the next meeting in November.
SC/2016/064	**FORWARD PLAN** The forward plan will be updated with actions arising from today's meeting.
SC/2016/065	**MATTERS TO BE ESCALATED TO THE BOARD OR OTHER BOARD COMMITTEES** • Training resource, capacity and compliance to the People and Culture committee • The cancellation of a named Gold Group for a key aspect of Safeguarding work and requesting attendance and priority of this are for the Chief Executive Officer and responsible officers in the CCG. As this is a system risk it is escalated to the Board and will also be included in the BAF.
SC/2016/066	**MEETING EFFECTIVENESS** Due to the fact the Committee had to vacate the meeting room due to a room booking error by the Education service. The meeting had to close earlier than expected to allow scheduled training to take place with an external party. Various items noted above were not discussed and would be deferred to the November meeting as follows:

	• Serious Case Review KN15 and ADS15 • Safeguarding Children Training Update • Triangle of Care • Carers Strategy • Supervision Policy And Procedure

Date and Time of next meeting:

The next meeting of the Safeguarding Committee will start at **1pm on Friday, 4 November 2016 and will take place in Meeting Room 1 –Albany House, Kingsway, Derby.**

MINUTES OF THE OF MENTAL HEALTH ACT COMMITTEE MEETING

HELD ON FRIDAY 26 AUGUST 2016 AT 10:00 AM MEETING ROOM 1, ALBANY HOUSE, KINGSWAY, DERBY

PRESENT:	Richard Gregory	Interim Chairman and Chair of this meeting
	Maura Teager	Non-Executive Director
	Dr John Sykes	Medical Director
IN ATTENDANCE:	Hilary Beckett	Associate Hospital Manager
	Christine Henson	Mental Health Act Manager
	Jacky Ingerson	Service Manager Central (AMHP) team
	Andrew Coburn	Legal Services Manager
	Tracey Holtom	Lead Professional for Safeguarding Adults
	Rachel Kempster	Risk and Assurance Manager
	Tim Slater	General Manager Campus
	Beth Masterson	Specialist Registrar
	Swetangi Ambekar	CAMHS Consultant
	Sue Turner	Board Secretary and Minute Taker
APOLOGIES:	Sam Harrison	Director of Corporate Affairs & Trust Secretary

MHA 2016/051	**OPENING REMARKS** The Chairman, Richard Gregory opened the meeting, welcomed everyone and introductions were made around the table. .
MHA 2016/052	**MINUTES FOM THE MEETING HELD ON 3 JUNE 2016** The Minutes of the meeting held on 3 June were agreed and accepted, subject to the following amendments: **MHA 2016/030 Electronic T2/T3 Forms:** The action "John Sykes to liaise with commissioners regarding this particular service receiver incident and provide an update at the next meeting in August" would be corrected to read *"John Sykes to liaise with clinicians regarding a particular CAMHS service receiver incident and provide an update at the next meeting in August and review the policy with Carolyn Green.".* **MHA 2016/031 Mental Health Act Committee Report:** The fourth bullet point "CTOs were high and 119 were received during one week alone" is to be substituted with *"CTOs were high and 119 were active on 3 June".* **MHA 2016/036 Review of policies required by the Revised Mental Health Act 1983: Code of Practice 2015:** The final sentence "Maura Teager congratulated Rachel Kempster on her sterling work in assuring the Trust was compliant with its policies" to be substituted with *"Maura Teager congratulated Rachel Kempster on her sterling work in assuring that policies were up to date and compliant with the Mental Health Act."*
MHA 2016/053	**MATTERS ARISING FROM THE ACTIONS MATRIX AND THE MINUTES** All actions and updates provided by members of the Committee were made directly to the matrix.
MHA 2016/054	**MENTAL HEALTH ACT COMMITTEE REORT INCLUDING SECLUSION MONITORING AND EQUALITY DATA** Christine Henson delivered her report which outlined details of Mental Health Act activity

that had occurred within the Trust in the last quarter for monitoring and assurance purposes. The report also contained statistics for the following data:

- Number of detentions by section type between the last two quarters
- Number of patients admitted to the Trust both formally and informally by ethnicity
- Changes in legal status compared to the previous quarter
- Use of seclusions within the Trust
- Use of emergency holding powers (section 5(2) and section 5(4))
- Use of community treatment orders
- CQC monitoring visits to the wards and action plans submitted to the CQC
- Collecting and reporting on the number of Deprivation of Liberty Safeguards (DoLS) applications made by individual wards within the Trust

Richard Gregory requested that the report front sheet contains an executive summary to describe how the Mental Health Act (MHA) and the Mental Capacity Act (MCA) is used within the Trust and highlight any issues for the Committee to address.

ACTION: Executive summary to show how the MHA and the MCA is used within the Trust and highlight any issues for the Committee to address

Detained Patients: The number of formal admissions had increased this quarter. This was considered to be due to an increase in recording of people who have lacked the capacity to consent to admission. The Committee requested that this data is to be captured in further reports to show trends and clusters and the impact on the workforce. It was also recognised that NPS (New Psychoactive Substances) use has also increased admissions.

ACTION: Capacity to consent to admission data to be included in future reports to show trends and clusters and the impact on detentions

Mental Health Act and informal admissions by ethnicity: It was noted that the ethnicity table has been improved and split into the two local authority areas of Derby City Council and Derbyshire County Council. The table reflected the population size of different ethnic cultures and future reports will contain a narrative to describe data regarding background ethnic population.

ACTION: Narrative to accompany table to describe data regarding background ethnic population in future reports

Seclusion: During the recent inspection, the CQC raised concerns regarding the management of seclusion within the Kedleston Unit as it was discovered that the Kedleston Unit were not recording incidents of seclusion. It was noted that Andrew Coburn and Jo Wileman are in the process collating information regarding these incidents. Action is being taken to bring his area in line with proper provision. Support is being provided to the leadership teams of the Kedleston Unit to ensure a new culture in record management is embedded.

Tracey Holtom clarified that exception reports are not always completed when people have been in seclusion over eight hours. However, these are not robustly completed and are not in line with the Code of Practice. The Committee recognised that the wards are overwhelmed by paperwork and it is hoped that the move to the Paris system will enable staff to be compliant with reporting once the system has been made simpler. It was agreed that Tracy Holtom and Rachel Kempster are to include a section on seclusion in the next report to provide the Committee with assurance that reporting is compliant with the Code of Practice.

ACTION: Tracy Holtom and Rachel Kempster to include a report on seclusion reporting and compliance with the Code of Practice in the next report.

The Committee was informed that a revised seclusion action plan is being led by Sarah Butt and will be reported to the Quality Committee. Tracy Holtom offered to liaise with Sarah Butt to ensure the next report received by the Quality Committee contains action taken to improve exception reporting. It will also be established whether the Trust requires a segregation facility and this will be reviewed and addressed by Sarah Butt.

It was agreed that Sarah Butt and Tracey Holtom will submit a report on seclusion reporting to the November meeting that will triangulate all findings and progress and set out how exception reporting is compliant and aligned with the Code of Practice.

The Committee was concerned that there is confusion regarding the difference between seclusion and segregation. It was agreed that a Blue Light will be issued to increase knowledge around seclusion and segregation and Tracey Holtom and John Sykes will ensure this knowledge is applied in practice.

It was noted that seclusion forms are being triangulated with Datix reports to capture 'nursed in segregation' in addition to the 'held in seclusion' field already in place. The seclusion report will in future be split to show the number of seclusions and the number of segregations that occur within the Trust each quarter commencing April – June 2016.

The Committee wished it to be noted that Christine Henson's report will be corrected to show that a patient had been secluded and not segregated on graph of seclusion activity.

ACTION: Seclusion Report to be submitted to the November meeting by Sarah Butt and Tracey Holtom that will triangulate all findings and progress and set out how exception reporting is compliant and aligned with the Code of Practice.

ACTION: Tracey Holtom will review the Blue Light that went out on 17 June with Rachel Kempster and John Sykes to ensure a revised Blue Light is issued that clearly defines the process for reporting seclusion versus segregation.

ACTION: Sarah Butt will establish whether the Trust requires a segregation facility.

ACTION: Christine Henson to correct the graph on seclusion activity to show that a patient had been secluded and not segregated

Rapid Tranquilisation: It was agreed that future reports would include a section to show how the Mental Health Act is applied to cases of rapid tranquilisation. Rachel Kempster added that this information is now being collated since the Blue Light was issued on 10 June reminding staff of the need to undertake physical monitoring of patients post rapid tranquilisation. She pointed out that this data also includes patients who were classed as "informally held" and was shown in data provided for Morton Ward where a patient had capacity and consented in their own best interest to IM rapid tranquilisation and the two patients on Ward 35 who were placed under emergency holding powers during the incident. Richard Gregory requested that John Sykes arranges for an audit takes place on this process and that Rachel Kempster investigates whether this incident was classed as 'under seclusion' or 'segregation'.

ACTION: Future reports to include a narrative section to show how the Mental Health Act is applied to cases of rapid tranquilisation

ACTION: John Sykes to arrange for an audit to be carried out regarding rapid tranquilisation.

ACTION: Rachel Kempster will investigate whether the incidents that occurred on the Morton Ward and Ward 35 were classed as 'under seclusion' or 'segregation'.

Section 5(2) doctor emergency holding power: Section 5(2) allows the doctor in charge (or their nominated deputy) the authority to hold an informal in-patient for up to 72 hours, whilst arrangements are made for a Mental Health Act Assessment to take place.

	It was noted that patients were properly assessed during the period 1 April to 30 June. John Sykes to contact consultants to establish whether patients are being detained due to smoking as the main issue for detention. **ACTION: John Sykes to establish whether patients are being detained under Section 5(2) due to smoking as the main issue for detention** **Section 131:** The Committee noted there were no admissions of a young person under that age 9f 18 to an acute mental health ward during this reporting period. **Deprivation of Liberty Safeguards DoLs:** The Committee noted that during the period 1 April to 30 June 2016, 27 DoLS referrals were made by the Trust. This was considered to be a standard amount and the way this information is collated will be improved. Christine Henson is in the early stages of improving the way data is collated and shown in the report. **Appointment of MHA/MCA Team Leader:** The Committee noted that this position will initially focus on the Mental Capacity Act ensuring staff receive training and that systems are in place to manage the Act. **RESOLVED: The Mental Health Act Committee noted and accepted the Mental Health Act Committee Report.**
MHA 2016/055	**CARE QUALITY COMMISSION VISITS AND ACTION PLANS PRODUCED BY THE TRUST** The CQC visit reports were submitted to the Mental Health Act Committee to ensure the Committee is aware of the CQC monitoring visits that have taken place within the Trust and the Action Statements provided by the Trust since the last meeting of the Committee held on 3 June. The Committee noted the actions highlighted by the CQC and the ward's response in relation to: • Lack of patient involvement in the production of Care plans • Renewal papers not being signed off on behalf of hospital managers • Distribution of Section 17 leave forms • Recording of capacity and consent in relation to treatment The Committee was assured that the issues raised by the CQC during their monitoring visits have been reviewed by the clinical team. **RESOLVED: The Mental Health Act Committee noted the CQC Visit Reports and Action Plans.**
MHA 2016/056	**SECTION 136 GROUP** This report provided the Mental Health Act Committee with an update on the focus and development of the S135/136 Group. Tim Slater gave an overview of 136 Group activity and informed the Committee that the Section 136 Group had recently reviewed its terms of reference, membership and key focus/objectives to ensure that the group continued to be effective in reviewing the use of S136 with the most relevant multi-agency representatives. In addition to this, it extended the group's scope to include S135 to support the development of a S135 protocol. Discussion took place as to whether a psychiatrist or Section 12 Doctor would attend the 136 Group and it was agreed that Beth Masterson would attend the 136 Group meetings in the capacity of a Section 12 Doctor.

	Whilst the 135 and 136 Group reports to the Mental Health Act Committee other agencies have a responsibility to report into their own organisations. It was agreed that as the Mental Health Act Committee is the Trust lead for this Group the Committee will give final endorsement to the terms of reference. This resulted in the terms of reference being approved, subject to the above responsibilities being included. The terms of reference would also be reviewed further in six months as this would allow the 136 Group to evolve and meeting effectiveness to develop. The draft minutes of the last meeting of the 136 Group were reviewed and discussed; these were the first draft of the minutes and were brought to the Committee to illustrate the context of discussion and that the terms of reference were being reviewed. An approved version of these minutes will be received at the next meeting of the Committee in November. Maura Teager asked that more action points and key dates be contained in the minutes as this would provide the Committee with assurance of activity. John Sykes advised that a 136 Group work plan should be formulated as this would set the structure of the Group going forward. Maura Teager made the point that more analysis on triage activity should be provided in the reports to the 136 Group and that they be detailed in the 136 Group meeting minutes received by the Committee. This resulted in discussion taking place on triage and 136 activity in the city. Jacky Ingerson informed the Committee that Commissioners hold regular multi-agency meetings regarding triage (now Mental Health Advice and Assessment service) and agreed that relevant data would be brought to the Committee in future reports. Tim Slater pointed out that during the recent inspection the CQC had noticed that 136 suites were not permanently staffed. The Committee recognised the challenges in staffing 136 suites and asked John Sykes to take the lead on 136 staffing as this will ultimately come under the spotlight. It was agreed that in the meantime, Rachel Kempster would check the risks on the risk register related to the 136 activity. **ACTION: Triage activity to be report to the 136 Group and be detailed in the 136 Group minutes as well as key dates and action points on 136 activity.** **ACTION: 136 Group forward plan to be formulated** **ACTION: John Sykes to take the lead on resolving 136 staffing.** **ACTION: Rachel Kempster will look at risks associated with 136 activity and report back to the Committee at next meeting.** **RESOLVED: The Mental Health Act Committee** **1) Considered the report.** **2) Received partial assurance from the contents of the draft (unapproved) S135/136 meeting minutes that the group continues to meet its objectives.** **3) Provided comment on and approved the recently revised S135/136 Group Terms of Reference.**
MHA 2016/057	**<u>POSITION STATEMENT ON WARDS VISITED BY THE CQC PRIOR TO INSPECTION</u>** Following the CQC's organisation inspection in June 2016, the Committee required an update on how previous action plans and the most recent findings are integrated to ensure consistent delivery of both CQC findings and Mental Health Act requirements. Tim Slater's report updated the Mental Health Act Committee on routine Mental Health Act action plans and current CQC position statement for Campus and summarised the current position against each actin plan for the Enhanced Care Ward, Morton Ward, and Cherry Tree Close. Tim Slater informed the Committee that he had scrutinised the action plans. He found that in the main the CQC actions had been immediately addressed but he had concerns

	about the evidence to support this and considered that greater focus would be given to ongoing monitoring and compliance. To support this, the report findings were shared across units and services as clear lessons to be learned and good practice shared. In addition to this, as part of the revised Campus Senior Leadership Team meeting structure, key action plans have been reviewed and this has been further extended in to area service meetings. Further consideration will be given to the current action plan process to improve monitoring and engagement with the Mental Health Act office. The Committee was assured that the senior leadership team had taken ownership of these actions in the form of its continuous performance management cycle. In addition to this the Committee was pleased to note that IMT have developed a portal to bring all these issues together to form a "real time" record which will allow good opportunities for monitoring this portal. Richard Gregory suggested sourcing an independent but senior level individual to take the form of a CQC inspection champion who would specifically check and monitor compliance and audit CQC findings. A similar exercise in another Trust he had chaired resulted in a positive learning experience for staff as well as valuable Board assurance. It was agreed that John Sykes would put together a business case for approval of this position by ELT. The Committee noted that greater focus and scrutiny is required with documentation. A single source of information should be available for visits and this was a common theme running across the reports. It was considered that the transfer to EPR would provide the revised rigour and scrutiny required as the process was midway through the transition towards EPR. **ACTION: John Sykes will take a business case through ELT for approval of an independent CQC inspector/auditor.** **RESOLVED: The Mental Health Act Committee** **1) Considered the report** **2) Received partial assurance from Campus services that CQC/MHA action plans are being acted upon and monitored for ongoing effectiveness** **3) Provided comment upon the current process for action plan submission and monitoring**
MHA 2016/058	**AREAS OF NON-COMPLIANCE IDENTIFIED BY CQC ACTION REPORT** Tracey Holtom presented her report which provided the Committee with an action plan and trajectory to rectify areas of non-compliance as identified by the Care Quality Commission Comprehensive Inspection in June 2016. The Committee noted that the action plan had been formulated to address and rectify deficits that have been identified by the regulator (CQC) relating to Regulation 11 (Need for Consent). Immediate actions were identified and implemented as a result of emerging findings for example a Blue Light was issued to reaffirm clinical standards. Other actions will focus on training, recording, audit, bench marking and standards to ensure a multi-pronged approach to address concerns. The Committee was concerned that the CQC found failings in training and compliance with the Mental Capacity Act. The Mental Health Act Committee will need its own action plan that will fit into the overall CQC action plan and will reflect the responsibilities of this Committee. It was agreed that a further report will be brought back to the next meeting in November that will include time lines against the actions and learning outcomes and show staff to be targeted. It was noted that by the next meeting in November the new MHA/MCA Team Leader will be in post and agreement of which staff will be targeted all of which will be addressed in the next report. John Sykes pointed out that the CQC action plan will be time lined and will reported

	through the Quality Committee and various actions will be included in the Mental Health Act Committee's forward plan for monitoring of these actions at each quarterly Committee meeting. Tracey Holtom informed the Committee that she is submitting a paper to TOMM (Trust Operational Management Meeting) in September regarding revising job descriptions to ensure they include capability with the MHA and MCA. She also explained that clinical tutors will go to in patient areas to carry out focussed work on skilling of staff. John Sykes added that the Clinical Audit plan will also form part of this performance management plan to ensure compliance with MHA and MCA. It was agreed that Rachel Kempster will work with Tracey Holtom to establish the risks around non-compliance with MHA and MCA and ensure these are included in the BAF and risk register. The Committee heard how the governance structure of the Mental Health Act Committee is being worked on and strengthened by Andrew Coburn and Tracey Holtom. Once this is finalised a report will be submitted to the November meeting which will reflect peer support from another mental health trust which will be tied into the report's action plan. and will show how this works into the GIAP **ACTION: Further report on areas of non-compliance with MHA and MCA identified by the CQC will be received as an agenda item at November meeting** **ACTION: Rachel Kempster will work with Tracey Holtom to establish risks around non-compliance with MHA and MCA and ensure these are included in the BAF and risk register** **ACTION: Report on Mental Health Act Committee Governance to be received at November meeting.** **RESOLVED: The Mental Health Act Committee** **1) Considered the action plan and approved it as a working document** **2) Scrutinised the contents and recommendations for other additional improvements to the plan**
MHA 2016/059	**<u>DERBY CITY AMHP UPDATE INCLUDING QUARTERLY DoLS REPORT, DERBYSHIRE COUNTY COUNCIL AMHP UPDATE</u>** The Derby City and Derbyshire County Council AMHP update was circulated at the meeting by Jacky Ingerson which contained statistics from the last quarter. Key points were noted as follows: • More section 2 referrals had been made compared to the previous quarter. • One warrant had been issued compared to earlier reports and this was considered to be quite unusual. Work is taking place on Community Treatment Orders as 35 had been received for the county. This was considered to be high compared to the city and Jacky Ingerson will prepare a narrative to establish why this figure seemed abnormal compared to Derby city statistics. Jacky Ingerson also informed the Committee that she will be carrying out a five year triage analysis of Mental Health Act work and this will take the form of a trend analysis and will show why so much work is carried out on Mental Health Act assessments. Attention would focus on area 136 at the start of the analysis and the analysis would give show how many people are discharged. John Sykes considered this was a good case for commissioning an audit of Mental Health Act assessment and that the audit should have a set criteria. It was agreed that John Sykes, Jacky Ingerson and Beth Masterson would discuss this further outside of the meeting and report on the outcome of these discussions at the next meeting in November. **ACTION: John Sykes, Beth Masterson and Jacky Ingerson will discuss outside of**

	the meeting how the audit of Mental Health Act work will progress and will report back in the November. **RESOLVED: The Mental Health Act Committee received and noted the statistics from the Derby City and Derbyshire County AMHP Update.**
MHA 2016/060	**MENTAL HEALTH ACT/MENTAL CAPACITY ACT TRAINING** Andrew Coburn delivered his report which provided the Mental Health Act Committee with assurance that the Trust is reviewing a package of bespoke training that raises awareness, educates staff and embeds a culture of understanding in respect of the Mental Capacity Act (MCA), Mental Health Act (MHA) and the Deprivation of Liberty Safeguards (DoLs). Andrew Coburn explained how the training package was being developed and that key members of staff have been identified who require the training as part of their role. The Committee recognised that time will need to be invested into embedding best practice and facilitating peer to peer learning going forward and asked that a timeline be produced for the training programme. It was noted that work is taking place to produce a training needs analysis which will establish the skills clinicians require to embed best practice and to determine the level of training to be provided. Concern was raised regarding the lack of appropriate resource to conduct the training as the newly appointed MHA/MCA Team Leader will only have the capacity to lead MHA/MCA training on a half time basis. It was recognised that more resource is required to train staff in MHA and MCA and the Committee recommended that John Sykes submits a business case to ELT for the approval of training manager resource. **ACTION: Action Plan and timeline to be produced for training as well as a training needs analysis** **ACTION: John Sykes to submit a business case to ELT for the identification of training resource.** **RESOLVED: The Mental Health Act Committee received and noted**
MHA 2016/061	**POLICY UPDATE** Rachel Kempster presented her report which completed the updates to the Mental Health Committee on the Trust's compliance with the policies, procedures and guidance which the Code of Practice says should be in place locally. Updates on the report have previously been submitted in November 2015, May and June 2016. The Committee acknowledged the proactive approach that had been taken to ensure all policies were in place and was assured that the process to ensure policies required by the Code has been completed. **RESOLVED: The Mental Health Act Committee received the report as assurance that the Trust has completed its review of policies detailed in the Mental Health Act Code of Practice**
MHA 2016/062	**ANY OTHER BUSINESS** John Sykes informed the Committee that a report will be received at the next meeting in November which will set out the Trust's compliance with the Mental Capacity Act and how the points raised in the PwC audit of the MCA have been addressed. **ACTION: Compliance with Mental Capacity Act to be agenda item for November** Jacky Ingerson pointed out that she is developing a system for reporting breaches such as breaches of less than 24 hour Section 5(2) to the Committee. She has a list of 8 – 10

	different breaches which she will be raising at a senior level and she will report on the outcomes to these breaches in her usual report to the Committee in November.
MHA 2016/063	**ISSUES ESCALATED TO BOARD, AUDIT COMMITTEE OR OTHER BOARD COMMITTEES** The following issues will be escalated to the Board: • Resource for Mental Capacity Act (MCA), Mental Health Act (MHA) and the Deprivation of Liberty Safeguards (DoLs) training manager • Resource for CQC inspector
MHA 2016/064	**MEETING EFFECTIVENESS** This was an exceptionally busy meeting and the Committee addressed what the Mental Health Act and Mental Capacity Act is concerned with.
MHA 2016/065	**2015-2016 FORWARD PLAN** It was agreed that the forward plan would be developed between John Sykes, Christine Henson and Rachel Kempster.
DATE OF NEXT MEETING **Friday 18 November, 2016 at 10.00am, Meeting Room 1, Albany House, Kingsway site.** *If you are unable to attend, please advise your apologies to Sue Turner, Board Secretary, extension 31203, for recording in the Minutes.*	

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

Safeguarding Adults Annual Report 2015 / 2016 and Programme of Work

Purpose of Report

This paper is the formal submission of the Safeguarding Adults Annual Report 2015 / 2016 and will provide an update of progress towards safeguarding adults. It includes a description of our systems and processes to protect adults and our plans to strengthen our work in 2015/2016. It includes some benchmarking, from available sources.

