Derbyshire Healthcare NHS
NHS Foundation Trust

Meeting of the Board of Directors

28 October 2015

Trust Headquarters, Bramble House, Kingsway Site, Derby, DE22 3LZ
Tel: (01332) 623700 Fax: (01332) 331254
Acting Chief Executive: Ifti Majid Chairman: Mark Todd

Better together

NOTICE OF BOARD MEETING
WEDNESDAY 28 OCTOBER 2015
TO COMMENCE AT 1.00 PM IN THE CONFERENCE ROOMS A & B,
RESEARCH & DEVELOPMENT CENTRE, KINGSWAY, DERBY DE22 3LZ

Item	Time	AGENDA	Enc Ref	Discussion led by
1.	1:00	Chairman's Welcome and Opening Remarks	**-**	Mark Todd
2.	1:05	Service User Story		
3.	1:30	Apologies for Absence Declarations of Interest		Mark Todd
4.	1:35	Minutes of Board of Directors meeting, held on 30 September 2015	**A**	Mark Todd
5.	1:45	Matters arising – Actions Matrix	**B**	Mark Todd
6.	1:50	Chairman's Report	**C**	Mark Todd
7.	2:00	Acting Chief Executive's Report	**D**	Ifti Majid
STRATEGY & GOVERNANCE & FINANCE				
8.	2:10	Board Committee Minutes: - Quality Committee (ratified September minutes) - Audit Committee (draft October minutes)	**E**	Jenna Davies
9.	2:20	Information Governance Update	**F**	Jenna Davies
10.	2:30	Board Assurance Framework Update	**G**	Jenna Davies
11.	2:40	Finance Director's Report Month 6	**H**	Claire Wright
B R E A K 3:00				
12.	3:15	Deep Dive in Suicide Prevention	**I**	John Sykes
PATIENTS, QUALITY AND SAFETY				
13.	3:40	Position Statement on Quality	**J**	Carolyn Green
14.	3:50	Integrated H&S Governance Annual Report (including H&S and Fire Compliance and Associated Training)	**K**	Carolyn Green
OPERATIONAL & PERFORMANCE REVIEW				
15.	4:00	Integrated Performance and Activity Report	**L**	Carolyn Gilby
FOR INFORMATION				
16.	4:10	I. Board Forward Plan II. Identification of any issues arising from the meeting for inclusion or updating of the Board Assurance Framework III. Discussion on future deep dives IV. Comments from observers on Board performance and content of meeting	**M**	Mark Todd

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. On this occasion the special reason applies to information which is likely to reveal the identities of an individual or commercial bodies.

The next meeting is to be held on 25 November 2015, at 1.00 pm in Conference Rooms A & B,
Centre for Research and Development, Kingsway, Derby DE22 3LZ
Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board. Participation in meetings is at the Chairman's discretion. `

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Wednesday, 30 September 2015

MEETING HELD IN PUBLIC

Commenced: 1:00 pm Closed: 4:10 pm

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

PRESENT:	Mark Todd	Chairman
	Ifti Majid	Acting Chief Executive
	Caroline Maley	Senior Independent Director
	Maura Teager	Non-Executive Director
	Jim Dixon	Non-Executive Director
	Phil Harris	Non-Executive Director
	Claire Wright	Executive Director of Finance
	Carolyn Green	Executive Director of Nursing and Patient Experience
	Mark Powell	Director of Business Development and Marketing
	Jayne Storey	Director of Transformation
	Jenna Davies	Interim Director of Corporate & Legal Affairs
IN ATTENDANCE:	Anna Shaw	Deputy Director of Communications
	Sue Turner	Executive Administrator and Minute Taker
For item DHCFT 2015/139	Sangeeta Bassi	Chief Pharmacist
For item DHCFT 2015/140	Peter Charlton	General Manager IM&T
VISITORS:	Carole Riley	Derbyshire Voice Representative
APOLOGIES:	Graham Gillham	Director of Corporate and Legal Affairs
	Tony Smith	Non-Executive Director
	Dr John Sykes	Executive Medical Director
	Carolyn Gilby	Acting Director of Operations

DHCFT 2015/128	**CHAIRMAN'S OPENING REMARKS, APOLOGIES, DECLARATIONS OF INTEREST** The Chairman opened the meeting by welcoming all present. Declarations of interest were received from the Chairman, Ifti Majid, Caroline Maley, Maura Teager, Tony Smith, Jenna Davies and Jayne Storey with regard to the employment tribunal.

DHCFT 2015/129	**SERVICE RECEIVER STORY** Service receiver visitors today were Norman and his partner and main carer Steven. Steven described how following the trauma of Norman losing his sight and diagnosis of cancer, Norman's mental health deteriorated. The Chesterfield Mental Health Team for Older Adults (CMHT) became involved in his care and throughout the journey Norman has taken, the team have supported both him and Steven. Steven was full of praise for the team, especially their main CPN in the CMHT, who had on many occasions promptly stepped in with the help they needed. He explained how he and the team had helped when Norman was admitted to hospital for an operation when he was diagnosed with cancer. The nursing staff in the acute trust did not understand the problems associated with Norman's sight loss. Being in the dark at night was distressing for Norman and the CMHT arranged for the lights to be left on at night. The CPN designed and placed a notice above Norman's bed to remind nursing staff as changes in staff had sometimes led to the lights being switched off. Unfortunately complications arose from Norman's surgery and his chances of survival were small. He recovered but his mental health had deteriorated. Steven knew that Norman needed to have visitors with him throughout the day and night and the CPN quickly arranged with the hospital for Norman to have visitors at any time. Norman's mental health deteriorated even further when he returned home and Steven gave up his job to care for Norman full time. The CMHT supported them both and gave Norman a "Boom Box". This is a device used for visually impaired people which plays audio files and also contains a radio. Norman's CPN recorded Norman's care plan and a relaxation therapy session to enable him to take control of his anxiety which worsens when Steven goes out of their home. Therefore the results are two-fold, supporting Norman to manage his symptoms and enabling Steven to have some time for respite. The "Boom Box" has been a great success and is very easy for Norman to use and Steven demonstrated to the Board how it allows Norman to play a relaxation breathing exercise whenever he feels anxious and listen to his care plan. Norman is veteran of the armed forces and receives weekly newspapers on a memory stick which he also plays on the "Boom Box". Members of the Board were pleased to note the care provided by the CMHT and the good progress and performance of our Trust staff and acknowledged their good work. The difficulties Norman had experienced while in an acute general hospital ward due to the lack of understanding from the staff was observed by the Board and members of the Board considered that Norman's and Steven's story could be anonymised and used for training staff in being psychologically aware of the additional specific sensitivities and nuances to care required with individuals with sight loss. The Chairman thanked Norman and Steven for sharing their very moving and personal story which would allow improvement and learning about how the NHS can work with a person's needs. **ACTION Ifti Majid to write to the named CPN to feedback on Norman and Steven's story and forward their compliment and extend the Board's thanks**

	RESOLVED: The Board of Directors expressed thanks to Norman and Steven for sharing their story which allowed them to understand the difficulties they have faced and consider the innovative practice of the "Boom Box", unique solutions to personalised care planning and receive a compliment for our North Older Persons Service, and in particular a named CPN.
DHCFT 2015/130	**MINUTES OF DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST BOARD MEETING, HELD ON 29 JULY 2015** The minutes of the Derbyshire Healthcare NHS Foundation Trust Board meeting, held on 29 July were accepted and approved.
DHCFT 2015/131	**MATTERS ARISING** The Board of Directors had received questions from Derbyshire Voice and a member of the public outside of the meeting relating to the removal of seclusion rooms in Trust wards, to request for the latest figures of patients having to go out of area for a psychiatric bed and the review of occupational therapy staff. Each of these questions was addressed in detail by Carolyn Green and a detailed narrative of these questions and answers is included as an appendix to the minutes. In response to the matter relating to seclusion rooms, Maura Teager added that as Chair of the Quality Committee, the committee's summary report represented what had been discussed and reported at the Quality Committee. The summary demonstrated the complexity of this situation as well as the physical care required when dealing with the effects of NPS drugs and the need for seclusion. This is not just for the safety of the person who requires seclusion but for the safety of the rest of the population on the ward. Representatives from Derbyshire Voice are members of the Quality Committee and the Seclusion Group and this offers them openness and transparency. There is also a national specification and 19 page document that will be submitted to the Seclusion Group and the Seclusion Group will be submitting a paper to the Quality Committee in November. With regard to the use of CCTV in seclusion rooms, it was explained that the use of CCTV recordings being detailed on patient records may be used for patient safety. Carolyn Green confirmed this decision is a recommendation but a detailed process is required and the decision is not made and is still open to advice from Trust Staff, exploration of this proposal within other Trusts and experts by experience feedback. The Board is sighted on the use of out of area beds and statistics are regularly reported to the Finance & Performance Committee. Regarding community mental health teams occupational therapy staff, this was reviewed in the Quality Committee in September. Skill mixing was taking place with nursing and extended the professional group and was an example of how we change the profile of our workforce group. **Actions Matrix:** All green completed items to be removed and all other updates were noted directly on the matrix.

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DHCFT 2015/132	**CHAIRMAN'S REPORT** The Chairman's report summarised his meetings and visits during the month. The Board noted that further information had been received on the outcome of the recent employment tribunal (ET). The tribunal had reconsidered their decision relating to the discriminatory dismissal of a previous member of the Board. As an organisation the Trust will look at the legal process and move forward to the next steps. **RESOLVED: The Board received and noted the Chairman's report.**
DHCF 2015/133	**ACTING CHIEF EXECUTIVE'S REPORT** This report provided the Board of Directors with some of the key national policy changes and announcements over the last month. The report also provided an update on work within the Derbyshire Health and Social Care Community as well as covering key issues internal to the Trust. The Board noted the Trust's key role working in support of colleagues employed in acute conditions and the impact on its services in preparation for the winter. Attention was drawn to the Public Sector Reform or Devolution Bid to Government known as D2N2. This was seen as having a positive impact on residents in Derbyshire and the Board welcomed the progress made on transformation and integration activity and the new models of commissioning Derbyshire CCGs are looking to pilot. Discussions took place on whether there was a need to reflect the impact of this project in the Board Assurance Framework (BAF). Carolyn Green commented that elements would be encompassed in our own analysis and a work plan will be set against all CQC feedback. **RESOLVED: The Board of Directors received and noted the Acting Chief Executive's Report.**
DHCFT 2015/134	**COMMITTEE SUMMARY REPORTS** The draft minutes of the recent meeting of the Audit Committee and the summary reports of meetings of the Quality Committee, Mental Health Act Committee and Safeguarding Committee were scrutinised and discussed and the Board felt informed of the main themes emerging within these committees. Maura Teager, Chair of the Quality Committee highlighted the lessons learnt from work completed by the Crisis Teams Resolution Services and the Board felt assured by the discussions held at the committee's September meeting. Discussions developed around the Raising Concerns at Work (Whistleblowing) Policy and Procedures. The Board recognised that the policy is to be revised in the light of new guidance and would be reviewed at the October meeting of the Audit Committee and at the Executive Leadership Team (ELT) meeting and a revised draft submitted to the Board at the October meeting. The Board also noted that in line with guidance from Monitor, the minutes of Board committees will be received for formal noting in future rather than the summary reports.

	ACTION: Revised draft of the Raising Concerns at Work (Whistleblowing) Policy and Procedures to be submitted to the Board at the October meeting. **ACTION: Committee minutes to be submitted to the Board in future.** **RESOLVED: The Board of Directors noted the contents of the Committee Summary Reports and the draft minutes of the Audit Committee.**
DHCFT 2015/135	**FINANCE DIRECTORS REPORT MONTH 5** This report provided the Board with an update on financial performance against the Trust's operational financial plan as at the end of August 2015. Claire Wright pointed out that this was the first report that reflected the new metrics published in the revised Risk Assessment Framework and showed the Trust had achieved a rating of 4 year to date and was forecast to achieve a 3 at the end of the year. The Board noted that temporary staffing was being closely monitored at ELT to ensure the Trust complied with the nursing agency threshold of 3% and that the Trust was not in breach of the non-mandatory ceiling that had been allocated by Monitor. Claire Wright assured the Board that capital expenditure was being closely monitored on an ongoing basis and she was confident the Trust would meet plan at the end of the year. Cost pressures were being managed and there was also an expectation that at end of the year CIP (Cost Improvement Programme) will be met. **RESOLVED: The Board of Directors considered the content of the paper and considered their level of assurance on the current and forecast financial performance for 2015/16.**
DHCFT 2015/136	**COMMUNICATIONS AND MEMBERSHIP STRATEGIES** The Trust Board approved new communication and membership strategies in November 2014. This report provided an update on activity over the last ten months and outlined further areas of development for the team. Questions were raised about the dedicated managers' e-bulletin currently being developed and scheduled to go live in December. The Board welcomed this opportunity to offer CQC inspection reminders to staff and that it would also provide a high level overview of what is going on regionally. It was also apparent that communications was being used to campaign for engagement within the communities and this report gave a broad picture of what the Communications and Engagement Team is involved in. The Trust Chair thanked Anna Shaw and the Communications and Engagement Team for rearranging the Annual Members Meeting to take place on Trust premises and the Board recognised the work the team had undertaken fielding some difficult matters over the last few months. **RESOLVED: The Board of Directors Trust Board noted the content of the**

	report on Communications and Membership Strategies.
DHCFT 2015/137	**DEEP DIVE IN MANAGING SICKNESS AND ABSENTEEISM** Jayne Storey presented the report into the Trust's current Sickness Absence information that linked to other employee relations activity. The 'deep dive' covered: • A Trust wide overview of sickness absence • Detailed analysis of sickness absence by Staff Group and Work Area • Analysis of sickness absence by reason • Focus on 3 key areas within the Trust The report showed in the main a stable trajectory of HR metrics except that the sickness rate for the Trust had steadily increased during 2015/16. This increase is in line with the national trend for Mental Health and Learning Disabilities Trusts for the same period and showed the Trust has a higher rate than the national average increasing month by month and is now at a level over 5%. 30% of sickness is due to stress and anxiety and this causes a continued risk to temporary staffing spend. The Board discussed and noted the following from the report: • There were some very clear messages from front line staff who asked to be empowered to manage short term sickness and frequency with more vigour and discipline. • Some staff considered the *Firstcare* sickness reporting process as an unnecessary barrier between managers and staff and it was understood that this process would be reviewed further. • Hot spots do not always correspond with pressures in service. There are other parts of our service where sickness does not appear to be as prevalent. • Stress and anxiety cannot always be perceived as being work related. Stress related sickness has reduced this year from last and reflects feedback from the annual staff health check. • CAMHS sickness had significantly reduced by 40%. • The management of staff on long term sickness is to be looked at further. It was agreed that an action plan would be formulated and show actions to be taken. Specific actions will be formulated from the staff health check to address the working environment, staff health and wellbeing and agency spend as well as other key areas to address the risks on the Board Assurance Framework (BAF). The action plan would also be shared with Monitor. **ACTION: The results of the deep dive in sickness absence will be reported to the People Forum at the next meeting on 13 October. The Finance & Performance Committee will receive a report from the People Forum at its next meeting in November and an update report on the action plan and results from these actions will be provided to the Board at its meeting in November. Monitor to receive an update report by the end of October.**

	RESOLVED: The Board of Directors acknowledged the Deep Dive Report and current position in relation to sickness absence and would provide continued support for preventative work around resilience
DHCFT 2015/138	**POSITION STATEMENT ON QUALITY** This report provided the Board with an update on the Trust's continuing work to improve the quality of its services in line with the Trust's Strategy, Quality Strategy and Framework and strategic objectives. The Safeguarding Children, Looked After Children and the Safeguarding Adults Annual Reports were formally noted by the Board. Discussions took place on how safeguarding papers should be noted bearing in mind they are both lengthy documents. The Board were assured by the scrutiny of the Safeguarding and Quality Committees' review of these reports and they were confirmed and accepted. It was recognised that both reports showed a level of focus, performance and commitment and the Board acknowledged the work carried out by the safeguarding teams. **RESOLVED: The Board of Directors noted the Quality Position Statement, together with the Safeguarding Children and the Safeguarding Adults Annual Reports.**
DHCFT 2015/139	**MEDICINE MANAGEMENT UPDATE** Carolyn Green provided a verbal update on Medicine Management. The Board noted that the outcomes from the deep dive carried out in July have been reviewed at ELT but there is a lack of required resources to carry this through at pace. Mark Powell has raised this as a concern and is discussing funding and support for medicine management with commissioners. The Board recognised the proposal in July's report for the required resources and that the financial plan for taking this forward is being progressed through ELT. **RESOLVED: The Board of Directors noted the verbal update on Medicine Management.**
DHCFT 2015/140	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT AND SAFER STAFFING** This report presented by Peter Charlton defined the Trust's performance against its Key Performance Indicators plus any actions in place to ensure performance is maintained. Compliance with the Trust's performance indicators is being actively monitored and corrective actions are put in place where appropriate. Areas covered in this report include, the Main Performance Indicators, Health Visitors, IAPT and Ward Safer Staffing. The Board thoroughly scrutinised the report and discussed current performance of safe staffing and gained greater assurance with problem areas including the rate of outpatients who did not attend and consultant cancellations. It was thought this is due to rescheduling of appointments rather than cancellations and is a matter that will be focussed on. New practices for issuing letters in PDF

	form was welcomed by the Board and it was noted that early intervention target rates should be explored through PCOG. **RESOLVED: The Board of Directors:** **1) Acknowledged the current performance of the Trust** **2) Noted the actions in place to ensure sustained performance**
DHCFT 2015/ 141	**FOR INFORMATION** **I. Board Development Programme:** Updated version of the programme would be reviewed at ELT. **II. Board Forward Plan:** Estates Design and Agile Working would be deferred from the October confidential session to November. **III. Board Assurance Framework:** Aspects were raised in the deep dive in Managing Sickness and Absenteeism and how they might impact the BAF to be considered. **IV. Future deep dives:** It was agreed that a deep dive into Suicide Prevention Improvement Plans would be the focus of the deep dive to be held at the next meeting in October. **V.** No comments were received from members of the public or observers **ACTION: Aspects raised in the deep dive in Managing Sickness and Absenteeism and how they might impact the BAF to be considered.**
DHCFT 2015/142	**CLOSE OF THE MEETING** The Chairman thanked all of those present for their attention and comments and closed the public meeting at 4:10 pm.
DATE OF NEXT MEETING The meeting of the board in public session is scheduled to take place on Wednesday, 28 October, 2015 at 1.00 pm. in Conference Rooms A & B, R&D Centre, Kingsway Site, Derby, DE22 3LZ (confidential session to commence earlier at 10.30 am).	

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Derbyshire Healthcare NHS
NHS Foundation Trust

Response to questions from Derbyshire Voice to the Derbyshire Healthcare NHS Foundation Trust Board

In 2013, a decision to work toward the removal of seclusion rooms in the Trust's wards.

In 2013 and 2014 concerns were raised by staff on the viability of this.

In 2014, a decision was made to hold and stop the removal of seclusion rooms, in all Trust wards.

This decision was reviewed by the quality committee with the Positive and Safe Working Group and Strategy Development. This changed in 2014; to. We will remove seclusion from open acute wards.

The Hartington unit and the Radbourne acute units had seclusion rooms removed. This objective was achieved.

The enhanced care ward at the Radbourne unit has a seclusion suite; it has two rooms, which are used as one high support area and are connected in the same space and area.

NHS England specification

The Kedleston unit low secure specification requires a seclusion room. It has two seclusion rooms on each of the low secure wards. These are seldom used.

DHCFT raised a question to the Board. We are still working towards reducing seclusion at this time; we hope one day that seclusion is ceased. Our commitment in 2014 was to remove seclusion from open acute wards.

The national specification for seclusion rooms has changed. All Mental health trust providers have to upgrade their facilities. This is a theme and pattern in many mental health CQC inspections, that older seclusion rooms do not meet the specification and require upgrade. Our seclusion room falls into this group. We have looked at options and our only real option is to build a building extension at the other side of the enhanced care ward, as the width and requirement for ensuite facilities cannot fit into the building width available in the current setting. The Quality Committee has been briefed on this issue.

The Quality committee were briefed in the incidents report of a serious incident where the investigation team have recommended the use of CCTV in the seclusion room. This is being explored, through the seclusion group, security and legal aspects of this recommendation. To explore this recommendation, the October seclusion group has an extended paper on the issue to debate. Service receiver groups were actively asked to give their views on the introduction of CCTV.

CCTV in seclusion rooms is not a recommendation in NG10.

The recommendation in NG10 is that seclusion rooms are a safer option to prolonged physical restraint over ten minutes. One of the compounding reasons for continued use of seclusion in enhanced care is the NG10 recommendation. The seclusion group has received information on seclusion and have had the emerging concerns of novel and new psychoactive substances (NPS). Being under the influence of NPS, and the use of physical restraint can increased risks to the respiratory system. If a person is under the influence of NPS seclusion rooms are a safer option than holding. This is an additional compounding reason for continued use of seclusion.

The NICE guideline NG10, was released at the end of June 2015, we are working through the recommendations and finding solutions. It is challenging but we continue to progress.

NG10 requires an immediate post incident debrief to be carried out for staff and service receivers in particular within 72 hours. This has been an area that the trust has not embedded and predates NG10 as a recommendation from the seclusion group work plan. Trust managers have been open and transparent throughout the life and work plan of the seclusion group that this is not happening routinely. It is offered and not accepted, it is sometimes not offered routinely. Senior nurses and SLM's have been invited to the seclusion group in October and going forward as a standing agenda item, to give further scrutiny to this issue.

In addition Carolyn Green wrote to all Directors of Nursing in England to ask ideas and solutions in implementing NG10. She received some responses, mainly no solutions. However, one Trust did respond to confirm what they had done. The Trust was honest that they had struggled and they had found a solution through using an independent advocate service, on a spot purchase arrangement. The advocate would see all individuals who had experienced a seclusion event and would ask them their view, record and write up their experience, feedback anonymously to the service on learning and advocate. The Trust has shared their checklist, service level agreement and has offered a visit to the service to see how it's working. We believe this solution is one our Trust would like to adopt and we are in negotiation with an advocacy service to explore whether this is viable. This proposal will be coming to the October seclusion group for discussion.

Our thanks go to Berkshire and SEAP

SEAP (support, empower, Advocate and Promote) Berkshire Advocacy Service for sharing their work

Derbyshire Healthcare NHS
NHS Foundation Trust

Board questions raised by a member of the public in a letter to the Derbyshire Healthcare NHS Foundation Trust Board

Question 1

In 2013 a decision to work toward the removal of seclusion rooms, in Trust wards.

In 2013 and 2014 concerns were raised by staff on the viability of this.

In 2014 a decision was made to hold and stop the removal of seclusion rooms, in all of the Trust's wards.

This decision was reviewed by the Quality Committee with the Positive and Safe Working Group and Strategy Development. This changed in 2014 and we will remove seclusion from open acute wards.

The Hartington unit and the Radbourne acute units had seclusion rooms removed. This objective was achieved.

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DHCFT raised a question to the Board. We are still working towards reducing seclusion at this time; we hope one day that seclusion is ceased. Our commitment in 2014 was to remove seclusion from open acute wards.

The national specification for seclusion rooms has changed. All mental health trust providers are having to upgrade their facilities. This is a theme and pattern in many mental health CQC inspections, that older seclusion rooms do not meet the specification and require upgrade. Our seclusion room falls into this group. We have looked at options and our only real option is to build a building extension at the other side of the enhanced care ward, as the width and requirement for ensuite facilities cannot fit into the building width available in the current setting. The Quality Committee have been briefed on this issue.

The Quality Committee was briefed in the Serious Incidents Report of a serious incident where the investigation team have recommended the use of CCTV in the seclusion room. This is being explored, through the seclusion group, security and legal aspects of this recommendation. To explore this recommendation, the October seclusion group has an extended paper on the issue to debate. Service receiver groups were actively asked to give their views on the introduction of CCTV.

CCTV in seclusion rooms is not a recommendation in NG10.

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Question 2

CCTV is an option, it is a recommendation that we are debating, and no final decision has been made. The cost is not £250,000.

Question 3

What are the latest figures of patients having to go out of area to get a psychiatric bed?

We had made significant improvements and the Trust was managing within its own bed stock, this has had some small periods of being in out of area beds. In the last three months we had two people in July, one person in August and one person in September.

The flow for in-patient adult beds has improved of late with the out of area bed usage being considerably reduced during recent months. This is as a result of timely and appropriate referrals into transition beds. The purpose of transition beds is to provide focused step down care for a 12 week period for patients who no longer require an acute bed however do require supportive interventions before stepping directly into community care.

Question 4

As regards community mental health teams, what is being done to replace occupational therapy staff?

Replacement of OTs in Community service.

Within the Neighbourhood developments the financial envelope has been allocated on the basis of GP population and commissioner income per area.

As OT posts become available for recruitment they are reviewed in the same way as any other discipline and required OT banding reviewed for the area. The Lead OT is currently involved in reviewing all Neighbourhood OT posts and ensuring there is a plan in place to develop an equitable OT skill mix across Neighbourhoods and comparable banding across the areas

The OTs have been assigned lead partnership development roles within the plans

BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - OCTOBER 2015						
Date	**Minute Ref**	**Action**	**Lead**	**Status of Action**	**Current Position**	**Enc B**
28.1.2015	DHCFT 2015/010	Committee Summary Reports	Jenna Davies	Actions to address consistency and level of detail of the summary reports would form part of the governance framework exercise.	The Well Led Framework Review has been brought forward and we will review on the outcome of governance framework exercise. Timeframe to be added. 30.9.2015: Items relating to the Well Led Framework will be completed by March 2016. New guidance shows that minutes should be provided to the Board rather than summary reports. Timeframe for governance framework exercise will be reported to and discussed at the Audit Committee.	Yellow
25.3.2015	DHCFT 2015/050	Integrated Performance and Activity Report and Safer Staffing	Carolyn Green	Carolyn Green to propose holding an administration excellence event to the Training Board	24.6.2015 No progress at this time, priority of training board has been mandatory and statutory training review and quality priorities. Carolyn Green will liaise with Training Board on this suggestion which was proposed from a quality visit. This is paused until we receive our HEEM allocation of funds, Carolyn Green will report request to People Forum. Aiming for administration excellence for out of hours teams. This is a long standing item and Cargolyn Green will stive to achieve this training. More information is awaited.	Amber
29.4.2015	DHCFT 2015/064	Corporate Governance Framework	Jenna Davies	Jenna Davies will lead the development of an improved Corporate Governance Framework	Improved version of Corporate Governance Framework deferred to October. Timeline in line with Well Led Framework.	Yellow
27.5.2015	DHCFT 2015/079	Integrated Service Delivery	Jayne Storey	Jayne Storey to plan a Board Development Session to cover the strategic risk of the transformation change process	Transformation has been discussed at varous committees. Will form part of discussion at October Board Development.	Amber
27.5.2015	DHCFT 2015/087	Integrated Performance and Activity Report and Safer Staffing Deep Dive	Jenna Davies/ Ifti Majid	Ifti Majid and Jenna Davies will take some of the best examples of reporting from the analysis and create a narrative using benchmarking where possible to redesign performance reporting within the Trust to be introduced post CQC visit.	Initial trial of revised executive summary report to be used in F&P with lessons learned being used to inform changes to the Board paper - aim for September Board to implement lessons learned in Board paper. This will also be reported through Finance & Performance Committee. Agreed at September meeting that in line with guidance from Monitor, minutes and not summary reports will now be included in Board packs. ACTION COMPLETE	Green
24.6.2015	DHCFT 2015/099	Staff Health Check	Jayne Storey	Jayne Storey to lead the Cultural Change Programme	In progress. Group who attended deep dive Staff Health Check in July will be meeting with leaders and will be encouaged to act on outcome of Health Check. Programme will be developed. Governors have asked for a update on this area. This is on the agenda for next meeting of COG.	Green
29.7.2015	DHCFT 2015/119	Verbal Workforce Strategy Update	Jayne Storey	Jayne Storey to provide an interim report to the Board outside of the meeting prior to a full update to the Board in September	Update was circulated to Board members on 30 July. People Strategy update is an agenda item for November Board. Activities to drive organisation change will be focussed on and OD activities will be addressed. Board Development in November will address differences between OD and People Strategies.	Yellow

29.7.2015	DHCFT 2015/122	Position Statement on Quality	Jayne Storey	Jayne Storey to raise current performance of training at the People Forum, together with the staff health check and preceptorship admission.	The People Forum has not met since the Board action. Performance of training and staff health check and preceptorship admission will be considered at the People Forum planned for 22 October and will reported to Finance & Performance Committee via People Forum summary.	Amber
29.7.2015	DHCFT 2015/126	AOB - Board Development Programme	Jayne Storey	Jayne Storey to provide a clearer definition of the Board Development Programme at the next meeting of the Board in September	Jenna Davies and Jayne Storey reviewing the purpose and programme for 2016 and will lead a discussion in the November Board Development session.	Yellow
30.9.2015	DHCFT 2015/134	Committee Summary Reports	Jenna Davies	Revised draft of the Raising Concerns at Work (Whistleblowing) Policy and Procedures to be submitted to the Board at the October meeting. Committee minutes to be submitted to the Board in future rather than summary reports.	Revised draft of the Raising Concerns at Work (Whistleblowing) Policy and Procedures deferred to November meeting.	Yellow
30.9.2015	DHCFT 2015/137	Deep Dive in Managing Sickness and Absenteeism	Jayne Storey	The results of the deep dive in sickness absence will be reported to the People Forum at the next meeting on 13 October. The Finance & Performance Committee will receive a report from the People Forum at its next meeting in November and an update report on the action plan and results from these actions will be provided to the Board at its meeting in November. Monitor to receive an update report by the end of October.	People Forum has been postponed. Update report on Managing Sickness and Absenteeism will be an agenda item for November Board.	Yellow
30.9.2015	DHCFT 2015/141	Board Assurance Framework	ALL	Aspects raised in the deep dive in Managing Sickness and Absenteeism and how they might impact the BAF to be considered.		Amber

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

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 28th October 2015

Chairman's Report

Background

It has been agreed that the Chair submits a written report to the Board.

Meetings attended

The following substantial meetings/visits have been made over the period since the last Board:

Attended initial meeting of Let's Loop Derby, focused on strengthening hearing loop provision in the city on 1 October
Attended Governors' Working Group for Quality on 7 October
Attended the Trust's event at the University of Derby for World Mental Health Day on 9 October
Attended Governor Development Working Group on 13 October
Attended board development session focused on strategy on 14 October
Attended Quality Committee on 15 October
Attended 4Es Stakeholder event in Long Eaton on 20 October
Attended Trust's leadership event on 21 October
Held Quarterly meeting with non-executive directors on 23 October

I also met with various Governors at their request and as part of the periodic one-to-one process agreed with the Council.

Points arising:

1. I reported to the Governor Development Working Group on my findings from my one-to-one meetings with governors (copy of paper available). Key points were the need to strengthen Trust support for governor/member engagement; clarification of the role of working group convenors; increase use of social media to provide governor training; improve geographical distribution of meetings; complete review of working groups; strengthen recording and monitoring of actions at meetings; and increase governor participation in quality visits.

2. The Governor Development Working Group on Quality highlighted some perceptions that professional models of care might not always seem compatible with formal quality governance assurance. Discussion took place on how the work of this group might relate to that of the Quality Committee.

3. The Trust's event at the University was very well-attended, attracted many new members and provided great opportunities to meet stakeholders including students currently attached to the Trust on placements. Well done to all concerned.

4. Our 4Es event produced interesting discussions on both the Erewash Vanguard project and smoking cessation. There was a strong demand for carer representation on the steering group for the latter.

5. At the Trust leadership event I learned that this Trust had the highest proportion of service receivers in employment in the country. Wow!

6. I made an announcement on my own position and the process for responding to that lies in the hands of the Council of Governors.

Legal Issues
There are no legal issues arising from this Board report.

Equality Delivery System
There are no specific impacts on REGARDS groups arising directly from this report.

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

Recommendation

The Board of Directors are requested to note the paper and challenge me on any item.

Report Prepared by: **Mark Todd**
Chairman

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 28th October 2015

Acting Chief Executive's Report

1. Introduction

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

2. National Context

2.1 Monitor is consulting on a cap on agency and bank hourly rates of pay for all staff in the NHS including doctors. These caps are planned to come into force from 23 November. Strictly speaking the caps are not a mandatory requirement for our Trust as an FT not in enforcement for financial reasons. However, Monitor 'strongly recommend' adoption by all Trusts. This consultation will require us to consider bank rates applied to our staff via our service level agreement with Royal Derby.

