Derbyshire Healthcare
NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust
Board of Directors

Conference Rooms A and B, Centre for Research and Development, Kingsway Hospital, Derby

3 July 2018 09:30 - 3 July 2018 12:00

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Derbyshire Healthcare
NHS Foundation Trust

NOTICE OF PUBLIC BOARD MEETING – TUESDAY 3 JULY 2018
TO COMMENCE AT 9:30 AM IN CONFERENCE ROOMS A&B
FIRST FLOOR, CENTRE FOR RESEARCH & DEVELOPMENT, KINGSWAY HOSPITAL

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks, apologies for absence and Declarations of Interest Register	Caroline Maley
2.	9:35	Treat Me Well Campaign	Carolyn Green
3.	10:00	Minutes of Board of Directors meeting held on 5 June 2018	Caroline Maley
4.		Matters arising – Actions Matrix	Caroline Maley
5.		Questions from governors or members of the public	Caroline Maley
6.	10:10	Chair's Update	Caroline Maley
7.	10:15	Chief Executive's Update	Ifti Majid
OPERATIONAL PERFORMANCE, QUALITY AND STRATEGY			
8.	10:25	Integrated Performance and Activity Report	Claire Wright/Amanda Rawlings/Carolyn Green/ Mark Powell
9.	10:45	Quality: - Infection Prevention & Control Annual report - Learning from Deaths - Mortality Report - CQC Inspection verbal update - Revalidation of Doctors Annual Report	Carolyn Green John Sykes Ifti Majid John Sykes
11:10 B R E A K			
10.	11:25	Freedom to Speak Up: - Self-assessment - Freedom to Speak Up Guardian report	Sam Harrison Kully Hans
11.	11:45	Board Committee Assurance Summaries and Escalations: People & Culture Committee 5 June, Mental Health Act Committee 9 June, Quality Committee 12 June 2018 *(minutes of these meetings are available upon request)*	Committee Chairs
CLOSING MATTERS			
12.	11:55	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Board Forward Plan - Meeting effectiveness	Caroline Maley

Questions that are applicable to the agenda, and at the Chair's discretion, can be sent by email to the Board Secretary up to 48 hours prior to the meeting for a response provided by the Board at the meeting. Email: sue.turner17@nhs.net

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

There will be no meeting held in August.
The next meeting will be held at 9.30am on 4 September 2018 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 Chair's discretion

NHS
Derbyshire Healthcare
NHS Foundation Trust

Our vision

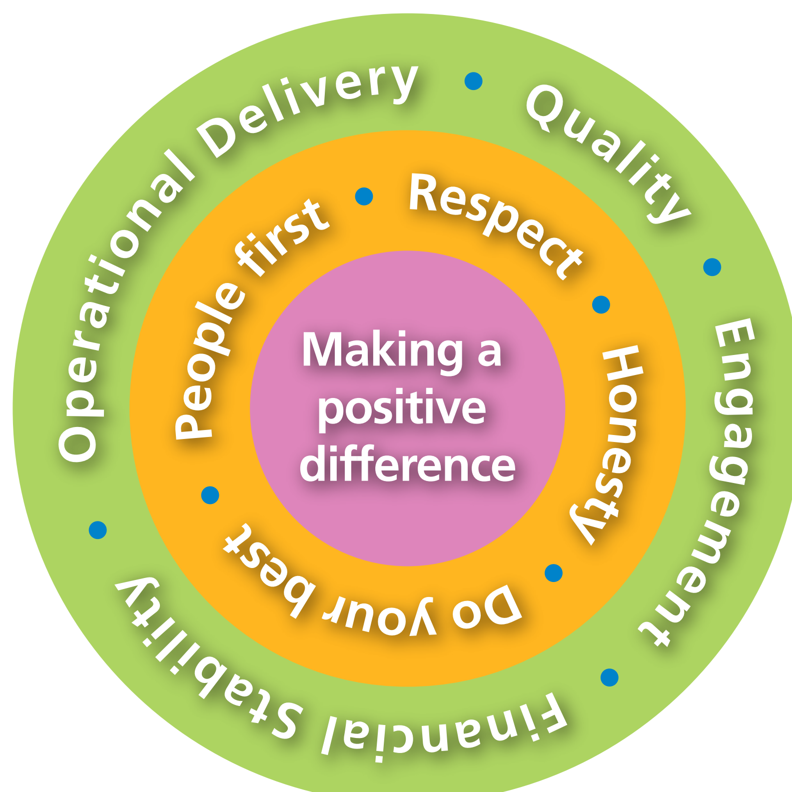
To make a positive difference in people's lives by improving health and wellbeing.

Our values

As a Trust, we can only provide good quality services through our dedicated staff, working together with a common purpose. Our values reflect the reasons why our staff choose to work for the NHS and Derbyshire Healthcare and the principles that bind us together in a common approach, no matter what our employed role is.