This annual report summarises the Annual report for the year 2015 to 2016 and this includes Safeguarding Board Strategic plans and the Trust position.

Executive Summary

- The purpose of this report is to provide the Trust Board with an overview of the current issues and themes within Safeguarding Adults and to provide assurance on the quality of the services.
- The Safeguarding Committee reviewed this paper on two occasions and commented on its content, accuracy and recommendations.
- The Care Act 2014 and the implications for the Trust.
- Safeguarding Adults team – Scope of safeguarding role and team structure, at year end 2015.
- To understand Safeguarding Adult service requirements in line with our community population needs.
- Safeguarding scrutiny by Commissioners Safeguarding Adults Self-Assessment (SAAF) and Peer review
- To have an overview of our responsibilities over the implementation of reporting standards for female genital mutilation.
- This report provides information to assure the Board on training compliance, which is improved performance with the need for continued scrutiny and prioritisation of training.
- Safeguarding Adult unit reporting structure and changes.
- An up-date on the changes and required work for PREVENT (programme for preventing children and young people from being drawn into terrorism), multi-agency public protection arrangements (MAPPA), multi-agency risk assessment conference (MARAC) and the required actions and timescales.
- A significant risk to the organisation and to providing safe care is working in a vacuum and not linking our internal work plan to the strategic aims of our wider geographical community and taking a systems approach to our Safeguarding organisational development. This paper as well as reporting on our own performance is linking to our commitments and system approach to our Safeguarding Boards.

Strategic considerations

- In order that standards remain high, organisational commitment to, to drive forward Trust performance in line with Safeguarding Adult Board strategic intentions and fully embed the Trust requirement for the Care Act 2014.
- 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.

(Board) Assurances

- A clinical audit programme will be redeveloped and delivered based upon this strategy work plan and readjusted built upon the Adult Safeguarding operational groups existing work plan and new intentions, this will be reported on in a separate committee paper.
- A defined work plan and mechanisms to meet new legislative changes are emerging and being defined.
- Compulsory training standards and compliance with systems and processes will be checked and assured through this process. This will include explicit links to conduct and capability should significant gaps in competence and knowledge be established.
- Due to significant legislative changes at this time only partial assurance can be given on the Trusts current performance.
- The Board can be assured that work is underway, national initiatives and guidance are being considered and plans are being developed to adjust our strategic plans and operational work plans in line with changes

Consultation

- This report has been reviewed by members of the Safeguarding team.

Strategic considerations

The Safeguarding Adults agenda is a faced developmental phase and the Trust will need to be flexible in its approach to embed new changes and reviews of practice and learning into the Trust's organisational development plan to ensure that all staff in the organisation are developing, learning and modifying their practice to embrace all of the significant changes in the Safeguarding work in 2015.

Legal and Governance

The Care Act 2014

Statutory duty to comply with PREVENT

The Criminal Justice Act 2003 ("CJA 2003") provides for the establishment of Multi-Agency Public Protection Arrangements ("MAPPA") in each of the 42 criminal justice areas in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders.

Equality Delivery System

This paper and the work of the Committee do not consider they disadvantage any group identified by REGARDS specifically. The Derby city and Derbyshire Health profiles are included to set the strategic context of safeguarding adults in our communities. We note that Derby city in particular has above average rates of crime, deprivation, child poverty and substance misuse which may impact upon our potential to Safeguard in our organisation. The Trust is minded to consider these statistics in his operational overview of Safeguarding Adults incidents in our community.

Recommendations

The Safeguarding Committee is requested to:

1) Note the complexity of Safeguarding Annual Adult report, the higher profile nature of this work, the changing landscape and receive assurance that a clinical strategy is in place and significant work is being undertaken in this area of clinical practice.
2) To receive assurance on the trust annual activity and on our work plan and integration with the Safeguarding Board agenda and to enable the Trust Safeguarding committee to lead and set the future direction for Safeguarding Adults in the Trust.
3) To give feedback on the report and scrutinise.
4) To agree this Annual report and its recommendations as outlined in the section work plans.

Report prepared by: **Tracey Holtom**
Lead Professional for Safeguarding Adults

Signed off by: **Carolyn Green**
Executive Director of Nursing and Patient Experience

Safeguarding Adults Annual Report and

Programme of work for 2015/2016

Introduction

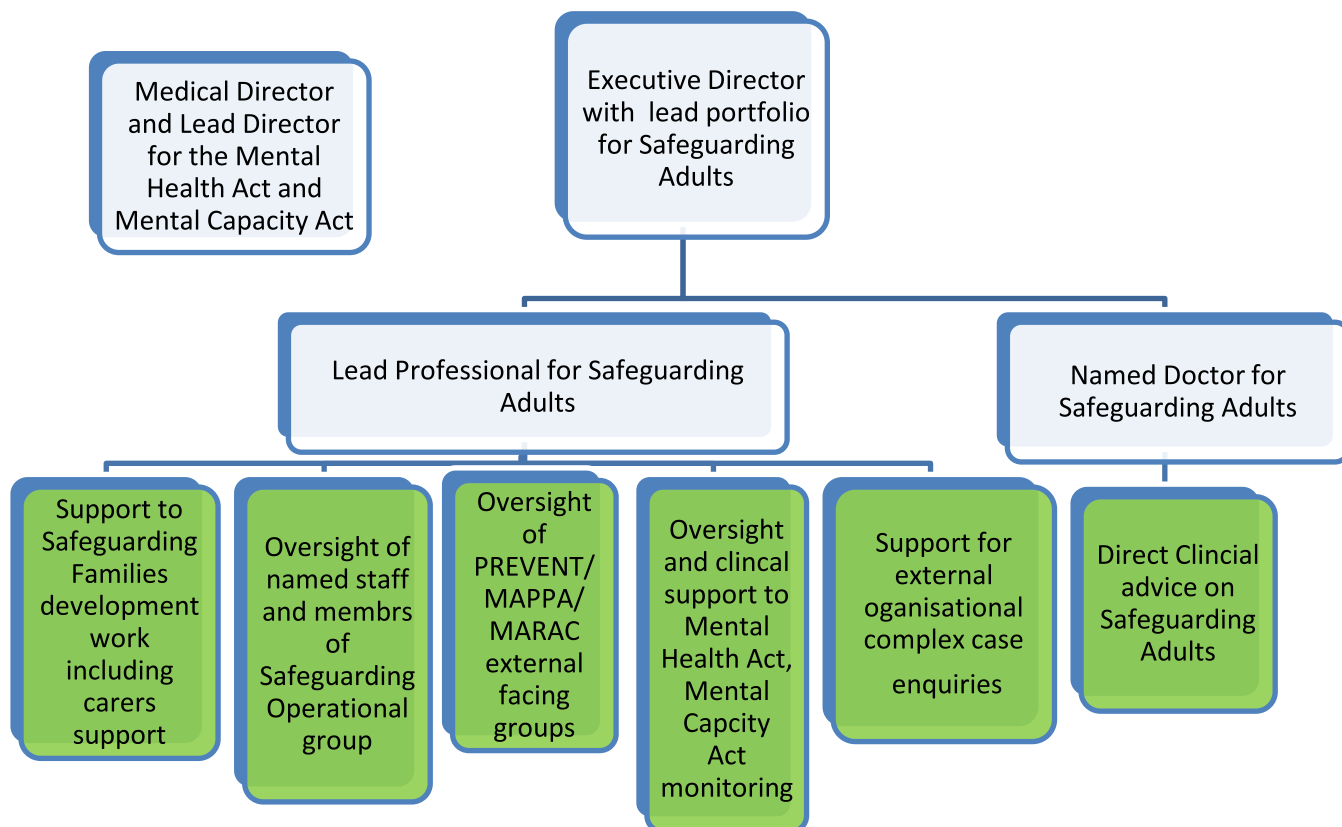
This Safeguarding Adults Annual report provides an updated position on the Trust's Safeguarding Adult work during 2015/2016.

In essence the principles of safeguarding which should underpin all work to protect people in the trust to ensure that they are protected from:

- Abuse and neglect
- Types of abuse and neglect
- Local authorities' responsibilities to carry out safeguarding enquiries where it is suspected that someone is suffering or at risk of abuse or neglect
- Creating Safeguarding Adults Boards (SABs) in every area to bring together the key local partners to focus on safeguarding strategy and practice
- Conducting Safeguarding Adults Reviews where there is a cause for concern about a particular case, to learn lessons for the future
- Sharing information between local and national organisations to support reviews and enquiries
- Providing independent advocates to enable some people who would otherwise have difficulty to take part in an enquiry or review.

Since the implementation of the Care Act 2014, the Trust has developed a safeguarding adult strategy in order to implement the now statutory requirements for our organisation. This had implications in governance reporting structures and ensuring a pathway between the Safeguarding Lead and the Board. A Safeguarding Board level committee is now embedded, giving scrutiny and assurance to the organisation.

The Safeguarding Adults Team – Scope of Safeguarding role and team structure and its working relationships with the wider safeguarding community



During 2015/2016, the Safeguarding Adults Lead professional has been in post and a Named Doctor for Safeguarding Adults has been reviewed and appointed too. As part of the strategic plan for Safeguarding Adults the meeting and governance structure has been reviewed and the representatives for the Trust's Safeguarding Adults agenda attend the following meetings:

Meeting	Frequency	Attendance	Attendee
Safeguarding Adult Boards for Derby City and Derbyshire County Councils	Quarterly	Full attendance	Executive Director of Nursing and Patient Experience and Safeguarding Adults Lead
Safeguarding Adults Operational Meeting	Bi-monthly	Full attendance	Safeguarding Adults Lead
Safeguarding Committee	Quarterly	Full attendance	Safeguarding Adults Lead
Channel Panel	Monthly	Full attendance	Safeguarding Adults Lead

Meeting	Frequency	Attendance	Attendee
Steering Group for Prevent	Quarterly	Full attendance	Executive Director of Nursing & Patient Experience
Gold Group		This has recently been re-launched	Chief Executive
PREVENT Forum	Quarterly	Full attendance	Safeguarding Adults Lead
Derby City and Derbyshire Safeguarding Adults Boards	Quarterly	Full attendance	Safeguarding Adults Lead
Multi-Agency Public Protection Arrangements Meeting Level 3	Monthly	Full attendance	Safeguarding Adults Lead
MAPPA Level 2	Monthly	Full attendance	Neighbourhood Team Managers
Strategic MAPPA Board Level 4	Quarterly	Full attendance	Executive Director of Nursing and Patient
Sub Groups of the Board City performance Sub Group	Quarterly	Full attendance	Safeguarding Adult Lead
Mental Capacity Act / Deprivation of Liberty Safeguards Sub Group	Quarterly	Full attendance	Safeguarding Adult Lead
DSAB City Audit Group	Quarterly	Full attendance	Safeguarding Adult Lead
Learning and Development	Quarterly	This has recently re-launched	Trust Training Manager
Customer Inclusion Group	Quarterly	Allocated staff member now attending	Head of Nursing for Community
Triangle of Care	Half Yearly	Full attendance	Safeguarding Adult Lead
MARAC	Fortnightly		Trust Leads
Adults at Risk Committee	Quarterly	Full attendance	Safeguarding Adults Lead

The Safeguarding Adult Lead and the Safeguarding Children's Lead continue to work concurrently on the intersecting agendas for each service. Both Leads attend Operational meetings regularly and share agenda items directly related to both services to forward the agenda of Safeguarding Families within the organisation.

The Named Doctor for Adults role has been reviewed and Dr Deepak Sirur has been appointed to this role as from August 2016.

The Safeguarding Adults team has appointed to a Complex Case Enquiry. This comprises of:

- One full time Psychologist.
- One full time seconded Case Worker

Safeguarding Adults - Prevention

Think Family

Think Family forms a significant part of the Safeguarding Adult agenda and work has continued this year to fully embed this strategy into all service areas ensuring that consideration for families is integral to the practice of our Clinicians.

Over the last year, the Think Family training has been rolled out across the organisation and audits have been developed and refined in order to measure the effectiveness of this training and the extent it has been embedded into practice. A benchmark audit has already been completed so improvement can be measured. We are awaiting the outcome of the audit by December 2016.

Triangle of Care

The Triangle of care forms an integral part of our Safeguarding Adult's commitment to Carers. We continue to be an active and participative member of the Triangle of Care Midlands Regional Meetings chaired by the Triangle of Care Project Lead. Derbyshire Healthcare Foundation Trust hosted the forum in September 2016 and received positive feedback.

The membership remains to share best practice and the SBARD tool for Carers has received positive feedback with participating Trusts seeking approval from Derbyshire Healthcare Foundation Trust to adapt and utilise the tool for their own organisations.

The Trust has continued to be supported with the initiative by the North and South Derbyshire Carers Forums. The Trust has welcomed and thanked the forums for their support and encouragement.

We are making continued progress with embedding and benchmarking our services during 2015/2016. This will continue into our community areas 2016/2017.

Triangle of Care Action Plan

Triangle of Care	Action	Date completed (RAG rating)	Progress
Triangle of Care Stage one self-assessment benchmark inpatients	All in-patient areas have completed self-assessment and action plans are in place. Monitoring and oversight by Heads of Nursing	Completed 2015	
Triangle of Care Stage two self- assessment neighbourhood teams	To commence stage two self-assessment benchmark for neighbourhood teams		In process Quarter 4 2016/2017
Awareness raising for the neighbourhood teams for the Triangle of Care	Awareness raising training sessions are available for staff to book onto via the booking line. General Manager for the neighbourhood teams has cascaded information to team managers in preparation for the self-assessment. Head of Nursing for Community has been identified to support teams in completion. Task and finish group is in operation to support roll out and completion		In process Complete by Quarter 3 2016
Presentation to the Triangle of Care Midlands Regional Group	To present up to date benchmark position for inpatient areas and outcome of initial benchmarking self – assessments for the neighbourhood teams. Led by the Safeguarding Adults and Carers Lead.		Quarter 1 2017/2018

Safeguarding Adult Service Requirements in line with our Community Population needs

Derby City and Derbyshire

Derby is a city has a population of 248,700 people with Derbyshire having an overall population of 770,600. (Census 2011). There is currently no update from Public Health on health profiles since 2015.

PREVENT and CHANNEL - Statutory Duty

The Trust continues to comply with the PREVENT duty that became statutory in July 2015 and has an identified PREVENT Lead who attends and participates in Channel Panel meetings.

To enhance the response of the organisation Safeguarding Adults Lead and the Safeguarding Children Lead attend regularly and contribute on cases involving young people and to enhance a Safeguarding Children and Adult opinion across all cases which lends itself effectively to the family inclusive policies of the Trust. The Safeguarding Adult Lead attends the Regional PREVENT forum on a quarterly basis

PREVENT training and referral performance is reviewed in a subsequent section of the annual report.

Update on actions from 2014/2015:

PREVENT duty	Action	Date completed (RAG rating)	Progress
1. Prevent Policy	Draft policy requiring sign off	Completed 2015	Requires review to be action 2016/2017
2. Prevent Leads are identified within the contract	Prevent Lead identified in the contract for the Trust	Completed April 2016	On-going
3. Training Workshop for Raising Awareness of Prevent level 3 Required as now mandatory for Mental Health staff	The Trust now has 5 WRAP 3 trainers	Completed October 2015	Trust Training Manager Continue roll out and trajectory is in place
4. Review PREVENT Policy	To incorporate Building Partnerships Staying Safe toolkit		Safeguarding Lead Quarter 4 2016/2017
5. To continue to monitor Prevent activity and report	Monitor activity by attendance and quarterly PREVENT return to NHS England	On-going	Safeguarding Lead On-going to date 2016

Safeguarding Adult Performance

There has been an increase in Adult Safeguarding referrals to social care in the year 2015/2016. Whereas this is welcome, we remain to have "cold spots" with some of our teams reporting no safeguarding referrals on datix for the year 2015/16. Further work is required to address this to move the organisation from a partial assurance to full assurance in 2016/2017.

We reviewed Dorset rated as 'Good' and 'Outstanding' services by the CQC. We reviewed Dorset annual report, which did not provide any performance or training information in their annual report. Their work was descriptive of actions only with no assurance of performance.