2.2 The CQC have published their annual review 'The State of Healthcare and Adult Social Care in England 2014/15. Although all areas are not yet rated, more than 80% of the GP practices rated so far were good or outstanding. In adult social care, nearly 60% of services were good or outstanding. The CQC rated 7% of services as inadequate over all sectors. Safety, as expected was a major focus and over one in 10 hospitals (13%) and a similar proportion of adult social care services (10%) were rated as inadequate for safety. The link between quality delivery and leadership was again re-enforced with more than nine out of 10 (94%) of services rated as good or outstanding overall were also good or outstanding for their leadership. Similarly, 84% of the services rated as inadequate overall were inadequately led.

It was good to see recognition of system wide problems and the need for systems to work together to resolve issues with staffing and workforce. Over the coming year based on inspections to date the CQC is stressing the need to:

- Building a collaborative culture that reaches out to people who use services and engages with all staff to ensure a shared vision and ownership of the quality of care they deliver.

- Being open and transparent and learning from mistakes, ensuring information and data are to hand to make good decisions and to understand what works (and what doesn't), using opportunities to learn from the best.

- Ensuring that services have the right staff and skill mix in place to ensure that care is always safe.

The full report can be read at:

http://www.cqc.org.uk/content/state-care-201415

2.3 NHS Improvement is the replacement for Monitor and the Trust Development Agency. It is being formed to drive and support both urgent improvements at the frontline and the long term sustainability of the healthcare system. Alongside that, it will be the health sector regulator.

Jim Mackey, Chief Executive of Northumbria Healthcare NHS Foundation Trust for the last 10 years, has been appointed as NHS Improvement's Chief Executive and he will be in post full time from 1 November.

Derbyshire Health and Social Care Community

2.4 Consultation plans remain on track for the 21st Century transformation change programme over North Derbyshire. The business case is likely to be presented to the Trust Board in November 15.

2.5 The Erewash Vanguard 'Value Proposition' has been approved by the Department of Health along with the required financial support. This will support a number of enabling schemes to be launched this year to set-up of a range of delivery work streams. Clinical service change will be supported from next financial year which will include investment to support the integration of mental health services into the two proposed hubs. A confirm and challenge to understand interdependencies between each of the work streams is scheduled for October

2.6 Southern Derbyshire Joined up Care Programme is holding a stakeholder session on the 5th November which a number of our NEDs and Governors are planning to attend. The purpose of the meeting is to share activities and plans to date along with proposed outcomes from some of the system change work.

3. Inside Our Trust

3.7 Many thanks to staff from Pleasley Ward, Southern Derbyshire Learning Disability Service, North Derbyshire Crisis Team and North Derbyshire Liaison Team who spent time with me over the last month sharing best practice examples, ideas for development and general concerns. In addition my thanks to Katie and Kim whom I met with their families at Southern Derbyshire CLDT, their stories were both heart-warming and concerning at the same time. A clear message that emerged from all of my visits this month is the importance of leadership focussed on quality outcomes and person centred planning.

3.8 On 21 October we held our second day long Spotlight on Leaders event focussing on quality, in particular looking at a thematic analysis of homicides, the role of experts by experience and smoke free environment. This meeting was attended by senior managers and clinical leads within the organisation.

3.9 Over the past few weeks we have seen pressure on both adult and older beds begin to subside with more people being supported in the community demonstrating the effectiveness of some new and innovative services such as the Dementia Rapid Response Team in the south and the in-reach teams linked to the Crisis and Home Treatment services for adults.

3.10 On 20 October we held the 4E's stakeholder meeting with a focus on the Erewash area. It was great to welcome colleagues from Erewash CVS, Erewash CCG and representatives from the Erewash mental health innovation project to discuss developments and future plans. What was very pleasing was the focus on the session was less about statutory services and more about working together to enable the local communities to develop more options for supporting people.

Legal Issues

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

Equality Delivery System

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

Consultation

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

Recommendation

The Board of Directors are requested to note and discuss the paper using its content to inform strategic discussion.

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

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE QUALITY COMMITTEE

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

Thursday, 10 September 2015

PRESENT:	Maura Teager	Chair and Non-Executive Director
	Ifti Majid	Acting CEO
	Phil Harris	Non-Executive Director
	Carolyn Green	Director of Nursing and Patient Experience
	Claire Wright	Executive Director of Finance
	Sangeeta Bassi	Chief Pharmacist
	Petrina Brown	Consultant Clinical Psychologist
	Wendy Brown	Clinical Director
	Sarah Butt	Assistant Director of Clinical Practice and Nursing
	Clare Grainger	Head of Quality & Performance
	Rachel Kempster	Risk & Assurance Manager
	Rubina Reza	Research and Clinical Audit Manager
	Chris Fitzclark	Derbyshire Voice representative
Deputising for Catherine Ingram	Nikki Rhodes	Involvement Manager, Derbyshire Voice
IN ATTENDANCE:	Sue Turner	Board Secretary and Minute Taker
Deputising for Deepak Sirur	David Hurn	Service Line Manager for Substance Misuse
	Hayley Darn	Nurse Consultant - Safety
	Kim Broadhurst	Lead Nurse
For item QC/2015/131	Sam Kelly	Consultant Nurse
For item QC/2015/131	Catherine Dunning	Senior Nurse
APOLOGIES:	Mark Todd	Trust Chairman
	Tony Smith	Non-Executive Director
	Jenna Davies	Interim Director of Corporate & Legal Affairs
	Bev Green	Releasing Time to Care Lead
	Nicola Fletcher	Lead Professional for Patient Safety
	Deepak Sirur	Consultant Psychiatrist in Substance Misuse
	Jayne Storey	Director of Transformation
	Dr John Sykes	Executive Medical Director
	Pam Dawson	Carer Forum
	Catherine Ingram	Chief Executive, Derbyshire Voice

QC/2015/126	**WELCOME AND APOLOGIES** The Chair, Maura Teager, opened the meeting and welcomed everyone.
QC/2015/127	**MINUTES OF THE MEETING DATED 13 AUGUST 2015** The minutes of the meeting, dated 13 August 2015 were accepted and agreed.
QC/2015/128	**MATTERS ARISING** The committee agreed to close all completed actions and updates were provided by members of the committee and noted directly on the actions matrix.

QC/2015/129	**SERIOUS INCIDENT REPORT** In the absence of Nicola Fletcher and John Sykes, Carolyn Green presented the Serious Incident Report which provides the Quality Committee with information relating to all Serious Incidents (SIs) occurring during August 2015. She highlighted points raised in the report and the committee noted that there had been a decrease in the number of incidents reported during August compared to July and that two of these incidents may be removed at a later date once further information is received. The committee also noted that these are the lowest number of incidents that have occurred over the last 12 months. Questions were raised about the narrative contained within the recommendations relating to incident W22530 and whether the summary represented the full report and recommendations. Carolyn Green explained this was a summary of a 36 page report. As part of the investigation into this incident, communication between team members was reviewed and it was discovered that two members of staff were in a relationship. Declarations of this and adherence to Trust policy are under review. In order to preserve aspects of confidentiality this was not discussed further during the meeting. Instead, Carolyn Green would allow Phil Harris and Maura Teager to have sight of the full report W22530 and would debrief them in confidence outside of the meeting. At the request of Chris Fitzclark, the committee agreed that an indication of overdue actions compared to the previous month will be shown in future reports to establish whether there are any trends. Rachel Kempster informed the committee that a good piece of work recently carried out with Nicola Fletcher had resulted in DATIX data indicating a theme to each action/incident as well as when this occurs in services, care planning and physical health. This was a useful exercise and shows links between incidents. **ACTION: Carolyn Green to arrange for Phil Harris and Maura Teager to have sight of full report W22530.** **ACTION: Reports to indicate overdue actions compared to the previous month to establish whether there are any trends** **RESOLVED: The Quality Committee scrutinised the report and received partial assurance of the emergent and current issues under a monitoring brief by the SI Group.**
QC/2015/130	**GUIDANCE ON THE CLINICAL MANAGEMENT OF ACUTE AND CHRONIC HARMS OF CLUB DRUGS AND NOVEL PSYCHOACTIVE SUBSTANCES** The committee was concerned with occurring evidence about how “legal highs” have had an impact on the Trust’s services, especially seclusion. There have also been a number of SIs and an incidence of sudden death. David Hurn, Service Line Manager for Substance Misuse provided the committee with the latest information on the clinical management of acute and chronic harms of club drugs and Novel Psychoactive Substances or NPS as they are to be called. He also talked about the legislation governing the sale of NPS drugs and the difficulties clinicians have in managing people who are presented to the Trust when they have used these substances. The committee noted that once NPS has been discussed at the Trust’s Nursing Conference taking place on 16 September the guidance policy will be considered by the Physical Care Committee and will also be referred to the Drugs and Therapeutics Committee and the policy will undergo a further update later in the year.

	ACTION: NPS use and guidance to be referred to the Drugs and Therapeutics Committee. Policy will also be reviewed by the Physical Care Committee and a further update of the policy will be carried out later in the year. **RESOLVED: The Quality Committee noted the guidance on the clinical management and the impact of NPS.**
QC/2015/131	**<u>CRHT (CRISIS RESOLUTION HOME TREATMENT)</u>** Samantha Kelly provided the committee with a position statement on the findings and recommendations of the Crisis and Home Treatment Quality Assurance Review completed in July 2014 on behalf of CRHT South and County. Maura Teager welcomed the report and the committee noted the critical actions that have already been put in place. • The Crisis and Home Treatment Quality Assurance Review conducted in July 2014 made a number of recommendations. In January 2015, concerns were raised by the Consultant Nurse in relation to observations of unsafe practice and staff wellbeing in the Derby City and South County CRHT team. The concerns raised were in addition to growing concerns and recommendations made within the original review. • These urgent concerns were addressed via the Trust's Emergency Planning response process, and the leadership team in the CRHT was supported in implementing a number of urgent and subsequent actions to improve safety. Discussions centred around the sustainable changes that had taken place and how shared lessons could be transferred to other services. The committee noted that listening to staff when they have concerns had encouraged people to raise concerns and these concerns were escalated and were responded to. The team fed back to the committee that they would like to learn from this experience and would ask senior team members to reflect on their experience and whether more support, should be more rapid, when early warning signs are present. The situation is improving with staffing levels and caseloads. Sickness absence has also decreased although referrals for consultation sometimes still outweigh staffing levels. Having an administration role within the structure has also made an improvement as this allows clinicians carry out the work they should be doing and reducing bureaucracy or tasks that could be filled by non-clinical team members. Ifti Majid observed that the team felt more stable and equipped to sustain this improvement. Sam Kelly replied that sustainability was still fragile. Skill mix has improved things and the compounding effect of the withdrawal of Derby city social work support and the subsequent impact on the Derby city recovery teams had placed substantial pressure on the system and the crisis team and this had escalated. Ifti Majid asked whether the crisis process in the north has reduced through changes that have been implemented. Sam Kelly explained that the north had a more stable clinical leadership and this was a strong case for how clinical leadership is viewed and the impact on senior clinical staff in the team. It was hoped that the changes put in place would mean service users would feel staff are listening to them more and have more time for them. There is also more consistency in staff and it is recognised that people recover better if there is stability with staff. Maura Teager commented that it would be helpful to see evidence of this.

	The committee received assurance with the sustainable changes that have been made. It was understood these can still be fragile as is staff confidence and monitoring of activity and early escalation of concerns was vital for continued team activity and clinical quality improvement. The committee wished to acknowledge the work being carried out by the crisis team and the changes that had been made for continuous improvement. **RESOLVED: The Quality Committee:** **1) Received partial assurance from CRHT Derby City and South County of actions in relation to the findings and developmental recommendations made within the Crisis and Home Treatment Assurance Review conducted in July 2014. Additional actions and reports in work plan to be presented to the QLT.** **2) Received full assurance from CRHT Derby City and South County of actions and stabilisation in relation to the concerns relating to safety of staff and patients raised in January 2015**
QC/2015/132	**SAFER STAFFING** Sarah Butt verbally updated the committee on progress made within the last month. Emergency planning measures have been lifted and this was a positive outcome. The emergency plan had been beneficial in immediate stability and there had been additional benefits such as a more positive culture on the Kingsway site with regard to supporting each other and cross fertilisation of ideas and staff across units. Sarah Butt was also pleased to report that the vacancy factor is being addressed and recruitment continued to be positive. She and divisional nurses regularly attend preceptorship meetings. A learning review is taking place around the management of preceptors and road shows have just been implemented to enhance the supervision of preceptorship nurses. Safer staffing skill mix reviews have taken place and are nearing completion and every ward has been visited in order to review ward information. The development of NHS choices performance indicators require additional action with the IT team to feed through key workforce information. . Carolyn Green was pleased to inform the committee of external assurance received in a letter from the Quality Assurance Group stating they had no concerns around staffing and that the Trust was being reviewed under a standard monitoring procedure. **RESOLVED: The Quality Committee noted the progress update on safer staffing and was assured by practices put to ensure the safety of staff and patients. Additional action to be confirmed with regard to the NHS choices website when completed**
QC/2015/133	**QUALITY ASSURANCE GROUP SUMMARY REPORT** The committee received and noted the Quality Assurance Group feedback summary of the meeting held on 1 September. No questions were raised. **RESOLVED: The Quality Committee received the Quality Assurance Group Summary Report.**
QC/2015/134	**RAISING CONCERNS AT WORK (WHISTLEBLOWING) POLICY AND PROCEDURE**

	The Raising Concerns at Work (Whistleblowing) Policy and Procedure was ratified earlier in the year. However, due to the policy's sensitivity, changes had been made to the policy. These changes were highlighted to the committee for approval and amendments were noted directly to the policy by Rachel Kempster. Further clarification was required to the flowchart relating to the area around the nominated Non-Executive Director advice/support. It was agreed that the policy would return to the committee at the next meeting in October for further clarification of this point, together with an enhanced explanation of the term "genuine concerns". **ACTION: Rachel Kempster to amend the policy with the slight corrections pointed out by the committee. She will also clarify the point relating to the nominated Non-Executive Director in the flow chart and explain the term "genuine concerns" and return the policy to the next meeting of the committee for formal ratification.** **RESOLVED: The Quality Committee:** **1) Received the Raising Concerns at Work (Whistleblowing) Policy** **2) Requested that it be clarified and amended and returned to the October meeting for formal ratification.**
QC/2015/135	**UNTOWARD INCIDENT INVESTIGATION AND REPORTING PROCEDURE** The committee was informed of certain changes that were made to this policy in June. Amendments relating to responsibilities for communicating death, serious injury or other event where a crime is suspected were accepted by the committee and noted directly to the policy by Rachel Kempster. Slight amendments to the investigation procedure on page 23 were also noted and approved as well as the terminology of serious incidents. **RESOLVED: The Quality Committee approved the amendments to the Untoward Incident Investigation and Reporting Procedure.**
QC/2015/136	**ITEMS INCLUDED FOR INFORMATION** • Specialist Services Quality Leadership Team minutes • Urgent and Planned Care Quality Leadership Team Minutes
QC/2015/137	**FORWARD PLAN** The forward plan would be updated in line with today's discussions and presented for reference at the next meeting of the committee.
QC/2015/138	**EFFECTIVENESS OF THE MEETING** Thorough and robust discussions were carried out. This was made more manageable as there were less items on the agenda

Date and Time of next meeting: The next meeting of the Quality Committee will take place on:
Thursday, 15 September 2015 at 2.15 pm
Venue: Board Room – Bramble House, Kingsway, Derby

DRAFT MINUTES OF THE AUDIT COMMITTEE HELD ON THURSDAY, 8 OCTOBER, 2015 AT 2.00 PM HELD IN THE BOARD ROOM, TRUST HEAD QUARTERS, BRAMBLE HOUSE, KINGSWAY SITE, DERBY DE22 3LZ

PRESENT:	Caroline Maley	Chair/Senior Independent Director
	Phil Harris	Non-Executive Director
	Tony Smith	Non-Executive Director
IN ATTENDANCE:	Claire Wright	Executive Director of Finance
	Carolyn Gilby	Acting Director of Operations
	Jenna Davies	Interim Director Corporate and Legal Affairs
	Rachel Kempster	Risk & Assurance Manager
	Ali Breadon	PricewaterhouseCoopers
	David Roper	Grant Thornton
	Sue Turner	Board Secretary and Minute Taker
APOLOGIES:	Ifti Majid	Acting Chief Executive
	Carolyn Green	Executive Director of Nursing
	Rachel Leyland	Deputy Director of Finance
	Stacey Forbes	Financial Controller
	Mark Stocks	Engagement Lead Grant Thornton
	Joan Barnett	Engagement Manager Grant Thornton
	Dr John Sykes	Executive Medical Director
	Rubina Reza	Research & Clinical Audit Manager

WELCOME AND APOLOGIES	
	The Chair, Caroline Maley opened the meeting and welcomed everyone present. The apologies were noted above.
AUD 2015/087	**MINUTES OF THE AUDIT COMMITTEE MEETING DATED 21 JULY 2015** An updated version of the minutes of the previous meeting of the Audit Committee held on 21 July 2015 was circulated and approved as an accurate record subject to: **AUD2015/082 Mental Health Act Committee Annual Report:** Wording of the third paragraph "Discussions took place on the legal impact for Approved Mental Health Professionals (AMHP) training" to be substituted with "*Discussions took place on the legal impact of Associate Hospital Managers training of the new Mental Health Act Code of Practice training".*
AUD 2014/088	**ACTION MATRIX** **AUD2015/076 Overview of Complaints and Themes:** **ACTION: Carolyn Green to provide a forward looking update on the results of the Healthwatch Derby survey.** All other updates provided by members of the committee were noted directly to the matrix.

AUD 2014/089	**MATTERS ARISING – REVIEW OF PWC HEALTH SECTOR RISK PROFILE AND BAF** Claire Wright's report provided the committee with a high level comparison of PwC Health Sector Risk Profile (as presented to July 2015 Audit Committee) with the organisation's Board Assurance Framework. The committee agreed with the report's conclusions that the Trust's approach to the BAF compares very well in many aspects and mirrors the risks highlighted by other organisations. A number of specific differences were discussed by the committee: • Pre and post-mitigation identification (called inherent and residual risks by PwC) • Granularity of action owners • Direction of travel compared to prior year The committee agreed to review BAF reporting following a Board Development session in February, 2016. **RESOLVED: The Audit Committee** **1) Considered the contents of the comparison and any points of difference compared to the organisations surveyed.** **2) Gained assurance that the Trust approach to, and content of, the BAF is satisfactory.**
AUD 2014/090	**BOARD ASSURANCE FRAMEWORK 2015/16** This was the second formal presentation of the Board Assurance Framework to the Audit Committee for 2015/16. An interim update report was provided at the previous meeting in July detailing the recommendation that a new risk (2c) be added to the BAF. Rachel Kempster informed the committee that the BAF had been reviewed by the Executive Leadership Team (ELT) and had been updated. The committee reviewed the updates to the BAF highlighted in blue. Minor changes were noted by Rachel Kempster and would be included in the updated version to be received by the Board at their next meeting on 28 October. The progress table showing the 'deep dive' of principal risks would also be updated by Rachel Kempster and would be submitted to the next meeting of the committee in December. Tony Smith referred to the first recommendation of the report that risk 4b be moved from the Finance & Performance Committee to the Quality Committee. He was concerned that this route would create a dislocation in governance with people/culture related issues as the People Forum reports to the Finance & Performance Committee. Jenna Davies agreed that the risk should be owned by the Finance & Performance Committee. Comments were raised on the following risks: • Risk1a: The action planning for the 2016/17 Mental Health Capacity Act should include the audit that took place and be dated for completeness. • Risk 2c: Risk descriptor does not capture principles around staff morale. This risk is around governance systems and process and the risk does not describe this

	accurately. The committee agreed Jenna Davies, Rachel Kempster and Ifti Majid will look at this in terms of the Well Led Framework and re-clarify this risk. • Risk 4a: There are gaps in control relating to the People Strategy. The wording of this should be changed to cover the lack of capacity to design and develop a People Strategy. Rachel Kempster informed the committee that evidence of completion is not compiled within the deep dive of risks. The BAF is updated in consultation with the executives. Caroline Maley pointed out that she would prefer evidence of completion to be supplied when deep dive of risks are carried out. **ACTION: Rachel Kempster will submit a progress table showing the 'deep dive' of principal risks to the next meeting of the committee in December** **ACTION: Wording of Risk 2c will be re-clarified by Jenna Davies, Rachel Kempster and Ifti Majid** **ACTION: Wording of Risk 4a should be changed to cover the lack of capacity to design and develop a People Strategy** **RESOLVED: The Audit Committee** **1) Agreed that the responsible committee for risk 4b be moved from the Finance and Performance Committee to the Quality Committee to enable a 'deep dive' to be undertaken on both this and risk 4a at the same meeting.** **2) Agreed this second presentation of the Board Assurance Framework for 2015/16 and for it to be presented to the Board of Directors at its meeting in October 2015.** **3) Agreed for the Audit Committee and Board to continue to receive a formal update on the BAF three times a year.**
AUD 2015/091	**<u>WELL LED FRAMEWORK AND MONITOR ACTION PLAN</u>** Jenna Davies presented the revised Well Led Tender which had been amended to reflect the requirement for the organisation to conduct a deep dive into HR Processes. She clarified the scope of the deep dive and explained that it would show how the Trust provides its HR service and how it develops leaders. The Well Led Framework will be regularly reviewed and updated with the Executive Leadership Team and Non-Executive Directors in order to build the evidence required and would regularly be received by the Audit Committee and the Board. The committee noted the tender and accepted that the Well Led Framework document needs to be progressed further. The Well Led Framework will be a standard Audit Committee agenda item in future and each report submitted to committee will contain a front sheet summary and show the key milestones and confirm the processes to be adopted. **ACTION: Forward plan to be updated and include the Well Led Framework as a regular agenda item.** **RESOLVED: The Audit Committee noted the update on the Well Led Framework and Monitor Action Plan.**

AUD 2015/092	**REVIEW OF THE AUDIT COMMITTEE'S TERMS OF REFERENCE** The Audit Committee's terms of reference are required to be reviewed an annual basis. The committee agreed to Penny Gee's recommendation that the text at 7.3 bullet point 3 be amended to read '*arrangements in place for preventing and countering fraud, bribery and corruption and managing security in compliance with the related NHS Protect Standards'*. In order to reflect delegated authority from the Board, the committee agreed to the following amended narrative to point 7.20 in the annual Accounts review section: ***Annual Report and Accounts Approval*** *7.20 To approve the Annual Report and Accounts including the Quality Report and Annual Governance Statement on behalf of the Trust Board. In doing so the Committee will determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:* • *The meaning and significance of the figures, notes and significant changes;* • *Changes in, and compliance with the accounting policies, practices and estimation techniques;* • *Areas where judgment has been exercised;* • *Explanation of estimates or provisions having material effect;* • *Explanations for significant variances;* • *The schedule of losses and special payments;* • *Significant adjustments in the preparation of the financial statements and any unadjusted statements; and* • *Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.* Items 7.21 and 7.22 are no longer required and will be removed. For completeness item 7.5 will now include the Mental Health Act Committee and the Safeguarding Committee and will be amended as follows: *7.5 As part of its integrated approach, the Committee will ensure appropriate information flows to the Audit Committee from executive management and from and between other board committees, principally the Quality Committee and Finance and Performance Committee, the Mental Health Act Committee and the Safeguarding Committee in relation to the Trust's overall internal control and risk management position. However, these other committees must not usurp the Audit Committee's role.* **RESOLVED: The Audit Committee formally adopted the amended Terms of Reference.**
AUD 2015/093	**REVIEW OF WHISTLEBLOWING ARRANGEMENTS** Jenna Davies's report gave an overview of the Raising Concerns at Work and Whistleblowing arrangements. She noted that the Trust was currently undertaking considerable work to improve whistleblowing arrangements. This would include the freedom to speak action plan and a review of the policy.

	The committee was not fully assured by the review of raising concerns and whistleblowing. There is more work to be done to raise awareness and reassure staff of the processes and the committee looked forward to the next report that will focus on what has taken place so far. **ACTION: Jenna Davies will provide a further report to the next meeting in December that will include an action plan and show progress to date.** **RESOLVED: The Audit Committee obtained partial assurance in the arrangements and processes for raising concerns and whistleblowing.**
AUD 2015/094	**PWC UPDATE REPORTS** In her report, Ali Breadon updated the committee with internal audit progress and activity since the last meeting. **Update on Internal Audit:** The committee received assurance that progress is on target in relation to the KPIs. Ali Breadon is holding discussions with the General Manager IM&T regarding the effectiveness of underlying processes for Information Governance (IG) delivery in preparation for the IG inspection by the Information Commissioner. She is also working with Ifti Majid on controls on confidential data. The committee was assured that PWC is looking at underlying processes of the IG Tool Kit and saw this as a value added practice for the organisation. **Refresh of the Annual Internal Audit Plan:** The refresh of the plan was produced in line with updated BAF risks and provided the committee with assurance. The Chair pointed out that BAF risk 2b contains very specific pieces of work and will also be tied into the Well Led Review. **NHS Audit Committee Questions:** These questions were included for information and will be worked through ELT and discussed at committee meetings and board meetings as appropriate. **ACTION: NHS Audit Committee Questions paper will also be circulated to Executives and NEDS and worked through ELT for discussion at committees and Board as appropriate** **Phase 1 Transformation Report:** The committee received partial assurance on this report. Tony Smith pointed out there were medium risk issues around documentation and the use of Project Vision and should be capture patient experience levels pre CIP implementation. Carolyn Gilby will seek a response from Kate Majid regarding transformation and Carolyn Green on the quality impact within Project Vision. Claire Wright would follow up CIP reporting with the project office and the next stage of the PwC audit will seek to establish whether this was an isolated issue. These issues will be risk rated at the end of the performance and included in the PWC report at the next meeting. **ACTION: Carolyn Gilby to co-ordinate a response from Kate Majid on transformation and Carolyn Green on the quality impact within Project Vision. Claire Wright will follow up the LD CIP reporting and PwC will seek to establish if this was an isolated issue.**

	Q1 Data Quality Memo: This was the first of these reports submitted by PWC. The committee was made of aware of one breach arising from the walk through tests. **RESOLVED: The Audit Committee received and noted the update reports from PWC.**
AUD 2015/095	**COUNTER FRAUD PROGRESS UPDATE** Penny Gee's report informed the committee of work completed to date in respect of the 2015/16 Counter Fraud, Bribery and Corruption Operational Plan. It was agreed that Rachel Kempster should if possible attend the 360 Assurance meeting for Audit Committee Chairs on 26 October which was going to be reviewing BAFs. Penny Gee had reviewed the Raising Concerns Policy and clarified some minor amendments that would be adopted by Jenna Davies. Submission of self-assessment for Fraud, Bribery and Corruption Standards 2014/15 is obtained to support recommendations and ratings. The committee noted that the ratings are the same as the previous year. Amber items will be taken up within the staff survey in relation to fraud and bribery and will be reported back at the end of the year. The Board and the committee received the summer edition of Fraudulent Times that had been circulated separately and looked forward to receiving the Autumn edition. **RESOLVED: The Audit Committee noted the contents of the Counter Fraud Progress Update and felt assured that actions will be taken as outlined in the report.**
AUD 2015/96	**REVIEW OF FORWARD PLAN** Monitor Action Plan and Well Led Framework will be added to the forward plan.
AUD 2015/097	**MEETING EFFECTIVENESS** The chair of the committee took the opportunity to confirm the levels of assurance for each item on the agenda. The meeting was well chaired. Reports were well received and scrutinised by the committee and prompted good discussions.
AUD 2015/098	**CLOSURE OF THE MEETING** The Chair thanked all those present for their attention and attendance and closed the meeting at 4:10 pm. **Date of next meeting:** Tuesday, 15 December at 10:30am. Venue: Trust HQ – Meeting Room 1 – Albany House, Kingsway, Derby DE22 3LZ.

Public Session
Derbyshire Healthcare NHS Foundation Trust
Report to Public Board 28 October 2015
5

Information Governance (IG)- Quarter 2 report

This report provides our performance update on our Quarter 2 progress towards meeting the requirements of the 2015-16 Version 13 Information Governance Toolkit as well as the work of the Information Governance Committee and Information Governance breach monitoring.

Executive Summary
- The IG Toolkit baseline was submitted on 30th July 2015 at 62% and not satisfactory. This is line with expectation for this time in the IG Cycle
- There has been a decrease in the number of reported IG incidents with 2 new reportable incidents this half year. These are both closed with no further action.
- The board is requested to approve the attached IG documents as part of the annual IG cycle

Strategic considerations
- To maintain high level of organisational performance

(Board) Assurances
- Full assurance on our IGT V 13 Toolkit submission
- Full assurance that we continue to progress the IG agenda
- Full assurance that IG breaches are monitored and responded to appropriately including any actions required

Consultation
- This report was accepted by the October Quality Committee

Governance or Legal issues
- Compliance with the IG Toolkit forms an important pillar of assurance around data protection (The Data Protection Act), confidentiality and information security

Equality Delivery System
- A high level of compliance with the IG Toolkit supports improved practice around data collection that enables analysis of activity supporting improving outcomes for all REGARDS Groups

Recommendations
The Committee is requested to:
- To acknowledge the initial IG Toolkit baseline
- To acknowledge the progress made with the IG work plan
- To confirm as fit for purpose the: IGC terms of Reference, IG Management Framework, IG Annual work plan and IG Specialist training work plan

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

Report prepared by: **Audrey Sirrel**
Information Standards Manager

Information Governance Group Work Plan 2015-16

The Information Governance Group work plan for 2015/16 will include:

1. Continue to manage the main business covered by the group, including any delegated decision-making responsibility, as set out in the approved Terms of Reference.
2. Agree and monitor the delivery of Information Governance requirements through an improvement plan based on the 2014/15(Version 12) of the Information Governance Toolkit

   The Information Governance Toolkit published standards will enable the delivery of other national, regional and local requirements.
3. Work to promote and maintain the current level of achievement as declared in the Statement of Compliance. For v12 this was 96% with level 2/3 attained for all standards
4. To ensure all Information Governance Toolkit standards directly supporting the NHS Care Record Guarantee Commitments will remain compliant at a minimum level 2 or above.
5. Provide assurance of good information governance as required by the local and national IG Assurance framework
6. To continue to demonstrate year on year improvements in compliance for each of the specific Information Governance initiative areas listed below:

   6.1.1 Information Governance Management

   6.1.2 Confidentiality and Data Protection Assurance

   6.1.3 Information Security Assurance

   6.1.4 Clinical Information Assurance

   6.1.5 Secondary Uses Assurance

   6.1.6 Corporate Information Assurance
7. Monitor the completion of actions to meet recommendations set out by Internal Audit reviews
8. Review and implement any recommendations from the ICO
9. Provide regular reports to the Quality Committee and Trust Board appraising them of any concerns, breaches or commendations

Audrey Sirrel June 2015
On behalf of Information Governance Group

Terms of Reference for Information Governance Committee

What	Main business covered by the Committee
	To ensure the Trust complies with national and regional information governance requirements including Confidentiality and Data Protection Assurance, Information Security Assurance, Clinical & Corporate Information Assurance, Secondary Uses Assurance and Information Governance Management. To provide the Trust Board with the assurance that an effective information governance assurance framework is in place within the organisation and which meet the terms and conditions of the NHS HSCIC Statement of Compliance. To direct, screen and monitor the development and implementation of relevant Information Governance related strategies, policies and procedures to ensure that the Trust complies with national and legal requirements such as the Data Protection Act 1998, Caldicott principles and NHS Code of Confidentiality. To ensure that all staff have access to appropriate and up to date guidance on keeping personal information secure and on respecting the confidentiality of service user information To evaluate all new processes, software and hardware to ensure compliance with Information Security, confidentiality and data protection requirements including advice and information provided by the East Midlands Strategic Information Governance Network (EMSIGN). To receive and implement advice relating to all aspects of information and communications technology security of relevance to the Trust To review the completion, implementation and monitoring of Information Governance Toolkit annual assessments and Improvement Plans including the preparation of annual toolkit submissions for Trust Board sign off and identification of any associated resource requirements. To monitor the mechanisms for the reporting and reviewing of all Information Governance incidents. To modify policies and procedures if required and informing the review of the Trust's management and accountability arrangements for Information Governance To review the mechanisms for and monitoring compliance with guidance, advice and staff training and Induction in Information Governance such as information security and confidentiality procedures and policies including the Staff Code of Confidentiality, compliance with pseudonymisation requirements and seeking consent for the sharing of information where relevant. To ensure mechanisms are in place for planning, recommending and implementing functions associated with the Senior Information Risk Officer (SIRO) and reporting as required To ensure that the Trust's approach to information handling is communicated to all staff and made available to the public
Delegation	Delegated decision-making responsibility.
	▪ Ensuring that the Trust's Information Security and Confidentiality procedures are reviewed and improved as part of the Information Governance Improvement Action Plan ▪ Ensuring a continuing programme of IM & T security and confidentiality risk assessments and reviews to be delivered by Information Asset Owners and Derbyshire Health Informatics Service ▪ Providing regular reports to the Risk Management Committee of the Trust Board on all these matters. ▪ Approving IG policy and procedure for ratification ▪ Approving change impact assessment forms, new information flows and information sharing agreements.