DHCFT Safeguarding Adult Referrals

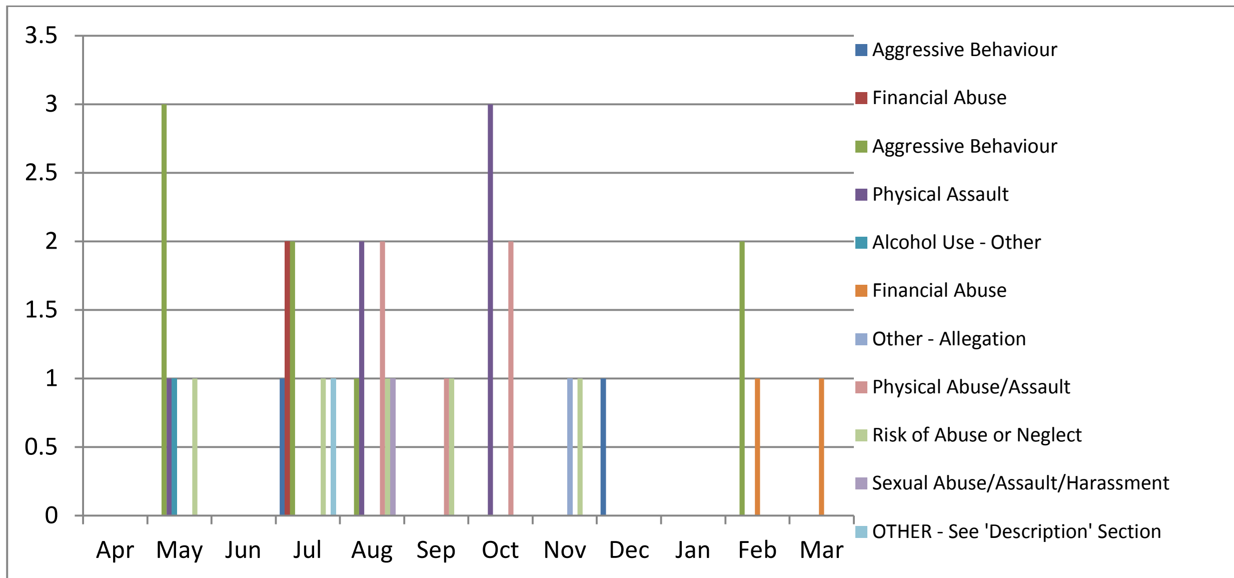
Safeguarding Adult Referrals	Total
2014/2015	179
2015/2016	208

Action Plan

Safeguarding Adult Practice	Actions	Date completed (RAG rating)	Progress
To thematically review Safeguarding incidents recorded on Datix	Review referrals and identify teams who are not reporting	Safeguarding Lead Quarter 3 2017	
To continue to raise need for Safeguarding compliance across operational and clinical structures	Cascade Safeguarding referral process to teams via the operational management process	Safeguarding Lead Quarter 4 2016/2017	
Scrutinise all teams performance across the Trust via the operational group	Safeguarding performance report to be generated by Datix for scrutiny at the Safeguarding Operational Group and report performance to the Quality Leadership teams for action	Safeguarding Lead Quarter 4 2016/2017	
To review and embed Safeguarding Champions within teams, which promotes and oversees the Safeguarding agenda in the areas	Safeguarding champions to be identified within each team. Plan to be developed to enhance knowledge and skill set for the champions	Safeguarding Lead Quarter 3 2017/2018	

DATIX Reporting
Safeguarding referrals to Social Care by Incident Grading

2014/15
Insignificant



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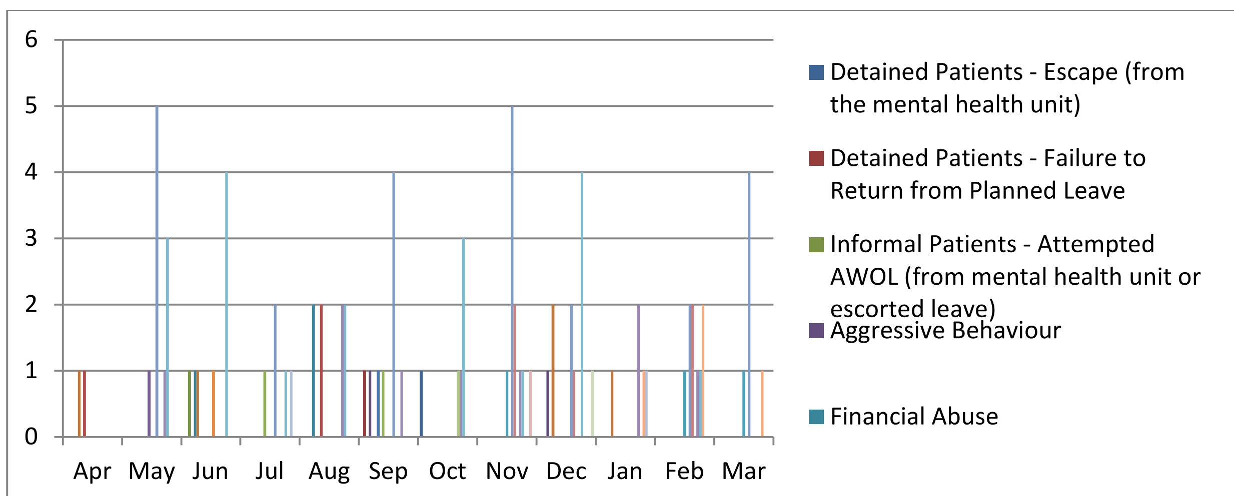

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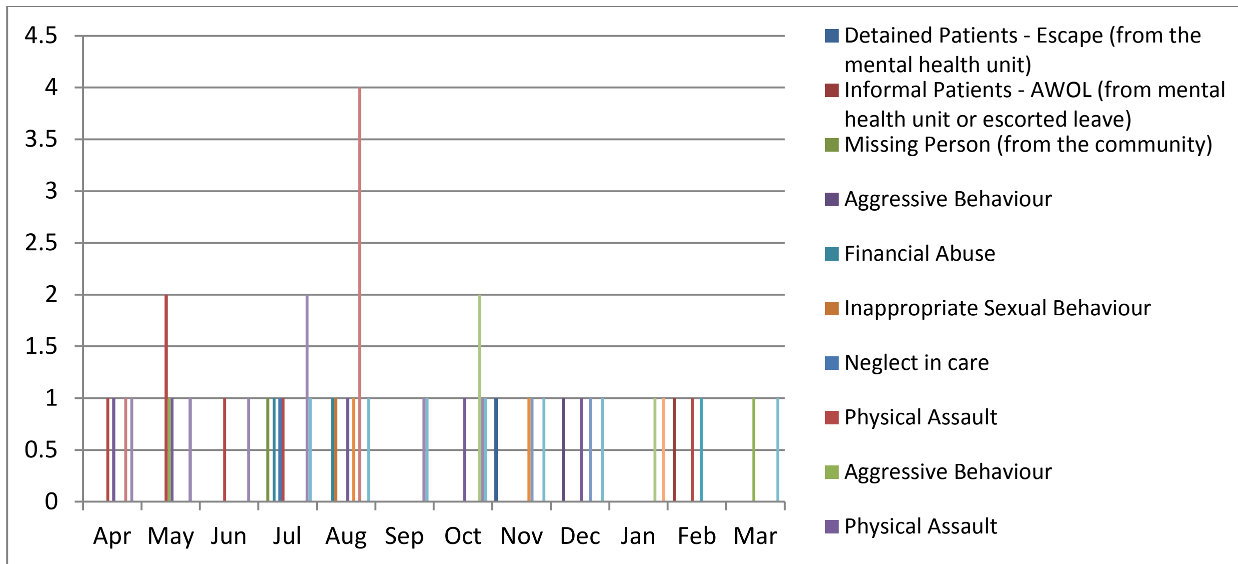

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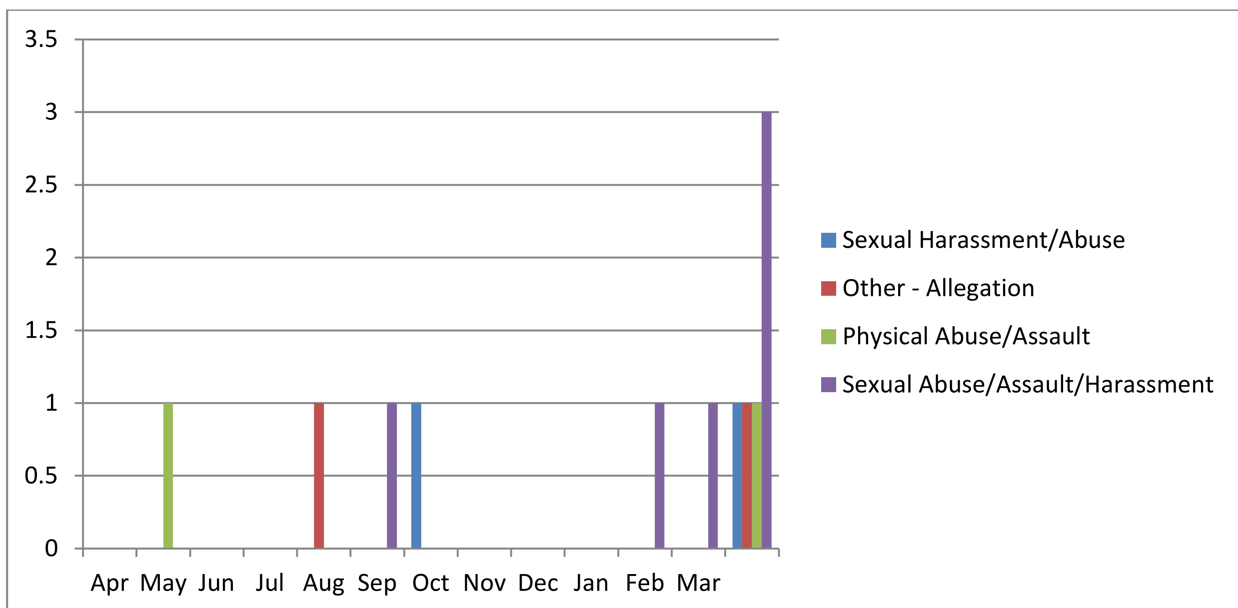
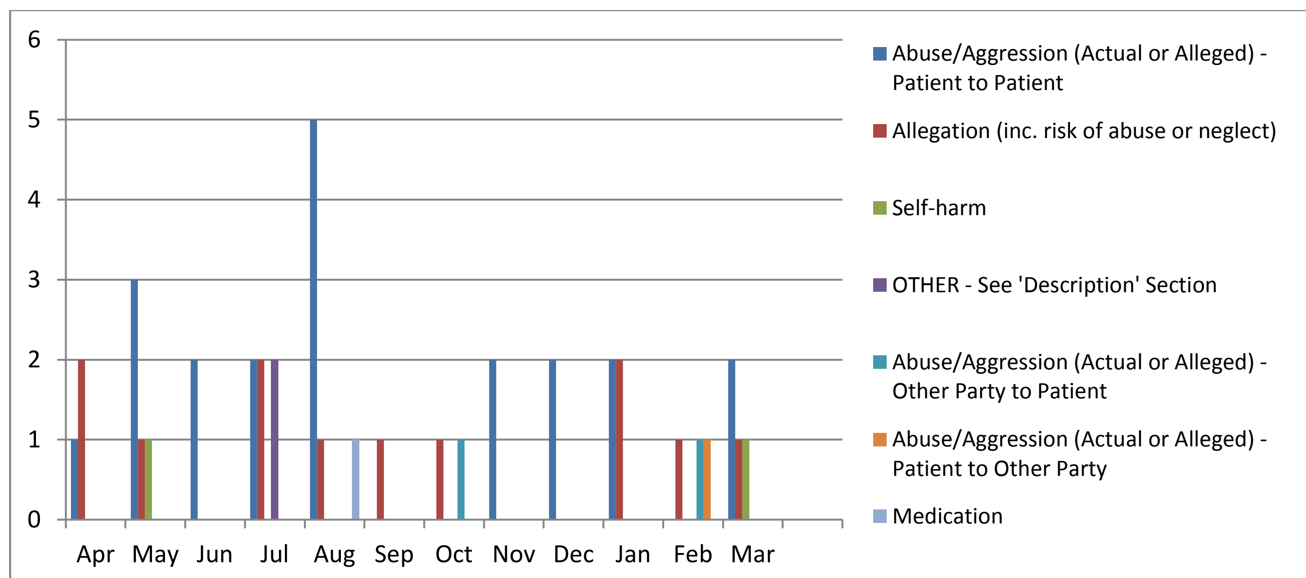


Safeguarding Referrals to Social Care by Incident Grading

2015/2016

Insignificant



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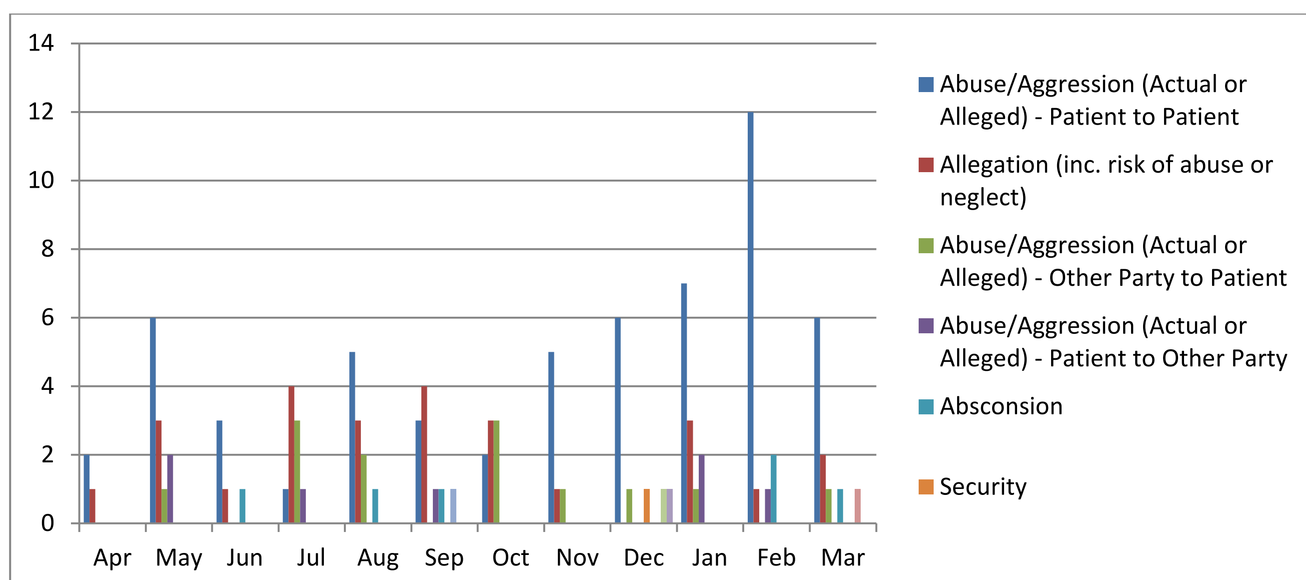
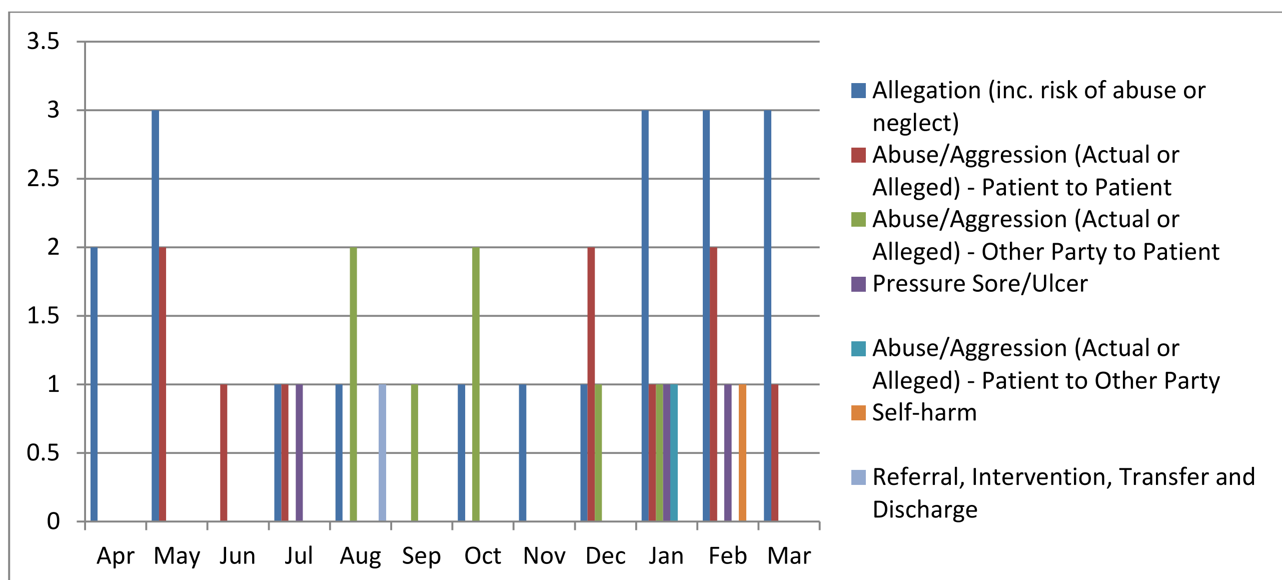


Moderate



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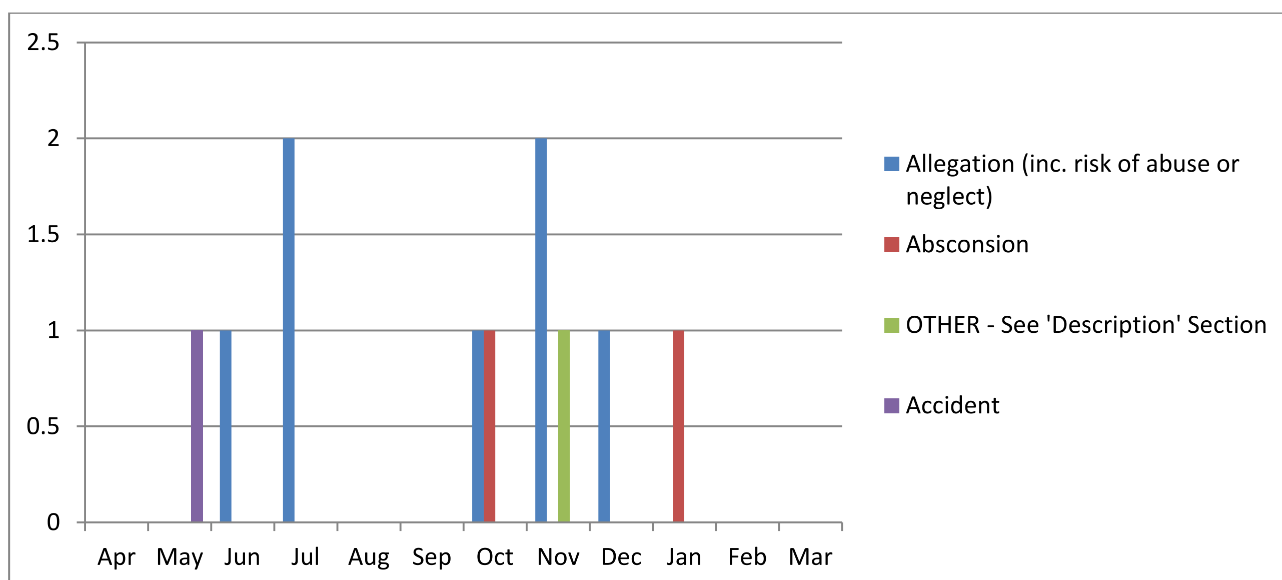


The graphs inform us that we have partial assurance with regards to reporting and grading of Safeguarding incidents. Further work needs to be completed to understand if we are "getting it right" for patients, that our recording is robust and an analysis of the themes can be undertaken.

The Datix system requires further realignment with the Care Act 2014 categories ensuring that we are recording correctly.

Analysis of incident grading to ensure that grading is consistent and correct.

There have been incidences reported for the year 2015/2016 where patients have been harmed in our care. A learning the lessons process needs to be put into place where we review each case of harm and cascade the learning to reduce the incidence of harm to patients. The following table is the action plan in place:

Safeguarding	Action	Date completed (RAG rating)	Progress
To embed a process of learning from Safeguarding incidents	To put a process in place where Safeguarding incidents are reviewed and learning cascaded. To review the need for an audit to ensure that learning has been embedded. Learning the lessons review has been arranged for a serious case. To review the outcomes of the review and utilise as a template moving forward		Commenced 2016 Safeguarding Adult Lead
Review categories on Datix and ensure alignment with the Care Act	Review categories on Datix and align	Quarter 3 2017 Safeguarding Lead and Patient Safety Lead.	
Datix incident grading	Review incident grading and accuracy. Plan for further training for teams on incident grading if discrepancy in incident reporting is identified	Quarter 3 2017 Safeguarding Lead and Patient Safety Lead Amber	This has commenced

CHANNEL Performance

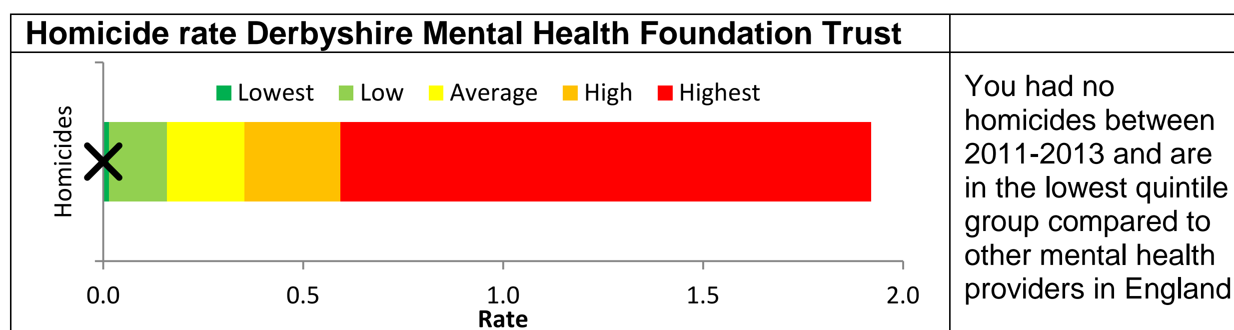
The Trust continues to refer to CHANNEL where there are concerns for patient's vulnerability to extremism. There are no benchmark figures for 2014/2015.

Prevent Referrals from DHCFT to CHANNEL 2015/2016	Total number where information and support have been provided to CHANNEL from DHCFT 2015/2016
7	39

Homicides

Trust Scorecard: Derbyshire Healthcare NHS Foundation Trust

The Trust is rated as one of the safest groups in relation to homicides rates across organisations, the Trust is awaiting an up to date scorecard.



(From The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness).

The Trust Safeguarding Lead is currently participating in the completion of a Domestic Homicide review. Await outcome from final report which is due in January 2017.

Female Genital Mutilation Data Sets

From 1 October 2015, it has become mandatory for all Health Trusts to collect and submit data in regards to FGM. The FGM Enhanced Information Standard instructs all clinicians to record into clinical notes when a patient with FGM is identified, and the type of FGM that has been carried out.

The recording systems for the Trust have been amended so that this information can be collected

To date no FGM has been recorded in adult mental health, this will continue to be monitored via data collection of the Trust recording systems.

Advice Calls to Safeguarding Lead

The Safeguarding Adults Lead takes calls directly from staff for advice and guidance; across the Safeguarding and Adult protection agendas for the organisation. During the early part of the year 2015/2016 calls were logged on to a log sheet, this has since been amended and advice calls are logged onto the electronic systems under specialist advisor. A performance reporting system on advice calls needs to be introduced that allows themes, advice quality to be scrutinised.

Themes of calls for Safeguarding Adult advice during the year 2014/2015

Calls to the Safeguarding Adult Lead are often complex and require multiple interventions including multi agency strategy meetings, on-going advice and support to staff, ongoing investigation and intervention.

Allegations of abuse from staff towards patients this has included sexual, attitudinal and care concerns.

Allegations relating to other organisational abuse.

Historical abuse including sexual, physical and neglect, this has particularly been a theme from IAPT. The adult safeguarding lead has visited the team to support managing expectations from disclosure.

Domestic Abuse this has included both staff and patients.

Neglect concerns at home.

Abuse concerns at home from relatives.

Public protection concerns in relation to patients who may harm.

Financial abuse.

Capacity and consent including DoLs.

Safeguarding concerns for relatives from patients.

Child concerns which have been passed to the Children's Safeguarding team.

The Trust has also received calls with regards to historical abuse by a Derbyshire Hospital now closed. This was at its most intense between January and June 2016. Receiving and return calls to survivors, compilation of medical notes including redaction, reviewing and in some cases taking the notes to people where they were vulnerable or there was sensitive information contained in the notes that may further compound distress.

Section 42 Enquiries

The Safeguarding Lead has undertook or actively participated in six section 42 enquiries.

The MASH is now up and running – there are currently 2 new appointments at Band 7 being recruited. Part of their role is to offer support and give advice on adult safeguarding issues to support the adult safeguarding enquiries.

Performance and Quality of advice calls	Action	Completed RAG rated	Progress
Develop a performance report that identifies volume and themes of safeguarding calls for advice	To develop a performance report	Safeguarding Lead Quarter 4 2017/2018	
Develop an audit that benchmarks and measures quality of advice in line with statutory, legislative and practice requirements	Develop a benchmark audit	Safeguarding Lead Quarter 4 2017/2018	
Develop MASH process	To develop MASH process between the 2 workers who will give adult advice and the Safeguarding. Ensuring that supervision, training and support are put into place	Safeguarding Lead Quarter 3 2016	

Safeguarding scrutiny by commissioners Safeguarding Adults Self-Assessment SAAF and Peer review

Healthcare Services and Commissioners have a duty to safeguard patients who may be least able to protect themselves from harm (No Secrets, DH 2000).

The Safeguarding Adults Self-Assessment and Assurance Framework for Health Care Services was originally developed by SHAs in collaboration with the Department of Health, Commissioners and Safeguarding Leads within their regional networks. The framework has been in place now since 2011; there have been three completed self-assessment SAAF's returned from the largest healthcare providers safeguarding training in Derbyshire including our Trust.

The Safeguarding Adults Assessment Framework requires the organisation to provide assurance on the following themes:

1. Guidance
2. Partnership and Collaborative Working
3. Safeguarding Adults at Risk
4. Training and Staff Development
5. Patient Safety Initiatives
6. Implementation of MCA and DOLs
7. Making Safeguarding Personal
8. Associated Workstreams

This year a SAAF was completed. Given the challenges with the introduction of The Care Act 2014 and the PREVENT Statutory Duty we have self- assessed all areas of the Safeguarding Adults Assessment Framework as working towards (Orange). The challenge and confirm meeting took place on 17 August 2016 a further review of progress with commissioners will take place in Quarter 4 2016.

The SAAF was accepted by Commissioners and an initial feedback letter was received which stated it was well written and with a wealth of evidence. Commissioners noted that this report accurately outlined achievements made in progressing the Safeguarding Adults agenda for our Trust and noted that the report openly defines the challenges faced by the growing Safeguarding Adults agenda. As a result of the submission of this year's SAAF, Commissioners have agreed a willingness to consider additional resources for the organisation. An option paper will be completed and submitted in order to achieve this.

We are pleased with the positive reception this year's assessment has received. A detailed action plan will be developed and operationalised in line with the recommendations and assurance will be given to the Committee on the progress against the plan.

Safeguarding Adults Training

Challenges and Position Statement

- Safeguarding Adult's Level 1 training is available as e-learning. This does not currently include Prevent. Further work is ongoing to ensure that there is a Level 1 training package that meets the needs of non-clinical staff.

- Safeguarding Adults Level 2 training was not compliant with trajectory at year end. This has been due to a combination of challenges :

  - Starters and Leavers due to turnover
  - Inpatient areas have had pressure on staffing due to recruitment – this has impacted on the ability to release staff for training.
  - Further professionals have been added into the compliance groups for Adult Safeguarding and this has impacted on the trajectory.

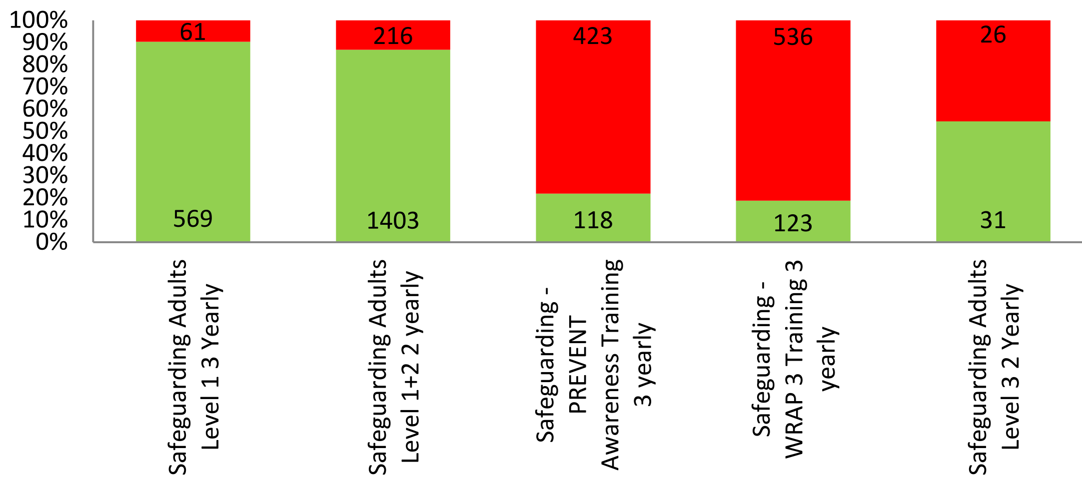
- Level 3 safeguarding adults training (Enquirers course) has been delivered by the CCG (Clinical Commissioning Group) three times in the trust. Further training will be planned in conjunction with other agencies. Some of the trust staff who have attended the Level 3 training were not part of the initial target group. The Learning and Development Sub-Group of the Safeguarding Boards are currently developing a Level 3 Safeguarding Adults Enquirers course which is nearing completion for multi-agency roll out across organisations. Further work needs completing within the Trust to correctly identify the target group for Level 3 training and passports amended to reflect this.

- PREVENT WRAP (Workshop to Raise Awareness of Prevent) Level 3 has been included into Safeguarding Adults Level 2 training since 12 October 2015. It is anticipated that all clinical staff (approximately 1700) who undertake Level 2 training will have received this by March 2018 as required by the Home Office and therefore is on trajectory for completion.

Training Compliance – at year end 2016:

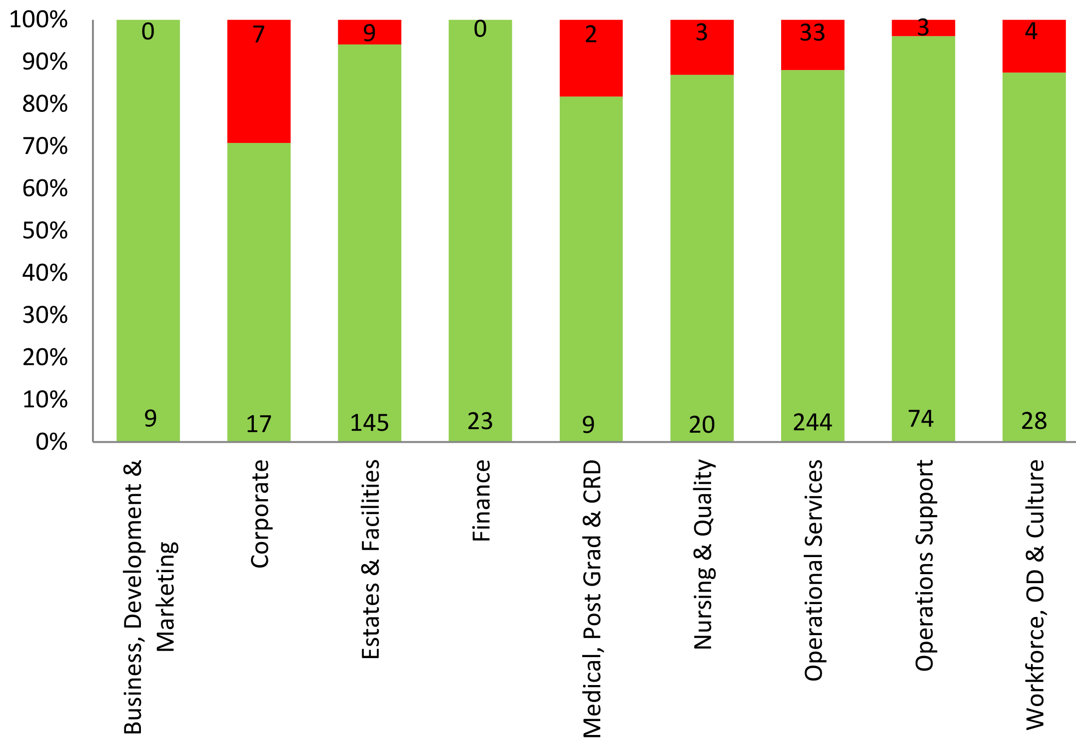
Competence Name	Target Group	Compliant	Non-Compliant	Compliant %	Non - Compliant %
C Safeguarding Adults Level 1 (Non Clinical staff) (3 Yearly)|	637	572	65	89.94%	10.22%
C Safeguarding Adults Level 1+2 (All Clinical Staff) (2 yearly)|	1627	1387	240	85.25%	14.75%
R Safeguarding Adults Level 3 (2 Yearly) Clinical Managers|	59	31	28	52.54%	47.46%
R Safeguarding - WRAP 3 Training (3 yearly)|	1677	219	1458	13.06%	86.94%

Safeguarding Adults Trust Wide Compliance Summary

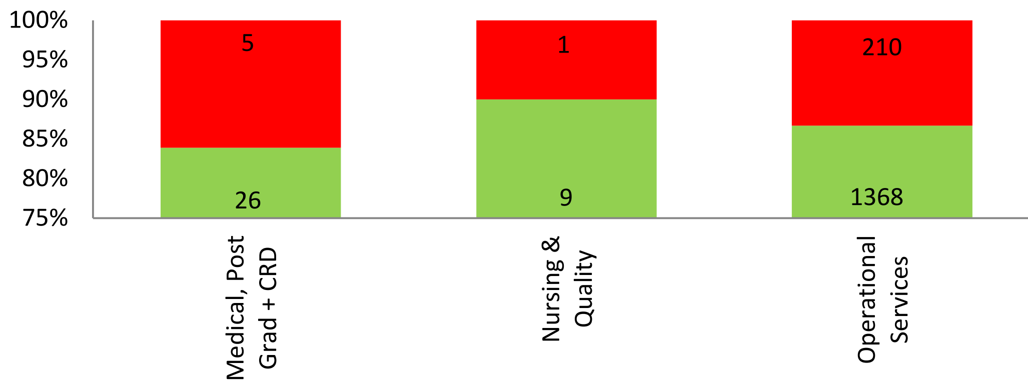


Graphs by Division

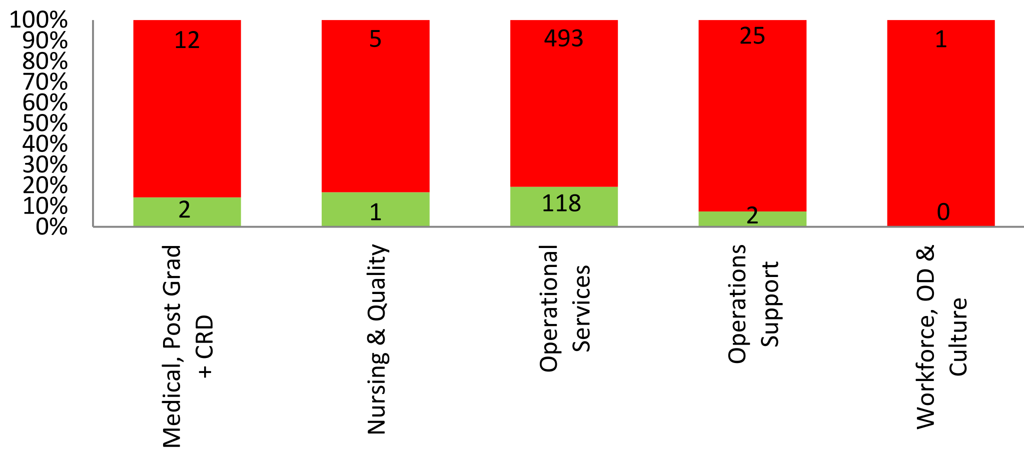
Safeguarding Adults Level 1 - Divisional Compliance



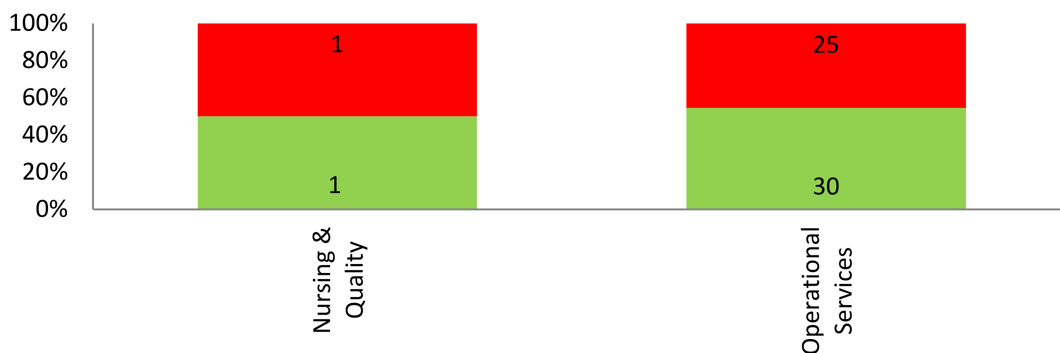
Safeguarding Adults Level 1+2 - Divisional Compliance



Safeguarding Adults WRAP - Divisional Compliance



Safeguarding Adults Level 3 - Divisional Compliance



Safeguarding Adults PREVENT Awareness - Monthly Numbers Attended

Training Name	2015 - 2016
Trust Induction	195

Governance of Safeguarding adults and our current position

The last year has seen a large change in the Safeguarding Adults arena. We have achieved the following progress:

Action	By who	Date completed	RAG Rating
1. Safeguarding Operational meeting	Safeguarding Lead	May 2015	
2. Dashboard for Derby City to be embedded via Safeguarding Performance Group	Safeguarding Lead	Not yet established in set up	
3. Level 2 training has been amended to incorporate all revised aspects of Care Act Level 3 training performance requires improvement. See training report plan in place for performance improvement	Training and Safeguarding Leads	Q2/3/4 improvements with full implementation March 2016	
4. Raise profile of safeguarding and changes following the Care Act	Safeguarding Lead	Awareness raising continues via training and Trust-wide. Communication strategy to inform on the Care Act.	Partial compliance on-going through to quarter 4 2017
5. FGM awareness raising and mandatory reporting from October 2015	Safeguarding Lead	Data sets have been set within the electronic systems. Data run report. Safeguarding Lead attended briefings on FGM by Department of Health.	
6. FGM Awareness raising	Safeguarding Lead	To continue to raise awareness of FGM throughout the organisation	Quarter 4 2016

Mental Capacity Act and DOLS

The application of the Mental Capacity Act within the Trust is inconsistent. This has an impact on the ability to ensure and assure that service receivers in our care are safeguarded. The Trust had identified that there was work to do and an action plan is in place reporting to the Mental Health Act Committee. Further concerns have been raised in regards to the Trust's application of the Mental Capacity Act following the Care Quality Commissions comprehensive inspection in June 2016. A further action plan has been developed and will be reported upon in the Safeguarding annual report 2017/2018.

MCA and DoLS action	Action	Date completed (RAG rating)	Progress
Process agreed with Mental Health Act Manager and Risk Manager for capturing DoLs referrals	To write a process for clinical areas. To monitor DoLs referrals via the Mental Health act office reported at the MHA Committee	Completed	
Technician in place who will oversee DOLs compliance and provide support and training to clinical staff	Job description and A2A completed	Completed March 2016	This has since been reviewed and a band 5 MHA/MCA professional job description has been completed, advertised and person has commenced into post
Work with older people around capacity and consent specifically as a high risk group	Baseline audit to be completed by the MHA/MCA professional and report back to the Mental Health Act Committee		
To provide 6 monthly updates to the Safeguarding Committee on MCA from the Mental Health Act Committee	To provide 6 monthly reports with analysis	Safeguarding Adult Lead, named Doctor for Safeguarding Adults. April 2017. Amber	

Multi-Agency-Risk-Assessment-Conference - MARAC

MARAC (Multi-Agency-Risk-Assessment-Conference) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. A victim/survivor should be referred to the relevant MARAC if they are an adult (16+) who resides in the borough and are at high risk of domestic violence from their adult (16+) partner, ex-partner or family member, regardless of gender or sexuality.

The Trust's Neighbourhood Team Managers attend the MARAC meetings across Derby City and Derbyshire County.

In 2014/2015, we identified the challenges to the resource availability and understanding of Domestic Abuse agenda across our services to provide full assurance. This continues to present challenge in this area and will require further work and planning for 2016/2017.

The Trust does not currently report on number of MARAC referrals made by the Trust. We are unable to assure on the consistency and standards of practice across all teams within the organisation. The Safeguarding Lead for Adults does not currently attend multi-agency groups in Derbyshire in relation to Domestic Abuse.

Multi-agency public protection arrangements (MAPPA)

The 2014/2015 annual report identified areas of work required around the MAPPA agenda. We have been able to align leads to the new operational management structure. We will be reviewing outstanding actions and adding relevant items to the work plan for Safeguarding Adults moving forward into 2016/2017.

The below action plan for MARRAC and MAPPA will be reviewed and progressed:

Action	By who	Progress
Establish a public protection operational meeting for MARAC and MAPPA reviewing the model from a victim and perpetrators perspective and outcome.	Safeguarding Lead	Quarter 1 2017
To ensure staff have the right support we will establish a supervision structure around the public protection agenda for MARAC	Safeguarding Lead	Quarter 1 2018
Benchmark against NICE Guidance on Domestic Abuse 2016	Safeguarding Lead	Quarter 4 2017
Profile raising of the MARAC agenda	Safeguarding Lead	Quarter 4 2016
Process to be established that enables the Trust to collect and report on referrals for MARAC	Safeguarding Lead	Quarter 4 2017

Action	By who	Progress
To establish contact with multi- agency Domestic abuse forums in Derbyshire	Safeguarding Lead	Quarter 4 2016
Develop a policy for MAPPA	Safeguarding Lead	Quarter 3 2016
Continue to develop and refine alert systems on PARIS for MARAC and MAPPA	Safeguarding Lead	Alert system in place for MAPPA. Refine the existing alert system for MARAC
To AUDIT MAPPA compliance	Safeguarding Lead and Forensic Psychiatrist	Quarter 4 2016

Complex case enquiries

The Trust has supported and continues to support two complex case enquiries:

Complex case enquiry 1 – There remains to be an on-going police inquiry following disclosure of allegations of historical organisational abuse. We have ensured that people have been supported to tell their story to us, that they have access to their medical records and that, where needed, we have supported people to read their medical records. There is a Case Manager and Psychologist now in place to ensure that the support, formulation and signposting are available.