Who	Membership and roles including identified Chair, Enforcer and Deputy Chair (where required).
Core	Executive Medical Director - Caldicott Guardian (Chair) Chief Operating Officer/Deputy Chief Executive - SIRO (Deputy Chair) Director of Corporate and Legal Affairs General Manager IMT and Records Information Standards Manager Records Manager IT Operations Manager Care Programme Approach Manager Risk & Assurance Manager Service User and Carer Representatives
Associates	Head of Patient Experience HR & Workforce
Attending Members Reporting Chairs	
When	Frequency & timing.
	4th Thursday of the Month. Reports to the Effectiveness Committee Quarterly. Reports to the Trust Board biannually.
Quorum	Minimum numbers and attendance.
	A quorum of a minimum of four core members including Chair/Deputy chair to attend for the meeting to proceed with decision making authority. Decisions would need to be carried forward where an executive director (chair) is not present. Each member will attend a minimum of 8 of the 12 scheduled meetings annually. Nominated staff may be identified by core members to deputise on their behalf.
Where	Venue(s)
	Kingsway Hospital
Reporting to	Next in-line Committee/Committee delegating responsibility
	Quality Committee
Responsible to	
	Quality Committee
Accountable to	
	Quality Committee
Groups & Officers Reporting Schedule	

Group/Officer	**Report on**	**Frequency**
Records Manager	Records Management	6-monthly
Information Standards Manager	IGC to Quality Committee	6-monthly
	IGC to Trust Board	6-monthly

Liaison/Key communications	

Group/Officer	**Liaison by (person/means)**	**Frequency**
Executive Management Group/ Trust Board	SIRO/Caldicott Guardian	As required

Approved by	Committee and Date
	Information Governance Committee July 2013 (initial) Information Governance Committee Sept 2015-review
Review/Monitor Terms of Reference	Date and Lead Officer/Group
	Compliance with terms of reference will be reviewed every 3 years as per Policy. Lead officer responsible is Dr J Sykes.

Information Governance Management Framework 2013/16

Robust Information Governance (IG) requires clear and effective management and accountability structures, governance processes, documented policies and procedures, trained staff and adequate resources. The purpose of the Trust's Information Governance Management Framework is to document the way in which it delivers against these requirements.

Senior Leadership

1. **Information Governance Executive Lead – Chief Operating Officer/Deputy Chief Executive**

   The Information Governance lead is accountable for ensuring effective management, accountability, compliance and assurance for all aspects of IG. The key tasks of an IG lead include:

   - developing and maintaining the currency of comprehensive and appropriate documentation that demonstrates commitment to and ownership of IG responsibilities, e.g. an over-arching high level strategy document supported by corporate and/or directorate policies and procedures;

   - ensuring that there is top level awareness and support for IG resourcing and implementation of improvements;

   - providing direction in formulating, establishing and promoting IG policies;

   - establishing working groups, if necessary, to co-ordinate the activities of staff given IG responsibilities and progress initiatives;

   - ensuring annual assessments and audits of IG policies and arrangements are carried out, documented and reported;

   - ensuring that the annual assessment and improvement plans are prepared for approval by the Trust Board or Executive Management Team in a timely manner;

   - ensuring that the approach to information handling is communicated to all staff and made available to the public;

   - ensuring that appropriate training is made available to staff and completed as

necessary to support their duties and for NHS organisations in line with requirements of the Informatics Planning component of the NHS Operating Framework for 2013/14 and onwards;

- liaising with other committees, working groups and programme boards in order to promote and integrate IG standards;

- monitoring information handling activities to ensure compliance with law and guidance;

- providing a focal point for the resolution and/or discussion of IG issues.

2. Senior Information Risk Owner (SIRO) – Chief Operating Officer/Deputy Chief Executive

The SIRO understands how the strategic business goals of the organisation may be impacted by information risks and acts as an advocate for information risk management on the Trust Board and providing written advice to the Accounting Officer on the content of the annual Statement of Internal Control (SIC) in regard to information risk.

The key responsibilities of the SIRO include:

- overseeing the development of the Trusts Information Risk Management policies, procedures and strategies as part of the Trust's integrated risk management and governance approach;

- ownership of the risk assessment process for information risk, including review of an annual information risk assessment to support and inform the Statement of Internal Control;

- reviewing and agreeing action in respect of identified information risks to ensure that information risks are followed up and incidents managed;

- ensuring that the organisations approach to information risk is effective in terms of resource, commitment and execution and that this is communicated to all staff;

- providing a focal point for the resolution and/or discussion of information risk issues;

- providing leadership and guidance to a number of Information Asset Owners;

- ensuring the Board is adequately briefed on information risk issues.

3. Caldicott Guardian – Medical Director

The Caldicott Guardian plays the role of "Guardian" of patient identifiable information to oversee the arrangements for the use and sharing of patient information. The key role of the Guardian includes:

- ensuring that the Trust satisfies the highest practical standards for handling patient identifiable information;

- actively supporting work to enable information sharing where it is appropriate to share, and advising on options for lawful and ethical processing of information;

- championing confidentiality issues at the Trust Board and acting as both the conscience of the organisation and as an enabler for appropriate information sharing;

- developing a knowledge of confidentiality and data protection matters, drawing upon support staff working within the Caldicott function but also on external sources of advice and guidance where available;

- ensuring that confidentiality issues are appropriately reflected in the organisational strategies, policies and working procedures for staff;

- overseeing all arrangements, protocols and procedures where confidential patient information may be shared with external bodies both within, and outside the NHS;

- developing the evolving Caldicott role and supporting the Trust's Caldicott function in line with the Caldicott Guardian manual.

4. Data Controller (Data Protection Act) – General Manager – IM&T and Records

The Data Controller is accountable for ensuring compliance with the Data Protection Act 1998. The Data Controller takes responsibility for ensuring:

- data protection issues are considered and action taken as appropriate as part of the overall information governance agenda;
- a data protection lead or manager is in place to organise and enforce the approach to data protection and report directly to the above individual;
- direction of work necessary to ensure full compliance with the Data Protection Act 1998 within the organisation.

5. Freedom of Information Lead – Director of Corporate & Legal Affairs

The Freedom of Information lead ensures organisational procedures and processes are in place to comply with the Act. The key responsibilities are to:

- ensure that the organisation complies with all aspects of the Act, associated Codes of Practice and related provisions in particular for contracting and procurement and minutes of meetings;
- provide reports to the Board (or equivalent) highlighting resource, performance and compliance issues;
- draft and / or maintain the currency of the organisation's policy;
- ensure that all staff are aware of their personal responsibilities for compliance with the Act and adhere to organisational policies and procedures;
- ensure training and written procedures are widely disseminated and available to all staff;
- ensure the general public has access to information about their rights under the Act;
- establish appropriate arrangements to deal with appeals and investigations into complaints about decisions and response times;

- liaise and work with other functions responsible for information handling activities, for example the Caldicott Guardian, data protection and information security staff;

- contribute to or liaise with external FOI networks or group

Key Policies

The Trust has a range of clear policies, procedures and strategies covering all aspects of the Information Governance agenda so that staff understand both the spirit and the detail of what they are expected to do. The following policies covering the key areas of Information Governance have been approved:

- Information Governance Policy
- Staff Code of Conduct for Confidentiality
- Data Protection Act Policy
- Information Security Policy
- Information Lifecycle Management Policy
- Freedom of Information Act Policy

The full list of approved organisational policies can be found on the Trust Intranet.

Key Governance Bodies

The Information Governance Committee is responsible for ensuring Trust compliance with all aspects of the continually evolving Information Governance agenda. It is the forum through which the key senior roles discharge their responsibilities.

The committee has a direct reporting role to the Quality Committee and the Trust Board.

- The Terms of Reference for the Information Governance Committee sets out its role and responsibilities.

Resources

Lead responsibility for the delivery of the Information Governance agenda is delivered primarily through existing roles and budgets within the Information Management, Information Technology and Records Management functions. Additional roles which contribute to the delivery of some Information Governance requirements include the

Corporate & Legal Services and Risk Management Departments.

- **Information Governance Management** initiative requirements delivery is the lead responsibility of the Divisional Manager IMT and Records.

- **Clinical Information Assurance** initiative requirements delivery is the lead responsibility of the Information Standards Manager.

- **Secondary Use Assurance** initiative requirements delivery is the lead responsibility of the Divisional Manager IMT and Records.

- **Corporate Information Assurance** initiative requirements delivery is the lead responsibility of the Records Manager.

    - **Freedom of Information Act** compliance is the lead responsibility of the Director of Corporate & Legal Affairs.

- **Information Security Assurance** initiative requirements delivery is the lead responsibility of the Divisional Manager IMT and Records.

    - **Incident reporting** in line with guidance provided within the „Checklist for Reporting, Managing and Investigating Information Governance Serious Untoward Incidents (Gateway reference: 13177) is provided by the Risk Management Department.

    - **IG SIRIs** are reported by the Information Standards Manager via the IG Tookit.

    - **Information Security Management** requirements compliance relating to specific Information Technology service delivery is commissioned from Derbyshire Health Informatics Service through a Service Level Agreement.

- **Confidentiality & Data Protection Assurance** initiative requirements delivery is covered jointly by the Information Standards Manager, Records Manager and IT Operations Manager.

Governance Framework

Responsibility and accountability for Information Governance is cascaded through the organisation management structure.

- The Trust Directorates through Directors and their Heads of Departments and Divisional General Managers are responsible for cascading Information Governance related implementation actions and issue resolution operationally at local service level to ensure compliance.

- All Trust Managers are responsible for ensuring that Information Governance related policies and supporting standards and guidelines are built into local processes and that there is on-going compliance by ensuring:

    - the working practices carried out within their division/department/service lines/teams are in line with the organisation's policy;

    - all staff within the work area are adequately inducted and trained and made aware of their personal responsibilities for information governance;

    - any third party organisations and employees within their areas are covered by appropriate Information Governance contract clauses.

- Identified Information Asset owners are required to take responsibility for providing assurance that information risk is being managed effectively for their assigned information assets and are directly accountable to the SIRO.

- Contract Managers responsible for relevant third party Service Level Agreements or Service Contracts are also responsible for the application of Information Governance Agreements as part of contractual arrangements with Parties. This is set out in the policy for Information Governance Agreement with External (or Third) Parties (Contractual Arrangements).

Training & Guidance

To ensure organisational compliance with the law and central guidelines relating to Information Governance, all staff must undertake appropriate IG training. Therefore IG training is mandatory for all staff including staff on temporary contracts of more than 3 months. Once staff have completed their Basic IG training an annual refresher course is required.

Additional role based training is also required for specific roles including specialist IG training for the Trust's IG Lead roles.

1. Information Governance Training Plan

No	Staff Group	Recommended Training	Frequency	2012/13
1.	**All Staff including new starters** (permanent and fixed term of more than 3 months - including agency	Introductory level Information Governance Training	Annual	Delivery Method online e-learning 1. Introduction to Information Governance
2.	**Facilities & Estates Staff** All staff employed within the F&E Department	Introductory level Information Governance Training	Annual	Delivery Method face to face and workbook based on e-learning module 1. Information Governance: The Beginner's Guide
3.	**Senior Information Risk Officer** Nominated Trust Senior Information Risk Officer (SIRO)	Foundation level Information Risk Management Training	Annual	Delivery Method online e- learning 1. NHS Information Risk Management: Foundation 2. NHS Information Risk Management for SIROs and IAOs

No	Staff Group	Recommended Training	Frequency	2012/13
4.	**Information Asset Owners & Information Asset Administrators** Assigned Information Asset Owners (IAO) and Information Asset Administrators (IAA)	Foundation level Information Risk Management Training	Once	Delivery Method online e-learning 1. NHS Information Risk Management: Foundation 2. NHS Information Risk Management for SIROs and IAOs
5.	**All Managers** Trust Managers (with staff management responsibility) – not required if asset owner or administrator training already undertaken.	Introductory level Information Risk Management Training - as part of the Values to Leadership Programme	Once	Delivery Method online e- learning 1. NHS Information Risk Management: Introductory
6.	**ALL staff who contribute to the recording of care in clinical records** within Derbyshire Healthcare Services.	Recording Care in Derbyshire Healthcare Services	Once	E-Learning
7.	**ALL staff requiring access to electronic patient record**	**One or more combinations of modules:** Paris CareNotes TPP	Once	Delivery Method 1 Day Taught Programme except for read only programme which is half a day only.

2. Training Plan for Information Governance Specialists

Confidentiality & Data Protection

- **The Caldicott Guardian in the NHS and Social Care or equivalent** - a practitioner level module aimed at newly appointed Caldicott Guardians and those needing to know more about the role of the Caldicott Guardian.

- **Patient Confidentiality** - a foundation level module aimed at all NHS staff to gain an understanding of patient confidentiality and the role of the Caldicott Guardian in the NHS.

Information Security

- **NHS Information Risk Management** - an introductory level module that is intended to provide an overview of the key elements of information risk management. Staff whose roles involve the handling of personal data will benefit from a greater understanding of Information Risk Management principles, and an insight into how these principles relate to their own roles.

- **NHS Information Risk Management** - a foundation level module intended to assist staff whose roles involve responsibility for the confidentiality, security and availability of information assets, in understanding and fulfilling their duties.

- **NHS Information Risk Management for SIROs and IAOs** - an introductory module that describes key responsibilities for the SIRO and IAO roles, and outlines the structures required within organisations to support those staff with SIRO or IAO duties. SIROs should also review the IRM Foundation module.

- **Password Management** - an introductory module on protecting sensitive data by choosing a good password.

- **Information Security Guidelines** - an introductory module on keeping information secure in and out of the workplace.

- **Secure Transfers of Personal Data** - a foundation level module that informs learners how to protect sensitive data from unauthorised access and accidental loss, damage or destruction during transfer and how to dispose of sensitive data when it is no longer needed.

Registration Authority

- **Introduction to Information Governance** - an introductory level module aimed at all NHS staff to inform them about good Information Governance.

- **Password Management** - an introductory module on protecting sensitive data by choosing a good password.

- **Information Security Guidelines** - an introductory module on keeping information secure in and out of the workplace.

- **Secure Transfers of Personal Data** - a foundation level module that informs learners how to protect sensitive data from unauthorised access and accidental loss, damage or destruction during transfer and how to dispose of sensitive data when it is no longer needed.

Clinical Information Assurance

- **Records Management and the NHS Code of Practice** - a foundation level module designed to provide practical information to enable understanding of the importance of good records management.

- **Records Management in the NHS** a practitioner level module designed to provide practical information and steps for the operational running, policy creation and strategy in relation to record management.

- **Access to Health Records** a practitioner level module providing advice on dealing with requests for access to patient records, both from the patient themselves and their friends and family.

Risk & Incident Management

Information security risk assessment and management processes are in place to ensure that the Trust identifies implements and manages controls to monitor and reduce the risk to the organisation, its person identifiable information and critical Information Assets.

- Details are covered in the Trust's Risk Assessment Procedure available on the intranet

Security incidents, suspected or observed, are required to be reported, recorded and investigated and appropriate actions taken to address the incident and learn lessons (where possible) so that they do not recur. This includes weaknesses identified in systems design or operational procedures that potentially may result in an information security incident.

- Details are covered in the Trust's Untoward Incident Reporting and Investigation Procedure available on the intranet

Information Asset Owners are required to take responsibility for providing assurance that information risk is being managed effectively for their assigned information assets and are directly accountable to the SIRO.

- Details are covered in the Trust's IT Systems Inventory (part of The Information Asset Register) available on the intranet

IG Management Framework Approval

This management framework is approved by the Information Governance Committee on 27/07/2013 and is due for review by1st August 21016.

Change History

Version	Status Approved by	Date	Comments
0.1	Information Governance Group	17/10/2010	Approved with updates to include Records Management and Carenotes training and update Governance structure.
0.2	Information Governance Group	26/01/2011	Updated version emailed.
0.3	Information Governance Group	09/03/2011	Updated following Internal Audit review to include IG training for IG specialists and update Governance structure.
0.4	Information Governance Group	02/02/12	Approved by IGC
0.5	Information Governance Group	25/07/2013	Approved by IGC
0.6	Trust Board	28/08/2013	Confirmed as fit for purpose
0.7	Trust Board	30/07/2014	Ratified as fit for purpose

Derbyshire Healthcare NHS Foundation Trust
Report to Audit Committee – **28th October 2015**

Board Assurance Framework (BAF) 2015/16
Update report

Purpose of Report: To meet the requirement for Boards to produce an Assurance Framework.

Executive Summary

The Board Assurance Framework (BAF) is a high level report which enables the Board of Directors to demonstrate how it has identified and met its assurance needs, focused on the delivery of its objectives, and subsequent principal risks. The BAF provides a central basis to support the Board's disclosure requirements with regard to the Annual Governance Statement (AGS), which the Chief Executive signs on behalf of the Board of Directors, as part of the statutory accounts and annual report.

This is the second formal presentation of the Board Assurance Framework to the Board (and Audit Committee) for 2015/16. An interim update report was provided to the Audit Committee in July 2015 detailing the recommendation that a new risk (2c) be added to the BAF.

Key themes

Since the last update of the 2015/16 BAF by the Board of Directors in May 2015, the following developments have taken place:

- A new risk (2c) has been added to the BAF. This was agreed by the Audit Committee in July 15. The new risk is that the Trust may be unable to maintain its regulatory compliance due to identified gaps in its governance systems and processes. The current risk rating is assessed as high.
- Of the nine risks identified in the BAF, three are currently graded as high. These are risks 2a and 3a which remain high from the previous update and the new risk, 2c.
- Risk 3b has been regraded down from high to moderate. This is due to the likelihood being reduced from 3 (possible) to 2 (unlikely) following retention of the contract for children's services. .
- A 'heat map' detailing the movement of all principal risks in shown in Table A.
- A plan to ensure the "named responsible committee" for overseeing each of the principal risks was approved by the Quality Committee in June 2015 with a mirror paper also agreed by the Finance and Performance Committee. Planned dates for the programme of 'deep dives' to be undertaken during 15/16, and the Committee lead for each, is shown is Table C.
- As risks 4a and 4b are interlinked, it was suggested to the Audit Committee that the responsible committee for 4b be moved from the Finance and Performance Committee to Quality Committee to enable a 'deep dive' to be undertaken on both risks at the same meeting. However the Audit Committee

felt that as the business related to these two risks was discussed at the Finance and Performance Committee, the deep dives both should be undertaken by that Committee. These will take place during one of the remaining three meetings of the Committee scheduled to take place before the end of March 2016.

- The BAF continues to be reviewed and updated by Executive Directors on a regular basis.

The 'Health Sector Risk Profile' published by PwC in July 2015 presents the findings of their benchmarking study of 25 NHS organisations in terms of what their significant risks were and how those risks were being managed. This paper was presented to the Audit Committee in July 2015 who asked that ELT consider the contents of the comparison and identify any points of difference compared to the organisations surveyed. The Director of Finance prepared a response on behalf of ELT and this was considered by the Audit Committee at its meeting in October 2015.

A) Risk rating 'heat map'

A diagrammatic 'heat map' is shown below to give an overview of the current level of risks identified in the BAF.

Likelihood	Consequence				
	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Rare 1					
Unlikely 2					**2b** **3b**
Possible 3				**4a** **4b**	**2a** **3a**
Likely 4			**1a** **1b**	**2c (NEW)**	
Almost certain 5					

- 1a, 1b etc. refers to number of each principal risk shown in first left hand column of BAF

Movement of the grading of risks compared from May 15 to Sept 15 is shown by the arrows in the heat map above.

B) 'Red' strategic risks

A summary of the four principal risks currently graded as HIGH are summarised in

the table below.

BAF ID	Risk title	Director Lead	Risk rating
2a	Failure to deliver the agreed transformational change at the required pace	Acting CEO	15 (HIGH)
2c	Risk that the Trust will be unable to maintain its regulatory compliance due to identified gaps in governance systems and processes	Acting CEO	16 (HIGH)
3a	Risk to delivery of the 15/16 financial plan	Executive Director of Finance	15 (HIGH)

C) Progress on 'deep dive' plan for principal risks

The table below details the planned dates for 'deep dives' of the principal risks to be undertaken by the relevant committee.

For risks that are currently graded as 'High', the 'deep dive' is required to be presented to the Audit Committee (rather than either the Quality Committee or the Finance and Performance Committee). This escalation is shown by the arrows in the table below.

Risk ID	**Subject of risk**	**Director Lead**	**Quality Committee**	**Finance and Performance Committee**	**Audit Committee**
1a	Clinical Quality	CG	Planned for Nov 2015		
1b	Unmet need	JSY		Planned for Jan 2016	
2a	Transformation	IM		→	Undertaken July 2015
2b	Organisation change	IM		Planned for Nov 2015	
2c	Regulatory compliance	IM		→	Planned for Jan 2016
3a	Financial plan	CW		→	Planned for Dec 2015
3b	Commercial strategy	MP		Planned for Mar 2016	
4a	Retain and recruit	JST		Date to be confirmed	
4b	Capability and capacity	JST		Date to be confirmed	

Strategic considerations

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

(Board) Assurances
This paper provides an update on all Board Assurance Risks

Consultation
Executive Leadership Team - 21st September 2015
Audit Committee - 8th October 2015

Governance or Legal issues
Governance or legal implications relating to individual risks are referred to in the BAF itself.

Equality Delivery System
None

Recommendations

- For the Responsible Committee for risks 4a and 4b to be centralised with the Finance and Performance Committee to enable a 'deep dive' to be undertaken on both risks at the same meeting.

- Agree this second presentation of the Board Assurance Framework for 2015/16

- Agree for the Audit Committee and Board to continue to receive a formal update on the BAF three times a year for 2015/16

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

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

BOARD ASSURANCE FRAMEWORK 2015/16 v2.3 (For review by Board Oct 15)

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

Key:
Internal Audit Reports from 14/15
Internal Audits Planned 15/16
Clinical Audit Programme 15/16
Changes since last reviewed by Board May 15

Strategic Outcomes 1. People receive the best quality care

	Principal Risk	Director Lead and named responsible Committee	Risk Rating	Impact (1-5)	Likelihood (1-5)	Key Controls	Gaps in control	Assurances on Controls (Internal)	Positive Assurances	Gaps in Assurance	Action plan: To increase effective controls. To gain assurance.	Action: due/review date	Progress on action	Risk Register ID
1a	Failure to achieve clinical quality standards required by our regulators which may lead to harm to service users.	Executive Director of Nursing and Patient Experience Quality Committee	12 MODERATE	3	4	1) Quality Strategy and quality governance reporting structure and workplans, including escalation of quality issues to the Board 2) Quality Visit programme 3) Incident investigation and learning, including robust mechanisms for monitoring actions plans following serious incidents and serious case reviews. 4) Investigation and learning from complaints and patient experience feedback including robust monitoring of action plans and feedback from HealthWatch 5) Agreed clinical policies and standards, available to all staff via Connect 6) Engagement with clinical audit and research programmes 7) Mandatory training and performance monitoring of uptake. Availability and uptake of development training. 8) 'Duty of Candour' monitoring and reporting processes 9) Challenge and assurance checks by Commissioners on concerns around quality issues 10) Clinical podcasts to inform staff of new and emerging good practice 11) Achievement of CQUIN and quality schedule targets including suicide prevention CQUIN. Roll out of 'safety plan' with training.	Timely completion of clinical audit projects Robust systems and processes to monitor NICE guidelines implementation Timely review of all policies Embedding of actions resulting from incidents and complaints into the medium to long term Understanding of reasons for higher than national average suicide rates Embeddedness of Quality Leadership Teams Quality and compliance with supervision standards 'Think Family' and carer feedback stating family inclusive practice is embedded Embedded personalised care planning. Routine assessment of capacity and consent Consistency of physical health care checks	Service improvement mapping and contributions i.e. positive and safe, reduction in the use of seclusion Clinical Audit Programme Compliance with NICE Guidelines National Audits i.e. National Audit of Schizophrenia and POMH UK Audits 'Clinical interest' led audits focused on local resolution of issues i.e. self harm in older adults to meet NICE guidelines, safe driving for people with dementia, oral health of patients on low secure unit, offering CBT for psychosis.	204/15 SUI Review 2015/16 Governance and Risk Management Arrangements 2015/16 Mental Capacity Act National Community Patient Survey results (above average) NHS Protect inspection 2014 ('green' rating throughout) HealthWatch survey 2014 (significant assurance) CQC visits / inspection MCA Audit	2014/15 Clinical Audit High staff vacancy rates Achievement of Quality Strategy in relation to care planning and capacity and consent	Continue to monitor progress against implementation of the quality strategy in relation to compliance with care planning and capacity and consent requirements	31/10/2015		3333
											Implement more robust processes for ensuring individuals are held to account for timely completion of clinical audit projects	31/10/2015		
											Implement robust systems and processes to ensure the Trusts position against NICE guideline compliance is explicit and relevant action is taken	31/12/2015	Engagement with QLT's underway to prioritise guidelines for review, allocate leads and undertake gap analysis.	
											Specific focus on ensuring the update of the now small number of policies overdue for review is completed and that tight processes remain in place going forward	31/12/2015	Escalation of policies overdue for review through Executive Leadership Team. Overarching governance of policies overseen by Quality Committee	
											Embedding of actions resulting from incidents and complaints into the medium to long term through Quality Leadership Teams	31/12/2015	C Green undertaking assurance check with CRG's to ensure messages from QLT's are effective. Learning Disability CRG completed. Others planned throughout Oct - Dec 15.	
											Undertake modelling work and hypothesis as to why higher than national average suicide rates. To include: work led by suicide prevention group focusing on compassion led and collaborative patient safety approach, negotiate with Commissioners on CQUIN to ensure continued approach to patient safety, continue to roll out suicide prevention training, undertake clinical audit against NICE self harm guidelines, implement a low threshold for external peer review on suicide rate and adopt any recommendations.	31/12/2015	New national benchmark reviewed at Aug 15 Quality Committee, showing suicide rate has not increased against national benchmarks as previously identified. Terms of Reference for Suicide Prevention Group have been agreed and plan is in place to progress work.	
											Roll out of e-Rostering and emergency procedures due to gaps in staffing capacity to meet domain	Completed	Emergency procedures have been stood down and normal operating processes for monitoring and managing staffing are in place	
											Complete second year of Think Family CQUIN and review out of date carers policy. Co-produce model of mutual expectations for family inclusive practice	31/10/2015		
											Revision of supervision policy which expires in Sept 15. Audit plan to be developed alongside	31/10/2015	Final draft of policy has been completed.	
											Senior nurses and OT's to undertake research project (EQIP) with Nottingham University whereby clinical teas will receive personalised care planning training as part of trial. Redeveloped personalised care training to be include din block training sessions from Autumn.	31/12/2015		
											Develop in-reach assistant practitioner/technician to audit clinical notes for consent and capacity compliance	30/11/2015	Interviews to take place 2/11/15.	
											Learning from any CQC inspection through analysis of other Trusts inspections as well as our own MHA visits. Incorporate learning into CQC preparedness workplan.	31/12/2015		
											Learning from quality visits, listening to views through developing a good practice compendium to be published on Connect to showcase good practice	On-going		
1b	Risk that potential changes instigated by commissioners or providers, may result in DHCFT being required to meet any resulting unmet need without additional resource e.g. changes in social services provision.	Medical Director Finance and Performance Committee	12 MODERATE	3	4	1) Representation at integrated planning meetings with north and south commissioners, ensuring the Trust is well informed around the commissioning direction of travel 2) Contracting groups enabling discussion and challenge around concerns re resources vs expectations 3) Transformation programme enabling the Trust to respond more flexibly to external changes 4) Working with commissioners to highlight need to maintain core services and parity of resources 5) Positive contracting agreements with commissioners 6) Monitoring of activity data through PCOG 7) Active waiting list management	Activity against block contracts, which are insensitive to activity changes until floors and ceilings have been breached Also do not differentiate between change sin different types of activity. Funding in core services, reduced as a result of Trust efficiencies programme Weak influence on social services strategic direction 'Hotspots' identified in CAMHS, children's and some adult mental health services regarding capacity and demand.		Sim:pathy data (and action plans), giving accurate data regarding our capacity and ability to respond to changing demand	Skill mix and capacity planning against population needs	Director of Business Development to become involved in contracting rounds to increase pressure for investment in core services	Completed		3334
											Strategic business plan to be revised.	Ongoing		
											Finance and operational teams to weigh up risks and benefits of mixed block and activity based contracts	31/12/2015		
											Recommendations and feedback for health and social care from Schedule 28 ruling to be implemented and feedback to Coroner	Completed	SBARD (Situation, Background, Assessment, Recommendation, Decision) communication tool for family and carers being implemented	
											Pro-work capacity calculator to be used to develop a workforce plan for neighbourhoods and campus. Needs to be developed to be fit for medical staffing. M Ridge arranging 2 days to work with teams to develop their skill mix and NICE requirements to plan composition of neighbourhood teams	31/12/2015 Completed	Plan to trial now underway	

							and demand. No shared agreement over way forward for risks identified to Quality Assurance Group Ability to satisfy Coroners Schedule 28 ruling identifying service pressures and quality of discharge				Quality Assurance Group (QAG) review and ownership of risk register	On-going	QAG risk register reviewed 1/9/15. New risk added including potential risk to pressure on services from move to smoke free.	