Complex case Enquiry 2 – A Psychologist is in place and supports the psychological needs of the people that have been affected by organisational abuse.

The Trust is a participative member of the Gold Groups for both complex enquiry cases. We are awaiting a decision from the Derbyshire Safeguarding Children Board as to whether this is going to be a Serious Case Review.

Reduction in Restrictive practices

The Trust has a policy and action plan in place for reducing reduction in restrictive practices. There is a working group that monitors and actions practice and policy change to continue the momentum of reducing restrictive practice. The Safeguarding Lead is an invited member to this group.

We have benchmarked against Northumbria Trust rated as ‘good’ or ‘outstanding’ by the CQC who report within their annual report.

In-Patient and Specialist In-Patient Services

The provision of staff attack systems, Closed Circuit Television Systems, Walkie Talkies, Ligature Cutters and Mechanical Restraint Equipment, have been provided to clinical teams on wards to support effective management of safety for both patients and staff, these systems of safety, have vastly reduced the serious incidents on in-patient wards, whilst acknowledging that due to an increase in acuity of service receivers and detentions under the Mental Health Act to keep service receivers and staff safe.

However, Derbyshire Health Care Foundation Trust will not be pursuing these practices.

Conclusion

The Safeguarding Adults agenda continues to face challenge to be fully embedded and operationalised throughout our organisation. In the coming year this will be further pressurised in the light of the recent CQC report. While progress has been made in developing a workable structure for senior management to work within, the work plan and strategy for Safeguarding Adults remains a work in progress.

The Safeguarding Adult Lead professional will be developing a comprehensive action plan for the key areas of challenge.

The Safeguarding Adults agenda is a faced developmental phase and the Trust will need to be flexible in its approach to embed new changes and reviews of practice and learning into the Trusts organisational development plan to ensure that all staff in the organisation are developing, learning and modifying their practice to embrace all of the significant changes in the Safeguarding work in 2015.

Tracey Holtom and Carolyn Green

Lead professional for Safeguarding Adults and the Executive Director of Nursing and Patient Experience

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

Looked after Children Annual report 2015/16

Purpose of Report
The Looked after Children Annual report summarises the year 2015/16 to provide assurance to the Trust Board that the Trust is fully discharging its statutory duties in this area of practice

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

(Board) Assurances

- The report outlines the service and duties under the Children Act (1989) and associated legislation
- The Safeguarding Committee on behalf of the Board has reviewed and scrutinised the report
- The service performance is solid and significant assurance was gained on the service performance
- The safeguarding committee will take oversight of the operations team in raising and monitoring the recommendations and the gaps in the workforce to meet this required clinical service

Consultation

- The Looked after children's team and the Safeguarding Committee

Governance or Legal Issues

Children Act (1989)

- Under this Act a child is defined as being ‘looked after, by the local authority if the child or young person is in their care for a continuous period of more than 24 hours by the authority. There are four main groups:
- Section 20 children who are accommodated under a voluntary agreement with their parents.
- Section 31 and 38 children who are subject to an interim care order or care order.
- Section 44 and 46 children are subject to emergency orders.
- Section 21 children who are compulsory accommodated including children remanded to the care of the local authority or subject to criminal justice supervision with a residence requirement.

Adoption and Children Act(2002)

- This Act modernised the law regarding adoptive parenting in the UK and international adoption. It also enabled more people to be considered by the adoption agency as prospective adoptive parents. This Act also places the needs of the child being adopted above all else.

The Children and Young People’s Act (2008)

- Legislates for the recommendations in the Department for Education and Skill’s 2007 Care Matters white paper to provide high quality care and services for children in care.

Children and Families Act (2014)

- This Act strengthens the timeliness of processes in place to ensure children are adopted sooner. Due regard is given to the greater protection of vulnerable children including those with additional needs
- Promoting the health and wellbeing of looked after children (March 2015)
- This guidance was issued by the Department of health and Education. It is published for local authorities, clinical commissioning groups, service providers and NHS England.

CQC regulatory standards specifically those which require compliance in safeguarding Adults and Children

Looked after children: Knowledge, skills and competences of health care staff intercollegiate role framework (March 2015)

- This document sets out specific knowledge skills and competencies for professionals working in dedicated roles for looked after children

Equality Delivery System

- The report represents the voice of the child, the rights of a looked after child to have effective access to healthcare due to the potential negative health outcomes of being a looked after child and the health checks and practices to mitigate this risk. The paper considers ethnicity, access and partnerships with the local authority.

Recommendations

The Board of Directors is requested to:

1) Note the duties of the Trust and understand the current provision and performance of the Looked After Children service
2) To receive assurance on the Trust's annual activity and on our work plan and be assured that the Safeguarding Committee will lead and set the future direction for this area and seeking and confirming assurance on this service
3) To receive and agree this annual report and its recommendations as outlined

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

Report prepared by: **Lesley Smales**
Designated Nurse Looked after Children

Derbyshire Healthcare NHS
NHS Foundation Trust

Annual Health Report for Looked after Children
1 April 2015 – 31 March 2016

Lesley Smales

Designated Nurse Looked after Children

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1. Introduction

The purpose of this report is to describe how health commissioners and providers have worked together, in partnership with the local authority to meet the health needs of children in care in Derby city.

It will outline service performance and set out the objectives and priorities over the next financial year for children in care in Derby city. In July 2015 an inspection took place by the Care Quality Commission (CQC) Derby city for looked after children and safeguarding. Within this report recommendation for looked after children have been included.

Looked after children and young people share many of the health risks and challenges and they often enter the care system with a worse level of health than their peers. This is often due to the blended effects of the impact of poor parenting, poverty, chaotic lifestyles, abuse and neglect (DH 2015).

The Royal College of Paediatrics and Child Health (2015) states that looked after children and young people have greater mental health problems, along with developmental and physical health concerns such as speech and language problems, bedwetting, coordination difficulties and sight problems. Furthermore the Department of Health (2015) argue that almost half of children in care have a diagnosable mental health disorder and two thirds have special educational needs. When there are delays in identifying or meeting the emotional and mental health needs this can have a detrimental effect on all aspects of their lives leading to happy healthy lives as adults.

The number of looked after children has increased steadily over the past seven years. There were 69,540 looked after children on 31 March 2015, an increase of 1% compared to 31 March 2014 and an increase of 6% compared to 31 March 2011.

Number of children looked after in England at 31 March 2013 to 2015

2013	**68,080**
2014	**68,800**
2015	**69,540**

Number of children looked after in Derby at 31 March 2011 to 2016

2013	**465**
2014	445
2015	470
2016	448

2. Statutory framework, legislation and guidance

Children Act (1989)

Under this Act a child is defined as being 'looked after, by the local authority if the child or young person is in their care for a continuous period of more than 24 hours by the authority. There are four main groups:

- ***Section 20*** children who are accommodated under a voluntary agreement with their parents.
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Promoting the health and wellbeing of looked after children (March 2015)

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Looked after children: Knowledge, skills and competences of health care staff intercollegiate role framework (March 2015)

- This document sets out specific knowledge skills and competencies for professionals working in dedicated roles for looked after children

3. Local partnerships and forums to support children in care in Derby city to promote their health needs

Corporate Parenting Committee

- These meetings are attended by the Designated Nurse for Looked after Children to report on health and well-being. Annual data on the health of looked after children is presented to this committee. Membership of this committee has enabled the service to consult with councillors, the Children in Care Council, Foster Carers and partner local authority services.

Derby City Children in Care, on the Edge of Care or Custody Commissioning Group

This group is attended by the Designated nurse. Its purpose is to establish a clear shared understanding of:

- The services currently provided
- Identification of need and key gaps in service provision
- Future developments required in order to improve outcomes and achieve budget reductions
- Commissioning priorities that will achieve the best outcomes and reduce risk
- Allocated and associated ‘programme budget’
- Allocation and associated resources from all commissioning partners.

To develop an integrated commissioning approach including:

- Evidence based services which deliver good outcomes and cost savings
- Performance management of services against an agreed outcomes framework to monitor cost and quality
- Monitoring progress of the Access to Resources team which incorporates placements and wider wrap around resources to support children and young people at the edge of care and /or custody

- Working with local providers to improve placement sufficiency and quality in particular for children and young people with complex needs
- Extending and reviewing the current panel system to strengthen complex placements, and shared responsibilities with health
- Influencing shared health priorities and the planning and decision making of the Health and Wellbeing Board.

By invitation to Children in Care Council by the young people

The Children in Care Council is for all children and young people in care. It provides a platform where young people can speak about issues that matter to them and contribute towards positive changes that benefit all.

Early Intervention and Integrated Safeguarding Missing Persons Monitoring Group

This is a multiagency forum that exists to monitor agencies responses to locate and also prevent children from going missing and take effective joint action where a child goes missing and is at risk of significant harm. This forum is attended by a Specialist nurse for looked after children

Child Sexual Exploitation Champion Workshop

A CSE champion contributes to the Derby Action Plan and Policy for CSE and supports the development of a safe, responsive and effective service for children and young people who experience or are at risk of CSE within their agency. These workshops are attended by a Specialist Nurse for Looked after Children

4. Profile of looked after children in Derby City

The tables below detail the profile for Derby city looked after children as at 31.3.16

Gender

Age	Male	Female
Under 1 year	9	11
1 to 4 years	48	30
5 to 9 years	55	38
10 to 15 years	103	60
16 to 17 years	55	39
Total	270	178 Grand Total 448

Ethnicity

White	349
Mixed Origin	62
Asian or Asian British	16
Black or Black British	10
Other Ethnic Origin	11
Total	448

Placement

Foster placement, with relative or friend	305
Secure Unit	5
Homes and hostels	44
Hostels and supportive residential placements	8
Residential schools	1
Other residential settings	9
Placed for adoption	36
Placed with parents	32
In lodgings, residential employment or living independently	8
Total	448

Boundary placements

Inside City Boundary	182
Outside City Boundary	266
Total	448

5. Organisation of health services in Derby city for looked after children in Derby city

a. Derby City Looked after Children Health Team

Role	Whole time Equivalent (wte)
Designated Doctor	0.1
Medical Advisors	1.0
Designated Nurse	0.2
Specialist Children in Care Nurses	2.04
Assistant Practitioner	0.42
Administration	1.46

The team delivers a holistic health care service for the looked after children of Derby city. Within this service they provide health assessments, education, training, information and a link to health for looked after children and young people, parents, carers and other professionals. It is a statutory requirement for Southern Derbyshire Clinical Commissioning Group to ensure the health needs of looked after children are met (DH 2015). The Paediatricians

undertake initial health assessments and the Specialist Nurses the review health assessments and undertake further assessments and actions as required. Furthermore the Specialist Nurses and administrators co-ordinate review health assessments for children and young people placed out of Derby city. The work of the team is detailed in the Commissioners service specification

In Derby city there are six local authority residential homes and four independent homes. There is an allocated Specialist Nurse for each local authority home and a Specialist Nurse oversees the independent homes. Additionally there is one Residential Home for children with disabilities this home is supported by Nurses from the Light House. Interagency work is an integral part of the teams work to ensure that looked after children are supported and have their needs met.

In March 2015 the Royal College of Nursing (RCN), Royal College of General Practitioners (RCGP), and the Royal College of Paediatrics and Child Health (RCPCH) updated the Looked after children: knowledge, skills and competences of health care staff Intercollegiate Role Framework. This document recommends that there continues to be a need for health care staff working in dedicated roles for looked after children at specialist, named and designated level.

5.1 The tables below show the recommended minimum guide to the resources required for these roles

Named Doctor
Minimum requirement includes one administration session per clinic (see British Association of Community Child Health guidance). Up to four looked after children for health assessment per clinic. 42 clinics scheduled per annum. Minimum of 1 PA (equivalent to 0.1 WTE or 4 hours per week) for named doctor role per 400 looked after children. This would include training, audit and supervision.

Named Nurse for Looked after Children
A minimum of 1 dedicated WTE Named Nurse for looked after children for each looked after children provider service. If the Named Nurse has a caseload the maximum caseload should be no more than 50* looked after children in addition to the operational, training and education aspects of the role A minimum of 0.5WTE dedicated administrative support. ***The precise caseload of looked after children held by the Named Nurse will be dependent on the complexity, geography, population and size of the catchment area served*

Medical Adviser for Fostering and Adoption
A minimum of 2 sessions/PAs (8 hours or 0.2 whole time equivalent) for approximately 400 children per medical advisor. This would include undertaking a medical, preparing reports and attending fostering/adoption panel.

Looked after children's Specialist Nurse
A minimum of 1 WTE* specialist nurse per 100 looked after children
**The required number of looked after children's specialist nurses will also depend on the complexity of caseload, geography, population and size of the catchment area served.*

Designated Doctor for looked after children
A minimum of 8 hours per week or 0.2 WTE per 400 Looked after children population (excluding any operational activity such as health assessments). Activities include provision of strategic advice to commissioners/service planners, preparation of annual health report along with designated nurse, advice regarding policies, adverse events, training and supervision.

Designated Nurse for looked after children
A minimum of 1 dedicated WTE* Designated Nurse Looked After Children for a child population of 70,000 A minimum of 0.5WTE dedicated administrative support to support the Designated Nurse Looked After Children
**While it is expected that there will be a team approach to meeting the needs of looked after children and young people the minimum WTE Designated Nurse Looked After Children may need to be greater dependent upon the number of Local Safeguarding Children's Boards, sub group committees, unitary authorities and clinical commissioning groups covered, the requirement to provide Looked After Child supervision for other practitioners, as well as the geographical areas covered, the number of children looked after and local deprivation indices*

The table below shows the requirement, the actual resource and the current gap in Derby city

Role	Requirement	Actual	Gap
Designated Doctor	**0.2 wte**	**0.1wte**	**0.1 wte**
Designated Nurse	**1 wte**	**0.2 wte**	**0.8 wte**
Named Nurse	**1 wte**	**0.6 wte**	**0.4wte**
Specialist Nurse	**4.5 wte**	**2.28 wte**	**2.22 wte**

This is a potential risk to quality.

5.2 Recommendation

The commissioning group and the Trust Safeguarding committee are asked to note the changes in minimum specifications for service design, and review how they

would like to mitigate this risk and give guidance and recommendations on this issue.

5.4 Administration

The Children in Care Administration Team is made of four members of staff totalling 1.46 wte. The purpose of all four roles is to provide a comprehensive administrative support service to the children in care health team, ensuring that all administration needs are fully met and that the administrative processes and procedures run smoothly. Responding and making decisions where necessary and follow up any action from health professionals from local and external areas with confidentiality, discretion and diplomacy due to the sensitive information regarding these vulnerable children.

Moreover the team maintains the waiting list for referrals made to the service from Derby City and Derbyshire County authorities requesting initial health assessments. An Excel database is also maintained to guarantee that accurate data is provided to health and other authorities. Once the referral is received, an appointment should be made within four weeks of the child entering the care system. The appointments for Derby City authority and Derbyshire County are made with Medical Advisors.

Appointments are also made and paperwork is compiled for the Children in Care Nurses who undertake the review health assessments. Out of area review health assessments – for those children living outside Derby City a letter is sent to the authority where the child is living requesting they complete review health assessment paperwork.

A mandatory tariff commenced in April 2014 for health assessments for children placed out of area a process has been further developed to raise and receive invoices more effectively.

The administration team provides an efficient and effective administrative service to the medical advisors ensuring distribution of completed reports are sent to the relevant authority, collate information with regards to adoption panels and maintain a database to ensure that the department, Clinical Commissioning Group and health professionals are provided with up to date accurate data where necessary. We also maintain a filing system of all Adult Health Reports and other relevant documentation pertaining to the adoption process.

6. Health Assessments

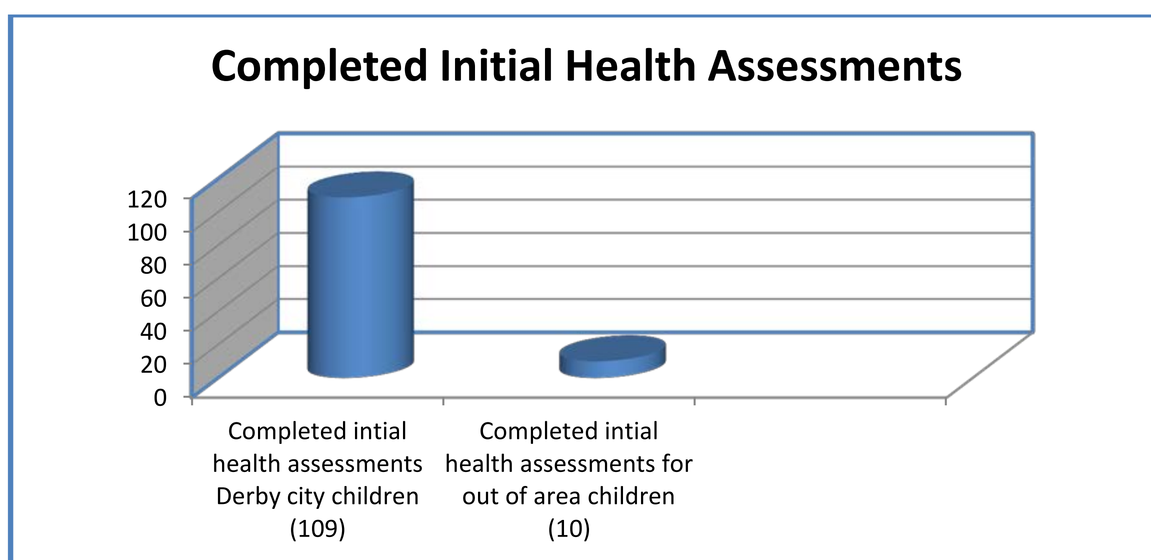
a. Initial Health Assessment (IHA)

A comprehensive and holistic review of a child's health should take place within 20 working days of a child coming into the care system. This is the

initial health assessment and is under taken by a medical practitioner. The healthcare plan resulting from this assessment should be available in time for the first statutory review by the Independent Reviewing Officer (IRO) of the child's care plan. The health assessment should be part of the child's care plan. The IRO's primary focus is to quality assure the care planning and review process for each child and to ensure that his/her current wishes and feelings are given full consideration.

Children's Social Care should notify the health services within 48 hours of being looked after. This request should include crucial information about the child's care arrangements, health history and consent for health interventions. The timelessness and quality of the IHA is central to ensuring the child's health needs are identified and addressed.

Number of completed IHAS from 1.4.15 to 31.3.16



The number of IHAs has reduced by 25% this year; this reflects the overall reduced number of children entering the care system. Community Paediatric trainees support some of the IHA clinics. Due to the positive relationship with social care they do not attend (DNA) rate remains low.

b. Review Health Assessment (RHA)

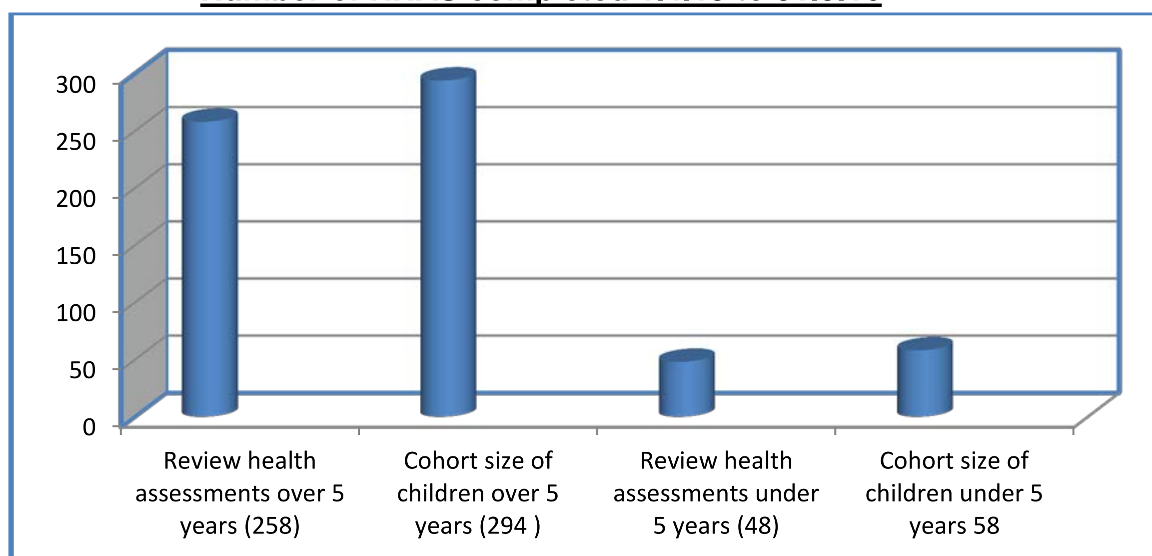
Following an initial health assessment a child should have a review health assessment every six months up until their 5th birthday and annually after their 5th birthday. The annual review health assessments of Derby city children placed in Derby City are completed by the Looked after Children nurses. For continuity of care, where possible, children and young people are seen by the same nurse.