Strategic Outcome 2. People receive care that is joined up and easy to access													
	Principal Risk	**Director Lead and named responsible Committee**	**Risk Rating**	**Impact (1-5)**	**Likelihood (1-5)**	**Key Controls**	**Gaps in control**	**Assurances on Controls (Internal)**	**Positive Assurances**	**Gaps in Assurance**	**Action plan: To increase effective controls. To gain assurance.**	**Action: due/review date**	**Progress on action**	**Risk Register ID**
2a	Failure to deliver the agreed transformational change, at the required pace could result in reduced outcomes for service users, failure to deliver financial requirements and negative reputational risk	Acting CEO Finance and Performance Committee (Audit Committee)	15 HIGH	5	3	1) Continued engagement though project teams and Patient and Carer reference group. 2) Integrated Service Delivery Programme Board, to provide internal mechanism for controlling compliance and risk etc. 3) Neighbourhood and Campus Assurance Boards providing assurance against quality strands. 4) Live data reporting around regulatory contract compliance and Quality Dashboard to Board. 5) Real time mechanisms for patient experience feedback 6) Operational structures monitoring progress via TOMM and PCOG 7) 'Deep Dive' reporting to Board focused on areas of concern. 8) Project Vision programme management assurance system giving independent 'live' reports 9) Learning Disability and Psychological Therapies to remain 'pan neighbourhood' for year 1 of implementation of transformational change	Lack of programme ownership throughout organisation Embedded transformational workstreams Insufficient visibility of health and social care community transformational plans Sufficient engagement with staff side	Audit to determine if discharge of service users from perinatal services is in line with operational policy Regulatory compliance reporting Contract compliance reporting Contract Governance Report 'Live' dashboards required of PCOG	2015/16 Transformation 2014/15 Transformation	Process for earn autonomy and decision making as close to patient services as possible Alignment between transformation and wider health community	Create map of all transformation activities in health and social care community to ensure appropriate attendance and influence at forums	Completed	First draft completed	3335
											Embedding transformational briefings with staff side at JNCC and with staff side members	Completed		
											Plan and deliver project sponsor and project managers training around roles and responsibilities	Completed	Undertaken as part of Programme Assurance refresher session 3/7/15.	
											Plan and deliver CORA training sessions to project sponsors and managers	Completed	Undertaken as part of Programme Assurance refresher session 3/7/15.	
											Review project delivery structure though ISDP Board	Completed		
											Increase flow of communication with revision of management and leadership structure	31/12/2015	Completed through to team manager level. Final stage to be completed end July 2015. Interim management structure in place due to current senior level acting up arrangements.	
											Develop revised performance improvement model to support earned autonomy	31/12/2015	C Gilby leading work to review way PCOG operates. This review will propose a model of earned autonomy to be supported throughout the organisation.	
											Complete roll out of neighbourhood model	31/03/2016		
											Commence consultation on campus redesign	Commence 31/12/2015		
2b	The high level of change within the organisation could lead to instability and a failure to meet contractual and regulatory key performance indicators	Acting CEO (responsibility for risk to move to Acting Director of Operations) Finance and Performance Committee	10 MODERATE	5	2	1) Data warehouse providing live information to support managers to respond in a timely way to changes in performance 2) High confidence in data quality 3) Monthly performance meetings whereby senior leadership team review and take action to control performance 4) Good relationship with Monitor Compliance Team. Their confidence in action taken by the Trust reduces reputational risk 5) Good relationship with commissioners resulting in a transparent approach to performance which encourages early warning when variance 6) Reporting to PCOG and TOMM includes detailed analysis of current performance	Team ownership of KPI's Capacity of local managers to respond to performance variance in timely manner	Integrated performance report to Board providing detailed performance information and supports independent challenge	2015/16 Information Governance (IG) toolkit and readiness for inspection 2015/16 Data quality - waiting times 2015/16 Business Continuity Planning 2014/15 EPR Project Review II, III	Lack of clinical (predominantly medical) confidence in the PARIS EPR system CQC visit to Derby City Looked After Children services and Safeguarding Children Team identified concerns with respect to the number of records in use.	Define and understand clinical (predominantly medical) concerns with the PARIS system.	Completed		3336
											Deliver action plan in collaboration with consultant body to support efficient and effective use of the PARIS system	Completed		
											Review of KPI's by Board	Completed	Paper outlining revised metrics considered by F&P July 15 and adopted.	
											Training and development to team managers re use and interrogation of reporting systems to improve efficiency	31/12/2015	PCOG considering best approach to deliver training	
											Move to neighbourhood management to align management resources to areas of highest need	31/03/2016	Decision taken by ELT to delay 'go live' until 31/03/16	
											Develop a performance framework	31/12/2015		
											Run project to adopt PARIS as the single patient record for all services (except children's and substance misuse services)	31/03/2016		
2c	There is a risk that the Trust will be unable to maintain its regulatory compliance due to identified gaps in its governance systems and processes	Acting CEO Audit Committee	16 HIGH	4	4	1) Governance committees and structures 2) Policies and procedures including workforce and organisational development and corporate 3) Risk management systems (risk, incidents and complaints), and processes for escalation 4) Trust Values	Effective flow and escalation of issues through governance related committees Consistent implementation of Trust policies and procedures Lack of overall governance framework Clear expectations of Governor and Board roles Failure to effectively	Well led' self assessment Committee self assessment		PWC audit Nov 14 'Governance arrangement, structures and processes' identified gaps in some areas of governance structures and processes. Workforce and organisational development procedures (including recruitment)	Complete a 'well led' governance review to identify gaps in governance structures and processes	31/01/2016	Board Development Sept 15 considered early self assessment draft.	3337
											Independent investigation to be undertaken to assess if behaviours within the Trust are in line with internal and external expectations and codes of conduct	30/11/2015	Investigations underway led by independent chair.	
											Governance Framework to be submitted to Board. To be reviewed in response to findings from 'well led' review and independent investigation.	31/01/2016		
											Revised Board and Governor induction programme planned, together with a policy for engagement with Governors.	31/03/2016	To be revised as part of 'well led' governance review.	

						communicate in an open and transparent way which may impact on staff morale.				Review of workforce and organisational development procedures including recruitment and communication with staff	31/12/2015	Terms of reference for HR/workforce review to be considered by Board Sept 15.		

	Strategic Outcome 3. The public has confidence in our healthcare and developments												
	Principal Risk	**Director Lead and named responsible Committee**	**Risk Rating**	**Impact (1-5)**	**Likelihood (1-5)**	**Key Controls**	**Gaps in control**	**Assurances on Controls (Internal)**	**Positive Assurances**	**Gaps in Assurance**	**Action plan: To increase effective controls. To gain assurance.**	**Action: due/review date**	**Progress on action**	**Risk Register ID**
3a	Risks to delivery of 15/16 financial plan If not delivered, this could result in regulatory action due to breach of Provider Licence with Monitor	Executive Director of Finance Finance and Performance Committee (Audit Committee)	15 HIGH	5	3	1) Monthly Financial Performance Reporting to Public Trust Board meetings provides assurance on financial performance, 2) Reporting to Finance and Performance Committee to gain assurance on all aspects of financial (and other resources) management on behalf of the Board, including oversight of CIP delivery and contractual performance 3) With regard to Cost Improvement Programme (CIP) delivery: Project Assurance processes and systems for in-year monitoring of CIP delivery and escalation procedures 4) System of delegated budgetary responsibility - in line with standing financial instructions and scheme of delegation 5) F&P and PCOG meetings: monitoring of contractual performance that impacts on contractual payments including activity levels, CQUIN and contract levers/penalties. 6) Service Line Reporting and other financial reporting systems and action planning at Finance & Performance, Performance and Contracts Overview Group (PCOG), Integrated Services Delivery Group (ISDG), Divisional meetings, IAPT Board and other groups	Risks to delivery of CIP plan outside of our control (e.g. other providers and wider health system factors)	Monthly financial reporting systems on current and forecast performance include "challenge and review" each month before reporting Pre-submission scrutiny of annual operational financial plan prepared and submitted to Monitor April (draft) and May (final) 2015. Delivers FSRR (previously COSRR) of at least 3 each quarter Budget-setting operational requirements were signed-off by those responsible for their delivery (and the Trust Board) In-year financial forecasts are co-owned by finance and the individuals responsible for their delivery 15/16 CIP is 100% allocated and has undergone scrutiny at quality panel. Existence of contingency reserve and the contingency reserve access request process Deep dives into forecasting and cash planning at F&P during 14/15 provided full assurance to F&P on systems and processes behind the figures (these systems are the same for 15/16) Large proportion of income guaranteed through block contract .	External Audit: the Audit Findings for DHCFT (year ended 31 March 2015) . Issued with Unqualified Opinion Confirmed External Audit:. Bespoke Key Financial Indicators 2014 report and bespoke Financial Resilience report show that aside from the gaps in assurance listed - the other indicators are amber or green (benchmarked against MH FT peers) . Strongest indicator is EBITDA Internal Audit: 2014/15 Finance Systems Audits (low rating) and PwC's annual report to Audit committee cites financial systems in their areas of good practice; stating "Our Financial Systems review has been rated low risk for the last three years and remains an area where the Trust demonstrates strong controls and processes." Monitor: FSRR (previously COSRR) submissions risk rating by Monitor as 3 or 4 Monitor: "Green" rating for Trust extant 5 year strategic financial plan (only 30% of Trusts rated as green) 2015/16 Cash forecasting and controls 2015/16 Contract Assurance Shared Business Services (SBS)	Gaps in assurance on CIP schemes in Project Vision Re: External Audit benchmarking for Financial KPIs and resilience: Areas to improve are: liquidity, return on assets , capital service cover, PSPP and Workforce (sickness and turnover) During transition to new service delivery model potential to increase gaps in assurance on reliably measuring financial performance by service line as moves take place. this impacts particularly on the reliability of service line reporting	Escalation processes from PAB to ensure gaps in assurance on system are closed or mitigated	Quarterly review	Project Vision and ledger will evidence progress	3338
											Extant financial strategic objective continue to increase liquidity and associated measures - this will be achieved by containing capital expenditure to depreciation levels, by delivering year on year surplus and by retaining proceeds of asset disposals. The key metrics highlighted in the benchmarking reports will be reported on throughout the year to F&P to provide oversight on progress with improvement	For each meeting of F&P	The Trust is planning a surplus, has capex programme limited to depreciation levels. Asset disposal receipts not received	
											Additional financial reporting to F&P, and other meetings as appropriate, to triangulate and validate overarching Trust financial performance.	For each meeting of F&P	Papers provided to F&P during 15/16 will provide evidence of additional reporting. 15/16 F&P feedback reports to Trust Board will provide evidence of assurance levels gained	
3b	Risk to delivery of the Commercial Strategy, if not delivered it could cause the Trusts financial position to deteriorate resulting in regulatory action (Likelihood reduced from 3 to 2 following retention of children's services)	Director of Business Development and Marketing Finance and Performance Committee	10 MODERATE	5	2	1) Regular briefing to ELT resulting in clear decision making about new / current service opportunities. 2) F&P reporting resulting in assurance on the key objectives of the Commercial Strategy. 3) Stakeholder and relationship management resulting in keeping the Trust competitive, with a strong reputation. 4) Inclusive approach in response to tender opportunities, resulting in a coherent joined up approach internally.	Unclear business development strategy Lack of clarity around collaboration and competition (i.e. Children's Services) Limited infrastructure to fully deliver the totality of the Commercial Strategy Unclear process for VFM review of current service lines	Successful retention of existing business in competitive market (i.e. Substance Misuse. Children's Services).			Review Commercial and Business Development infrastructure to ensure it aligns to the Strategy.	31/10/2015	Proposal for changes to business development team to be considered by ELT Oct 2015	3339
											Formulate a clear business development plan for 15/16 (PYE) and 16/17.	31/12/2015	Strategic priorities identified in 15/16 (including children's services and offender healthcare services) on track. Priorities for 16/17 currently being developed by ELT.	
											Develop a robust and fully resourced project plan to retain Children's Services.	Completed	Plan in place. Intent to award contract letter received	
											Refresh Commercial Strategy	31/12/2015		
											Agree use of 1 Commercial Assessment Framework Tool to use across all service lines (new / current).	31/12/2015	Decision making framework being developed as part of core service portfolio. This tool will be used to inform new business opportunities as well as to review current services for commercial viability.	

	Strategic Outcome 4. Care is delivered by empowered and compassionate teams												
	Principal Risk	**Director Lead and named responsible Committee**	**Risk Rating**	**Impact (1-5)**	**Likelihood (1-5)**	**Key Controls**	**Gaps in control**	**Assurances on Controls (Internal)**	**Positive Assurances**	**Gaps in Assurance**	**Action plan: To increase effective controls. To gain assurance.**	**Action: due/review date**	**Progress on action**	**Risk Register ID**
4a	Failure to recruit, retain and engage capable and compassionate staff, leading to a risk that could impact on service receiver care	Director of Transformation Quality Committee	12 MODERATE	4	3	1) Communication strategy to engage and inform staff: to take staff on the journey through national, county and Trust changes 2) 2013-2015 People Strategy in place, and reports on progress if the strategy it Board on a monthly basis 3) Detailing of the annual workforce plan and tracking of progress, including reporting of risks to F&P and Board. 4) Proactive recruitment based on workforce profile 5) Monitoring impact of People Strategy and plan through People Forum 6) Transformation programme which defines and assures progress of the programme of change 7) Training and Development framework which defines training needs for staff and monitoring delivery through Board 8) Working in partnership with staff side to deliver transformational change 9) Visible, engaging and listening collective leadership	Identified activities to support the delivery of the People Strategy - values based recruitment, proactive actions following staff survey Lack of current People Strategy	Structured approach to responding to the Annual Staff Survey Key metrics reported to Board Safer staffing data	Benchmarking data provided at a National and Regional level External recognition re values based recruitment Annual staff survey CQC visits / inspection 2015/16 Appraisals 2015/16 HR processes - recruitment	Action plan to support staff survey findings Evaluation of interventions - leadership development	Establish a robust action plan to support staff survey outcomes	Completed	Staff survey 'high level roadmap' supported by People Forum' completed May 15. Further update to June 15 Board 'Healthcheck' completed and shared 'Spotlight on Leaders' events to engage leaders Podcasts by senior managers	3340
											Revision of existing People, Education and Leadership strategies to combine into overall People Strategy	31/01/2016		
											Further develop a robust programme of evaluation to ensure the effectiveness of the leadership programme and monitor through the People Forum	31/10/2015		
4b	Failure to have sufficient capability and capacity to deliver required standard of care resulting in a risk to our service receivers	Director of Transformation Quality Committee	12 MODERATE	4	3	1) Robust workforce planning process 2) Monthly People Strategy update to Board highlighting risks or other strategic considerations 3) QIA system in place 4) Safe staffing reports to Board, actual v target level of staff per inpatient area 5) Bi-annual workforce planning and costs report to F&P to ensure workforce plan met 6) Timeliness of recruitment activity - vacancy control process 7) Quarterly workforce planning reports to ESEC (People Forum) demonstrating actual v plan	Failure to have a robust talent management process which aligns appraisals to succession plan and identifies personal and professional development needs	Tracking and delivery of Training Needs Analysis Triangulation of appraisal output, TNA and workforce skills against workforce plan Safer staffing data	Full spend of HEEM funding Annual Staff survey: Progress against specific actions	Gap in assurance on talent management process Closer alignment of transformation workforce requirements to workforce planning process/L&D activities	Establish a robust talent management process and monitoring system	31/01/2016	Team management discussion document prepared for leadership team	3341
											Refreshed People Strategy with key activities defined	31/12/2015	In development	
											Additional reporting to ESEC (People Forum), F&P and Board	31/12/2015	Learning & Development & Education teams attending transformation / workforce workstreams	

Abbreviations

CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CEO	Chief Executive Officer
CIP	Cost Improvement Programme
CORA	a project management software tool
COSRR	Continuity of Services Risk Rating
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation payment
CRG	Clinical Reference Group (accountable to QLT's)
DHCFT	Derbyshire Healthcare NHS Foundation Trust
EBITDA	Earnings before interest, taxes, depreciation and amortization
ELT	Executive Leadership Team
EPR	Electronic Patient Record
ESEC	People committee
F&P	Finance and Performance Committee
FRR	Financial Risk Rating
FSRR	Financial Sustainability Risk Rating
HEEM	Health Education East Midlands
JNCC	Joint Negotiation Consultative Committee
KIP	Key Performance Indicator
NICE	National Institute for Health and Care Excellence
PAB	Programme Assurance Board
PARIS	Electronic Patient Record solution provided by Civica
PCOG	Performance and Contracts Overview Group
POMH-UK	Prescribing Observatory for Mental Health
PSPP	Public Sector Payment Policy
PYE	Part Year Effect
QLT	Quality Leadership Teams (accountable to Quality Committee)
QC	Quality Committee
SIRI	Serious Incidents Requiring Investigation
SLA	Service Level Agreement
TOMM	Trust Operational Management Meeting
VFM	Value for Money

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 28th October 2015

Finance Director's Report Month 6

Purpose of Report

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

Recommendations

The Board of Directors is requested to:

1) Consider the content of the paper and consider their level of assurance on the current and forecast financial performance for 2015/16.

Executive Summary

- There is a favourable performance in the first half of the year; we are ahead of plan by £1.2m, the forecast is to achieve the planned underlying surplus of £1.3m. However there continue to be both cost and income pressures within the financial forecast for the next six months. The Executive Leadership have therefore agreed management action to address pressures as far as possible and the reported forecast assumes the success of these actions.

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

- The Financial Sustainability Risk Rating is a 4 year to date and forecast to achieve a 3 at the end of the year.

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

- Cash is currently above plan but is forecast to be lower than plan at year end.

- Capital expenditure is forecast to spend the full plan but is currently someway behind plan due to reprioritisation of schemes and revised start dates.

Strategic considerations

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

Board Assurances

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

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

Consultation

- The Executive Leadership Team discuss and agree the key assumptions contained in the forecast financial position and agreed risk management actions to enable delivery of the planned financial surplus.
- Finance and Performance Committee challenges key strategic aspects of financial performance and financial risks and receives additional financial performance information to support its assessment of assurance in financial plan delivery.
- Performance and Contracts Overview Group regularly discuss many aspects of financial performance and forecast assumptions.
- Capital Action Team oversees delivery of the Capital Expenditure.

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

Governance or Legal issues

Monitor aspects:
The information reported in this report is consistent with the information contained in the quarter 2 compliance return due to be sent to Monitor on 30th October 2015 which is included in the confidential Trust Board session for sign off.

Also contained in the report this month is our current expenditure levels on agency nursing expenditure in readiness for compliance monitoring from 1st October 2015 onwards reporting.

There are no other governance or legal exceptions to note.

Equality Delivery System

This report has a neutral impact on REGARDS groups.

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

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

FINANCIAL OVERVIEW
SEPTEMBER 2015

1. Overall Financial Performance

Income & Expenditure – key statistics

We have achieved an underlying surplus of £609k in the month of September which is £499k better than plan. Operational profitability as measured by EBITDA[1] is better than plan by £497k in the month. This equates to 10.9% of income compared to a plan of 6.2%.

Year to date we are ahead of plan by £1.2m in both EBITDA and bottom line surplus. This equates to 7.7% of income compared to a plan of 5.8%.

The forecast position is an underlying surplus, excluding impairments, of £1.3m which is as per plan. EBITDA is forecast to be ahead of plan by £133k which equates to 6.4% compared to the plan of 6.2%.

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

STATEMENT OF COMPREHENSIVE INCOME	SEP 2015								
	Current Month			Year to Date			Forecast		
	Plan	Actual	Variance Fav (+) / Adv (-)	Plan	Actual	Variance Fav (+) / Adv (-)	Plan	Actual	Variance Fav (+) / Adv (-)
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical Income	10,233	9,980	(252)	60,918	59,769	(1,149)	121,914	120,519	(1,395)
Non Clinical Income	832	813	(19)	5,129	5,081	(48)	10,248	9,826	(422)
Pay	(8,251)	(7,839)	412	(49,239)	(47,885)	1,355	(98,335)	(96,053)	2,283
Non Pay	(2,131)	(1,775)	356	(13,009)	(11,990)	1,019	(25,646)	(25,980)	(333)
EBITDA	**682**	**1,180**	**497**	**3,798**	**4,974**	**1,176**	**8,181**	**8,313**	**133**
Depreciation	(283)	(291)	(8)	(1,700)	(1,756)	(56)	(3,389)	(3,377)	12
Impairment	0	(0)	(0)	0	(0)	(0)	(300)	(300)	(0)
Profit (loss) on asset disposals	0	0	0	0	31	31	0	31	31
Interest/Financing	(181)	(172)	9	(1,135)	(1,088)	47	(2,221)	(2,138)	84
Dividend	(108)	(108)	(0)	(650)	(650)	(0)	(1,300)	(1,559)	(259)
Net Surplus / (Deficit)	**110**	**608**	**499**	**313**	**1,512**	**1,199**	**971**	**971**	**0**
Technical adj - Impairment	0	(0)	(0)	0	(0)	(0)	(300)	(300)	(0)
UnderlyingSurplus / (Deficit)	**110**	**609**	**499**	**313**	**1,512**	**1,199**	**1,271**	**1,271**	**0**

- Clinical income was behind plan in the month by £252k increasing the year to date under achievement to £1.1m due to the continuation of two main drivers:
    - cost per case income is lower than planned due to lower activity levels and lower occupancy levels

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

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

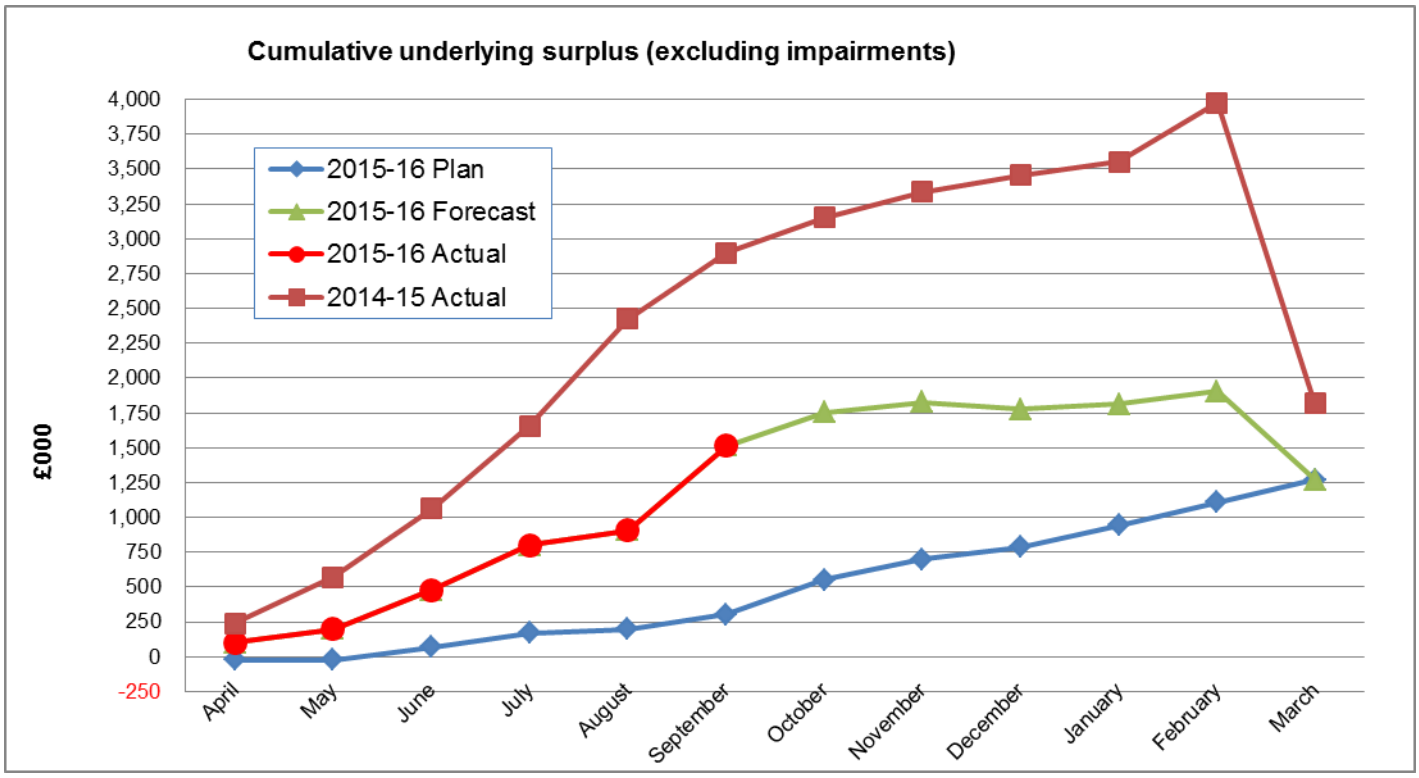
With the assumed levels of activity and occupancy, along with the start dates of service developments, clinical income is forecast to remain behind plan by £1.4m at the end of the financial year. The key risks to clinical income are achieving forecast cost per case income in light of updated transformation planning requirements and staffing levels.

- Non-clinical income is slightly behind plan in the month by £19k increasing the year to date adverse variance to £48k and is forecast to be behind plan by £422k. The underachievement of the forecast income relates to miscellaneous other income.

- Pay expenditure is underspent by £412k in the month which has increased the year to date underspend to £1.4m. The forecast has favourably moved by £877k and is forecast to be under budget by £2.3m at the end of the financial year. The main drivers within the forecast underspend are changes to staffing levels as a result of activity levels (offset by less income in some places), the later assumed start dates for service developments (less cost but also less income as above), unspent contingency reserves along with the balance of the budgeted pay-award funding now that all awards have been actioned.
  The key risks to pay expenditure performance are successfully containing the cost of temporary (particularly agency) staffing and capping the use of contingency reserves.

- Non pay expenditure is underspent in the month by £356k increasing the year to date underspend to £1.0m. This is mainly driven by the phasing of some of the replacement efficiency schemes which has a different phasing to the original plan. The forecast year end position is an adverse variance to plan of £333k. The forecast underspend is driven by additional expenditure forecast in the later part of the financial year and changes in CIP schemes between pay and non-pay. The main non pay risks are PICU cost-pressure containment and managing the use of contingency reserves.

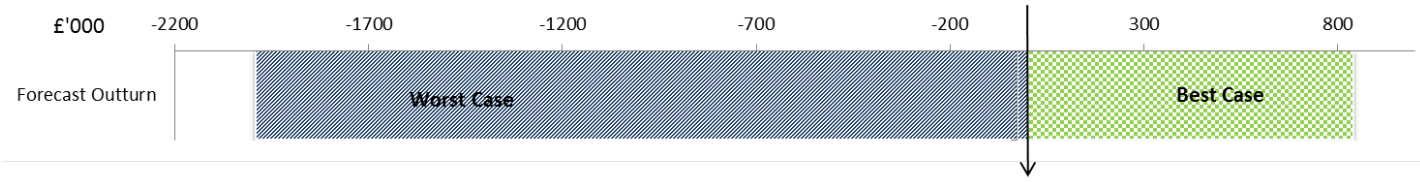
The graph below shows the cumulative underlying surplus for both actual and forecast compared to the plan, along with a comparison of the previous year's performance.



The actual underlying surplus for the first half of the year is above plan as described above. The forecast assumes a further increase in surplus in October due to increased income. The surplus then becomes fairly static over the remaining months until the last month of the financial year when year-end transactions are forecast.

Forecast Range

Best Case	Likely Case	Worst Case
£0.84m favourable variance to plan	On plan	£1.99m adverse variance to plan



NB: Position of arrow shows current likely case forecast outturn

The best case of £839k better-than-plan assumes clinical income could improve slightly, staff cost savings being reduced by different recruitment timings and current cost pressures improve sooner than in the likely case.

The worst case forecast includes an assumption that clinical income could worsen by £779k due to reductions in activity levels and delays in service developments. Other factors include increases in PICU out of area placement cost pressures and further continuation of other cost pressures for which improvements are assumed in the likely case.

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

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

2. Regulatory Compliance

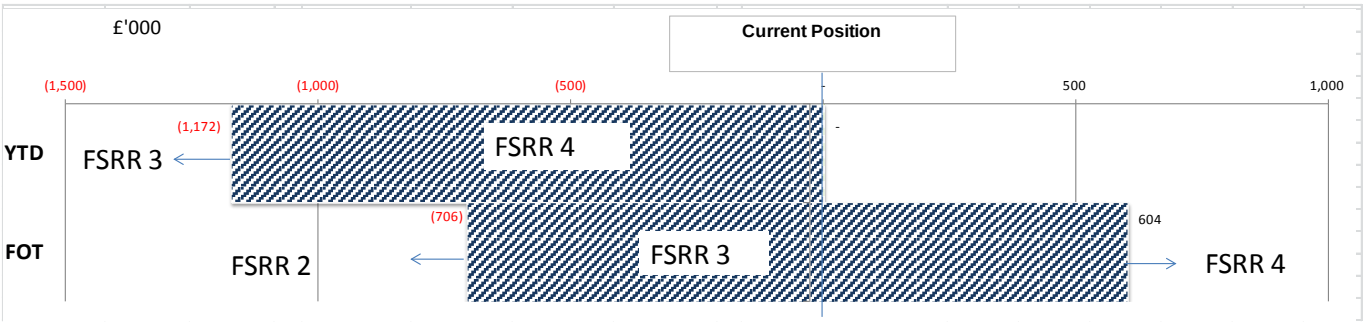
2.1 Financial Sustainability Risk Rating (FSRR)

Year to date our Financial Sustainability Risk Rating (FSRR) is an overall score of 4, with a 4 on three of the four individual metrics. The forecast FSRR is a 3 overall with a 3 on three of the individual metrics and a 4 on the variance to plan metric.

Financial Sustainability Risk Rating	**YTD Actual**	**Forecast**
Debt Service Cover	3	3
Liquidity	4	3
I&E Margin	4	3
I&E Margin Variance	4	4
Weighted Average	**3.75**	**3.25**
Overall FSRR	**4**	**3**

The headroom in £'000s, to a FSRR of 2/3 and up to a 4 is shown in the chart below, both for year to date (YTD) and forecast outturn (FOT). This is for indicative use based on a set of assumptions. It serves to illustrate the impact of improving or worsening revenue and cash, but there would be other variables that could also have an impact.

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



The liquidity ratio measures the Trust's ability to pay its bills from its liquid assets in terms of days and therefore the higher the number of days, the better. At the end of September the number of days is +3.5 and is forecast to be -1.6 at the end of the financial year (which would still generate a rating of 3 for that metric). The Trust Board is reminded that benchmarking provided by external auditors illustrates that the peer average is nearer to +24 days, therefore our liquidity must remain a strategic priority for us to continue to improve.

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

2.2 Agency Nursing Rules

Monitor has published their Agency Nursing rules, which take effect from 1st October. Contained within these rules is a maximum ceiling for the cost of qualified nursing agency expenditure that Foundation Trusts can spend. The cost ceiling for our Trust is 3%, which is based on the Trust average for last financial year. Currently we are exceeding this ceiling but all agency staff usage is being monitored at team level within the clinical divisions. September showed improvement towards a return to a spend of 3% which is our trajectory for October onwards.

2015-16	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Total qualified nursing	£3.037m	£3.134m	£2.914m	£2.941m	£3.044m	£2.927m
Agency qualified nursing	£0.164m	£0.171m	£0.116m	£0.139m	£0.199m	£0.112m
%	5.4%	5.5%	4.0%	4.7%	6.6%	3.8%

This information is reported monthly through the Performance Contracts Overview Group and also through Finance and Performance Committee. Submissions to Monitor are made through the monthly and quarterly compliance returns.

Aside from the introduction of qualified nursing agency spend ceilings, Monitor are also currently consulting on introducing bank and agency pay rate caps, for all staff at all grades. The outcome of the consultation will be known in November. If agreed, the caps will be put into force in November with a staged reduction in rates from November 2015 to April 2016.
Monitor have also signalled their intent to extend the spend ceilings to other staff groups.

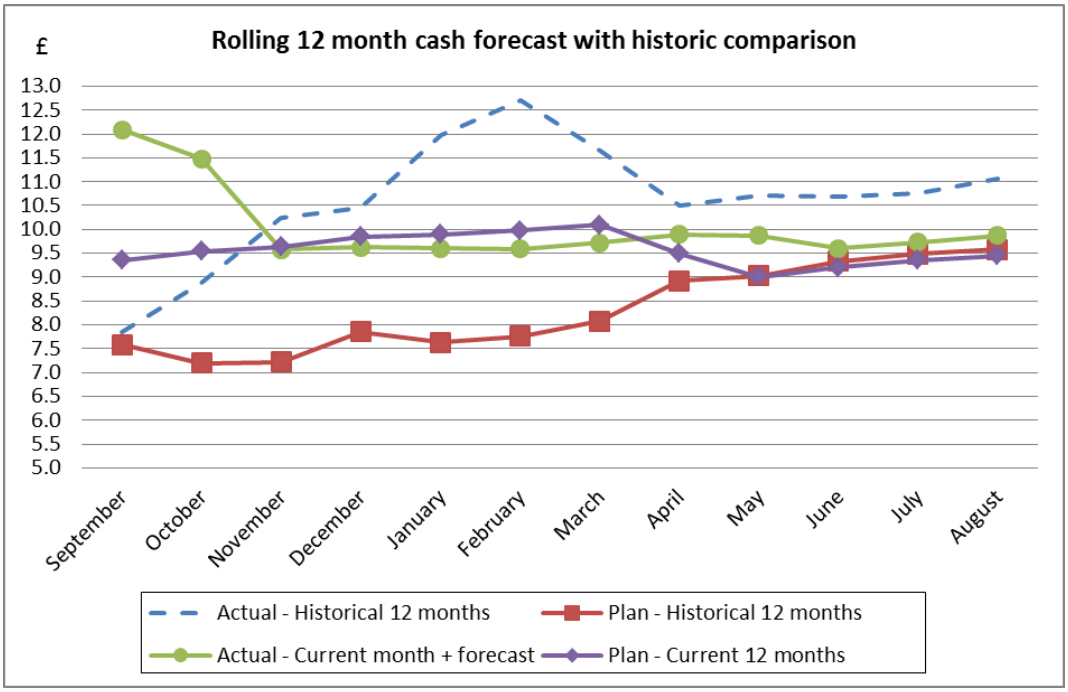
The impact of these measures will be explored in the half year agency report to Finance and Performance Committee in November.

3. Efficiency / Cost Improvement Programme (CIP)

Year to date CIP achieved is £2m which is ahead of plan by £111k (5.8%). This is an improvement on last month's year to date position. The reason for the change is that replacement schemes have a different delivery phasing to the original schemes. The forecast assumes that all risks to delivery of efficiency savings are mitigated and the target is fully achieved by the end of the financial year. Programme Assurance Board continues to performance-monitor CIP delivery which is reported to Finance and Performance Committee who have delegated authority from Trust Board for oversight of CIP delivery.

4. Cash Balances

The cash balance at the end of September was £12.1m which is ahead of plan by £2.7m, this is driven by the surplus, lower capital expenditure and also some large invoices remain unpaid due to ongoing contract discussions.
The levels of cash are then forecast to reduce in October and November due to payment of outstanding debts due to contract resolutions. Cash is then forecast to remain constant over the remaining months, where it ends the financial year £0.4m behind plan.



At the end of the first half of the year we have achieved a net current assets position of £1.2m. We are forecasting to end the year with net current liabilities of £0.4m.

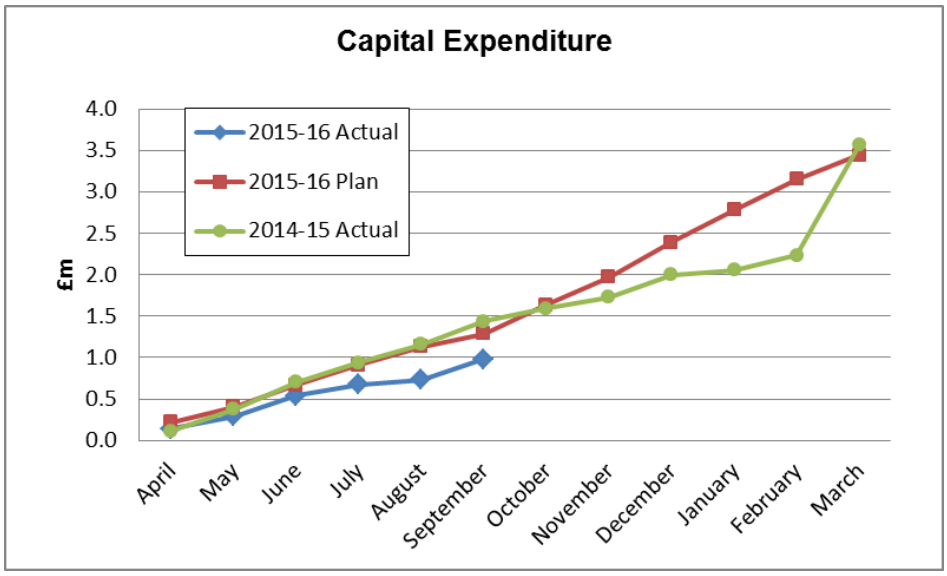
5. Capital Expenditure

Capital Expenditure is £308k behind the plan at the end of September.

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

The capital expenditure plan will continue to be subject to review for clinical priorities and there is an increasing likelihood of a variance from plan, particularly as lead-in times for new projects may mean those schemes could cross into the new financial year.

Trust Board will receive a draft forward five-year capital expenditure plan at the November meeting.



Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 28 October 2015

Deep Dive into Suicide Prevention

Executive Summary

The national suicide rate has been increasing significantly since 2006 particularly in middle aged men. This is likely to be linked to economic factors often compounded by social isolation with alcohol or substance misuse representing a "final pathway". There has been a relentless rise in hanging as a method of suicide. Opiates (particularly methadone but also Tramadol) are the most common types of drug taken in fatal overdoses.

We have seen these trends replicated in our patient population. The Trust has no more suicides than other similar organisations but the problem is increasing in Derbyshire as elsewhere in the country. We therefore need to do everything possible to address this public health concern with our partners and the people of Derbyshire.

This report summarises the work we are undertaking to reduce the suicide rate in our patient population and in the general population.

Board Assurances

- Our standard approach to suicide prevention training is described and the new initiative to replace this with an evidence based Connecting with People training plan

- The suicide prevention plan will sit within an overall safety plan for an individual patient. The Safety Planning Group is a separate parallel workstream which is not described in this paper.

- The development of a Suicide Prevention Strategy for the Trust is outlined. Trust members have contributed to the regional suicide prevention strategy.

- The Trust is research active in this area with a Centre for Self Harm and Suicide Prevention. A 12 month activity update is included.

Gaps in assurance due to variations in practice and the efforts to close them are discussed.

Equality Delivery System

Certain groups, eg middle aged men with mental health problems, are thought to be at particular risk. The Trust does not have a focussed approach to suicide prevention based on these sorts of demographics. Likewise people below 25 are more likely to have access to pro-suicide websites prior to their death than other groups and may be more prone to engage in a suicide pact on line. The issue of particularly at risk groups will be considered as part of the Suicide Prevention Strategy development.

Parity of esteem and resources for psychiatric care are well rehearsed issues. The National Confidential Inquiry into Suicide and Homicide has indicated that patients who have to access inpatient care outside of district may be more at risk of suicide than those receiving care in local units. Strenuous efforts are applied to the management of bed availability within Derbyshire. Commissioners are aware of the issues around inpatient care for children and adolescents.

Recommendations

The Board of Directors is requested to:

1) Consider the report
2) Dive deeply and consider what further assurance is required regarding the suicide prevention agenda

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

Report prepared by: **Dr John Sykes, Dr Allan Johnston and Jenny Ness with contributions from Bob Gardner and Keith Waters**

Deep Dive into Suicide Prevention

Standard Trust Suicide Prevention Training to date

- Trust e-learning package on risk management: this has to be completed every 3 years – 869 out of 1437 in date

- Awareness of suicide/self harm: this is a half day taught module aimed at registered staff but support staff have also attended. This module is not mandatory, 69 staff have attended

- Suicide specific conferences/courses: Our staff will attend one day conferences and courses related to the management of suicide

- Ad hoc training happening within teams, for example the Crisis Teams (North and South) and older adults' community teams have received training provided by Bob Gardner and Keith Waters. This has primarily been related to action from a serious incident review.

Connecting with People Training (CWP) Suicide Prevention Training

- Rigorously validated suicide prevention awareness and response training analysed by RCPsych and Prof Louis Appleby amongst others

- 100 staff trained to date targeted at acute services eg Inpatient and CRHT teams

- Our Train the Trainer programme dates have been set for 22 and 23 October 2015 with CwP training 9 of our staff in Derby

- 9 trainers selected via long listing, short listing and interview process

- First Training date set for 6 November 2015 and advertised via Connect

- Funding for CwP agreed at Training Board

- Clinical and administrative support provisionally agreed – Sam Kelly, Faith Sango, Nick Holborn

- Plan is for 4 courses per month, with between 10 and 24 delegates each session meaning a minimum of 480, to a maximum of 1150 trained / year

The DHCFT Suicide Prevention Strategy

In the process of producing our first draft of the DHCFT Strategy

- Informed by national, regional and local strategies

- Partnership working progressing well with the Derbyshire Suicide Prevention Forum started following the DHCFT Conference in January. DHCFT is leading/promoting this Derbyshire wide work

- 3 meetings held in August, September, October with 1 further date planned for draft completion by on 5th November 2015

- Service receiver representation has been integral to the development of the strategy through attendance at meetings with 3 service receiver representatives. Email feedback received from other service receivers which has been discussed and integrated into the strategy. Derbyshire voice also have used social media platforms, informal internal feedback mechanisms, and formal representative meetings to provide the strategy group with detail added to our strategy

- We Anticipate completion of draft by 5th November

- We with then take the first draft for Consultation with:
  All DHCFT CRGs
  Service receivers
  Trust Board
  Derbyshire Suicide Prevention Forum (Derbyshire wide group)

Clinical Variation

Patients at risk of suicide broadly present in two main ways. In one group the risk presents itself due to their past history of self harm or ongoing high risk behaviour. Clinicians engaging with these patients should therefore be aware of the potentially increased risk and will be able to apply their suicide prevention training directly as part of a safety plan. The greatest predictor of risk is past risky behaviour.

The second group present a less obvious risk of suicide. They are vulnerable because of their mental health problems and social situation but the risk is ambient rather than overt. Suicide prevention strategies and safety planning will still be applicable but probably less directly effective. Clinicians need to be vigilant for any signs of increased risk but otherwise safety is assured by the routine application of high quality care in a consistent manner. In cases where the application of care is patchy and a death occurs, contributory factor are often identified (due to the inconsistency) but no direct cause is attributable. This is not to say that the contributory factors are insignificant. Avoidable deaths may occur due to the accumulation of a number of contributory factors in a particular time and place.

This is why it is important to ensure that high quality care is delivered consistently with a reduced degree of untoward clinical variation. There is a tentative proposal to create a “heat map” using a combination of Trust data and public health data to get an overall picture geographically of suicide rates within Derbyshire.

The introduction of the electronic patient record will enable data to be captured and analysed routinely which will allow us to compare clinician to clinician and team to team. Variation in practice and outcomes can then be analysed and challenged as necessary.

The Quality Leadership Teams are mapping out our compliance with NICE guidelines and this will allow us to commission audits that are focussed on areas where practice needs to improve.

An overview of clinical audit itself has been the subject of an internal audit and there is a comprehensive action plan around our approach to this with recent evidence that this is being effective.

The Serious Incident Group are continuing to develop their approach regarding investigations that are timely and making recommendations and action plans which are “owned” by the individual clinicians and clinical teams. Further development of ideas to learn the lessons more widely across service areas need to develop although we do have systems such as the Blue Light Alert system and Practice Matters system. Links with our training and education strategy need to be developed.

Derbyshire Healthcare NHS Foundation Trust

Self-harm & Suicide Prevention Research Centre

12 Month Activity Update - October 2015

People conducting & co-ordinating this work:

Keith Waters, *Director of the SH & SP Research Centre*

Jennifer Ness, *Liaison Team Research Project Manager*

Muzamal Rehman, *Multicentre Study of Self-harm Research Assistant*

1. Opportunities for patients and carers to participate in research

We have worked to provide increased opportunities for our patients and carers to participate in national research through our on-going involvement in the national Multi-Centre study of Self-harm. In addition, we have supported the Clinical Research Team on the following national studies:

- **Predictive Accuracy and Clinical Acceptability of Risk Scales for Repeat Self-harm** [Manchester University] which is now closed and to which 101 participants consented to take part.
- **The "Listen Up" project** investigating the feelings associated with self-harm in looked after children [Nottingham University].

We are also discussing with colleagues at Exeter University a possible multi-centre collaboration on 'Exploring the use of language and suicidal thoughts'.

2. Opportunities for staff and patients to shape and lead research

Some of our studies have enabled staff and patients to play a role in shaping our local areas of research and development:

- **Mind the Gap: Group Facilitation for Frequent Repeaters of Self-harm.** [Health Foundation Award funded study, Led by Sue Ellis] was developed and implemented by members of the South Liaison team who identified a gap in service provision (on both national and local scale). This study is now closed to recruitment and results are being analysed.

- **e-DaSH (Depression and Self-Harm) study**: A Randomised Controlled Trial (RCT) of the clinical and cost effectiveness of NICE recommended problem solving cognitive behaviour therapy (PS CBT) delivered remotely versus

Treatment As Usual (TAU) in adolescents and young adults with depression who repeatedly self-harm. This East Midlands CLAHRC (Collaboration for Leadership in Applied Health Research and Care) study is open to recruitment in the North and South Liaison Teams with Bob Gardner and Sarah Grainger as the local Collaborators and has so far recruited 8 participants to the clinical trial.

3. Opportunities for Trust colleagues and organisational development

We are working to increase opportunities for staff and organisational development in the following ways:

- offering placements for Trust staff seeking experience in research and self-harm & suicide prevention as well as work experience placements for students;
- hosting a consultation open to all Trust staff to discuss what they would like from the Centre
- Supporting the initial exploration of ideas and project set ups e.g. the follow up of patients retained on a Section 136 study and implementation, evaluation of Liaison team delivered suicide awareness training.
- The centre has further developed its external facing webpages within the Trust website to try to increase our visibility and availability to the public: http://www.derbyshirehealthcareft.nhs.uk/get-involved/research-and-development-home/sh-and-sp/

4. Embed research as a core skill

We continue to work to embed a culture that values research and development as a core skill:

- Keith Waters is working within the Trust's transformation project to embed suicide prevention and learning from losses within the new neighbourhood model
- Supporting service evaluations e.g. school nurse involvement in training evaluation
- Supporting both Liaison teams to record and capture their clinical data in a reliable and consistent way so that they can use it to inform ongoing service evaluations and developments
- Feeding back regularly to the teams the relevant research findings and service developments from international sources e.g. fixed agenda item on team meetings, regular emails containing key findings and clinical implications, research display board containing latest relevant research.
- Supporting and informing the development of suicide awareness training (and it's evaluation) e.g. all staff training sessions within Royal Derby ward areas

5. National collaborations and partnerships

We continue to collaborate and work in partnership with others:

- Continuing collaboration with Oxford and Manchester University on the MCM study and other pieces of work

- Other organisations that we collaborate with on an ongoing basis include University of Leeds, University of Bristol, University of Nottingham, Harmless, Psychiatric Liaison Accreditation Network, RAID Network.
- Keith Waters has been appointed as:
    - ⇒ Clinical advisor to the East Midlands Academic Health Science Network
    - ⇒ Elected as a member of the National Suicide Prevention Alliance Steering group and leading on "Providing the right help" programme area and advising on the "Suicide Bereavement" programme area (There are 7 programme areas in total).
    - ⇒ Critical friend for Sheffield CCG for the development of their Liaison Psychiatry services.
- We are now part of the National "Access to CRISIS care development" with the National Collaborating Centre for Mental Health. A program commissioned by NHS England to support the delivery of the mental health crisis concordat and achieving better access to mental health services by 2020 through the provision of a policy implementation programme.
- We are working with Maria Michail and colleagues at the Institute of Mental Health to support the development of a training package for GPs.
- Further promote our East Midlands Self-harm & Suicide Prevention Research Network (EM-SRN):
    - ⇒ Hosted regional East Midlands Self-harm and suicide prevention Research Network (EM-SRN) conference. We host these regional events bi-annually.
    - ⇒ The network now has a webpage (http://www.derbyshirehealthcareft.nhs.uk/get-involved/research-and-development-home/sh-and-sp/emsrn/), discussion forum and bi-annual face to face meetings/conferences.
    - ⇒ The membership is growing and is reaching out to and connecting a variety of professions and organisations across the region.
    - ⇒ The network has been made an organisational member of the National Suicide Prevention Alliance.
    - ⇒ Traffic and knowledge sharing in the network discussion forum is increasing.

6. Income generation

We have seen some success in attracting external income to achieve growth in our R&D Capacity and Capability as demonstrated by the following:

- ⇒ Securing funding from the Department of Health for the 2015/16 period of the multicentre self-harm study,
- ⇒ Succeeding in our application for a SHINE award from the Health Foundation which has funded liaison team staff time, training and Susan Ellis's lead role in the study.

⇒ The South Liaison team received funds from Manchester University for their participation in the national study on risk scales for repeat self-harm.

⇒ Conferences hosted by the Centre are also hosted on a cost recovery basis whenever appropriate.

Publications, conferences and training October 2014 to October 2015

Publications

1. **Bergen, H., Hawton, K., Webb, R., Cooper, J., Steeg, S., Haigh, M.,…& Kapur, N. (2014). Alcohol-related mortality following self-harm: a multicentre cohort study. Journal of the Royal Society of Medicine, (5)8. Doi: 2054270414533326**
   The aim of this paper, from the multicentre study of self-harm, was to assess alcohol-related premature death in people who self-harm compared to the general population - whilst taking socioeconomic deprivation into account. Causes of death for all the self-harm patients captured within the multicentre study within a 10 year period were analysed. More males died from an alcohol-related death than females. Interestingly, alcohol related death was associated with unemployed or sick/disabled status, alcohol use at the time of the self-harm act and lack of psychosocial assessment following a self-harm act, as well as a referral to drug or alcohol service. Alcohol related premature death in people who self-harm was not associated with socio-economic deprivation (income, education, employment and housing).
   Locally disseminated to: North and South Liaison teams; EM-SRN group.
   Local clinical context and implications: The relationship found here between alcohol related death and unemployment, as well as registered sick/disabled status, is particularly important to note given the recent economic recession and changes in benefit allowances within England. The Both Derbyshire Healthcare's Liaison teams are in a position to identify, assess and signpost on anyone presenting to hospital with a combination of substance misuse and mental health or social care needs.

2. **Ness, J., Bergen,H., Waters, K., Hawton, K., Kapur, N., Cooper, J., Steeg,S., & Clarke, M (2015). Alcohol use and misuse, self-harm and subsequent mortality: an epidemiological and longitudinal study from the multicentre study of self-harm in England. Emergency Medicine Journal. doi 10.1136/emermed-2013-202753**
   Research has consistently shown alcohol use and misuse to be associated with self-harm and suicide but evidence from large-scale long term studies has been lacking. Alcohol misuse within the general UK population has increased in recent years but up until now it was not known whether this was also the case within the self-harm population. This longitudinal study of the MCM study's database between 2000 and 2009 showed alcohol use and misuse in self-harm patients to be more common than has been previously reported and alcohol misuse to have increased significantly in this population between 2000 and 2009, particularly in women. The findings highlight the need for clinicians to investigate alcohol use in self-harm patients and for ready availability of alcohol treatment specialists within hospitals to facilitate prevention of adverse alcohol-related outcomes.

Locally disseminated to: North and South Liaison teams; EM-SRN group; Mortality group.
Local clinical context and implications: This paper highlights the need for integrated multidisciplinary psychiatric teams (like our Liaison teams which are now working to the RAID model), in order for increased patient access to alcohol specialists within general hospitals, the opportunity for dual assessments of substance misuse and mental health/social situations and improved integrated pathways for care beyond the hospital. And indeed, since the implementation of the South Liaison teams, alcohol misuse advice and guidance as well as full psychosocial assessments have increased due to the joint working of substance misuse and mental health specialist practitioners.

3. **Hawton, K., Bergen, H., Cooper, J., Turnbull, P., Waters, K., Ness, J., & Kapur, N. (2015). Suicide following self-harm: Findings from the Multicentre Study of self-harm in England, 2000-2012. Journal of Affective Disorders, (175)147-51. doi: 10.1016/j.jad.2014.12.062**
   An act of self-harm does not necessarily indicate a wish to die. Self-harm is a human behaviour resulting from extreme experiences of distress and despair. For some it may be an impulsive act or a coping mechanism. However, research has shown that people who self-harm are at higher risk of death from all causes, but particularly suicide, compared to the general population.
   In this study from the MCM project, over 40,000 patients who had attended one of the study hospitals with self-harm were followed up for mortality. Of the patients who died within the study period, 19% had suicide recorded as cause of death. However, this is likely to be an underestimate as a large percentage of deaths involving drug overdose were recorded by coroners as accidental.
   Locally disseminated to: North and South Liaison teams; EM-SRN group.
   Local clinical context and implications: The findings of this study indicate that people who have self-harmed are at increased risk of death from external causes (suicide, accidental, open verdicts). This study confirms the importance of taking every act of self-harm seriously regardless of apparent motive or means. The findings re-enforce the South Liaison team's aim to see, assess and develop a care plan with all patients that present to the Royal Derby hospital having/ who are thought to have self-harmed regardless of method or motive. Psychosocial assessments following a self-harm act have repeatedly been shown to have a protective influence, reducing the risk of repeat self-harm and suicide.

4. **Owens, D., Kelley, R., Munyombwe, T., Bergen, H., Hawton, K., Cooper, J., & Kapur, N. (2015). Switching methods of self-harm at repeat episodes: Findings from a multicentre cohort study. Journal of affective disorders, (180), 44-51. doi: 10.1016/j.jad.2015.03.051**

   Frequencies of self-poisoning and self-injury as methods of self-harm differ between hospital and community environments. This has often led to confusion around the concept of self-harm. Categorising a patient simply based upon the method they have used to harm themselves will be clinically misleading and it is thought that many people will switch between types of method.
   This study aimed to determine the frequency, pattern, causes and characteristics of switching methods by those repeatedly presenting to hospital with self-harm. The pattern of repeat self-harm was established for over 33,000 consecutive self-

harm episodes captured as part of the MCM study. Of the 23% of patients who had more than one episode of self-harm (within an average of 30 months), one third switched methods. This was particularly true for young men and people with a history of self-harm behaviour.
Disseminated to: Liaison teams, CAMHS Liaison teams, EM-SRN group.
Local clinical context and implications: This study shows how changeable self-harm behaviours can be. Clinicians must avoid false assumptions about people's risks or needs based solely on the method used in one act of self-harm. Both the North and South liaison teams aim to offer every patient presenting with self-harm a full psychosocial assessment regardless of perceived intent or self-harm history.

5. **Kapur N, Steeg S, Turnbull P, Webb R, Bergen H, Hawton K, Geulayov G, Townsend E, Ness J, Waters K, Cooper J. (2015). Hospital management of suicidal behaviour and subsequent mortality: a prospective cohort study. *The Lancet Psychiatry* (2, 9) 809-816. doi.org/10.1016/S2215-0366(15)00169-8**
Self-poisoning and self-injury are associated with a high risk of suicide or death from any cause but the effect of routine aspects of hospital management on mortality risk is unknown. Using data from the MCM study we assessed the relationship between four aspects of management (psychosocial assessment, medical admission, psychiatric admission, referral for mental health follow-up) and death by suicide or any cause within 12 months of the hospital attendance.
Of 38 415 individuals presenting with self-harm, 261 (0·7%) died by suicide and 832 (2·2%) died from any cause within 12 months. Most aspects of management were associated with a higher mortality risk. Psychiatric admission was associated with the highest risks for both and all-cause mortality. We found that sex, age and history of self-harm all significantly impacted upon the level of risk related to different clinical management. This was an observational study and so we cannot infer causation. However, our finding that clinical services seem to reserve the most intensive levels of treatment for patients at highest risk is reassuring. Aspects of routine management might be associated with a lower mortality risk but these effects vary by clinical subgroup.
Disseminated to: Liaison teams, CAMHS Liaison teams, EM-SRN group.
Local clinical context and implications: This study shows that different clinical management following a self-harm attendance to hospital is related to the risk of death by natural causes or suicide. But that socio-demographic characteristics play a part in this relationship. Clinicians need to consider numerous variables to determine what is best for an individual patient. Both the North and South liaison teams aim to offer every patient presenting with self-harm a full psychosocial assessment and informed care plan.

6. **Turnbull P, Webb R, Kapur N, Clements C, Bergen H, Hawton K, Ness J, Waters K, Townsend E, Cooper J (2015).Variation by ethnic group in premature mortality risk following self-harm: a multicentre cohort study in England. British Journal of Psychiatry, In Press.**
Incidence and risk factors for self-harm vary according to ethnicity. People who self-harm have been shown to have increased risk of premature death, but little is known about mortality following self-harm in ethnic minority groups. We used data from the Multicentre of self-harm in England study linked with a national mortality dataset to investigate premature death in South Asian and Black people in

comparison with White people. After adjusting for age, gender and area-level socioeconomic deprivation, the risk of all-cause mortality was lower in South Asian and Black people versus White people. Suicide risk was significantly lower in Black people than in White people. Prevalence of risk factors for premature death, such as previous self-harm, psychiatric treatment or concurrent alcohol misuse, was lower in South Asian and Black people than in White people.
Will be disseminated to, (following publication): Liaison teams, CAMHS Liaison teams, EM-SRN group.
Local clinical context and implications: This study shows that the risk of death following self-harm is lower in South Asian and Black people than White people in the UK, and they also have lower prevalence of risk factors for premature death. Awareness of both protective and risk factors will help to inform clinical decisions following assessment.

Submitted:

7. **Ness J,** Hawton K, Bergen H, Waters K, Kapur N, Cooper J, Steeg S, Clarke M. **High volume repeaters of self-harm: Characteristics, patterns of emergency department attendance and subsequent deaths based on findings from the Multicentre Study of Self-harm in England**. *Submitted to CRISIS September 2015*

8. **Townsend E,** Ness J, Waters K, Kapur N, Turnbull P, Bergen H, Hawton K. **Self-harm and life problems: findings from the Multicentre Study of Self-harm in England.** *Submitted to Social Psychiatry and Psychiatric Epidemiology September 2015.*

9. **Clements C**, Turnbull P, Hawton K, Geulayov G, Waters K, Ness J, Townsend E, Khundakar, Kapur N. **Quantifying the burden of self-harm presenting to general hospitals: a comparison of data from the Multicentre Study of Self-Harm in England and Hospital Episode Statistics**. *Submitted to the British Medical Journal September 2015*

10. **Hawton K,** Bergen H, Geulayov G, Waters K, Ness J, Cooper J, Kapur N. **Impact of the recent recession on self-harm: longitudinal ecological and patient-level investigation from the Multicentre Study of Self-harm in England.** *Submitted to Journal of Affective Disorders September 2015*

11. **Clarke, M**., Gilbert, P., McEwan, K., Ness, J., & Waters, K **Measuring feelings of arrested escape (entrapment) and arrested anger in people presenting to an Emergency Department following an episode of self-harm.** *Submitted to Psychology and Psychotherapy: Theory, Research and Practice*

12. **Waters, K. Assessing risk of suicide and self-harm**. In P*sychiatric & Mental Health Nursing: the craft of caring.* Third Edition. CRC Press | Taylor & Francis Group.

Conferences hosted

1. 21st January 2015 - East Midlands Self-harm and Suicide Prevention Research Network Meeting, Jubilee Campus, University of Nottingham

2. 30th January 2015 – Suicide Prevention Awareness Conference, Research and Development Centre, Kingsway
3. Planning: 22nd March 2016 - Multicentre Study of Self-harm in England Conference, Nottingham

Conferences presented/facilitated at

4. 8th October 2014 – Suicide Prevention Stakeholder Event
5. 24th October 2014 – Self-harm awareness – Myths, misconceptions and making a difference, the Psychiatric Accreditation annual conference
6. 27th November 2014 – Veteran Stakeholder Event, Chetwynd Barracks, Nottingham
7. 12th December 2014 – RAID Network Event, Birmingham
8. 26th May 2015 - Royal College of Psychiatrists, Suicide Prevention Special Interest Day
9. 15th July 2015 - Quest Event. Staff as second victims of self-harm and suicide . Blackbrook House.
10. 28th September 2015 – Mindtech Conference: Getting Technology into Clinical Practice - Benefits and Barriers to going paperless, Institute of Mental Health
11. 6th October 2015 - EMAHSN Mental Health Innovation Day - Suicide Prevention Workshop, Nottingham

Formal Training Sessions

12. October 2014 - Suicide Awareness Training to Social Care colleagues in North Derbyshire
13. October 2014 - Suicide Prevention Training to Police call handlers
14. December 2014 – Suicide Prevention Training to the Crown Prosecution Services (Leicester and Nottingham)
15. February 2015 - Suicide Prevention Training to East Midlands Occupational Health Staff
16. March 2015 – Suicide Awareness and Triage Training to the South CRISIS team
17. May 2015 - Suicide Prevention Training to an East Midlands Occupational Health Management Company
18. June 2015 – CRISIS training
19. June 2015 – Royal Derby Hospital MAU and ED Suicide Prevention Training
20. September 2015 Primary Care SH training under EMAHSN role

Ongoing (multiple sessions delivered throughout the year):

21. Connecting With People training – so far delivered the full modules to over 80 Derbyshire Healthcare Trust colleagues.
22. STORM training – delivered multiple sessions to NHS Trusts in Coventry and Oxleas

23. Self-harm and Suicide Prevention Research Involvement presentations as Derbyshire Healthcare's Junior Dr training sessions
24. Suicide Awareness and Responses Training for Derby Teaching Hospitals Foundation Trust (Royal Derby Hospital colleagues)
25. Suicide Awareness and Prevention training (SAPT) throughout the East Midlands

Regular attendance/presence

Strategy Groups

1. Derbyshire Strategy group
2. Derbyshire Healthcare Trust Strategy group
3. Leicestershire Suicide Prevention Strategy group
4. Lincolnshire Suicide Prevention Strategy group
5. Nottinghamshire Suicide Prevention Strategy group – met with leads and planned ongoing attendance for next year (commencing in July).
6. Developing connections with Northamptonshire's Suicide Prevention Strategy group – exploring the possibility of developing and delivering Suicide Awareness training to GPs
7. East Midlands Academic Health Science Network Strategy Meetings

Other Groups

8. National Suicide Prevention Alliance (NSPA)
9. Liaison Psychiatry Nurses Network, Royal College of Nursing
10. Psychiatric Liaison Accreditation Network (PLAN)
11. Annual Lancet Psychiatry Symposium
12. Annual British Isles workshop, Centre for Suicide Prevention, University of Oxford.
13. Annual Suicide Bereavement Conference, Centre for Mental Health and Safety, University of Manchester.

Other Significant Meetings 2014/15

14. September 2014 – participated in CQC visits
15. January 2015 - Meeting with Geraldine Strathdee to discuss national suicide prevention training and approaches
16. January 2015 – Meeting at House of Commons regarding suicide prevention and mental health awareness
17. July 2015 – Self-harm media briefing
18. August 2015 – Personality Disorders pathway project
19. September 2015 – World Suicide Prevention Day, Chesterfield Market Place

Serious untoward incidences/investigations

1. Led on two SUIs within Derbyshire Healthcare Trust in 2014/15
2. Keith Waters was appointed the external independent investigator for a SUI within Derby Teaching Hospitals NHS Foundation Trust.

Summary of how we are contributing to knowledge and practice at the local and national level *[this list is for illustrative purposes and is not exhaustive]*

Local

1. Training in research, self-harm management and suicide prevention for Derbyshire Healthcare, Derby Hospitals, Derbyshire GPs, etc.,
2. Close working with the Trust's two Liaison teams – Supporting critical thinking, service evaluation, development and innovation, proactively established research portfolio, information and knowledge sharing, implementation of research into practice
3. Conducting own and collaborating in research studies - putting the Trust on the map as a recognised and valued leader in the field of self-harm and suicide prevention research.
4. Supporting Trust staff to undertake service evaluations, research projects and implement latest evidence into practice.
5. Supporting staff to engage and collaborate in research and policy development nationally.
6. Setting up a Trust staff support network around self-harm and suicide prevention work.
7. Working to support the Trust's transformation project to ensure suicide prevention and learning from losses is embedded within the new neighbourhood model.
8. Play an active role in the Derbyshire Suicide Prevention Strategy group.

Regional

1. Play an active role in county strategy groups
2. Encourage and facilitate implementation of research, information and knowledge sharing and a decrease in duplication of work.
   a. Work closely with partners e.g. CLAHRC, Harmless, Institute of Mental Health, EM Academic Health Science Network, University of Nottingham.
   b. Established the East Midlands Self-harm and Suicide Prevention Research Network (EM-SRN) with a virtual discussion forum. – Co-ordinated by us and open to all professionals.
   c. Host conferences and help to facilitate or speak at other's events throughout the region.

National

1. Provide training to organisations, professional groups
2. Speak at conferences and facilitate workshops
3. One of three partners conducting the Multicentre study of self-harm in England (funded by DoH and recognised as the number one indicator of self-harm rates in England). This study generates an enormous amount of clinically essential knowledge and guidance. National strategies, polices and clinical guidance are based on evidence produced by our study e.g. National suicide prevention strategy, NICE guidelines for Self-harm.
4. We are an active member of the National Suicide Prevention Alliance (NSPA). We are an elected member of their steering group and actively support the alliance in their work.

International

1. International Alliance for Suicide Prevention e.g. promote and support activities in relation to World Suicide Prevention Day.
2. Host Conferences which are attended by international delegates.
3. Our research and clinically relevant expertise is recognised all over the World. For example in August 2014, Hon member of the Australian Parliament and Suicide Prevention Lead for Australia, John Dawkins, requested to spend a day with us to learn more about the work we do and how he can implement similar work in Australia.