Appointments are arranged by the Looked after Children administration team. The child/young person and their carers are invited to attend this appointment at Sinfin Health Centre. Other venues depending on the child or young person's needs and wishes are also used.

Children with special needs who are under the care of a Community Paediatrician have their review health assessments completed by their Community Paediatrician.

Children and young people placed outside of Derby city have their assessments completed by their local GP, the local Looked after Children nursing team or local School Nurses and Health Visitors ,depending on the arrangements in that area. There continues to be challenges with other local health authorities due to the capacity of the receiving authority. Therefore a number of children and young people do not have their health assessments within the timescales. Each child or young person has access to universal services when they move out of area and a robust transfer process is followed. From the assessments health care plans are developed with health issues identified within timescales and named professionals and carers are then specified to address these issues.

Number of RHAS completed 1.4.15 to 31.3.16



152 review health assessments were not completed in timescales

Reasons for RHAs not being completed within timescales:

- Young person declining the assessment
- Children and young people were not brought for their assessment by their carers; further appointments were made, resulting in lateness of assessment.
- Reliance on out of area health services completing the assessment within timescales on our behalf. As a service we have very limited control over the timescales.

c. Immunisations

Immunisations up to date	Number completed	Cohort size	Percentage
April 2015 to March 2016	**350**	**352**	**99.4%**

Many children and young people enter the care system with incomplete or unknown immunisation status. This year there has been an increase of 1.6%, Derby city continue to be above the national average for up to date childhood immunisations.

d. Dental Checks

Dental checks up to date	Number completed	Cohort size	Percentage
April 2015 to March 2016	**278**	**352**	**79%**

A significantly high number of looked after children and young people enter care with dental problems. Oral health is vital to children's social success as well as their physical health. Irregular and missing teeth can make children feel less attractive socially, a particularly important issue for adolescents. A child may not start to see a dentist in his or her own right until the age of 2. It is recommended that carers of babies and very young children take them to their own dental check-ups so that they become familiar with the dental environment.

At every health assessment it is confirmed whether a child or young person has had an up to date dental inspection. The data below shows a decrease of 13.5% this year**.** 98.0% of the children and young people are registered with a dentist but disappointingly a significant number of carers have not made appointments for the children and young people they care for and therefore are not up to date with their dental checks.

The importance of attending the dentist and good oral health is going to be prioritised in the future health training for carers and residential care staff.

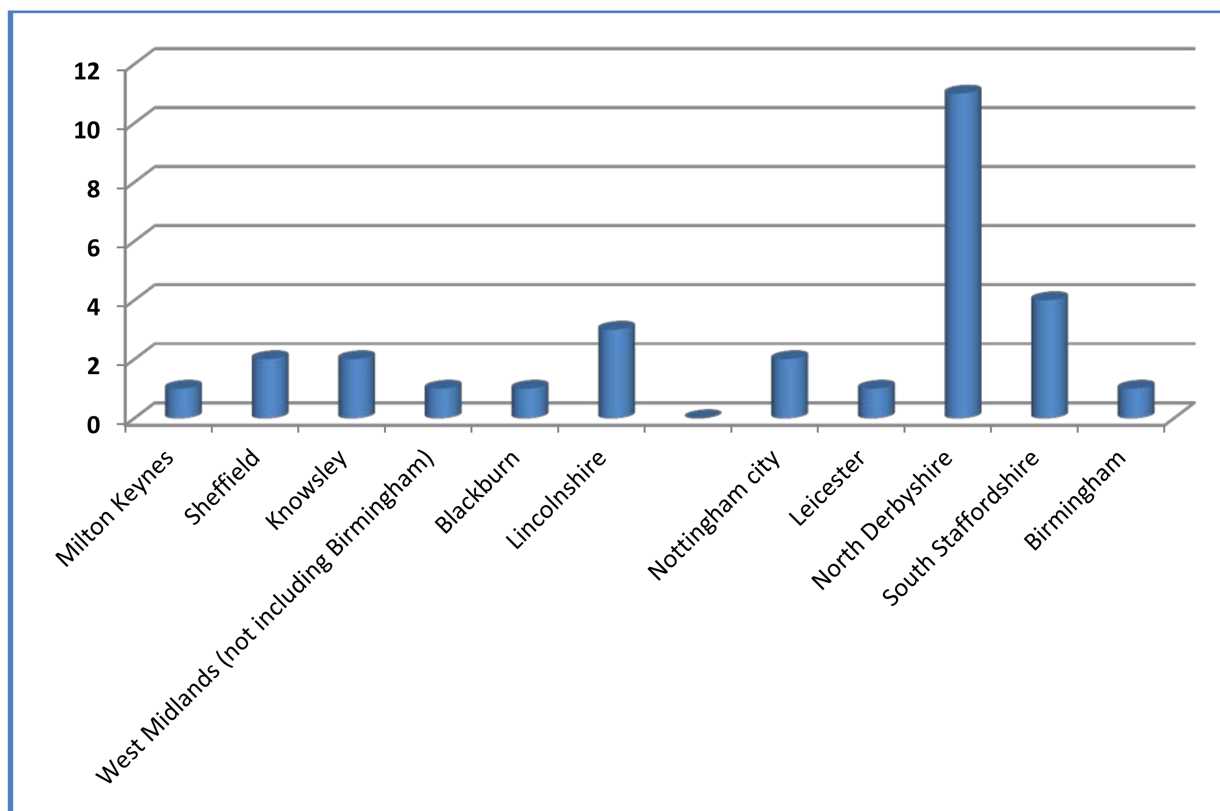
% Previous year's data for health assessments, immunisations and dental checks

Derby	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Annual review health assessments	**72.7%**	**73.9%**	**83.3%**	**79.4%**	**88.5%**	**87.8%**
6 monthly Review health assessments	**53.8%**	**38.5%**	**66.7%**	**58.3%**	**77.4%**	**84.5%**
Immunisations up to date	**95.5%**	**92.8%**	**95.8%**	**98.5%**	**97.8%**	**99.4%**
Dental checks up to date	**69.7%**	**75.4%**	**94.4%**	**85.3%**	**92.5%**	**79.0%**

Actions to be taken

Annual review health assessments **6 monthly health assessments**	Continue to work with the Local Authority to support children and young people to attend for their health assessments. Seek clarification as to whether a Specialist Nurse could be employed to undertaken review health assessments within a 25 mile radius. This would improve the timeliness and quality.
Immunisations	Continue to discuss the importance of having the immunisation programme with children young people and their carers
Dental checks up to date	Highlight the importance of good dental hygiene and carers taking the children and young people in their care to regular dental appointments

Number of RHAS completed for out of area children



Not all review health assessments requested by other authorities for children and young people placed in Derby city are completed within timescales. Although as a team we endeavour to complete them in a timely manner this is not always possible due to capacity.

Strengths and Difficulties Questionnaires

This questionnaire was introduced by the Department of Education's data collection for looked after children after 31 march 2008. This tool is an outcome measure that is used for tracking the emotional and behavioural difficulties of looked after children and young people at a national level. The SDQ is a clinically validated behavioural screening questionnaire for use with 4 to 17 year olds.

Social care has a responsibility to send the questionnaire to carers and should be completed in time to help inform part of the review health

assessment. The SDQ helps inform decisions about consideration for specialist mental health and psychological assessments.
A task and finish group with staff from both Social Care and the LAC health team was established this year with a clear process to ensure timeliness for the review health assessment. See appendix 2.
There has been a significant improvement with the timeliness of these questionnaires being available at the time of the child or young person's review health assessment.

Number of SDQ's completed (eligible ages)

SDQ	**Yes**	**No**	**Total**
Number	**183**	**132**	**315**
Percentage	**66.7%**	**33.3%**	**100%**

7. Adoption by Dr Marudkar and Dr Kapoor Medical Advisors

- 2 Medical Advisors for Derby city have a monthly commitment to attend one adoption panel each. At these panels a matching and suitability for adoption report is submitted. For each case 3 step reports are prepared:
- A preliminary Agency Decision Making (ADM) report for suitability for adoption. This is detailed first report from medical adviser for Agency decision maker. 43 reports were prepared this year compared to 47 last year.
- A Final ADM report for suitability for adoption this is an update of the preliminary report incorporating information from the social care document of the child permanence report. 52 reports were prepared this year compared to 38 last year. From January 2016 it was agreed to prepare a single ADM report instead of preliminary and final reports. 11 such reports were prepared.
- A matching update report for the matching stage is then completed as part of the final ADM report. 63 reports were prepared this year compared to 59 last year.

Additionally, one individualised letter for prospective adopters is provided detailing health issues and implications for the child. 23 letters were prepared this year compared to 38 last year.

If further individual consultations are required then a telephone or face to face consultations are arranged with prospective adopters. A total of 11 consultations have been undertaken this year. This number remains constant from last year

Furthermore Medical Advisors continue to provide adult health assessment reports for prospective adopters and foster carers until 31st January 2016. From 1st

February 2016, this role has been completed by a specialist GP, Dr E Maclachlan. A total of 76 adult health reports have been prepared until 31st March 2016 compared to 107 last year.

Adoption related activity for April 2015 – March 2016

Activity	Number
Number of adoption panels	22
Children suitable to be placed for adoption (SPA)	35
Children matched and placed	57
No. of Preliminary ADM reports prepared	43
No. of Final ADM reports prepared	52
No. of single ADM reports prepared (from Jan 16 onwards)	11
No. of Matching reports prepared	63
No. of Adoption Advice Letters prepared	23
No. of Prospective Adopter Consultation (face to face) and report preparation	2
No. of Prospective Adopter Consultations and report prepared (telephone consultations)	9
Number of CIC initial health assessments (IHA)	109
DNA Rate for IHA clinic	0
Medical advisor's adult health reports (AH) for prospective adopters and foster carers	76
No of adoption panel training days attended	
No. of training sessions for prospective adopters	3

8. Quality assurance for health assessments

A quality standards audit tool has been developed to audit initial and review health assessments. This tool is based on Annex H and each assessment should relay the story of the child or young person, reflect their needs and wishes, the assessment identifies any health needs and the resulting health care plan outlines any recommendations, persons responsible and timescales are identified.

A randomised audit has been undertaken using this tool see appendix 1.

9. The Voice of the Child

In order to promote and respect the rights of children it is essential that children and young people are listened to and their views responded to. The voice of the child should be embedded in all aspects of service development and delivery.

At every health assessment where ages appropriate a child or young person is given the opportunity to be seen alone. Confidentiality is explained to each child or young person at each consultation. Every child aged over 11 is asked to complete an adolescent wellbeing questionnaire at their review health assessment; this information aids to inform their emotional wellbeing and helps the young person demonstrate how they are feeling and puts the individual in control of communicating their distress, concerns, strengths and their needs. At every consultation the electronic health record has a dedicated free text space to record the child or young person's feelings and wishes as it is important to record children's views in their own words. Where a child is not able to verbalise it is important to record attachment to the carer, containment, reciprocity and body language.

10. Training

All the members of the Looked after Children's Health Team complete mandatory training and other relevant training to update their knowledge around current issues, legislation and practice relating to looked after children and young people. Furthermore all nurses and doctors attend annual level 3 safeguarding training

All Nurses have regular supervision both clinical and safeguarding. There is also an open door policy for nurses to discuss complex cases with the Designated Nurse.

The Designated Nurse delivers training to student Health Visitors and School Nurses at the University of Derby twice yearly and a Specialist Nurse with the support from the Assistant Practitioner delivers training annually to Residential Care Workers and Foster Carers. This is twofold to promote learning to the future profession and support recruitment into our children's service at an early stage.

The Medical Advisors deliver training to prospective adopters three times a year. This training is well received and appreciated by adopters as evidenced by the written feedback provided by the group, which is collated and included in appraisal activity. Furthermore the Medical Advisor and Designated Nurse provide training on looked after children's issues to General Practitioners (GP) during their GP VTS course once a year, which is an important aspect of work to highlight key responsibilities and raise the profile of the heath and support needs of looked after children and their families.

There are also two adoption panel training days organised by the adoption team, a written feedback is obtained and is included in appraisal activity. The Medical Advisors keep their own knowledge up to date by attending Regional Clinical network meetings, which also include peer group discussions of complex cases.

11. Priority Actions for the Looked after Children team and provider organisation

- To continue to work hard within the multiagency arena to ensure best outcomes for the children and young people in our care

- Timeliness of health assessments. Continue to work with our Social Care partners to ensure there is a robust system in place to ensure data is recorded in a timely and accurate method for both health and social care systems

- Regularly monitor performance through quarterly assurance reports.

- Consideration of a job description, role, given to a dedicated CAMHS team or secondment of a CAMHS professional into the looked after children multiagency team. To expand and further develop the psychological wellbeing service offer.

- Consideration given to the recommended minimum guide to the recourses required for looked after children health team roles.

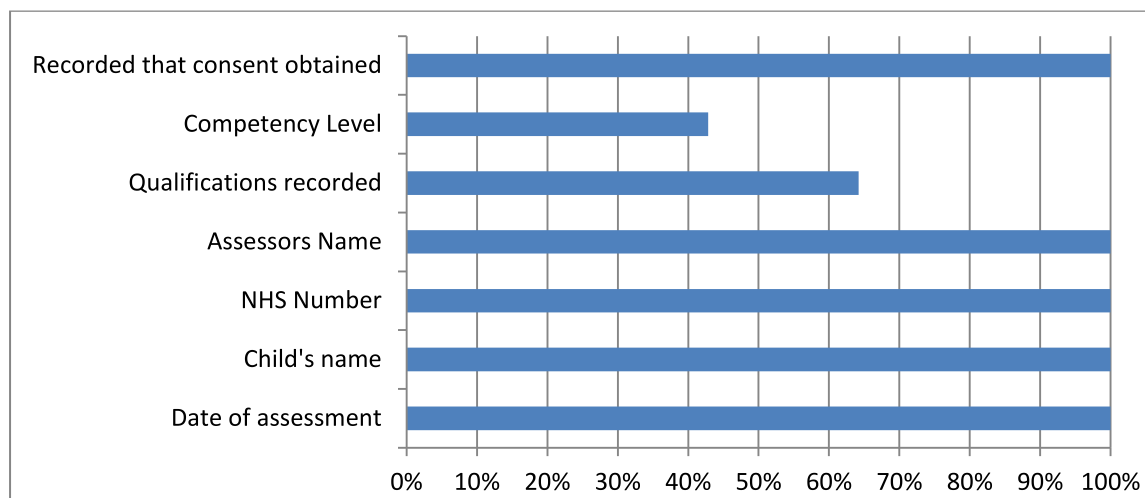
Appendix 1

Quality Audit for Initial and Review Health Assessments

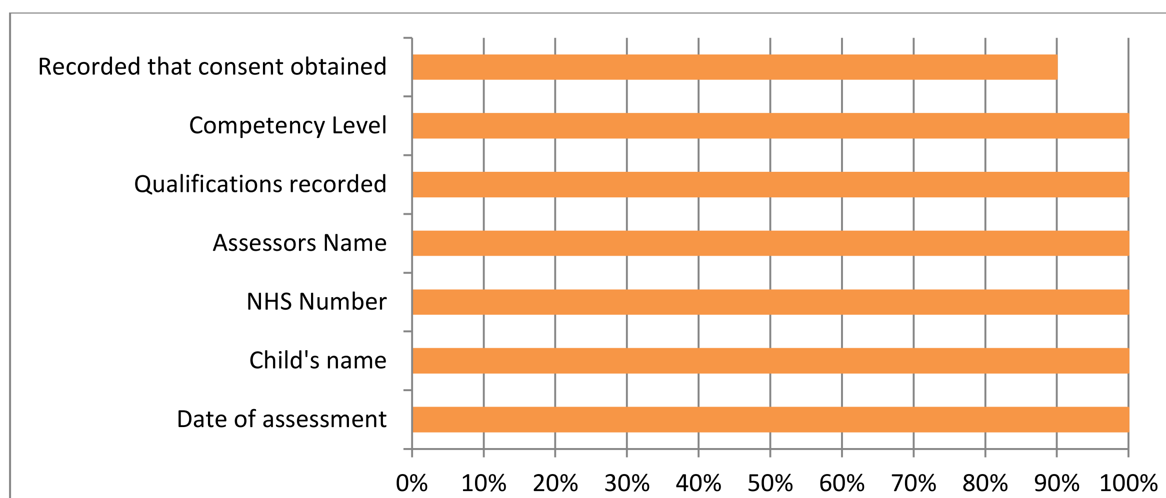
The following are randomised audits of initial and review health assessments with actions to address shortfalls. This audit will be repeated in June 2016

Section One – Standards

Initial Health Assessments



Review Health Assessments

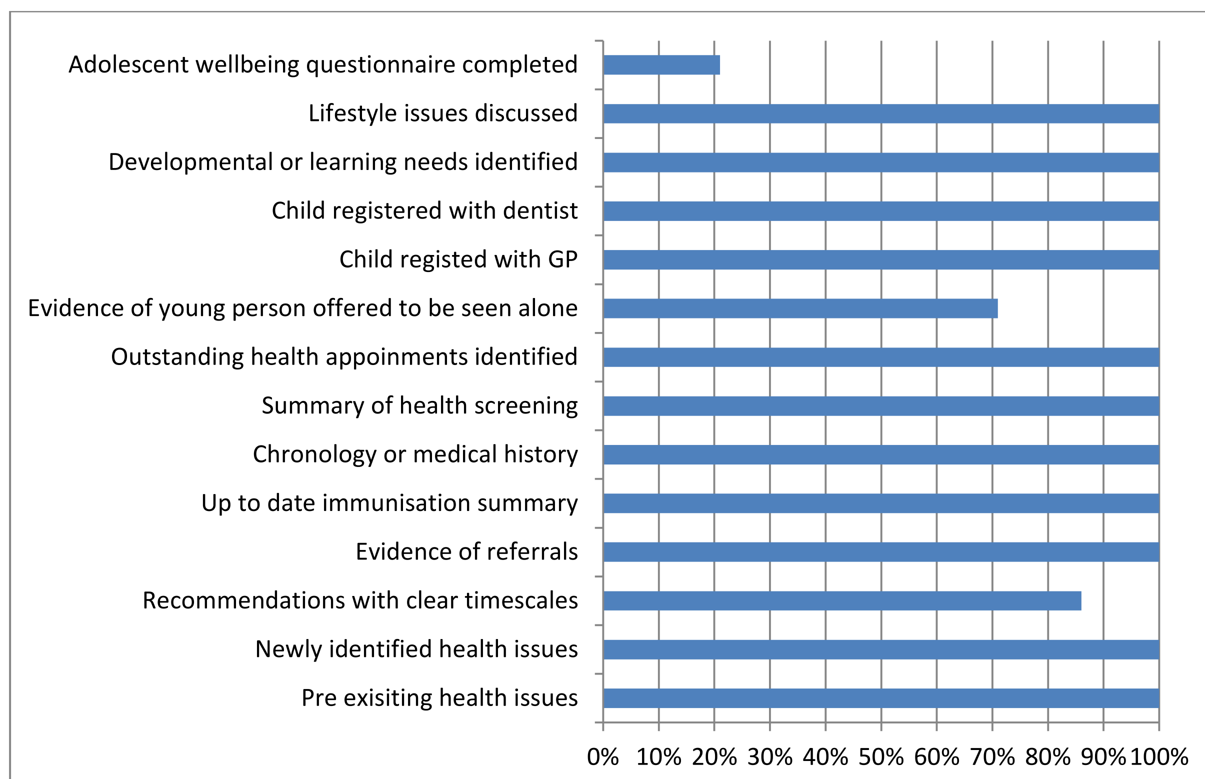


Actions for Section 1

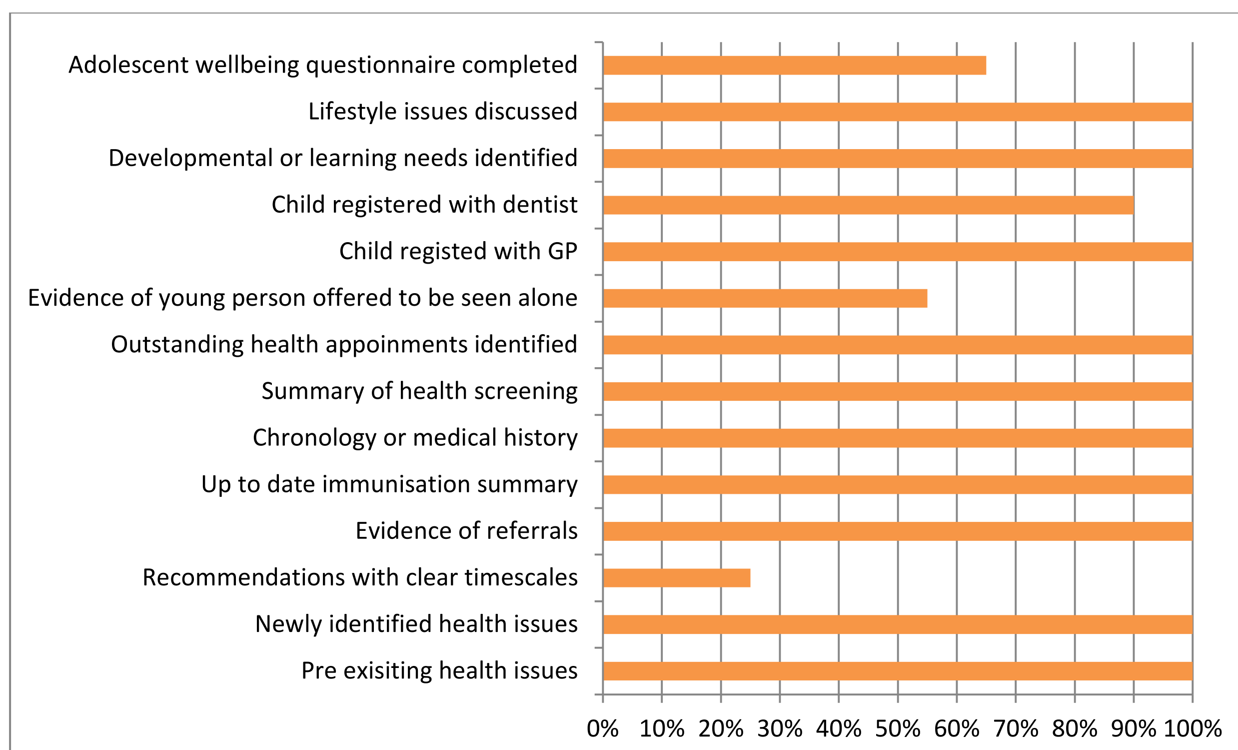
- Assessors' qualifications to be recorded onto the health assessment BAAF paperwork. On 5 occasions this was not recorded. Assessors' qualification to be recorded on the BAAF paperwork
- Consent is always recorded on systmone, it is essential that this is transferred on to the health assessment BAAF paperwork.

Section 2 – The Health Assessment

Initial Health Assessments



Review Health Assessments

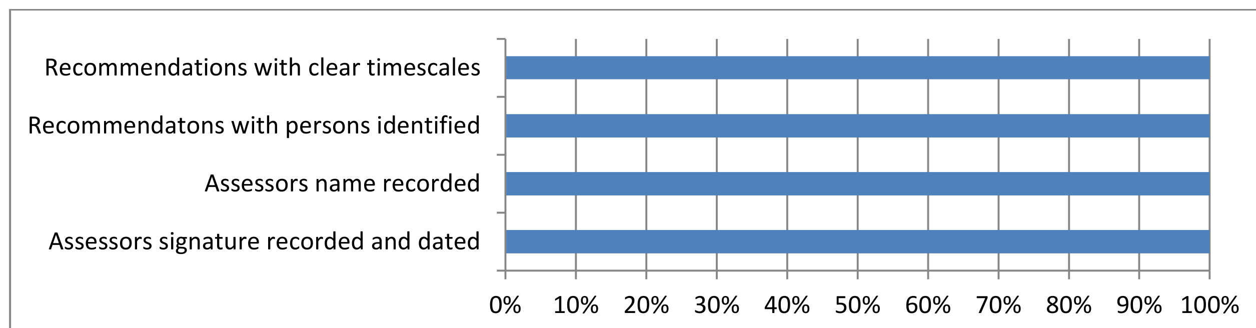


Actions for Section 2

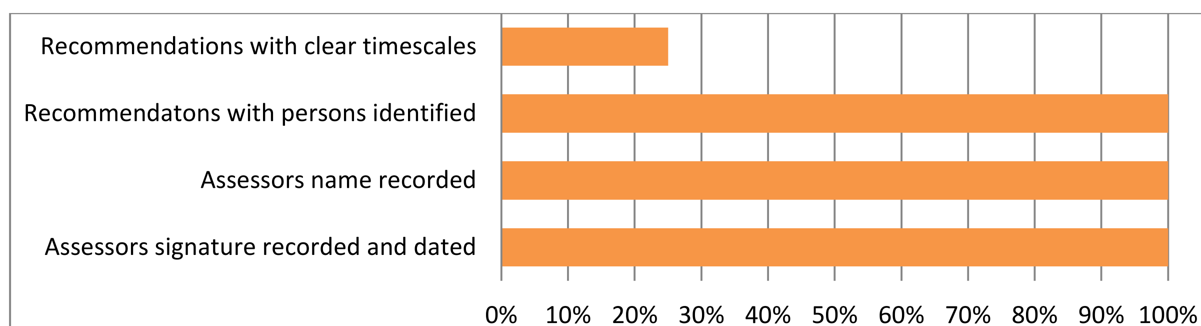
- Adolescent wellbeing questionnaire to be completed for all children over 11 years.
- Clear recording when children decline to complete the adolescent wellbeing score
- A new process has been agreed with the Local Authority to ensure the timeliness of the SDQ to inform the review health assessment. To be evaluated in June 2016
- Clear recording of the child's wishes and feelings on systmone and the BAAF form
- Clear recording on systmone and the BAAF form that the child had an opportunity to be seen alone where age -appropriate

Section 3 The Health Care Plan

Initial Health Assessments



Review Health Assessments



Actions

- Each recommendation on the health care plan to have a defined timescale. It is not acceptable to record asap

The results from this audit have been shared with the Children in Care medical and nursing team. There will be a re audit in June 2016.

Appendix 2

SDQ Pathway

Purpose

The local process for undertaking the Strengths and Difficulties questionnaire (SDQ) has been carried out by the Local Authority Social Work team as part of the annual data collection to the Department For Education as part of the SSDA903 data collection since 2008. The purpose of this change of the process is to carry out the SDQ at the time of the statutory health assessment in accordance with recommendations from statutory guidance (DH/DfE 2015). The benefits of this change of process will be to assess, identify and improve the emotional and mental health outcomes for looked after children in a timely manner.

What is the SDQ Strengths and Difficulties Questionnaire?

The SDQ is designed for general behavioural health screening of children 4 to 16 years of age, consisting of a one-page form of 25 items. The forms are completed by carers for all children 4 – 16 years of age and by children and young people aged 11 – 16 years.

Responses to 20 of the 25 items generate a "total difficulties" score, based on subscale scores in "emotional symptoms," "conduct problems," "hyperactivity," and "peer problems," which are derived first. In addition, this tool provides a "pro-social behaviour" (strengths) subscale score.

Overview of Scoring

The SDQ takes the parent/guardian or young person approximately five minutes to complete. Each item is reported as "not true," "somewhat true," and "certainly true." Multiple scoring methods provided fall into two categories: hand-scoring or computer-based. Providers should expect some time will be needed to learn how to score this tool, but it should be fairly easy to score once it is familiar.

The SDQ is copyrighted but available for free at www.sdqinfo.com. It is translated into over 60 languages.

General Information

Local authorities are required to ensure the short behavioural screening questionnaire (SDQ) is completed for each of their looked after children between the ages of 4 and 16 and 17 inclusive by the child/young person’s carer. The questionnaire should be completed by the main carer, preferably at the time of the child’s statutory annual health assessment. The Local Authority is responsible for the collection of completed questionnaires; marking the SDQ; storing the data; and returning the data to the DfE as part of the SSDA903 data collection.

The completion of the SDQ emotional screening tool will be offered to and undertaken by:

- The child's foster carer/residential home carer/parent or guardian for all Children aged 4 to 16 (Form P 4-16)
- The child or young person aged between 11 to 17 years to complete Self-form (Form S 11-16)

Completion of the SDQ is straightforward and there should only be rare exceptions where it cannot be completed. Having learning difficulties should not be a barrier to a child from having a questionnaire completed that relates to them. However where a looked after child has disabilities which mean that it would not be possible or appropriate to complete a questionnaire then that should be noted by the Paediatrician or Nurse undertaking the health assessment in the record.

Derby City Children placed out of the local area

For Derby City children who are placed out of the Local Area a request to the looked after children team in the accommodating authority will be asked to undertake the SDQ on behalf of Derby City and returned with the statutory annual health assessment for processing. This will ensure that the emotional and mental health needs of Derby City Looked after Children living out of area are identified and met.

Monitoring Compliance and Effectiveness

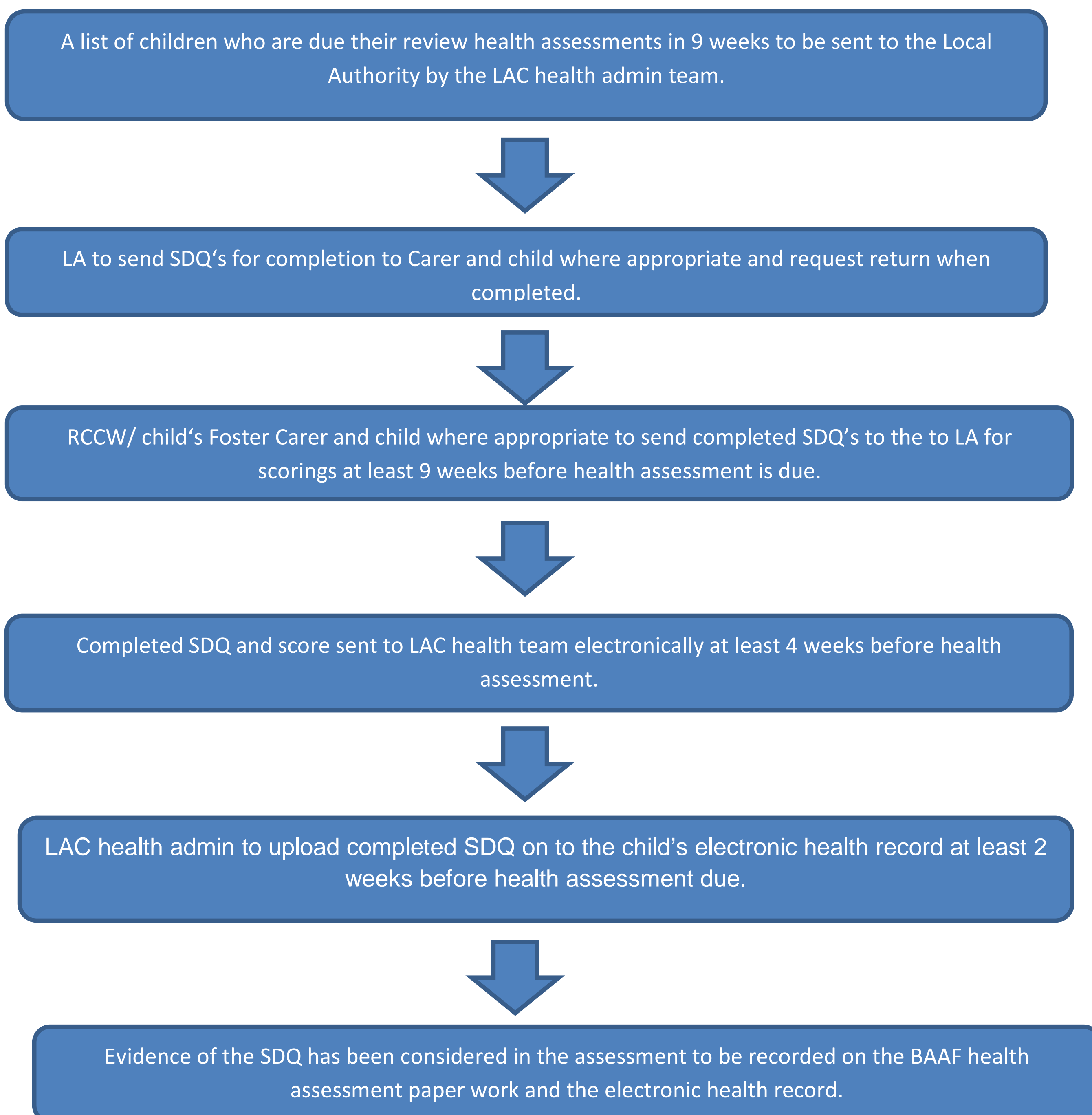
The Local Authority is responsible for the Collection of completed questionnaires; marking the SDQ; storing the data; and returning the data to the Department for Education as part of the SSDA903 data collection. The Local Authority is required to return the data for all children who have been looked after for at least 12 months on the 31st March each year for children between four and 16 years of age inclusive. Children who are looked after under an agreed series of short term placements excluded from the SSDA903 data collection.

Monitoring compliance and effectiveness of the SDQ will be carried out as part of the statutory Initial and Review Health Assessment audit by Derbyshire Healthcare Foundation Trust and results will be discussed with Commissioners of the service to be used to aid strategic developments and service planning.

References

- Department of Health Department of Education (2015). Statutory Guidance on Promoting the health and well-being of Looked After Children. DfE DH Publications. Crown Copyright.
- RCN, RCPCH (2015) Looked after Children: knowledge, skills and competence of health care Staff. Intercollegiate Role Framework.
- Department for Education (2013) Children Looked After by Local Authorities In England Guide to the SSDA903 collection 1 April 2013 to 31 March 2014.
- Department for Education (2010) The Children Act 1989 Guidance and Regulations Volume 2: Care Planning, Placement and Case Review.
- National Institute for Health and Clinical Excellence Social Care institute for Excellence (2010) Looked-after children and young people. NICE public health Guidance 28.

SDQ Flow Chart



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

Engagement and Culture Plan

Purpose of Report:

To provide the Board with an approach to deliver the change in culture and improvement in staff engagement the trust is seeking.

Executive Summary

The Trust has stated an improvement journey to improve staff engagement and involvement. There is compelling evidence demonstrating the links between an engaged workforce and patient outcomes. Over the last six months we have commenced a new approach to staff engagement and the early findings of this work have been analysed alongside previous listening events and surveys to form a clear view of what is needed to change the culture and improve staff engagement.

There are challenges within the findings for senior management and leaders. There is a view that there is a disconnection between the operational workforce and senior leaders and the need for 'visible' leadership which when understood is about showing compassion and appreciation and above all about feedback and taking actions.

This paper will present an approach to engagement based on learning from good practice in other Trusts. If the board supports the approach outlined in this paper investment will be required as this is a two year programme of change. We will be using the resources and support available to us from NHS Improvement in the form of a Culture and Collective Leadership Programme which gives us access to a community of learning. In a previous paper to the People and Culture Committee we set our vision for engagement and plan to develop the new Engagement Group and develop a' Pioneer' role supporting engagement through teams. We will have a development programme to support the role. In addition, our engagement approach will be strengthened by a new quarterly Pulse check starting in January 2017. The Pioneer role will have a key part to play in making this work. We are now ready to take this forward and will set out the approach in this paper. In addition, the paper recommends a multi-faceted approach to improvement, with an acknowledgement that a different form of leadership support and development is required. This is about developing a collective leadership approach working through and strengthening teams, taking on board the need to have greater devolvement of decision making. We have already started to build networks amongst different staff groups and have observed the way in which staff are developing and gaining confidence.

Key to the approach is a commitment from senior leaders and an acknowledgement that investment in both time and resources is needed. This is in effect an organisational development strategy which must also be mindful of the need to plan for the coming

together of two organisations in the near future, as well as the need to understand the wide system changes.

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

(Board) Assurances

The Board can be assured that there is a programme of improvement and plans to improve engagement and change culture.

Consultation

This approach is based on the views and voices of staff and has been developed in partnership with staffside.

Equality Delivery System

No impact on REGARDS population specifically within this paper - in developing the programme of change and engagement - clearer emphasis with regards to Equality will be identified – particularly within our systems and processes.

Recommendations

The Board of Directors is requested to:

1) Agree the approach and direction
2) Note that investment will be required to take forward the suggested approach

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

Report prepared by: **Sue Walters**
Senior Staff Engagement Project Lead

Derbyshire Healthcare NHS Foundation Trust
Report to the Board 7 December 2016

Engagement and Culture Plan

1. Introduction

This paper will set out a plan for increasing staff engagement and involvement it will describe and build upon our approach to staff engagement and maintain the momentum over the last year and is based on a strong relationship with staffside.

This paper will present the findings on staff engagement, why we believe it is important and our proposal of how we intend to improve going forward. This is an engagement plan as we know that engagement levels are not only an indicator of the culture of organisations, but one of the most important influencers of patient outcomes. In turn, we know that there is compelling evidence that health care organisations achieve better outcomes for patients where there is a collective approach to leadership - the quality of leadership is the most important influence on culture. We recognise that culture will not change by accident, a strategic approach is critical to success.

The views of staff run through this plan and its findings and proposals are derived from listening and making sense of their voices and passion to make a difference for patient in their care. It will also take into account the impact of recent inspections and the proposed merger with DCHS. This will require a joint proposal and plan in order to ensure as smooth a transition as possible and retain the best of each organisation.

2. Progress

Over the last six months there has been new approach to staff engagement. Part of this has taken the form of interviewing staff and teams to get a clearer view of challenges and gaps. Some of this has involved the analysis of existing feedback from listening events as well as reviewing previous staff survey and friends and family feedback. The approach we have undertaken has provided us with rich learning, and has demonstrated the value of appreciative inquiry and participative approaches. However, this has also served to stress over and over the crucial impact of a caring and compassionate leadership on staff morale.

Key themes have been identified and are used to form a platform for our approach. (Table 1) Appendix 1 provides more detail.

These are:

- Leadership, values and behaviours
- Trust and Credibility
- Systems and processes

Table 1

Systems and processes	*Trust and credibility*	*Leadership, Values and Behaviours*
• Decision making slow (8 *months after a complaint about a member of staff and no response)* • No consistency on following/implementing recruitment policies – (*people put on 8A following a JE which other staff do not perceive as fair)* • Appraisal process not understood or implemented fairly (*Sent paperwork and told to complete then its signed off without discussion*) • HR processes for job evaluation and recruitment can be slow. *Managers sometimes do not ask for support from HR and interpret policy incorrectly*.	• Lack of two-way Feedback – *what happens with feedback to ELT?* • Clear communication cascade needed – aligned to Board • Trust in the process that it will be fair, in terms of whistleblowing, and complaints etc. • Feeling that need to escalate complaints to a higher level in order to be heard • Managers don't always feel they have adequate control over resources • Actions are not followed through • Relationships between HR and staffside still improving • Following incidents staff are looking for a learning environment rather than the perception of consequences and repercussions	• Senior leaders are seen as separate and disconnected /Perceived as 'invisible' • General Managers perceived as' not strategic' by some, and yet have huge span of responsibility • View that some Band 6 and 7 are not' living up to the banding' • New Band 7s (Neighbourhoods especially) 'sink or swim' • Needing to seek permission • Managers asking for coaching/mentoring support during interview discussions • No real succession or talent planning • No clear leadership 'competencies' - what sort of leadership do we want?

3. Approach underpinning our engagement plan

A pathway approach to engagement is being undertaken based on the work of Professor Michael West and learning from Engage for Success[1]. This approach stresses the need to focus on staff engagement enablers such as influence and motivation and to be able to measure the feelings and visible behaviours in response to these enablers. Therefore, we have agreed a new Pulse check starting in January which will enable us to measure improvement across teams. This alone is not sufficient and so our main approach is about enabling the system to connect across networks, allowing ideas to emerge and building the capacity of staff to resolve issues themselves. It is in effect about *changing culture*. This is fundamentally a new way of working in organisational development but evidence from Vanguards and

[1] [1] http://engageforsuccess.org/using-stage-stage-approach-increase-employee-engagement

system thinking demonstrates that this is the most effective and sustainable way to transform.

We will combine this approach with a coaching programme for leaders accessing programmes via East Midlands Leadership Academy, (EMLA) and also refresh out internal coaching bank.

We will develop members of the Engagement Forum to build their confidence to work more effectively with senior leaders in giving and receiving feedback. This will be combined with recruitment to a wider group of champions, known as pioneers, who will promote engagement in their teams.

We will strengthen the current Spotlight on Leaders sessions to offer bespoke leadership and masterclasses. We know that this has evaluated well in recent sessions.

We will build on existing networks of Band 7 and Band 6 leadership networks to promote collective leadership approaches., and develop community of practice model.