Resources to find out more [Up to date as of 12.10.2015]

1. Centre for Self-harm & Suicide Prevention Research
   http://www.derbyshirehealthcareft.nhs.uk/get-involved/research-and-development-home/sh-and-sp/

2. Multicentre Study of Self-harm in England
   http://cebmh.warne.ox.ac.uk/csr/mcm/

3. East Midlands Self-harm & Suicide Prevention Research Network (EM-SRN)
   http://www.derbyshirehealthcareft.nhs.uk/get-involved/research-and-development-home/sh-and-sp/emsrn/

4. National Suicide Prevention Strategy
   https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england

5. National Suicide Prevention Alliance
   http://www.nspa.org.uk/home/about-us/

6. National Confidential Inquiry
   http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/

7. NICE Guidelines for the Short term Management of Self-harm
   https://www.nice.org.uk/guidance/cg16

8. NICE Guidelines for the Long term Management of Self-harm
   https://www.nice.org.uk/guidance/cg133

9. Help is at Hand – Support for those bereaved by suicide
   https://www.gov.uk/government/news/you-are-not-alone-help-is-at-hand-for-anyone-bereaved-by-suicide

Derbyshire Voice – Representative Structures

Derbyshire Voice works with a group of trained, past or present receivers of mental health services to *'represent'* the views of other mental health service receivers (SR's) at mental health strategic meetings. We call them Reps.

Each Rep is regularly supervised, monitored and supported to ensure that they are canvassing the views of other SR's and are expected to be in touch, through a variety of methods, with a network wider than themselves. A constituency, so to speak.

Each month, every Rep must submit written 'outreach'. These are the views, opinions and experiences of other SR's that they have been in contact with.

The office collates all of these mainly unsolicited views into themes about services and produces a 'Top Priorities' list from the SR's perspective for the month, thus providing up to date information. This is sent to each Rep.

Each Rep provides written feedback, from the SR's perspective on each and every meeting they attend. This written feedback is collated at the office on a monthly basis and sent to all Reps so that they each have an overview of what their peers are involved in with the meetings they attend. This stops the reps from being in 'silos' of specific service areas but also allows for experts in certain areas of services.

So the Reps have all the information about the work of their peers. They have all the themes of priority issues etc from the larger network. The office also produces a list of monthly action for them to take to their next round of meetings, based upon the 2 documents mentioned above. This 'closes the circle' and offers assurance that the voices of our networks are heard, through the Reps at the strategic meetings.

And then the cycle starts again…

In addition, Derbyshire Voice has a fairly active Twitter page, a consistent and regular following on our Facebook page and a vibrant 'seasonal' Mad Pride social media presence. We use these on occasion to 'solicit' views/opinions and experiences from people who have used particular services or have specific treatments/diagnosis. These are often at the request of service providers and commissioners who want to use these networks to gather some particular information.

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 29 October 2015

POSITION STATEMENT ON QUALITY

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

Executive Summary

1. SAFE SERVICES

1.1 Safe staffing and efficiency

On 13th October 2015 NHS England wrote to all Trusts to provide an update on safe staffing and efficiency. The letter recognised the hard work being done by Trusts to get the balance right between keeping services safe and the best use of resources. The letter reminded all trusts that the safe staffing guidance is there as a benchmark but should not replace the judgements of professionals working at the front line. NHS England confirmed their continuing support to trusts to secure both safe staffing and greater efficiency.

Further work will include work on the Model Hospital led by Lord Carter; this is aiming to introduce a more sophisticated approach to measurement of nursing time and its connections with outcomes, costs and other critical measures. Further guidance will also be produced.

From 19 October the cap on the use of nursing agency staff will be mandatory. A four week consultation on proposals to cap the rates for agency staff and to encourage workers back into substantive and bank roles has commenced. The proposals include the following principles:

- An overall rationale to bring agency pay in line with substantive pay by April 2016.
- Price caps would apply to all doctors, nurses and all other staff in NHS trusts and foundation trusts.
- Rules will apply to all NHS trusts, NHS FTs in breach of their licence for financial reasons and those in receipt of interim support from DH - although all others will be strongly encouraged to comply.
- There will be a phased approach to implementation with break clauses in place for local managers and clinical leaders to override the rules under exceptional circumstances in the interests of patient safety.
- Ceilings and frameworks for agency nursing still apply. There are plans for agency expenditure ceilings to be extended across all staff groups from 2016/17.

The consultation closes on 13 November 2015.

Our Assistant director of Clinical professional practice is just completing the ward based skill mix review, using a new trust designed narrative judgements of professionals model of skill mix review and decision making completed in 1:1 sessions with each senior nurse from each unit. This analysis considers incidents, patterns,, themes, the view of the senior team, stability in team and a site visit rather than a HURST model skill mix review which is primarily a number and and a spreadsheet analysis without review of the wider environmental of patient presentation factors.

1.2 **State of Care report**

On 15 October 2015 the State of Care report was published by the Care Quality Commission. This was the first one that included drawing from the findings from the new inspection model. As well as the full report the association of foundation trusts and trust issued an 'on the day briefing'.

Main findings include:

- Areas where more work is needed to improve processes include ligature points and gender segregation on wards.
- Safety is still a priority for the majority of trusts with staffing shortages, training and development for staff as a key issue.
- Emergency departments require more support and training in order to care for people with mental health problems in a crisis.
- Commissioners to ensure there is adequate provision of mental health beds and children's mental health services.
- Board assurance and governance processes must be more connected to the front line and must take into account the impact of pressure on the service delivery.
- To recognise the importance of values based leadership.

Some important statistics set out in the report are highlighted.

- 94% - more than 9 out of 10 of the services the Care Quality Commission have rated as good or outstanding overall have been rated good or outstanding for leadership.
- The Care Quality Commission took more enforcement actions in 2014/15 in relation to the inspections they carried out: in 7% of inspections compared with 4% in 2013/14.
- Safety is highlighted as the biggest concern across all of the services the Care Quality Commission rated. Over one in 10 hospitals (13%) and a similar proportion of adult social care services (10%) were rated as inadequate for safety.
- 50% - half of re-inspections have resulted in improvements in ratings.

Our response

- We will be looking again at our safety domain learning from other organisations.
- We have an assurance process for reviewing ligatures through the Statutory standards group and we continue to scope for new products, and continue with ligature minimisation based upon risk assessments and National learning from the Mental health and Learning Disability communications on other Trusts hazards
- We will continue our work on safer staffing as reported last month, completing our skill mix review for November 2015.
- We will include the recommendations in our discussions with our commissioners through the Quality Assurance Group to take into consideration for our work in 2016/17.
- The Quality Committee met on 15 October 2015 and was briefed on our proposals for ensuring gender sensitive service, mitigation and monitoring plans
- Our services based at the Hartington unit and Derby Royal will continue to provide training to staff in the acute hospital emergency departments as part of our commissioning for quality and innovation national agreement.

1.3 **Derbyshire Suicide Prevention Partnership Forum**

The Derbyshire suicide prevention partnership forum is hosting a conference on Thursday 22nd October 2015 9.30am – 1.30pm at the Post Mill Centre, South Normanton, Derbyshire.

Our response

We are contributing to the event with presentations by lead professionals from the Trust. Discussions will take place on:

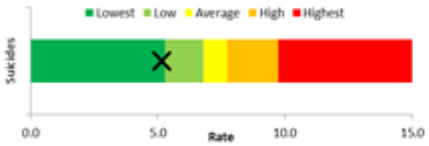
- High Risk Groups
- Bereavement following suicide
- Suicide awareness training
- Crisis intervention
- Community and voluntary contribution

As an organisation we are mindful that although our last Trust benchmarking report (2014) showed that

Published after our Annual report

Suicide

Suicides among middle-aged men with mental health issues have soared by 73% since 2006, which may be attributed to a combination of alcohol, job loss and debt, according to an authoritative new report. Published August 2015



Suicide rate

The suicide rate in your Trust was 5.1 (per 10,000 mental health contacts*) between 2011-13 and in the lowest quintile compared to other mental health providers in England.

This **is a factor for our communities** that we have tackle as a public health and access issue.

Better together

We stated at our Annual general meeting that we would continue to support our community as a public health issue and highlight the needs and issues and we continue to do this through the Derbyshire Suicide Prevention Partnership Forum

1.4. 2015/16 Emergency response and public protection (ERPP) Assurance Process for Derbyshire Healthcare NHS Foundation Trust

The self- assessment was undertaken on the 10 September 2015, Hardwick Clinical Commissioning Group have confirmed that the panel evaluated your organisations Level of Compliance as **SUBSTANTIAL** using the following levels.

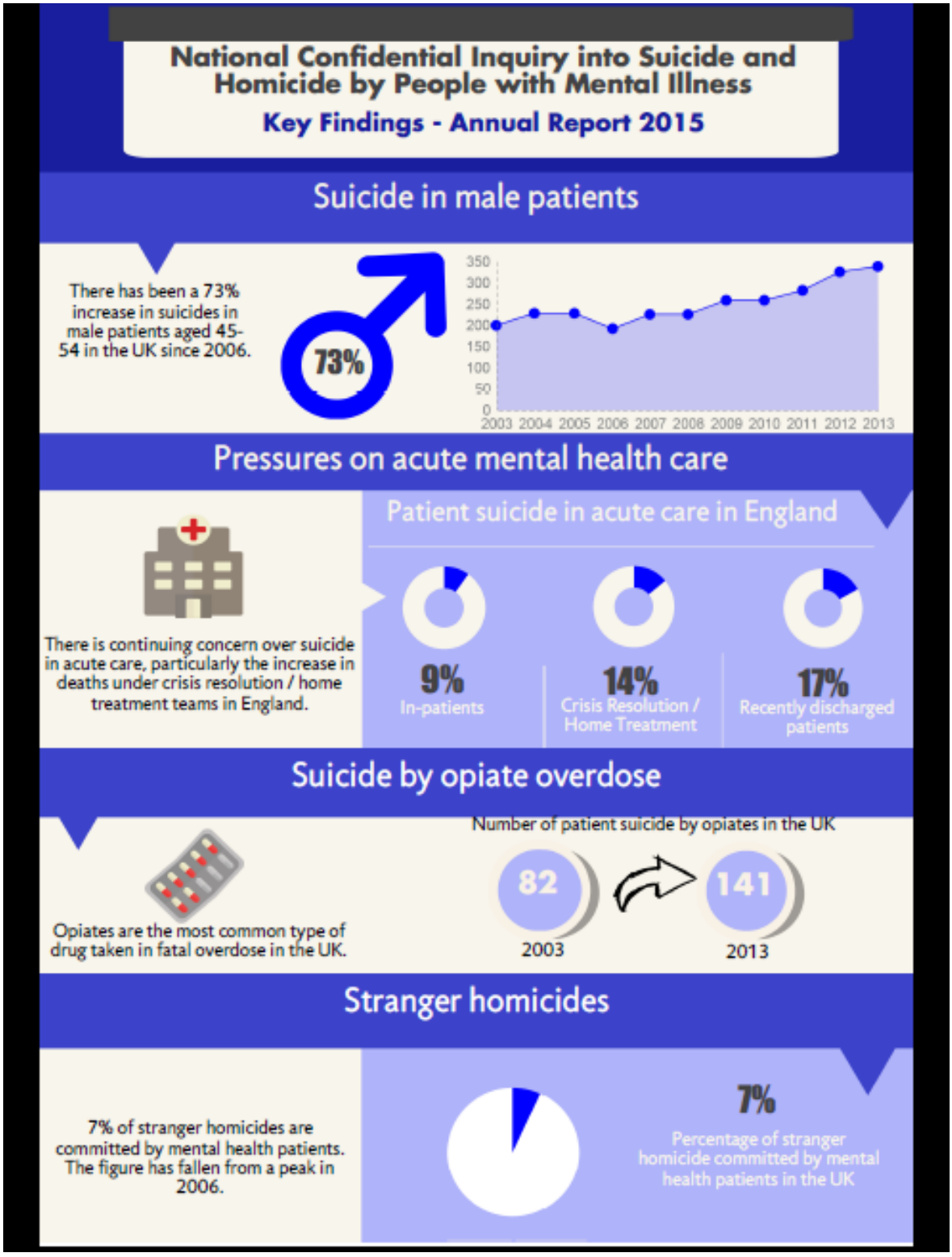
Compliance Level	Evaluation and Testing Conclusion
Full	The plans and work programme in place appropriately address all the core standards that the organisation is expected to achieve.
Substantial	The plans and work programme in place do not appropriately address one or more the core standard that the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

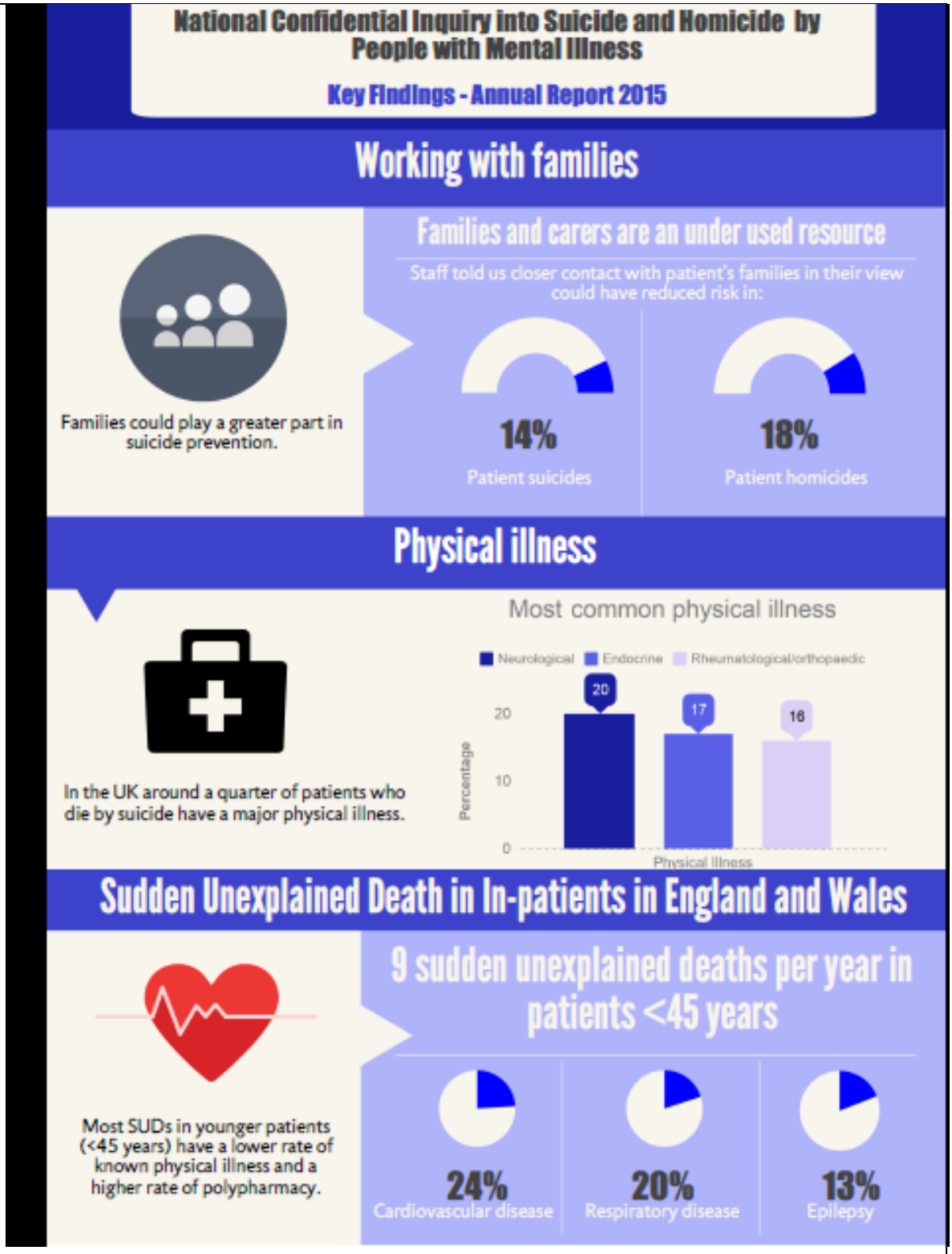
The panel stated that **"**the trust has a number of effective mechanisms in place for EPRR and an accurate self-awareness of areas requiring further attention, which included a Lockdown Plan and further Training and Exercising".

Our response

We have work plan to address those areas where further attention is required. A further meeting is planned for February 2016 to update commissioners of progress. The Health and Safety Committee continue to monitor progress.

1.5 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness





Our response to this report

The physical healthcare committee and the drugs and therapeutics committee have been asked consider the report, what does it mean and make any recommendations that we need to consider in the Quality Committee and in future work plans.
Our Trust statistics are outlined below and we have asked the physical health

committee and our Nurse consultant to analyse some of the factors associated in this area, to help us understand how we can improve life outcomes. We are mindful of two factors the Derby city and Derbyshire life expectancy. Health in summary- Health profile Derby city published in 2015

The health of people in Derby is generally worse than the England average. Deprivation is higher than average and about 23.8% (12,100) children live in Poverty. Life expectancy for both men and women is lower than the England average.

Adult health
In 2012, 24.3% of adults are classified as obese. The rate of alcohol related harm hospital stays was 801*, worse than the average for England. This represents 1,856 stays per year.

The rate of smoking related deaths was 303*. This represents 374 deaths per year. Estimated levels of adult smoking are worse than the England average.

Other key risk related issues that may impact upon our community that as an organisation we need to factor into our healthcare work, is the Derby city community being below England average with above average levels of Deprivation for Adults and families, worse levels of Children and families in poverty, higher levels of Statutory homelessness and above England levels of violent crime (violence offences).

In Derbyshire

Health in summary
The health of people in Derbyshire is varied compared with the England average. Deprivation is lower than average, however about 16.3% (21,900) children and their families live in poverty. Life expectancy for both men and women is similar to the England average. Life expectancy is 7.9 years lower for men and 5.8 years lower for women in the most deprived areas of Derbyshire than in the least deprived areas.

In 2012, 24.7% of adults are classified as obese, worse than the average for England. The rate of alcohol related harm hospital stays was 718*, worse than the average for England.

The rate of smoking related deaths was 283*. This represents 1,301 deaths per year.

Rates of statutory homelessness, violent crime, long term unemployment and drug misuse are better than average.

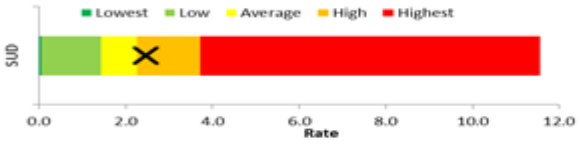
All of these factors should be taken into account in our strategic planning and monitoring of health and well-being issues in our organisation.

Our death rates, non suicide

We have a quality priority to **monitor physical health care monitoring** and spot comorbidities and prevent unexplained death

Sudden unexplained deaths (SUD)

The SUD rate* between 2011-13 was 2.5 (per 10,000 hospital admissions) in the high quintile group compared to other mental health providers in England.



Better together

Our response

We have work plan to address those areas where further attention is required to continually consider the physical healthcare needs of those in our care.

This will include analysis and scrutiny of these issues at the quality committee, a review of the work plan of the physical healthcare committee, the physical healthcare CQUIN and the developmental work of the Drugs and therapeutics meetings to analyse our prescribing patterns against best practice

2. EFFECTIVE SERVICES

2.1 Quality Surveillance Group

The quality surveillance group met on 12 August 2015, following the meeting it was confirmed that our Surveillance Rating was **Routine**. This is the most positive rating which means 'No specific concerns but watching eye on any dips in performance'.

Definitions

Green Routine Surveillance – No specific concerns but watching eye on any dips in performance
Amber Enhanced Surveillance – Concerns need to be reviewed at every meeting due to existence of recover action plans/increased visits/contractual measures.
Red Risk Summit Required – Significant concerns beyond the need for enhance surveillance, which reinstate further action in form of a risk summit.

Our response

We welcome this rating as assurance of the high quality of care we provide.

3. RESPONSIVE SERVICES

3.1 Physical Healthcare

On 14 October 2015 the BBC highlighted the importance of physical health checks for people with poor mental health. The report considered the finding from Nuffield Trust and Health Foundation think tanks which stated most admissions were for physical ailments. We also noted the links between social deprivation and failing health with individuals with mental health conditions, which need to be considered by the physical healthcare committee.

Our response

We have a commissioning for quality and innovation agreement with commissioners which is specifically looking at admissions to emergency departments. We continue to work with our physical healthcare committee to consider, the analysis of these findings and what our Trust can do to support service receivers to access service and at the earliest opportunity aswell as maintain well being.

Strategic considerations

- We will consider the findings from local and national reports in our planning for 2016/17.

(Board) Assurances

- Assurance on the overall high quality of care we provide through our positive assessment from the quality surveillance group.
- Partial assurance from our assessment on emergency planning and public protection assessment.
- Assurance on our safer staffing, taking into consideration the key messages and our plans for future work.
- Assurance that we are a learning organisation, noting our responses to national and local reports, findings to influence our current strategy development and work plans.

.

Consultation

This report has not been previously shared.

Governance or Legal issues

The Quality position statement supports our evidence of compliance with the Care Quality Commission regulations, Monitor's quality framework and the fundamental standards of quality and safety published by the Care Quality Commission.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

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. Note the quality position statement.

Report prepared by:

Clare Grainger
Head of Quality and Performance on behalf of:
Carolyn Green
Executive Director of Nursing and Patient Experience

Public Session
Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 28 October 2015

Health and Safety Annual Report 2014/15

Purpose of Report: This report provides the Board of Directors with an Annual Health and Safety Report. The report outlines the activities and achievements in Fire,Health and Safety, Moving and Handling and Security Management for April 2014 to March 2015.

Executive Summary

- The Trust is working towards maintaining compliance with the Regulatory Reform (Fire Safety) Order 2005, The Manual Handling Operations Regulations 1992, and the Health and Safety at Work etc. Act 1974. The compliance is declared following the Health and Safety Audit process and Fire Risk Assessment process. Work continues to embed policies and procedures. A number of health and safety policies and procedures have undergone revision within the last 12 months all are up to date.

- Fire Training currently stands at 85.57% as of 31st March 2015. The Health and Safety Team continue to look at ways to maintain and improve the attendance at fire training. The Health and Safety Team have targeted those who have not obtained compliance in 2 years continually.(80.5% 2013/14)

- Moving and Handling Level 2 (assisting people to move community and in-patient) stands at 83.3% as of 31st March 2015.(78.5% 2013/14)

- Throughout 2014/15 the Health and Safety Team have monitored trends through incident data and made recommendations where appropriate, continued to work closely with divisional leads to ensure preventative measures were implemented.

- The Health and Safety Audits through 2014/15 has noted improvement across many areas. The Health and Safety Team will continue through 2015/16 to assess the evidence, quality and suitability of documented risk assessments through the Health and Safety Audit process and advice on areas of improvement.

- NHS Protect Security Management standards compliance self-review was completed and submitted to NHS Protect during November 2014. A follow up audit was carried out by NHS Protects Quality Team during August 2015. Overall the compliance was ‘Excellent’

- The Health and Safety Committee together with its sub-committees the Trust Police Liaison Group and Derbyshire Healthcare (fire) Liaison Group, Statutory Standards Group, have overseen a programme of work to ensure that evidence is available to demonstrate the Trust is working towards compliance with The Health and Safety at Work etc. Act 1974, The Regulatory Reform (fire safety) Order 2005, Manual Handling Operations Regulations 1992, NHS Protect Security Management Standards and all other health and safety related statute. Evidence is available for all key requirements, within the scope of the Trusts service provision. Key elements, such as incident reports, are reported on a more frequent basis.

Strategic considerations

- Strategic Outcome 1 – People receive the best quality care
- Strategic Outcome 2 – People receive care that is joined up and easy to access

(Board) Assurances

- Assurance that the Trust is working its way towards full compliance with the Health and Social Care Act 2010 and relevant Care Quality Commission Standards
- Assurance that the Trust continues to be compliant with the Regulatory Reform (Fire) Safety Order 2005
- Assurances that the Trust continues to be compliant with all relevant Health and Safety Statutes.

- **Consultation**
- The information in this report has been monitored through Quarterly Trust Health, Safety and Security Committee, Bi-monthly Specialist Fire Safety meetings, Bi-monthly Police Liaison Meetings, monthly Ligature Meetings, arranged for the purpose of focused pieces of work, together with the Trust Statutory Standards Group (terms of reference attached for information).
- A previous report Health and Safety half yearly update was received by the Health, Safety and Security Committee and Quality Committee in November 2014.
- Technical advice having been sought from Estates Department, Derbyshire Constabulary, Derbyshire Fire and Rescue services, other specialist providers and the Trust Moving and Handling Manager in relation to these issues.

Governance or Legal Issues

There are legal issues under the Regulatory Reform (Fire) Safety Order 2005, the Health and Safety at Work etc. Act 1974 and the health and Social Care Act 2010 contained within this Report.

Care Quality Commission Regulations this report provides assurance to:

- Outcome 4 (Regulation 9) Care and Welfare of people who use services
- Outcome 10 (Regulation 15) Safety and suitability of premises
- Outcome 11 (Regulation 16) Safety, availability and suitability of equipment
- Outcome 12 Regulation 210) Requirements relating to workers
- Outcome 14 (Regulation 23) Supporting staff
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
- Compliance with the Health and Safety at Work etc. Act 1974 (HSWA)
- Compliance with the Regulatory Reform (Fire Safety) Order 2005
- Compliance with the Manual Handling Operations Regulations 1992
- Compliance with First Aid at work Regulations 1981
- Compliance with Management of Health and Safety at Work Regulations 1999
- Compliance with Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

Equality Delivery System

There is a positive impact on Regards Group as elements of this report relate to the specialist safety arrangements for those patients termed ‘Bariatric’.

Recommendations

The Board of Directors is requested to approve the content of this report.

Report presented by:	**Carolyn Green Executive Director of Nursing and Patient Experience**
Report prepared by:	**Carrina Gaunt Health and Safety Manager**

Health and Safety
Annual Report 2014/15

1. Introduction

This report details the Annual position 2014/15 for Fire,Health and Safety, Moving and Handling and Security Management .

2. Compliance with Regulatory Reform (fire safety) Order 2005, declaration. (RRO)

The **Fire Risk Assessment** programme ensures that all premises from which the Trust operates have been assessed in relation to the fire safety standards set out in both the RRO 2005 and HTM 05:01, which reduces the likelihood of a fire occurring, together with lessening the impact should a fire occur. The Trust achieves a very high standard of compliance.

The Fire Risk Assessment programme is complete and all identified improvements included in actions plans to ensure full compliance.
Summary of Planned Preventative Maintenance

Servicing of First Aid Fire Fighting Equipment
Testing and maintenance of Fire Alarm Systems in accordance with BS5839
Testing and maintenance of Emergency Lighting Systems in accordance with BS5266
Testing and maintenance to Fire Dampers
Mains electrical test (5 yearly)
Portable Appliance Testing
Gas Appliances testing

Summary of Significant Actions

New Fire Alarm System at Resource Centre
Placement of Fire Blankets at Bayheath House
Repair of damaged Smoke Seals
General House Keeping

2.1 Compliance with Manual Handling Operations Regulation (1992), declaration (MHR)

The Trust continues to work towards compliance with the MHR 1992, with appropriate systems in place to manage key risks and assurances. Maintenance of standards is paramount in ensuring we are able to demonstrate compliance and therefore assure our patients that we can provide a safe environment and service.

2.2 NHS Protect Security Management Standards

NHS Protect Security Management standards compliance self-review tool has been completed and submitted to NHS Protect during Nov 2014. Overall the self-reviewed compliance level is high, with the action below ongoing.

- Embedding of business continuity risk assessments within the Trust risk assessment procedure.

  NHS Protect Quality Assurance Team conducted a focused assessment on the Trust's Self-review tool, during August 2014. The outcome of which, was 'excellent' with the assessors declaring full compliance, evidence against each standard was submitted prior to the visit and tested by way of NHS Protect Staff selection interviews of the day, evidence of best practice was demonstrated to full effect.

2.3 **Health and Safety at Work etc. Act 1974 (HSWA)**

The **Health and Safety Compliance Audit** programme gives assurance (compliance with HSG65 – Health and Safety Management Model), that risk assessments are available, suitable and sufficient, and that they are implemented by all, to the effect of reducing risk to its lowest possible level, ensuring that premises from which we operate and tasks that are undertaken, are done so, in the safest possible manner, to reduce the likelihood and impact of incidents/accidents, improve the health and safety culture, reputation, staff retention and lessen the likelihood of litigation.

All in-patient areas continue to be audited on an annual basis; patient access areas every 2 years; and staff only areas are audited on a 3 yearly basis. However audits may be undertaken at an increased frequency owing to significant change, or following a major incident. Challenges are arising from the consolidation of premises occupied by DHCFT staff, usually arising from the Estates Strategy, and the continuing introduction of hot-desking/desk sharing. A number of audits also indicate that there is a lack of storage space. These are issues that are being managed at a local level and will continue to be monitored by the Health and Safety Team.

Risk assessments have continued to be added onto the Datix risk management system. Compliance levels are generally high, and risk assessments are of a good standard, with low and medium level improvements being identified through the audit process.

High Improvement summary: 3 in-patient areas had Ligature Risk Assessments available, they were not in accordance with the Ligature Policy updated in 2014, now resolved.

Medium Improvement summary: Examples of these actions are: Routine fire drill to be arranged (there should be at least 1 per year); requiring risk assessments to be reviewed or updated when teams have moved office base; priority areas requiring risk assessments that may otherwise appear to be managed and controlled;

In some premises or teams it has been found that risk assessments may need updating or reviewing in light of new policies, or where teams occupy multiple sites, they have been omitted from the risk assessment entered on Datix, but we are working with the teams to ensure that risk assessments are suitable and sufficient.

Low Improvement summary: any of these actions have related to risk assessment, but may be in relation to documenting existing good practice. Low

priority aspects of a premises or team's operation, e.g. therapeutic activities; for any risk assessment, if a listed control is the completion of a checklist, this should be done. DSE assessment in relation to laptop usage and possible need for accessories, support has been given to Risk Assessors to ensure that these low level actions are implemented.

3. Significant Risks Identified

There are no significant risks identified in this report.

4. Assurance Position

4.1 The Trust Board receives Health and Safety reports on a half yearly basis, detailing progress and compliance against key standards, as well as any significant risks. This Annual report will detail the activity for April 2014 to March 2015.

4.2 The Trust Health and Safety Committee met on a Quarterly basis. The Committee is chaired by the Head of Patient Safety and reports to the Quality Committee. The Committee monitors health and safety against legislative requirements and programme of work to ensure that key actions are undertaken and evidence is monitored to demonstrate compliance.

In addition to receiving updates and monitoring work plans from it's sub-groups the Health, Safety and Security Committee has ensured, through thorough review and approval in consultation with staff side, all Health, Safety and Security Policies, and has monitored compliance with all health, safety, fire and security related standards. Monitored Health and Safety related incidents and followed up action (where SIRI was not applicable)

Received updates and approved further action in relation to focused Health and Safety Reports (ligature/Bariatric).

Received data in relation to Legionella Risk Assessments and Sampling, issues identified during summer, as Medical Annex becomes little used outlets, owing to the absence of students, Issue to be monitored.

Approved and overseen a programme of work in relation to workplace stress, via the 'healthy workforce sub-group'.

4.3 The Trust Police liaison meeting meets on a bi-monthly basis. The meeting is chaired by the Trust Health and Safety Manager and reports to the Trust Health and Safety Committee. The meeting gives opportunity for direct liaison with Derbyshire Constabulary and ensures operational continuity and effective sharing of information.

The Group has moved the Trust towards the adoption of the Derbyshire Constabulary Missing Persons Policy from a previous Trust Policy, lessening the likelihood for miscommunication. Established effective working relationships and information/intelligence sharing. Ensured effective and rapid resolution to crime.

4.4 The Derbyshire Healthcare (Fire) Liaison Group meets bimonthly. The Group is chaired by the Trust Health and Safety Manager and reports to the Trust Health and

Safety Committee. The meeting monitors fire safety against legislative requirements and programme of work to ensure key actions are undertaken and monitors evidence to demonstrate compliance, the group offers a range of Healthcare Fire Officers expertise and effective communication across all Healthcare organisations in Derbyshire, Derbyshire Fire and Rescue Service are in attendance and this forum allows for effective multi-agency communication.

This Group has provided a joint approach across Derbyshire health community in response to strike action taken by the Fire Brigades Union.

4.5 Trust Director with responsibility for health and safety and Chair of the Trust Health and Safety Committee is held by the Head of Patient Safety with the Director of Nursing and Quality and Patient Experience acting as Board Advisor.

4.6 The Trust currently employs 1 WTE Health and Safety Manager, who is supported by 1 WTE Health and Safety Advisor.

5. Key Performance

Brief statistical summary for the period reported on:

Health and Safety Audit 2014/15

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Target	4	4	4	4	4	4	5	4	4	5	5	5	52
Complete	4	10	3	8	5	3	2	4	2	5	10	14	70

Fire Risk Assessment 2014/15

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Target	2	-	2	3	3	3	4	3	3	3	3	3	32
Complete	2		2	3	3	3	4	3	3	3	3	3	32

Health and Safety Training

Competence Name	Meets Requirement %
C Fire Safety (All Staff)	85.57%
C Health and Safety Awareness (3 Yearly - All Staff)|	70.82%

	Q1	Q2	Q3	Q4	Total
RIDDOR notifications					
Fatalities	0	0	0	0	**0**
Specified Injuries (major)	0	0	0	2	**2**
Over 7 day absence	4	2	1	1	**8**
Member of public taken to hospital	0	0	0	0	**0**
Notifiable Disease	0	0	0	0	**0**
Total	**4**	**2**	**1**	**3**	**10**

5.1. **RIDDOR** Data –

Of these 10 accidents reported to the Health and Safety Executive 6 were as a result of restraining a service user, or other assault by a patient towards a member of staff, including 1 of the specified injuries, resulting in a broken bone.

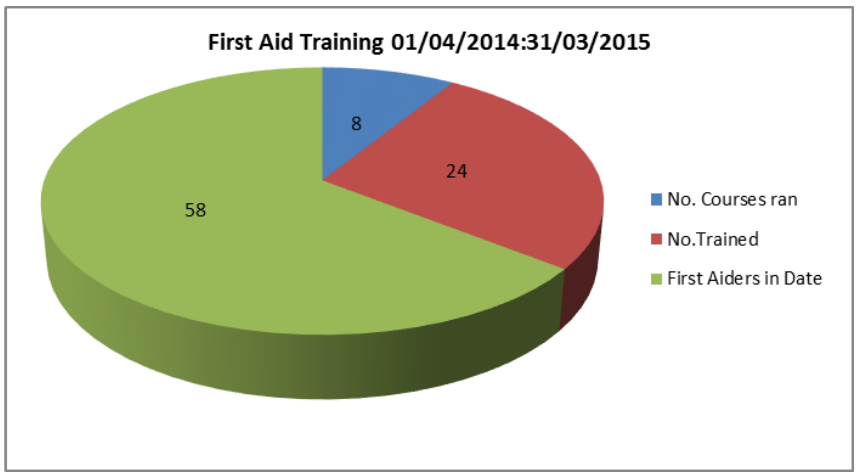
Since the introduction of the change from over 3 day reporting to over 7 day reporting, we have seen an overall reduction in the number of accidents reported. The total reported this year is comparable with the same number last year.

Specified Injuries:

1. Staff member was elbowed in the ribs when carry out a restraint movement with a patient.
2. Staff member slipped on ice on the pavement when visiting a patient at home.

Over 7 day injuries:

1. Staff member cut his finger quite deeply when he trapped his hand in a door.
2. Staff member strained her back whilst escorting a patient to A&E.
3. Staff member injured his knee when put to the floor by a patient.
4. Staff member was punched in the face by a patient. This was unprovoked.
5. Staff member was hit hard around the head by a patient.
6. Staff member was punched in the face by a patient.
7. Staff member walking on corridor slipped and fell in a puddle of water 13.30 (cause of puddle unknown). Area immediately made safe.
8. The staff member was attending a group therapy session and sat on a low chair (the only available chair). They had not anticipated that the springs under the seating were soft so jolted back causing a sharp pain in lumbar spine. Pre-existing condition lead to injury (12 years ago).



5.2 There are 58 First Aiders trained within the Trust, each First Aider must renew their licence within 3 years and 28 days to remain in date, courses are planned in accordance with expected renewal.

5.3 **Performance Narrative**

5.4 Work continues on providing evidence of key standards being met in accordance with the Health and Safety at Work etc Act 1974, the Manual Handling Operations Regulations 1992, the Regulatory Reform (Fire Safety) Order 2005, NHS Protect Security Management Standards.

5.5 Compliance with fire training for the defined target group stands at 85.57% as of 30th March 2015. This is a rolling 12 month figure and represents the staff currently in date.

5.6 Compliance with level 1 moving and handling training for the defined target group stands at 76.83% as of 30th March 2015. This is a rolling 36 month figure and represents the staff currently in date.

5.7 Compliance with moving and handling level 2 (assisting people to move community and In-patient) for the defined target group stands at 83.30% as of the 30th March 2015.

5.8 Compliance with health and safety awareness training for the defined period stands at 70.82% as of 30th March 2015.

5.9 The **Fire Risk Assessment** programme ensures that all premises from which the Trust operates have been assessed in relation to the fire safety standards set out in both the RRO 2005 and HTM 05:01, which reduces the likelihood of a fire occurring, together with lessening the impact should a fire occur.

Completed		**Not completed**	**Comments**	**Deadline for completion of actions**
Fire Risk Assessment undertaken	32	0		
Annual (HTM)	17	0		
Bi-Annual (RRO)	15	0		
Action Plans	32	0		
Significant actions identified	33	0	All actions complete or are included in a capital programme for 2015/16	31st March 2015
Non urgent actions identified	17	0	All actions complete or are included in a capital programme for 2015/16	31st March 2015

5.10 The **Health and Safety Compliance Audit** programme gives assurance (compliance with HSG65 – Health and Safety Management Model), that risk assessments are available, suitable and sufficient, and that they are implemented by all, to the effect of reducing risk to its lowest possible level, ensuring that premises from which we operate and tasks that are undertaken, are done so, in the safest possible manner, to reduce the likelihood and impact of incidents/accidents, improve the health and safety culture, reputation, staff retention and lessen the

likelihood of litigation, all target areas have been audited this year, with demonstrable evidence found in areas of compliance to all health and safety related risks, most actions that have arisen have been formed from enhancing the quality of the documentation available.

5.11 The **Health and Safety Training** programme ensures that staff are equipped to provide the highest standard of care, in both emergency and non-emergency situations, compliance across health and safety standards is consistent year on year, small improvements have been made this year to increase the figure. The Health and Safety Team have chased those staff who haven't obtained this compliance for 2 years or more.

5.12 The **First Aid at Work Training** programme ensures that adequate numbers of First Aiders are available at each premise the Trust operates from, to ensure that staff are equipped to provide the highest standards of care, in both emergency and non-emergency situations, the Trust currently has 58 trained First Aiders.

5.13 The standard of the Trust's **Security Management** was audited by the NHS Protect Quality Team who confirmed that we were providing an 'Excellent' standard, work will continue this coming financial year in maintaining this level of compliance.

6. Benchmarking

NHS Estates provide data from other Trust's around the country in terms of 'Actual Fires' occurring within the Trust (see table 1.1)

Table 1.1 –Actual Fire Benchmarking

Fires this Period	Year	DHCFT	Other Trusts
Actual Fire	2012/13	0	2
Actual Fire	2013/14	1	4
Actual Fire	2014/15	1	3

6.1 Surveillance Data Reporting - Fire

6.1 All Actual Fires are reported to NHS Estates by a member of the Health and Safety Team, a thorough fire investigation is also undertaken, which includes recommendations for action, we are fewer than average by comparison.

6.2 Any recommendations made as a result of single fire reviews are monitored by the Trusts SIRI Process and the Board.

6.3 There has been 1 Actual Fire (30th March 2015).
Tumble Dryer. Blue Light C91 circulated.

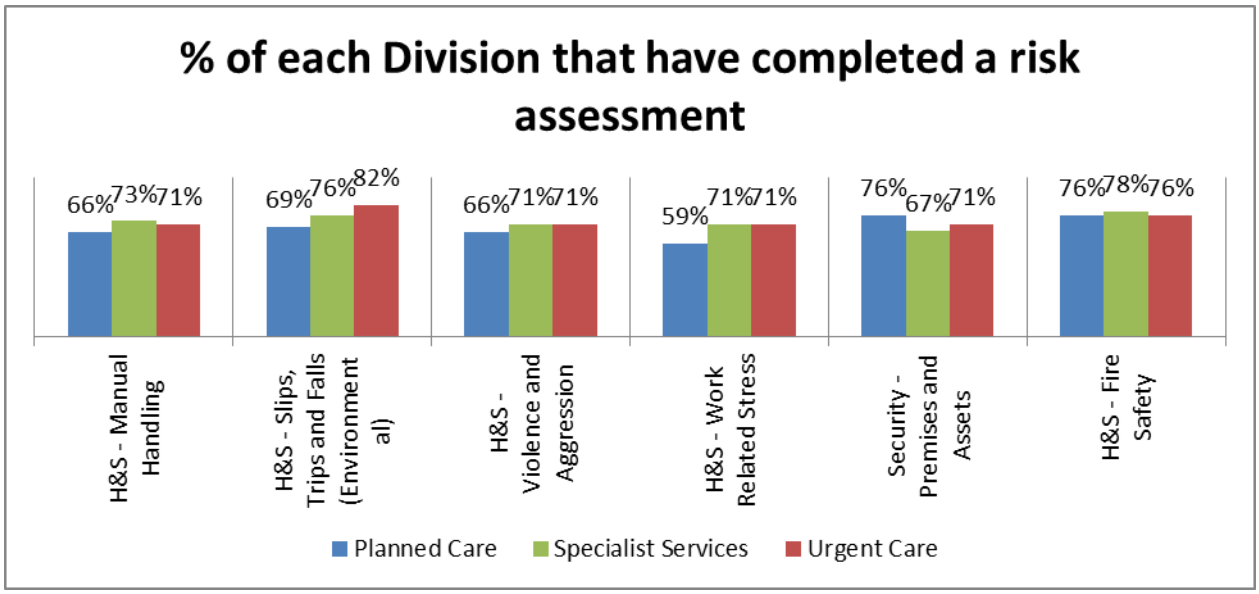
6.4 There have been 19 false alarms (30 March 2015).

Causes False Alarms	
Steam/Spray	***13***
Accidentally – Staff	***2***
Fault with Alarm	***1***
Malicious Patient	***3***

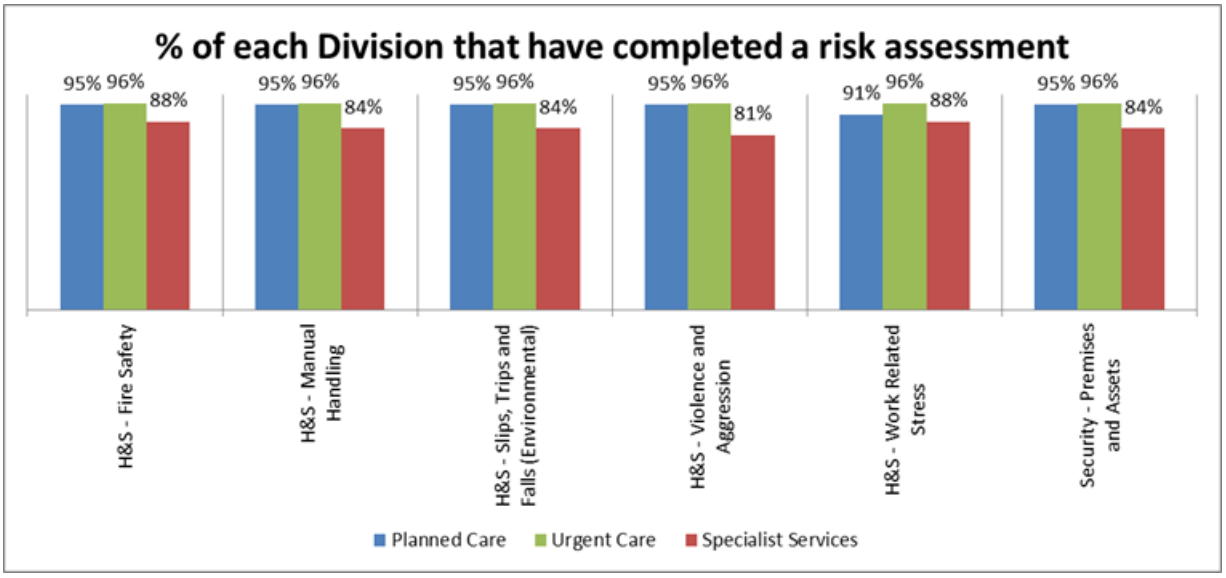
In response to the number of false alarms being caused by sprays, the sensitivity of the detector head has been altered, this does not affect the pre-alarm facility built into the system and still gives rise to early warning of change in the atmosphere, we have agreed with Derbyshire Fire and Rescue Service to a commitment to reduce the number of false alarms we have year on year, and endeavour to continue to work towards this.

6.5 **Surveillance Data Reporting – Health and Safety Audit**

Data for 2013/14 for comparison



Data for 2014/15



A Significant increase is noted in Risk Assessment compliance figures compared to last year.

7. The Health and Safety Audit Results

Action summary as of 31 March 2015

Action	Urgent	High	Medium	Low
Identified	0	3	95	205
Completed	0	3	69	80

Following the full implementation of Datix Risk, 2013/14 has seen the Health and Safety Audit re-designed to be a qualitative process, to provide advice and support, and to help Risk Assessors manage the range of health and safety related risks that exist within their work area. It is expected that Risk Assessors will provide the auditor with a range of documentary evidence to satisfy that their risk assessments are embedded within working practice, and to evidence that control measures identified within documented risk assessments are providing adequate risk reduction. The documents required are as follows:

Slips, Trips and Falls checklist
Workplace checklist
Workplace stressors checklist
Lone Working protocol
Security arrangements
COSHH File (where Applicable)
5 sets of Patient notes (in-patient area only)
Moving and Handling Risk Assessment and Plans
Falls Care Plan

The Audit includes a visual inspection of the workplace, where the auditor will give advice and support and seek to be assured that the risks within the environment are adequately managed. A thorough action plan is provided within 7 days of the Audit visit. The actions are rated, and Risk Assessors/Mangers are expected to have resolved any identified actions within the timescale below:

Urgent - to be rectified immediately
High - to be rectified within 1 week
Medium - to be rectified within 1 month
Low - to be rectified within 6 months

It is expected that completed action plans be returned to the Health and Safety Team within 6 weeks of receipt, having documented action taken/planned action. Health and Safety Audits and related action plan returns are monitored by the Trust Health and Safety Committee. Failure to return action plans within the given timescale may result in a re-audit

Display Screen Equipment continues to be used more and more throughout the Trust, and together with the continuing Estates Strategy in terms of business teams moving offices, the requirement for assessment of work stations continues to be very important in preventing musculoskeletal injuries and driving the healthy workforce agenda. To support this, the Health and Safety Team have implemented an upgrade to the online DSE Package currently purchased to support an e-learning package and Risk Assessment module, the upgrade has enhanced features for both the user and the Team Managers, giving better access to reports. The Health and Safety Team continually monitor the system to ensure that adequate and timely responses are received by all users, from their managers to any concerns raised.

The DSE course is an annual requirement for those who spend an hour or more, most days at their computer. The DSE self-assessment completed by staff involves responding to a number of questions (see Table below) concerning how comfortable they are working at their workstation and computer/laptop.

The position of the DSE system (31st March 2015) **918** users have accounts on the system, **632** have completed the course, **286** are outstanding. Outstanding assessments are followed up by the Health and Safety Team on a regular basis, follow up includes site visits, return to work assessments, manager liaison and follow up, on some occasions referral to Occupational Health for specialist assessment is required.

Staff assessments following sickness absence (as a result of Musculo-skeletal Disorder). During 2014/15 Moving and Handling Advisor has completed 45 staff assessments due to musculo-skeletal disorder. These assessments have been completed following referral from Occupational Health Services. The purpose of these assessments is to provide clear guidance in relation to reasonable adjustments aimed at maintaining staffs safety so far as is reasonably practicable.

Table to show numbers of type of issue raised by staff in their Self-Assessment which have been resolved by either the Team Manager or H&S Manager, Apr 14 to March 15

Questions	Number of Resolved issues
What is the maximum continuous time you spend on your computer before changing to another activity?	204
If you use a laptop, do you need to be supplied with any additional accessories to enable comfortable operation or carrying? If you do not use a laptop please click on No.	65
Can your screen be swivelled from side to side and tilted up and down?	52
Is there enough room at your workstation for you to change position and vary movement?	51
Do you need to be supplied with a footrest?	45
If your chair has arms, do they interfere with your comfort when keying or using the mouse? If your chair does not have arms answer No.	45
Is the noise level at your workstation comfortable to work in?	44
Is the temperature at your workstation comfortable to work in?	40
Is the keyboard you use separate from the screen and easy to move?	35
Do you need to be supplied with a document holder?	31
Is your desk surface large enough to allow you to position your equipment correctly for comfortable working?	27
Is your screen at a comfortable height?	27
Is your chair stable, safe and comfortable?	26
Is the backrest of your chair adjustable to support your back correctly and comfortably?	26
Is the air quality around your workstation comfortable?	24
If you had a health and safety concern relating to your DSE work would you know who to speak to?	22
Is the lighting level around your workstation comfortable to work in?	22
Is the height of your desk suitable for comfortable working?	19
Can you find a comfortable keying position?	13

Are the characters and images on your screen clear and of adequate size for comfortable viewing?	12
Do you understand the arrangements for eye and eyesight tests?	12
Is the device (mouse or trackball etc.) you use separate from the keyboard and easy to use?	11
Do you have any problems with glare or reflections on your screen which you are unable to resolve?	11
Can you adjust the height of your seat to a comfortable position?	10
Is there enough space to rest your hands in front of the keyboard?	10
Are the keyboard and workstation surfaces glare free?	10
Does your device work smoothly and at a speed that is suitable to you?	9
Do you have sufficient leg-room under your desk for your comfort?	9
Is the screen image stable and flicker free?	7
Have you been adequately trained in the use of the software so that you can complete your work effectively and comfortably?	7
Are the symbols on the keys clear and easy to read?	4
Is the software suitable for the DSE tasks you do?	4
Can you position the device close enough to you for comfortable working?	3
Can you adjust the contrast of your screen to produce images that are clear and easy to view?	2
Can you adjust your screen's brightness for comfortable viewing?	1
Grand Total	**940**

Please note that there are no unresolved issues from this period.

There is a number of staff members raising concerns regarding the length of time they spend at the screen and keyboard without a rest, staff are advised to take a rest from the screen and keyboard at least every 55 minutes to ensure the hazard of repetitive strain is avoided.

As the Estates strategy continues to be implemented across the Trust, the organisation sees more staff using laptops as part of their working practice, It is essential that staff who use a laptop are provided with adequate laptop accessories in order to work their DSE Safely and in accordance with HSE Guidelines, the Health and Safety Team work closely with the IT Department, to ensure effective methods are in place.

8. Training and Education

8.1 Fire training is closely monitored by the Health and Safety Manager and the Trust Health and Safety Committee.

8.2 Moving and Handling Training Level 1 has been available for staff to complete via E-learning.

8.3 Moving and Handling Training Update, Level 2, has continued to be delivered within the compulsory training block. Those staff not attending this block of training, staff working in specialist services, have received training delivered by Moving and Handling Advisor and/or Moving and Handling Link Workers on an ad-hoc basis in order to meet the training needs of the staff group. This is a 2 yearly competency.

Moving & Handling Induction has continued as a full day, outside of the compulsory training block. From January 2015 an Induction 'block' has been put in place which includes Moving & Handling Induction. This is aimed at timely delivery of essential/compulsory training. There are 14 places available on the Moving & Handling Induction, the courses have been fully booked however there continues to be a number of non-attendees that are now followed up by the Learning and Development Team.

9. Focus on the safe evacuation of the Bariatric patient

A paper was submitted to the Quality Committee in November 2014 that reviewed the Trust equipment available for the safe evacuation of patients with Bariatric needs. This scoping review was to assess compliance for the statutory requirements for safe evacuation.

The initial scoping exercise was undertaken in relation to the Radbourne Unit only.

The Hartington Unit, although not able to provide a dedicated Bariatric Suite, does accept Bariatric patients into upper floor wards presently with adaptations made to existing equipment to accommodate compliance with safe evacuation requirements.

The Committee asked that further analysis into the financial implications of the suggested recommendations was undertaken.

Upgrade the existing lift from standard to fire-fighting standard which would enable the bed to be evacuated using the lift in the event of a fire. In order to ensure that the whole upper floor of the Radbourne Unit is accessible to those with Bariatric needs we will convert both lifts.

Funding has been approved and work will be completed during 2015/16.

The current Bariatric Guidance/Protocols will change to ensure that in all other areas of the Trust Bariatric patients will be nursed on ground floors only (completion June 2015).

10. Focus on Ligature Risk Reduction

As part of the routine, follow up and audit of a new policy and in preparation for a planned inspection by the Care Quality Commission (CQC), it was necessary to review all Ligature Risk Assessments in the Trust to ensure they are suitable and sufficient.

Service Line Managers and Service or Ward Managers were asked to ensure that Point of Ligature Risk Assessments had been either carried out or reviewed for all of the premises or areas that they are responsible for.

During December 2014 the Health and Safety Team carried out Audits of the Risk Assessments to ensure they were all suitable and sufficient, also to monitor subsequent action plans.

Red Risks were identified within the Risk Assessments and a multidisciplinary team (MDT) has followed up these hazards in order to address actions required.

The MDT was asked to focus this financial year on Red Risks identified within the bedrooms and bathrooms/toilets at the Kedleston Unit and Melbourne House to ensure that the risks were reduced so far as is practicable.

The elimination of Red Risks in these areas was concluded April 2015.

In order to prioritise the risk profiles of patients within each setting, in terms of likelihood to access a Ligature Point for the purpose of strangulation should be considered. Historical incident data shows that the likelihood to self-harm is more common in the Acute setting, therefore work to reduce/eliminate Red Risks within the Radbourne Unit and Hartington Units will be prioritised during 2015/16.

11. Policies and Procedures

All Trust Health and Safety Policy are reviewed and approved at the Trust Health and Safety Committee with consultation with staff side representatives from all recognised Trade Union Groups.

11.1 The Trust Security Policy and Procedures was reviewed and approved in May 2014.

11.2 The Trust Fire and Arson Prevention Policy was reviewed and approved in May 2014.

11.3 The Trust First Aid at Work Policy was reviewed and approved in May 2014.

11.4 The Trust Occupational Road Risk Policy was reviewed and approved in May 2014.

11.5 The Trust Safe Hot water Policy was reviewed and approved in May 2014.

11.6 The Trust Safe Use of Personal Protective Equipment Policy was reviewed and approved in May 2014.

11.7 The Trust Working Alone in Safety Policy was reviewed and approved in May 2014.

11.8 The Trust Bomb Threat Policy and Procedure was reviewed and approved in September 2014.

11.9 The Trust CCTV Policy was reviewed and approved in September 2014.

11.10 The Trust Taser Policy was reviewed and approved in September 2014.

11.11 The Trust Managing Work related Stress Policy and Procedure was reviewed and approved in September 2014.

12. Conclusion and recommendations and strategic direction for next year.

The Trust has a number of measures in place to assure our patients that services are safe. A multi-disciplinary approach, with strong leadership at local level is required to maintain and enhance the existing standards.

The **Fire Risk Assessment** programme ensures that all premises from which the Trust operates have been assessed in relation to the fire safety standards set out in both the RRO 2005 and HTM 05:01, which reduces the likelihood of a fire occurring, together with lessening the impact should a fire occur.

The **Health and Safety Compliance Audit** programme gives assurance (compliance with HSG65 – Health and Safety Management Model), that Risk Assessments are available, suitable and sufficient, and that they are implemented by all, to the effect of reducing risk to its lowest possible level, ensuring that premises from which we operate and tasks that are undertaken, are done so, in the safest possible manner, to reduce the likelihood and impact of incidents/accidents, improve the health and safety culture, reputation, staff retention and lessen the likelihood of litigation. 2014/15 has seen a huge increase in the compliance levels with Risk Assessments.

The **Health and Safety Training** programme ensures that staff are equipped to provide the highest standard of care, in both emergency and non-emergency situations.
The standard of the Trust's **Security Management** will be scrutinised to ensure that we are providing a safe and secure environment; any resulting action plan will be overseen by the Trust Health and Safety Committee during 2015/16.

Moving and Handling Training focuses on assessment of individuals, striking the balance between staff safety and individual patient need. There are clear systems and processes in place to assist staff in the assessment and planning of people handling activities. This is detailed within Moving & Handling Policy and discussed within face to face training. Should current good practice not meet an individual's needs, following assessment, there is a formalised process for staff to follow which includes seeking input from DHCFT Moving & Handling Advisor. Staff within Facilities and Estates continue to receive annual face to face training. Programme content has been updated for 2015/16 following consultation with the members of the staff group.

Health and Safety Appendices

Appendix 1

Terms of Reference for Trust Health, Safety and Security Committee	
What	A single Committee overseeing the responsibilities for the management and monitoring of Health, Safety and Security compliance in the Trust. The committee will: ▪ Ensure effective consultation and involvement of all Trade Unions and staff representatives in the Health and Safety Management of the Trust. ▪ Promote co-operation between management and staff in instigating, developing, carrying out and communicating measures to ensure the health and safety at work of staff. ▪ Report on the inspections of progress made on Health and Safety Audits, together with summaries of action taken. ▪ Assist and advise in the development and implementation of, health and safety and security policies and procedures and the Trusts Emergency Plan ▪ Implement security management within the Trust by establishing a pro-security culture and maintaining effective systems of security ▪ Consider reports and factual information provided by the Health and Safety Team, Risk Management of Falls, Moving and Handling, Security and Fire in order that the Committee can discuss trends and recommend Trust action. ▪ Receive reports from enforcing authorities and monitor progress of actions ▪ Provide information for the Trust Board's Annual Report.

Who	Head of Patient Safety (Chair) Health and Safety Manager - Co-ordinator (Deputy Chair and Co-ordinator) *Union representatives – RCN, Unison and others at their request *Head of Estates and Facilities *Head of IMandT Occupational Health Nurse *Workforce and OD representative *General Manager – Acute and Community Care Division (or representative) *General Manager – Specialist Services Division (or representative) *Divisional Nurse representative NED Champion *Associates* Falls Lead/ Moving and Handling Manager Health and Safety Advisor Corporate Risk and Assurance Manager Nurse Consultant – Safety	
Quorum	Quorum: Chair (or their deputy). Also: - at least 3 staff representatives (denoted by *), including at least 1 divisional representative - at least management representatives - at least 1 union representative	
When	Quarterly	
Where	Kingsway Site (wherever possible). Agendas and papers will be circulated at least 5 working days prior to the meeting	
Why	To ensure compliance with The Health and Safety Committee Regulations 1977, NHS Security Management Service's regulations and all other applicable statutory requirements,	
How	The Committee will ensure progress is undertaken and monitored through the overseeing of annual work plans for health and safety and security and a schedule for reports to be presented.	
Reporting to	Patient Safety Committee	
Responsible to	Executive Director of Nursing and Quality	
Accountable to	Quality Committee	
Review and Monitoring	Annually	

Appendix 2

Terms of Reference for Police Liaison Group

Terms of reference for the Police Liaison group

What

The Police Liaison Group, consisting of members from Derbyshire Healthcare NHS Foundation Trust and Derby Constabulary is to co-ordinate the partnership arrangements and provide a forum to develop a better understanding of the 2 organisations. It will raise awareness of how they can work together and develop partnership arrangements for Trust services.

Who

- Local Security Management Specialist
- Police Inspector
- Service Line Managers

A representative should attend the meeting if the nominated person is unable to do so.

When

Quarterly

Where

Kingsway Site

Why

- To ensure the operational management of security within the Trust and surrounding beat area is informed by both professional and multi-disciplinary advice.
- To develop and review related policies along with operation and procedural methods of maintaining a safe and secure NHS.
- To make the processing of offenders against the NHS and its staff more efficient.
- To effectively reduce the instances of calls for police assistance and resources.
- To promote best practice in risk management.
- To facilitate the flow of information between both agencies.
- To ensure that effective channels exist for operational discussions between the 2 agencies.

How

- Providing the Trusts and Derbyshire Constabulary with a forum for disseminating useful information.
- Reviewing and developing clear arrangements and procedures to deal with Security/Crime issues
- Review or implement policy for ensuring there are adequate measures in place to reduce the risk
- Ensure a protocol is arranged for the exchange of information between the organisations
- By considering trends from the analysis of fire incidents, to offer recurrence prevention advice and best practice
- Advising, recommending and reviewing clinical and corporate policy, procedures, standards and guidelines to support an integrated approach to Security.
- The sharing of information with partner agencies.

Reporting to

Trust Health and Safety, Security Committee

Responsible to	
Trust Health and Safety, Security Committee	
Accountable to	
Quality Committee	
Liaison/Key Communications	
Trust Health and Safety, Security Committee	

Appendix 3

Terms of reference for the Derbyshire Healthcare Fire Safety Liaison Group

What

The Derbyshire Healthcare Fire Safety Liaison Group, consisting of members from Derbyshire Healthcare NHS Foundation Trust, Derbyshire Fire and Rescue Service, Derby Royal Hospital NHS Foundation Trust, Royal Chesterfield Hospital NHS Foundation Trust and Derbyshire Community Health Services NHS Trust, will:

- ensure that fire safety standards are being met within the Trust
- raise awareness of new and changing regulations and procedures
- consider actions required as a result of incidents, where appropriate
- Monitor Fire Risk Assessments (especially in relation to shared premises)
- Share information with regards to compliance with the Regulatory Reform Fire Safety Audit
- Compare information to provide satisfactory comparisons across all Derbyshire Healthcare provision
- Monitor Fires (actual) and monitor unwanted fire signals (false Alarms)
- Receive reports regarding compliance with the Regulatory Reform (Fire Safety) Order 2005

Who

Each specialist Fire Safety Advisor will chair 1 meeting per year

Carrina Gaunt, Health and Safety Manager
Steve Edgeley, Trust Fire Manager
Alan Dakin, Estates and Facilities Operations Manager
Paul Aveston, Fire Safety Officer, Derbyshire County PCT
Graham White, Fire Safety Officer, Community Health Services
David Needham, Chesterfield Royal Hospital
Daniel Illsley, Building Manager/Surveyor
Paul Brooks, Royal Derby Hospital Trust
Representatives from Derbyshire Fire and Rescue Services.

When

Quarterly

Where

Countywide

Why

- To ensure that the operational management of fire safety within the Trusts is informed by both professional and multi-disciplinary advice
- To develop and review related policies along with operational and procedural methods of maintaining a safe and secure Trust
- To promote best practice in fire safety
- To facilitate the flow of information between agencies
- To ensure that effective channels exist for operational discussions between the agencies

How
• Providing the Trusts and Derbyshire Fire and Rescue with a forum for disseminating useful information. • Reviewing and developing clear arrangements and procedures to deal with fire safety issues • Review or implement policy for ensuring there are adequate measures in place to reduce the risk of fire • Ensure a protocol is arranged for the exchange of information between the organisations • By considering trends from the analysis of fire incidents, to offer recurrence prevention advice and best practice • Advising, recommending and reviewing clinical and corporate policy, procedures, standards and guidelines to support an integrated approach to Fire Safety. • The sharing of information with partner agencies.
Reporting to
Trust Health and Safety, Security and Resilience Committee
Responsible to
Trust Health and Safety, Security and Resilience Committee
Accountable to
Trust Board
Liaison/Key Communications
Trust Health and Safety, Security and Resilience Committee

Appendix 4

TERMS OF REFERENCE

What	**Statutory Standards Group**

- To ensure that Statutory Standards are being met within the Trust
- To formulate action plans to ensure implementation of statutory standards, and from risk assessments
- To monitor such action plans through to completion
- To raise awareness of new and changing regulations and procedures
- To agree advice to be provided to the Trust on current status
- To consider actions required as a result of incidents, where appropriate

Who

Carrina Gaunt: Health and Safety Manager (Chair)
Robert Morgan: Health and Safety Advisor (Vice Chair)
Ray Merrin: Estate Manager
Kevin Fletcher: Acting Head of Estates and Facilities
Liz Bates: Deputy Head of Estates and Facilities
Lesley Watson: Acting Estates Senior Project Manager
Ian Johnson: CAFM and Contracts Manager
Dave Nicklin: Estates Officer

When

Bi Monthly

Where

Kingsway Site, Derby

Why

- To ensure the Trust meets the requirements of Statutory Standards
- To ensure adequate action plans are developed
- To monitor progress in implementation of action plans
- To ensure the Trust Board has an accurate picture of the level of compliance in the organisation
- To consider implications of new or revised legislation, and whether further actions are required

How

- Receiving reports from relevant departments on current status
- Receiving advice from relevant specialist advisers on gaps and areas for further development
- Receiving up dates on statutory requirements, changes in legislation or guidance from individuals on the group
- Developing action plans in consultation with operational managers where necessary
- Receiving feedback on progress with implementation of action plans from relevant individuals

Reporting to	
Trust Health, Safety and Security Committee	
Responsible to	
Quality Committee	
Accountable to	
Trust Board	
Liaison/Key Communications	
• Capital Action Group • Trust Health and Safety and Security Committee • Facilities Group • Business Unit Meetings	

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 28th October 2015

Trust Performance Report – Key Performance Indicators Compliance

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

Executive Summary

- New summary section has been included.
- The Trust continues to be compliant with all Monitor regulatory indicators
- The recording of Payment by Result Clusters and Health of the Nation Outcome Scores 12 month reviews continue to be challenging however there have been recent improvements
- The rate of outpatients who did not attend is still causing concern
- Health Visitor performance remains strong and IAPT recovery rates remain above target
- The Trust continues to have qualified staffing vacancies that impact on staffing fill rates, Ward 34 is most adversely effected. An audit is current underway to establish the accuracy of the information used to feed the Safer Staffing return.