Our approach to leadership development will be based on:

- Developing distributed and inclusive leadership capability
- Tailored support for Executive leads and service leads
- Embedding improvement expertise in teams
- Creating a spirit of inquiry and building on what works
- Encouraging small scale initiatives
- Build on existing networks and develop a communities of Practice approach
- Development of Talent Management processes

To lead the organisation forward in the evolving we need individuals who are capable of:

- creating a compelling vision and taking people with them;
- leading across boundaries; utilising high levels of emotional intelligence in order to influence through a shared mission or goal;
- being in the present, but also horizon scanning;
- promoting and developing distributed leadership (i.e. leadership at all levels, not just at ‘the top’);
- embracing diversity, innovation and being open to alternative views;
- demonstrating and promoting compassion for ‘self’ and others, with a focus on improvement and accountability.

4. Learning from emerging and best practice

As part of developing the strategy we have considered good practice in other areas, as well as exploring resources and available tools. Learning from other Trusts highlights:

- Board level commitment
- Executive sponsorship
- Dedicated resource to drive the approach
- Working through teams is crucial
- Development programme for 'champions'

Organisation	Relevant Learning
Derby Teaching Hospitals NHS Foundation Trust Royal Hospitals	Using learning from NHSI Culture and Collective Leadership tool. Invested in leadership development programme. Quarterly Pulse check.
Derbyshire Community Health NHS Foundation Trust	DCHS Way embedded across the trust. Ongoing leadership development. Staff Forum which meets jointly with Executive Team, with good training programme for members. Quarterly pulse check.
Dudley and Walsall Mental Health Partnership NHS Trust	A programme of investment in workplace advisors and change champions. Investment in organisational development support to drive the programme long term.
Wrightington, Wigan, and Leigh NHS Foundation Trust[2]	Developed the WWL Way - A set of 8 tools based on 9 Enablers. A 6 month Pioneer Programme with 10 teams each cohort. It Platform to store data and analyse feedback. Executive Sponsor for each team and Board level high profile sign up.
Royal Bournemouth and Christchurch NHS Foundation Trust	Using the NHSI Resources and has invested in and recruited champions from teams to drive engagement. Executive sponsorship a key factor. Investment in organisational development lead.

5. Key resources

NHS Improvement Culture and Collective leadership resource

NHS Improvement with the Centre for Creative Leadership and the Kings Fund has made available a cultural change and collective leadership programme developed

[2] http://www.nhsemployers.org/~/media/Employers/Documents/Retain%20and%20improve/The%20WWL%20way%20Implementing%20sustainable%20staff%20engagement.pdf

from the work of Professor Michael West. In addition to the work of West and colleagues, a number of reports have highlighted the need for both cultural and leadership change in the NHS. These include the Rose Review, the report of the Mid-Staffs NHS Foundation Trust Inquiry and the Berwick Review. The Five Year Forward View also states that achieving quality requires a 'caring culture, professional commitment and strong leadership'

The NHSI programme has been tested in three Trusts Central Manchester University Hospitals NHS Foundation Trust; East London NHS Foundation Trust (Mental Health) and Northumbria Healthcare NHS Foundation Trust. Plus, a number of other Trusts are now using the resources. The Programme consists of three phases:

- Phase 1 Discover - Diagnostic to identify culture
- Phase 2 Design - Develop strategic and collective leadership
- Phase 3 Deliver - implement and evaluate

The current available resources focus on Phase 1 as Phase 2 and 3 are still being developed and will be available in 2017. Use of the resources would enable the Trust to have a deeper understanding of culture. We do have detailed understanding already of the challenges within the Trust. However, more work needs to be undertaken to understand the following areas:

- Understanding of the patients' experience of culture
- Leadership workforce analysis
- Leadership Behaviours

The Programme is broken down into the five key elements known to influence culture:

- Vision and Values
- Goals and Performance
- Support and Compassion
- Learning and innovation
- Teamwork

The above five elements are definite factors in the recent analysis of interviews and surveys in the Trust. All of them are about developing a collective responsibility for interconnectedness within and across the organisation. All are linked to good relationships and trust building, which underpins much of the work on culture. None of the elements are at odds with the ethos and values of the Trust, especially in the desire to be a learning organisation We know as well that higher levels of engagement correlate with innovation and improvement at work (Hakanen et al)

NHS Improvement recommends that even if other elements are not used, Board Interviews are a crucial element and should not be missed. The Board diagnostic consists of 14 questions. The culture and leadership programme and the well-led framework are complementary. However, the board interviews address a broader

range of cultural elements than the well led framework, and delve deeper into the board's influence on the culture and leadership of the organisation.

We propose to train up Pioneers and Engagement Forum members to undertake interviews and present findings. We will be able to use the dashboard available from NHSI and the results of our quarterly Pulse check to have tangible results to feedback into teams.

Yorkshire and Humber Co-Creation Network

The Co Creation network is part of the Yorkshire and Humber Leadership Academy and has offered the Trust free support when required to develop Communities of Practice.

East Midlands Leadership Academy (EMLA)

EMLA currently operates a membership approach and the Trust contributes £15k allowing all staff in theory to have access to development opportunities. This is a valuable resource and we are now reviewing the programmes and will promote them with leaders in the first instance. It is important for leaders to network and learn from others as well as hear latest research and policy. At the moment we are not accessing this appropriately.

6. Where are we now?

- We have a clearer understanding of the challenges facing the Trust and areas to be addressed
- The Engagement Forum is now established and is jointly chaired with Staffside and the interim Director of People and Organisational Effectiveness. We will start a process of development with the group from January
- All managers are receiving basic leadership training on key HR polie.
- Staff survey complete 2nd December and plans are in place to roll out findings January and February.
- The new Pulse check is ready for January 2017
- Organisational development plans in preparation for in patient areas such as Radbourne and Band 7 leads.

7. What Will Success Look Like?

The successful implementation of the approach will be shown on a number of levels and across a range of 'measures'. Ultimately, improved leadership capacity and capability, combined with the effective identification and support of talent, at every level of the organisation, will improve the staff experience (and support recruitment and retention) and have a direct and positive impact on patient outcomes - these are the main drivers for investing in leadership and talent development.

8. What needs to happen next?

- Development sessions for Engagement Forum
- Recruitment of Pioneer roles
- Begin process of agreeing leadership programme
- Refresh and relaunch Trust coaching bank and access coaching development from East Midlands Leadership Academy.
- Begin organisational development programme with Radbourne
- Begin action learning/peer support for senior leaders

9. Challenges

- The approach will require a visible commitment from the Board and an investment in resources.
- Staff shortages and the high number of vacancies
- Maintaining a focus on the development needed on bringing together two cultures
- Resources to support leadership development and OD

10. Recommendations

The Board is requested to:

- Acknowledge progress made on analysis of data and identifying areas for development
- Discuss the approach being suggested and support to look at the resourcing requirements
- Agree the commitment to the Pioneer approach and Engagement Forum

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 7 December 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	0	0	10	1
Core 5 - Council of Governors	3	0	0	0	3
Core 6 - Roles and Responsibilities of Board Members	5	1	3	1	0
Core 7 - HR and OD	8	0	1	7	0
Core 8 - Raising concerns at work	1	0	0	1	0
Core 9 - Fit and Proper	1	0	0	0	1
Core 10 - CQC	2	1	0	1	0
Core 11 - NHS improvement undertakings	6	0	0	3	3
Total	53	2	7	32	10

Since the last Board meeting there have been changes in Board RAG ratings for the Core 7 HR and OD, and the Core 5 Council of Governors recommendations.

Core 1 – HR and Associated Functions
It was agreed at the November meeting of the People and Culture Committee that the evidence underpinning the proposed sign-off of two further recommendations within Core 1 could be used to prepare blue forms (for R25 and R35). The blue forms will be submitted to the December meeting of the People and Culture Committee for sign-off. Board approval of this will then be sought in January 2017.

Core 4 – Corporate Governance
The evidence underpinning the Core 4 recommendations will be submitted to the Audit and Risk Committee on 13 December. Five blue forms for the following recommendations have been prepared and will be submitted to the Audit and Risk Committee for sign-off on 13 December. Board approval of the sign-off will then be sought in January 2017.

Core 5 – Council of Governors
It was agreed at the Council of Governors meeting held on 24 November that all three Core 5 Council of Governors recommendations were complete. Two blue forms are attached for Board scrutiny and 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.

Overall, Board RAG ratings have improved and 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 licence 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

Core areas have been discussed at respective Board Committees.

Governance or Legal Issues

This paper links directly to NHSI enforcement action and associated licence Undertakings.

Equality Delivery System

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

Recommendations

The Board of Directors is asked to:

1) Note the progress made against GIAP recommendations
2) Discuss the areas rated as 'off track' and 'some issues', seeking assurance where necessary on the mitigation provided
3) Formally approve the blue forms as presented and confirm that these are now complete.
4) Agree at the end of the Public Board meeting whether any further changes are required to the GIAP following presentation of papers, outcomes of item specific discussions and/or other assurances provided throughout the meeting.

Report presented by:	**Kelly Sims** **Project Support Officer**
Report prepared by:	**Samantha Harrison** **Director of Corporate Affairs and Trust Secretary**

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 have been changes in Board RAG ratings for the Core 7 HR and OD, and the Core 5 Council of Governors recommendations.

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Overall, Board RAG ratings have improved and progress has been made in the areas that are currently rated as 'off track' or 'some issues'.

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Core 6 - Roles and Responsibilities of Board Members	5	1	3	1	0
Core 7 - HR and OD	8	0	1	7	0
Core 8 - Raising concerns at work	1	0	0	1	0
Core 9 - Fit and Proper	1	0	0	0	1
Core 10 - CQC	2	1	0	1	0
Core 11 - NHS improvement undertakings	6	0	0	3	3
Total	53	2	7	32	10

2. Red Rated 'Off Track' recommendations

There are 2 recommendations rated as Red as detailed in the table below (6 last month):

Core Area	Recommendation	Action(s)	Mitigation
Core 6 - Roles and Responsibilities of Board Members	RR1 - Implement proposals to improve succession planning at Board level, including ensuring that Governors are adequately engaged in this process. Alongside this, develop processes for succession planning for Senior Leader positions	Develop and approve Board level, key divisional and corporate leaders succession plan	A mitigation plan was agreed at October's Remuneration & Appointments Committee, with succession planning process being led by Amanda Rawlings and Ifti Majid. Further development of the succession plan was discussed at the November and December Remuneration and Appointments Committee and proposed to be deferred until the new year due to priorities of other work areas.
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, two posts have been appointed to within the HR team to add capacity to speed up the recruitment process

3. Amber rated 'some issues' rated recommendations

There are 4 recommendations rated as Amber as detailed below (7 last month):

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. This recommendation is to be revisited as part of closer collaboration work with DCHS.
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 QLT's 3) For a 6 month period Don and MD to attend QLTs to provide coaching and oversight of meeting effectiveness	QC agreed that in order to progress this recommendation to completion it would need to see evidence of escalation templates, minutes of meetings, work plans linked to the Quality Committee forward plan, attendance embedded on the minutes and risk register. QLT leads will need to attend QC on a rotational monthly basis but detailed QLT updates from each Team will be provided monthly. When the Committee has received all this information from each QLT consistently on a monthly basis for four months the Committee indicated 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 Area	Recommendation	Action(s)	Mitigation
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. A review of the programme delivered to date and proposals to the year end to be presented to Remuneration and Appointments Committee 7 December meeting.
	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 to the Board	Implement 360 degree feedback for all BM's	Approval of proposed process to be presented to Remuneration and Appointments Committee 7 December meeting.
	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 will be provided to 7 December Remuneration and Appointments 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 be made resolving all cases in line with Trust policy. Robust review undertaken and regular review by Executive Leadership Team. Status to be reviewed at December PCC with a view to status becoming 'on track'.

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 at its 11 October meeting received an update on progress against actions to address recommendations, including a preliminary review of the embeddedness and robustness of work already undertaken. As agreed Sam Harrison has completed a full review against the original context of the recommendations outside of the meeting and has liaised with the Committee Chair to agree the approach and presentation to the December meeting. This review has resulted in the proposal for completion of five recommendations (blue forms) and proposal that one of the recommendations is no longer applicable. These proposals will be reported to the Board subject to agreement at the Audit and Risk Committee.

4.2 Remuneration and Appointments Committee

The Committee reviewed the recommendations and a review of recommendations against their original context has been undertaken. An update on progress against recommendations was discussed at the 2 November meeting and 7 December meeting.

4.3 Quality Committee

The Quality Committee reviewed all of the recommendations that it is responsible for at its October meeting. The five 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 been delivered and are complete.

4.4 People and Culture Committee

The People and Culture Committee agreed that a sub group of the Committee would undertake a full review of all actions within their five recommendations on behalf of the Committee. This took place on 11 November and the outcomes were reported back to the November Committee meeting. The result of the review was that blue forms could be completed for two further recommendations; these will be submitted to the December People and Culture Committee meeting and subject to approval, be presented to the January Board meeting.

4.5 Finance and Performance

CorpG5 focusses on the work of the Finance and Performance Committee who reviewed this recommendation in the context of the Deloitte original narrative report. This recommendation was also covered in the Deloitte Phase 1 report and the Committee reviewed this feedback at their September meeting. The Committee agreed that they were satisfied with the level of scrutiny and debate. Further work to provide assurance on the embeddedness of actions undertaken is being implemented as part of wider work on Core 4, and includes observation and of the Committee.

Derbyshire Healthcare NHS Foundation Trust
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Report from Council of Governors
12 October and 24 November 2016

The Council of Governors (CoG) met on 12 October 2016 and 24 November 2016 at the Ashbourne Centre, Kingsway, Derby. This report provides a summary of issues discussed for noting by the Trust Board.

12 OCTOBER 2016 EXTRAORDINARY MEETING

The meeting was chaired by Caroline Maley. Nine governors were in attendance. The Council of Governors discussed agenda items including:

THE STRATEGIC OPTIONS CASE

Ifti Majid gave an update on the Strategic Options Case (SOC) and proposed timescales for receipt of the finalised document and, subject to approval by the Board, subsequent due diligence of business case processes. It was highlighted that governors would review the SOC at the Council of Governor and Board Development session on 27 October.

APPOINTMENT OF NON-EXECUTIVE DIRECTORS

Jim Morrissey, Lead Governor, presented the recommendation from the Governors' Nomination & Remuneration Committee to appoint two Non-Executive Directors (NEDs) to fill the vacancy left by Jim Dixon and the additional NED role on the Board. Council of Governors approved the appointment of both Richard Wright and Barry Mellor.

DEPUTY TRUST CHAIR

Jim Morrissey, Lead Governor, presented the recommendation of the Governors' Nominations & Remuneration Committee to appoint Julia Tabreham to the position of Deputy Trust Chair effective 1 November 2016. Council of Governors approved the appointment.

24 NOVEMBER 2016

16 governors were in attendance. The CoG discussed agenda items including:

ACTING CHIEF EXECUTIVE'S REPORT

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

STRATEGIC OPTIONS CASE

The summary Strategic Options Case (SOC) was formally received by the governors, following discussion on 27 October at the development session held with the Council of Governors and Board of Directors. Questions relating to the SOC, which had been identified at the Governance Committee of 11 October, as per governors' role to hold Non-Executive Directors (NEDs) to account, were noted and responses given by NEDs and Executive Directors.

INTEGRATED PERFORMANCE REPORT

The Integrated Performance Report (IPR) which provides an integrated overview of performance as at the end of September 2016 was presented. The focus of the report was highlighted to include workforce, finance, operational delivery and quality performance.

REPORT FROM THE GOVERNORS' NOMINATIONS & REMUNERATION COMMITTEE

Richard Gregory presented the update from the meetings of the Nominations & Remuneration Committee held on 21 September, 11 November and 23 November 2016. (The minutes from the meeting held on 14 November 2016 were discussed in the confidential session of the CoG – see below). Business covered by the meetings included agreeing the recruitment and selection of the clinical NED post, and proposals for the Deputy Chair role and recommendations to appoint Richard Wright and Barry Mellor as NEDs. These recommendations were subsequently approved at the extraordinary CoG held on 12 October 2016. The interview process for the clinical NED post was undertaken on 23 November 2016 and a paper was tabled to propose the recommendation that Dr Anne Wright be appointed to the role. The CoG agreed this proposal with the start date to be agreed with the successful candidate.

FEEDBACK FROM NON-EXECUTIVE DIRECTORS ON OPERATIONAL PLAN

Following discussion of the operational plan 2017-19 at the governors' development session held on 15 November where governors had been given the opportunity to feed in their views to the Operational Plan, governors had requested feedback from NEDs following their discussion of the operational plan at the Board Development Session focussing on this held on 16 November. NEDs duly outlined their input and it was noted that these comments had been incorporated into further updates of the Operational Plan. It was noted that the first draft of the Operational Plan had been submitted to NHS Improvement as per the deadline of 12 noon on 24 November 2016. The final version of the plan is to be submitted on 23 December 2016.

REPORT FROM GOVERNANCE COMMITTEE

Reports of business covered at Governance Committees held on 20 September, 11 October and 9 November 2016 were noted. This included updates on implementation of the Code of Conduct for governors, membership and engagement, holding to account and training and development. It was noted that the Committee was felt to be working effectively in covering key areas of governors' responsibilities.

GOVERNANCE IMPROVEMENT ACTION PLAN

Governors received an update on the delivery of the GIAP and an overview of the actions that the Council of Governors is responsible for seeking assurance on delivery. Governors were provided with an overview of performance against all recommendations set against each respective core area, as reported to the Trust Board on 2 November 2016. Governors also confirmed completion of all actions related to recommendations falling to Council of Governors' oversight and agreed that the 'blue forms' should be submitted to Trust Board for ratification.

REPORT FROM TASK AND FINISH GROUP

John Morrissey, Lead Governor, presented the report of the Task and Finish Group that had been convened to undertake an independent review of the actions of the Trust Board in the circumstances following the Employment Tribunal. The group had met over several months and had been supported by an independent legal advisor. The report concluded that the NEDs had not acted as if accountable to the CoG but there had since been a marked change in this approach and relationships had now much improved. Governors accepted the report and thanked the Task and Finish Group for undertaking this review and supported the view that there was now a good relationship with NEDs and that all parties were now clearer on their responsibilities and accountabilities.

CQC SUMMIT FEEDBACK

Carolyn Green presented details of the CQC summit that took place on 8 November 2016. This was noted to be a positive experience for the Trust where changes and improvements undertaken by the Trust since the June inspection had been highlighted. Governors had been present at the summit and were thanked for their input. Governors noted the update, acknowledging work undertaken and the further actions required to fully address and embed required changes.

COUNCIL OF GOVERNORS ANNUAL EFFECTIVENESS SURVEY

Sam Harrison presented the results of the annual effectiveness survey undertaken by governors for the first time during September 2016. The detailed results were noted and key highlights outlined including the assurance that all respondents were aware of the Trust's values and strategy. Opportunity for contact with the Board of Directors and opportunity for dialogue with NEDs was also noted for its positive response. Areas for further action were noted to include a focus on communication with members and stakeholders (both in terms of improving effectiveness of engagement and the sufficiency of communication) and this is to be scheduled for discussion at the Governance Committee in January/February 2017 to map out how governors can be supported to address this.

CONFIDENTIAL SESSION

The CoG also met in confidential session on 24 November to discuss proposals for the future Chair and Chief Executive leadership of the Trust. This followed recommendations from the Board's Remuneration and Appointments Committee and following discussion by the governor's Nominations and Remuneration Committee held on 14 November.

RECOMMENDATION

The Board is asked to:
- Note the summary report from the Council of Governors.

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

2016-17 Board Annual Forward Plan

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	Apr-16	May-16	Jun-16	Jul-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
		Deadline for papers	18 Apr	16 May	20 Jun	18 Jul	26 Aug	26 Sep	24 Oct	28 Nov	3 Jan	23 Jan	20 Feb
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 NHSI Annual Plan submissions and governance statements, including financial plan and budgets (subject to change for NHSI deadlines each year) *Confidential*	FT Constitution/NHSI Risk Assurance Framework (RAF)	X										X
CW	NHSI Compliance Return (Public)	NHSI Single Operating Framework		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 SOs, SFIs, 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	

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Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	Apr-16	May-16	Jun-16	Jul-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
SH	Committee Assurance Summaries (following every meeting) - 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	Fit and Proper Person Declaration	Licence Condition FT4		X									X
MP	Emergency Planning Report								X				
SH	Board Effectiveness Survey											X	
SH	Report from Council of Governors Meeting		X				X	X		X		X	
OPERATIONAL PERFORMANCE													
CG, CW, AR, MP	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
MP	Agency Controls									X	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 Adults Annual Report	CQC Mental Health Standard Contract								X			
CG	Control of Infection Report	Health Act Hygiene Code		X									
CG/JS	Integrated Clinical Governance Annual Report including MHA/Governance/Complaints and Compliments/SIRIs/Patient Safety/NHS Protect (LSMS) and Emergency Preparedness/H&S (including H&S and Fire Compliance and Associated Training)	CQC and H&S Act							X				

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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	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			

* Incorporated in Quality Position Statement