Strategic considerations

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

(Board) Assurances

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

Consultation

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

Governance or Legal issues

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

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

Recommendations
The Board of Directors is requested to:
1) To acknowledge the current performance of the Trust
2) To note the actions in place to ensure sustained performance

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

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

Performance Summary Dashboard October 2015

Performance Dashboard (Monitor & Exceptions)

15-16 Performance Dashboard	Target	Aug	Sep
- Monitor Targets			
- CPA 7 Day Follow Up	95.00%	98.97%	95.21%
- CPA Review in last 12 Months (on CPA > 12 Months)	95.00%	96.80%	96.15%
- Delayed Transfers of Care	7.50%	0.41%	0.35%
- Data Completeness: Identifiers	97.00%	99.37%	99.39%
- Data Completeness: Outcomes	50.00%	93.68%	93.86%
- Community Care Data - Activity Information Completeness	50.00%	87.45%	87.69%
- Community Care Data - RTT Information Completeness	50.00%	92.31%	92.31%
- Community Care Data - Referral Information Completeness	50.00%	71.40%	71.66%
- 18 Week RTT Less Than 18 Weeks - Non-Admitted	95.00%	96.17%	95.98%
- 18 Week RTT Less Than 18 Weeks - Incomplete	92.00%	95.64%	94.48%
- Early Interventions New Caseloads	95.00%	115.80%	112.50%
- Clostridium Difficile Incidents	7	0	0
- Crisis GateKeeping	95.00%	100.00%	100.00%
- IAPT Referral to Treatment within 18 weeks	95.00%	98.98%	98.85%
- IAPT Referral to Treatment within 6 weeks	75.00%	90.61%	89.29%
- Locally Agreed			
- Patients Clustered not Breaching Today	99.00%	75.89%	76.52%
- Patients Clustered Regardless of Review Dates	100.00%	94.72%	94.42%
- CPA HoNOS Assessment in last 12 Months	90.00%	80.92%	82.16%
- Schedule 4 Contract			
- Consultant Outpatient Appointments Trust Cancellations (Within 6 Weeks)	5.00%	6.32%	5.47%
- Consultant Outpatient Appointments DNAs	15.00%	15.72%	16.85%
- Outpatient Letters Sent in 10 Working Days	90.00%	58.56%	58.12%
- Outpatient Letters Sent in 15 Working Days	100.00%	85.41%	85.91%

Safer Staffing(September 2015)

Ward name	Day		Night	
	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)
Audrey House Residential Rehabilitation	96.5%	101.0%	100.0%	100.0%
Child Bearing / Perinatal Inpatient	119.1%	136.4%	107.1%	160.0%
CTC Residential Rehabilitation	100.0%	97.2%	100.0%	100.0%
Enhanced Care Ward	70.8%	110.9%	88.1%	109.7%
Hartington Unit Morton Ward Adult	100.0%	96.0%	70.6%	148.6%
Hartington Unit Pleasley Ward Adult	101.7%	95.0%	115.6%	91.5%
Hartington Unit Tansley Ward Adult	94.3%	108.6%	66.0%	134.7%
Kedleston Unit - Curzon Ward	101.7%	99.2%	103.3%	98.2%
Kedleston Unit - Scarsdale Ward	97.5%	96.7%	100.0%	100.0%
KW Cubley Court Female	107.7%	94.2%	97.2%	99.2%
KW Cubley Court Male	97.8%	95.9%	91.8%	103.9%
KW Melbourne House	99.2%	98.2%	78.3%	117.9%
KW Tissington Unit Older People	98.4%	91.3%	89.7%	102.0%
LRCH Ward 1 OP	101.2%	96.2%	91.7%	112.7%
LRCH Ward 2 OP	100.0%	102.2%	97.4%	100.0%
RDH Ward 33 Adult Acute Inpatient	97.0%	103.8%	97.9%	103.1%
RDH Ward 34 Adult Acute Inpatient	84.8%	122.5%	50.0%	254.8%
RDH Ward 35 Adult Acute Inpatient	106.0%	99.3%	100.0%	134.3%
RDH Ward 36 Adult Acute Inpatient	99.5%	91.9%	79.5%	136.7%

IAPT Recovery Rates

Indicator name	Aug-15	Sep-15
Recovery Rates KPI 6 / (KPI 5 - KPI 6b)	**56.59%**	**56.71%**
Partial and Full Recovery Rates	**72.05%**	**74.42%**

Health Visitors

15-16 Health Visitor Dashboard	Target	Aug-15	Sep-15
% 10-14 Day Breastfeeding coverage	95.00%	99.40%	96.10%
% 6-8 Week Breastfeeding coverage	95.00%	97.40%	98.40%
% Still Breastfeeding at 6-8 Weeks	65.00%	62.70%	65.70%

Variance Commentary

Indicator	Target	Over/under Performance	Rationale for Variance	Actions	Confidence in Actions
Patients clustered regardless of Review Dates and Patients clustered not Breaching Today	100% clustered and 99% in date	Under	Patients not cluster and clusters not reviewed to required timescale	Working with teams to address under-performance and increasing training	Low
Consultant Outpatient Trust Cancellations (within 6 weeks)	5%	Under	Staff sickness	Continue to adhere to clinic cancellation authorisations process	Medium
Consultant Outpatient did not attends	15%	Under	Patients missing appointments without giving prior notice	Detailed analysis of outpatient activity to be undertaken Text message reminders will be sent from 19th October 2015	Medium
Outpatient Letters	100% in 15 days and 90% in 10 days	Under	Letters not completed to agreed timescales	The Medical Director and Clinical Directors to manage the solutions and produce trajectory for achievement of this target.	Low
Safer Staffing	Between 90% and 125 % of planned roster	Under	Staff vacancies and increased observations	Recruitment currently underway/ audit is current underway to establish the accuracy of the information. Additional training information being developed and delivered to teams.	Medium

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

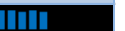
Introduction

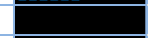
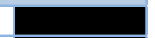
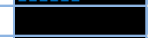
The following Performance Compliance report is organised into the following sections;

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

1 Trust Performance Dashboard

Key to colour coding	
Compliant with target	
Target exception	

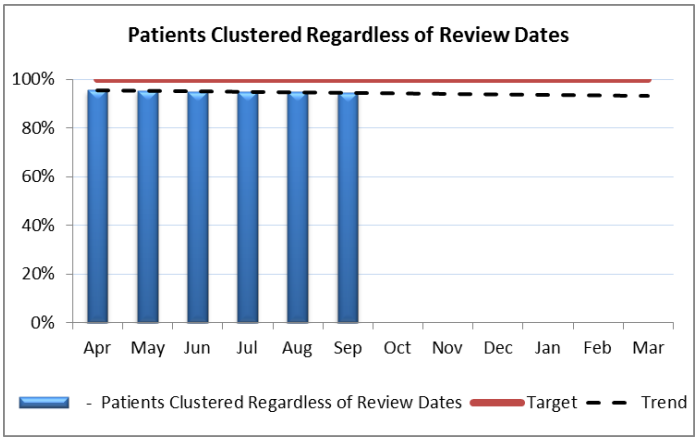
15-16 Performance Dashboard	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Trend
- Monitor Targets														
- CPA 7 Day Follow Up	95.00%	96.19%	97.62%	99.15%	97.27%	98.97%	95.21%							
- CPA Review in last 12 Months (on CPA > 12 Months)	95.00%	96.69%	96.32%	96.34%	96.35%	96.80%	96.15%							
- Delayed Transfers of Care	7.50%	0.75%	0.67%	0.68%	0.69%	0.41%	0.35%							
- Data Completeness: Identifiers	97.00%	99.32%	99.30%	99.37%	99.38%	99.37%	99.39%							
- Data Completeness: Outcomes	50.00%	94.16%	93.69%	93.43%	93.53%	93.68%	93.86%							
- Community Care Data - Activity Information Completeness	50.00%	87.99%	87.87%	87.71%	87.65%	87.45%	87.69%							
- Community Care Data - RTT Information Completeness	50.00%	92.31%	92.31%	92.31%	92.31%	92.31%	92.31%							
- Community Care Data - Referral Information Completeness	50.00%	72.19%	71.84%	71.84%	71.97%	71.40%	71.66%							
- 18 Week RTT Less Than 18 Weeks - Non-Admitted	95.00%	95.65%	95.63%	95.29%	95.76%	96.17%	95.98%							
- 18 Week RTT Less Than 18 Weeks - Incomplete	92.00%	95.58%	95.06%	95.65%	95.47%	95.64%	94.48%							
- Early Interventions New Caseloads	95.00%	163.60%	126.10%	126.50%	119.60%	115.80%	112.50%							
- Clostridium Difficile Incidents	7	0	0	0	0	0	0							
- Crisis GateKeeping	95.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%							
- IAPT Referral to Treatment within 18 weeks	95.00%	99.44%	99.41%	99.48%	99.05%	98.98%	98.85%							
- IAPT Referral to Treatment within 6 weeks	75.00%	89.03%	85.69%	85.15%	87.00%	90.61%	89.29%							
- Locally Agreed														
- CPA Settled Accommodation	90.00%	99.29%	99.12%	98.93%	98.89%	98.85%	98.54%							
- CPA Employment Status	90.00%	99.44%	99.31%	99.27%	99.24%	99.12%	98.92%							
- Data Completeness: Identifiers	99.00%	99.32%	99.30%	99.37%	99.38%	99.37%	99.39%							
- Data Completeness: Outcomes	90.00%	94.16%	93.69%	93.43%	93.53%	93.68%	93.86%							
- Patients Clustered not Breaching Today	99.00%	74.71%	75.01%	75.34%	75.46%	75.89%	76.52%							
- Patients Clustered Regardless of Review Dates	100.00%	95.58%	95.41%	95.03%	94.81%	94.72%	94.42%							
- CPA HoNOS Assessment in last 12 Months	90.00%	81.63%	80.43%	79.83%	80.27%	80.92%	82.16%							
- 7 Day Follow Up – All Inpatients	95.00%	95.12%	97.80%	98.56%	97.79%	97.37%	95.78%							
- Ethnicity Coding	90.00%	94.19%	95.17%	95.52%	94.77%	93.92%	92.67%							
- NHS Number	99.00%	99.92%	99.96%	99.97%	99.98%	99.97%	99.96%							

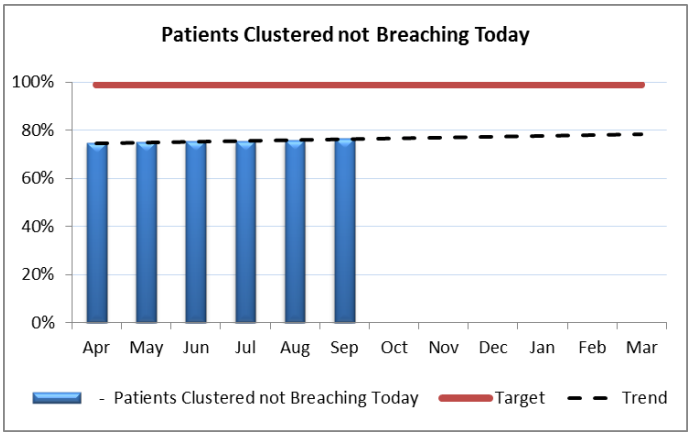
15-16 Performance Dashboard	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Trend
- Schedule 4 Contract														
- Consultant Outpatient Appointments Trust Cancellations (Within 6 Weeks)	5.00%	4.12%	3.28%	4.95%	3.89%	6.32%	5.47%							
- Consultant Outpatient Appointments DNAs	15.00%	15.90%	15.70%	17.25%	17.61%	15.72%	16.85%							
- Under 18 Admissions To Adult Inpatient Facilities	0	0	0	0	0	0	0							
- Outpatient Letters Sent in 10 Working Days	90.00%	78.29%	69.49%	72.47%	66.33%	58.56%	58.12%							
- Outpatient Letters Sent in 15 Working Days	100.00%	88.57%	86.00%	87.38%	86.09%	85.41%	85.91%							
- Average Community Team Waiting Times (Weeks)	N/A	5.91	5.77	5.33	4.95	4.94	4.77							
- Inpatient 28 Day Readmissions	10.00%	12.50%	5.88%	5.44%	11.84%	10.48%	9.77%							
- MRSA - Blood Stream Infection	0	0	0	0	0	0	0							
- Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0							
- 18 Week RTT Greater Than 52 weeks	0	0	0	0	0	0	0							
- Discharge Fax Sent in 2 Working Days	98.00%	98.45%	98.95%	98.56%	98.59%	100.00%	98.73%							
- Fixed Submitted Returns														
18 Week RTT Greater Than 52 weeks	0	0	0	0	0	0	0							
18 Week RTT Less Than 18 weeks - Incomplete	92.00%	93.66%	92.94%	94.48%	94.35%	95.00%	94.48%							
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0							
Completion of IAPT Data Outcomes	90.00%	98.33%	97.65%	96.35%	96.66%	98.36%	98.50%							
Ethnicity Coding	90.00%	93.62%	94.75%	95.64%	93.60%	94.54%	91.86%							
NHS Number	99.00%	100.00%	100.00%	99.99%	99.99%	99.99%	99.99%							

1.1 Exception Items and Specific Areas of Interest

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

1.1.1 Locally Agreed – Patients clustered regardless of Review Dates and Patients clustered not Breaching Today





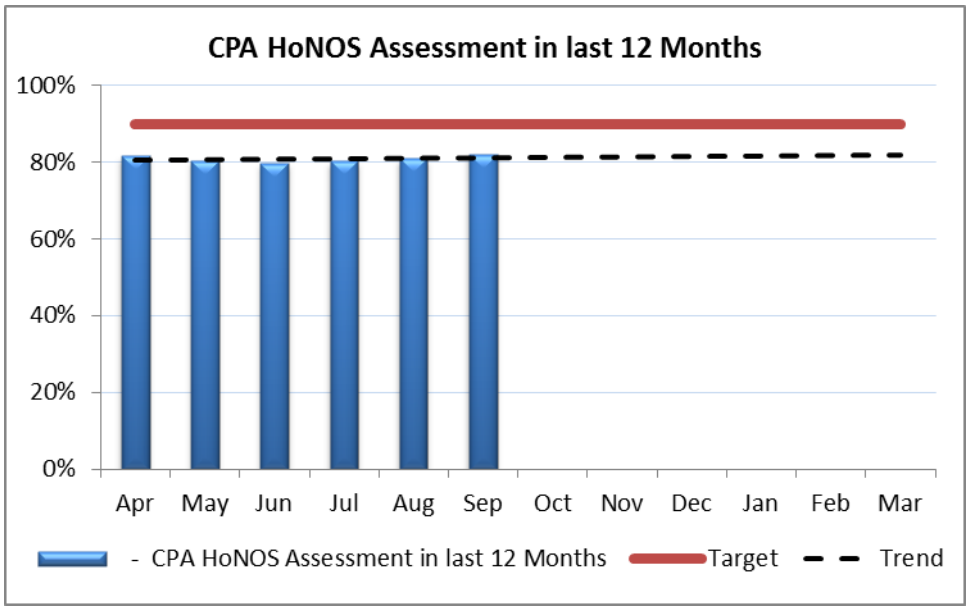
The Payment by Results Advisor continues to work with teams and individuals offering training, support and advice. We are taking the opportunity of the 'WorkPro' road-test to emphasise the importance of timely and accurate clustering. We highlight the importance of Clusters for understanding demand and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

Trust	Board meeting	Cluster in date Target	Cluster in date Actual	Clustered Target	Clustered Actual
5 Boroughs Partnership	July	-	-		81.8%
Barnet, Enfield and Haringey	September	85%	85%	-	-
Berkshire	September	95%	76%	-	-
Coventry and Warwickshire	September	-	-	95%	96.3%
Cumbria	July	80%	83.10%	90%	87.3%
Derbyshire	October	99%	76.9%	100%	94.4%
Dudley and Walsall	October	75%	47.5%	75%	93.7%
Greater Manchester West	July	100%	83.2%	100%	94%
Norfolk and Suffolk	July	-	-	99%	97%
Nottinghamshire	September	-	-	95%	96.5%
South West Yorkshire	September		76%	98%	96%

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

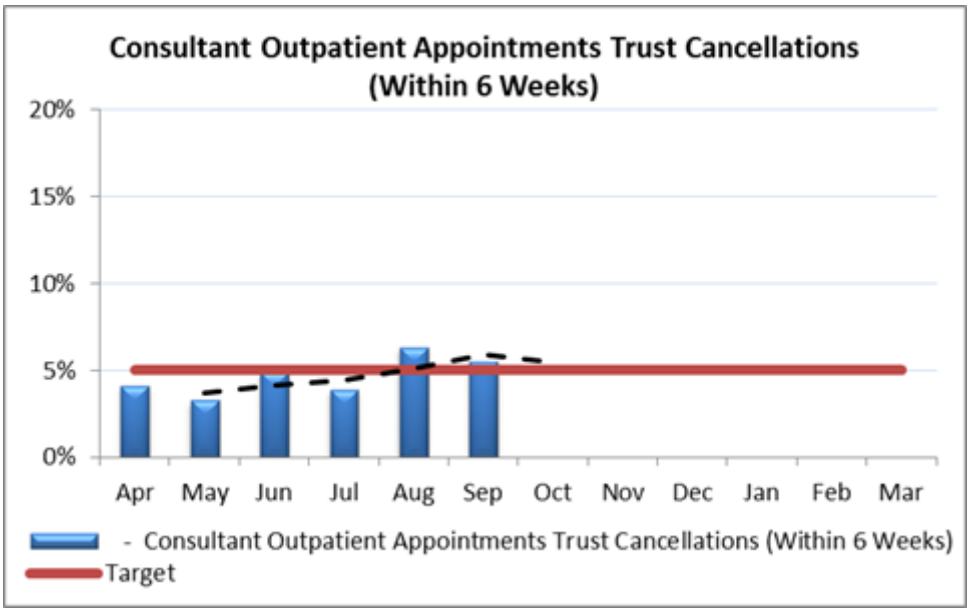
- Data cleansing
- Make improvements in practitioner clustering
- Highlight to staff responsible for clustering the issues needing to be resolved
- Monitoring performance
- Team based training
- Agree new targets with the commissioners

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



Health of the Nation Outcome Score assessments are part of clustering so by improving the clustering position we will improve the Health of the Nation Outcome Score assessments position by default. Please see comments and action plan in section 1.1.1

1.1.3 Schedule 4 – Consultant Outpatient Trust Cancellations (Within 6 Weeks)

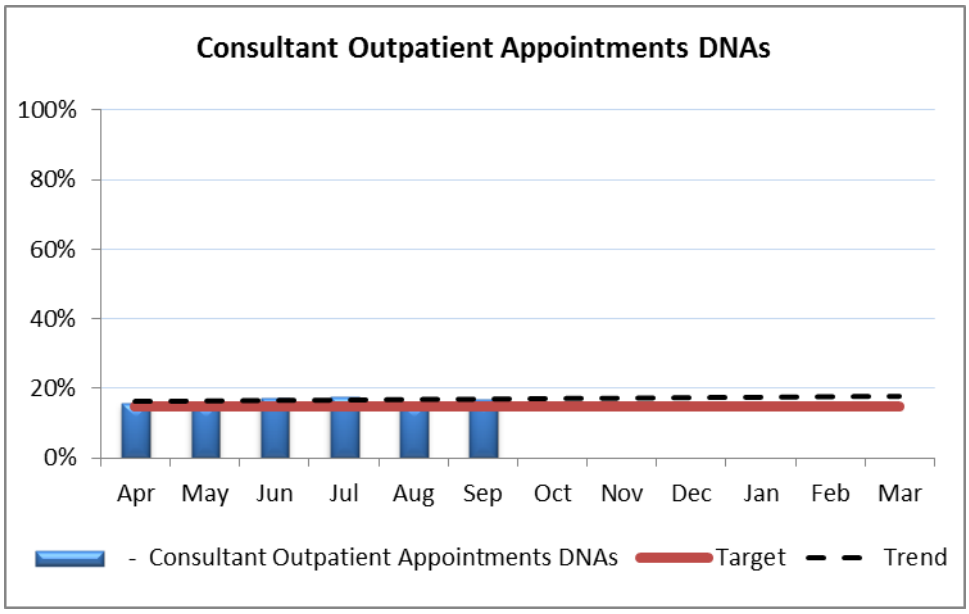


Comments: The majority of cancellations were owing to staff sickness (36%)

Action planned:

- To continue to monitor
- To continue to adhere to the clinic cancellation authorisations procedure

1.1.4 Schedule 4 – Consultant Outpatient Did Not Attends

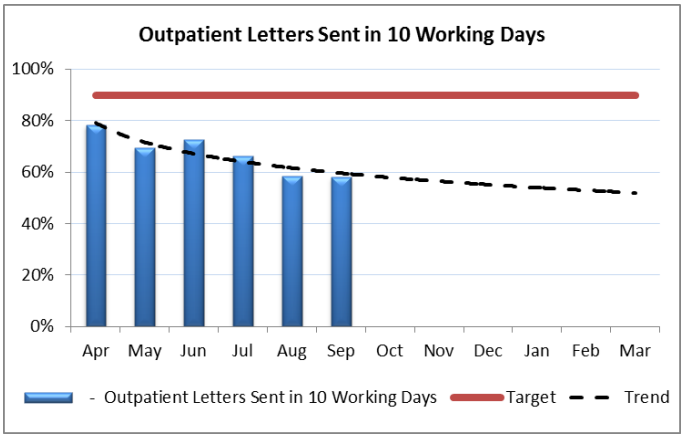


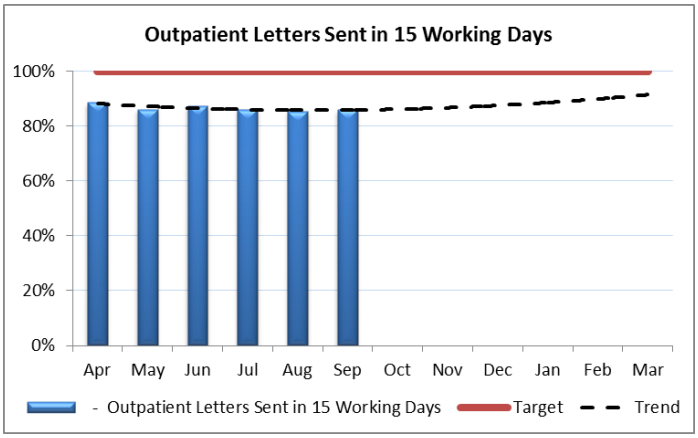
Work is continuing to try and increase the number of patients consenting to receive text message reminders.

Action planned:

- Detailed analysis of outpatient activity to be undertaken
- Text message reminders will be sent from 19th October 2015

1.1.5 Schedule 4 –Outpatient Letters





- 1925 letters were produced and signed off in time in September from 3385 dictations. This gives us a 57% compliance rate.
- 1460 of the 3385 letters breached.
- 11% of the doctors (and their associated processes) contributed to 47% of the breaches. The table below shows the 11% of doctors with 30 or more breaches.
- 6 of the 14 doctors in the table below have appeared in previous tables so would suggest ongoing issues.

Letters (Created By)	Letter in Time	Breach	Total Letters	% Compliance
Consultant 1	23	99	122	18.85%
Consultant 2	23	76	99	23.23%
Consultant 3	5	72	77	6.49%
Consultant 4	8	42	50	16.00%
Consultant 5	43	41	84	51.19%
Consultant 6	37	40	77	48.05%
Consultant 7	20	36	56	35.71%
Consultant 8	19	35	54	35.19%
Consultant 9	1	35	36	2.78%
Consultant 10	29	34	63	46.03%
Consultant 11	77	33	110	70.00%
Consultant 12	28	31	59	47.46%
Consultant 13	31	31	62	50.00%
Consultant 14	0	30	30	0.00%

- An essential upgrade to the latest version of the Dictate IT software lost us almost 4 days of typing and increased the work in progress buffer to around 1,400 letters (which needed catching up on). These issues are resolved except there will be some more hours downtime when additional memory is provided to the server as part of the longer-term solution.

Action planned:

- The Medical Director and Clinical Directors to manage the solutions and produce trajectory for achievement of this target.
- A consultant dashboard is being developed to improve accessibility of individual performance information around key areas such as letters.

2 Health Visitor Dashboard

2.1 Key Performance Indicators

15-16 Health Visitor Dashboard	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Health Visitors (FTE) in Post ESR	N/A	69.85	68.72	67.65	67.36	67.36	68.47						
Health Visitors in Post (Headcount)	N/A	82	81	80	79	79	80						
Number of Student Placements (Headcount)	N/A	9	9	9	9	9	12						
Number of Student Placements (FTE)	N/A	9	9	9	9	9	12						
Number of mothers receiving antenatal check	N/A	195	152	204	226	167	197						
% Births that receive NBV within 10-14 days	N/A	88.00%	88.41%	92.00%	91.47%	92.84%	88.50%						
% NBVs undertaken after 15 days	N/A	12.00%	10.20%	8.00%	6.10%	6.00%	6.90%						
% Children who received a 3-4 month review	N/A	5.30%	11.40%	7.80%	9.60%	9.50%	7.10%						
% Children who received a 12 month review	N/A	97.70%	98.40%	98.20%	97.60%	98.20%	97.30%						
% Children who received a 12 month review at 15 months	N/A	97.50%	95.10%	97.30%	97.70%	98.40%	98.20%						
% Children who received a 2 to 2.5 year review	N/A	94.90%	95.40%	97.60%	98.50%	97.70%	96.50%						
% Staff who have received child protection training	N/A	63.40%	63.00%	62.50%	63.30%	63.30%	61.30%						
% 10-14 Day Breastfeeding coverage	95.00%	99.00%	99.00%	98.50%	99.00%	99.40%	96.10%						
% 6-8 Week Breastfeeding coverage	95.00%	100.00%	99.70%	100.00%	99.20%	97.40%	98.40%						
% Still Breastfeeding at 6-8 Weeks	65.00%	65.10%	70.40%	71.70%	72.90%	62.70%	65.70%						

2.1.1 Exception Comments

No exceptions

3 IAPT Services Dashboard

3.1 Dashboard

Total Derbyshire CCSs AQP KPI and Activity Data 2015/16

Indicator no.	Indicator name	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
3a	The number of people who have been referred for Psychological Therapies (during the reporting quarter)	997	936	966	1132	931	1195	0	0	0	0	0	0	6157
3b	The number of active referrals who have waited more than 28 days for treatment	427	384	352	266	251	260	0	0	0	0	0	0	
4	The number of people who have entered Psychological Therapies	817	733	855	861	753	819	0	0	0	0	0	0	4838
5	The number of people who have completed treatment (for any reason)	535	511	577	629	488	610	0	0	0	0	0	0	3350
6	The number of people who are "moving to recovery"	274	253	313	294	249	317	0	0	0	0	0	0	1700
6b	The number of people completing treatment who did not achieve caseness at the commencement of treatment	38	51	38	48	48	51	0	0	0	0	0	0	274
7	The number of people moving off sick pay and benefits	35	40	45	42	42	53	0	0	0	0	0	0	257

	Recovery Rates KPI 6 / (KPI 5 - KPI 6b)	**55.13%**	**55.00%**	**58.07%**	**50.60%**	**56.59%**	**56.71%**							**55.27%**
	Partial and Full Recovery Rates	**75.45%**	**72.17%**	**75.32%**	**68.50%**	**72.05%**	**74.42%**							**72.95%**

3.1.1 Exception Comments

No exceptions regarding recovery rates.

4 Ward Safer Staffing

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

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

Ward name	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
Audrey House Residential Rehabilitation	96.5%	101.0%	100.0%	100.0%	No	Not Required
Child Bearing / Perinatal Inpatient	119.1%	136.4%	107.1%	160.0%	Yes	We have broken the current fill rate tolerances for day and night care staff due to observation levels and high levels of infant care when mothers are unable to do that themselves. We have also had a new starter who has been supernumerary during induction period requiring additional staff to support with this.
CTC Residential Rehabilitation	100.0%	97.2%	100.0%	100.0%	No	Not Required
Enhanced Care Ward	70.8%	110.9%	88.1%	109.7%	Yes	3 new RNS that have joined staff since 21/09/15 but are awaiting PIN numbers so recorded as care staff until then. Deficit of 2.6 RNs budgeted will be addressed for next years budget setting. 2 x RNs of long term sick. Rota arranged to maintain staffing skill requirements for C and R and ILS.
Hartington Unit Morton Ward Adult	100.0%	96.0%	70.6%	148.6%	Yes	The reason is on Morton ward we are carrying some band 5 vacancies- we are waiting for new starters to come so some of these posts are recruited into. Also we have a Band 6 currently on maternity leave and are backfilling her post with HCA bank staff.
Hartington Unit Pleasley Ward Adult	101.7%	95.0%	115.6%	91.5%	No	Not Required
Hartington Unit Tansley Ward Adult	94.3%	108.6%	66.0%	134.7%	Yes	The ward continues to catty band 5 vacancies although this is improving month on month as vacancies are filled however vacancies continue to make it difficult to allow x2 band 5's on nights, with deficit being filled by NA.
Kedleston Unit - Curzon Ward	101.7%	99.2%	103.3%	98.2%	No	Not Required
Kedleston Unit - Scarsdale Ward	97.5%	96.7%	100.0%	100.0%	No	Not Required
KW Cubley Court Female	107.7%	94.2%	97.2%	99.2%	No	Not Required
KW Cubley Court Male	97.8%	95.9%	91.8%	103.9%	No	Not Required

Ward name	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
KW Melbourne House	99.2%	98.2%	78.3%	117.9%	Yes	we continue to have difficulties in recruiting into RN posts, as such we have directed our resources to times of highest clinical need. On the shifts we are unable to provide with 2 RN's we attempt wherever possible to fill these with experienced NA's who are familiar to the ward.
KW Tissington Unit Older People	98.4%	91.3%	89.7%	102.0%	Yes	Rate broken at night due to R/N maternity & sickness
LRCH Ward 1 OP	101.2%	96.2%	91.7%	112.7%	No	Not Required
LRCH Ward 2 OP	100.0%	102.2%	97.4%	100.0%	No	Not Required
RDH Ward 33 Adult Acute Inpatient	97.0%	103.8%	97.9%	103.1%	No	Not Required
RDH Ward 34 Adult Acute Inpatient	84.8%	122.5%	50.0%	254.8%	Yes	All approved vacancies have now been filled but not all have commenced employment , hence unfilled shifts will continue
RDH Ward 35 Adult Acute Inpatient	106.0%	99.3%	100.0%	134.3%	Yes	we have broken the current fill rates due to having on going high level observations.
RDH Ward 36 Adult Acute Inpatient	99.5%	91.9%	79.5%	136.7%	Yes	The increase in staffing ratio was due to an increase in patient engagement levels

Action planned:

- An audit is current underway to establish the accuracy of the information used to feed the Safer Staffing return.
- Additional training information being developed and delivered to teams.

2015-2016 Board Annual Forward Plan

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

2015-2016 Board Annual Forward Plan

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

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