Our Trust values are:

People first – We put our patients and colleagues at the centre of everything we do.
Respect – We respect and value the diversity of our patients, colleagues and partners and support a respectful and inclusive environment.
Honesty – We are open and transparent in all we do.
Do your best – We work closely with our partners to achieve the best possible outcomes for people.



Declaration of Interests Register 2018/19

NAME	INTEREST DISCLOSED	TYPE
Margaret Gildea Non-Executive Director	• Director, Organisation Change Solutions Limited • Non-Executive Director, Derwent Living	(a, b) (a)
Gareth Harry Director of Director of Business Improvement & Transformation	• Chairman, Marehay Cricket Club • Member of the Labour Party	(d) (e)
Geoff Lewins Non-Executive Director	• Director, Woodhouse May Ltd • Director, Arkwright Society Ltd	(a, b) (a)
Ifti Majid Chief Executive	• Kate Majid (spouse) Chief Executive of the Shaw Mind Foundation which is a global mental health charity	(a, d)
Caroline Maley Trust Chair	• Director – C D Maley Ltd • Trustee – Vocaleyes Ltd. • Governor, Brooksby Melton College	(a, b) (a, d) (a, d)
Mark Powell Chief Operating Officer	• Chair of Governors, Brookfield Primary School, Mickleover, Derby	(e)
Amanda Rawlings Director of People and Organisational Effectiveness (DHCFT)	• Director of People and Organisational Effectiveness, Derbyshire Community Healthcare Services (DCHS) • Co-optee Cross Keys Homes, Peterborough	(e) (e)
Dr Julia Tabreham Deputy Trust Chair and Non-Executive Director	• Non-Executive Director, Parliamentary and Health Service Ombudsman • Director of Research and Ambassador Carers Federation • Member of Sir Alex Allan's Parliamentary and Health Service Ombudsman's Clinical Advice Service Review	(a) (d) (a)
Dr John Sykes Medical Director	• Undertakes paid assessments of patients at the request of the local authorities under the Mental Health Act and Mental Capacity Act and acts likewise for solicitors representing patients.	(e)
Richard Wright Non-Executive Director	• Executive Director, Sheffield Chamber of Commerce • Chair Sheffield UTC Multi Academy Trust • Board Member, National Centre of Sport and Exercise Medicine Sheffield	(a) (a) (d)

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

(a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those dormant companies).
(b) Ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
(c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
(d) A position of authority in a charity or voluntary organisation in the field of health and social care.
(e) Detail any connection with a voluntary or other organisation contracting for National Health Services, or hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or any other body which could be seen to influence decisions you take in your NHS role. (see conflict of interest policy - loyalty interests).

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 July 2018

Treat Me Well

Purpose of Report

This report is to share with our Trust Board and the public the national campaign led by MENCAP called Treat me well. Our staff are attending Board to support with Board Education on this important matter, after a recent week of national highlights on people with Learning Disabilities and or Autism.

Executive Summary

Overall individuals with Autism and Learning Disabilities struggle to access psychological care, mental healthcare and physical healthcare.

Our Learning Disability colleagues are attending to provide information to the Trust Board through this national campaign, videos to make the Board think and to ask for their practical assistance in championing the cause of Learning Disability people in our community and in our service transformation developments.

Although there are changes to clinical standards for the Learning Disability services and new standards that our own Learning Disability our services are developing benchmarking to meet the standards. The new Learning Disability standards directly respond to the Treat Me Well campaign. This paper is about the voice of people with a Learning Disability and Autism, the risks associated to their life outcomes throughout discrimination in mainstream services by diagnostic over shadowing where their needs are not met because the focus is placed upon their Learning Disability not their other comorbid health conditions.

The Treat Me Well campaign is lobbying NHS organisations of all forms

- *But we know the treatment people with a learning disability get in hospital is still not good enough in many parts of the country. This has to change.*
- *1200 people with a learning disability die avoidably in hospital, each and every year.*
- *Our campaign, Treat Me Well, calls on NHS staff to make reasonable adjustments for people with a learning disability which can help to save lives.*

Our Board should also be aware that the number of individuals with Profound Multiple Learning Disabilities (PMLD) with complex needs is increasing in our community and the need of this section of our community is significant. In our own system plans the work stream associated with this group, are not present.

Our Learning Disability colleagues would like our Trust to sign the campaign and also step in to enable our community to hear the voice of this campaign and influence our partners and improve our own Physical Healthcare and communication in our own organisation.

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

Assurances

This is a report to influence our Executive Board thinking and consideration of our Clinical strategy in this area.

Consultation

This is a National development supported by MENCAP to raise the profile of people with Learning Disability and Autism and meet their needs our staff have expressed concerns why we have not signed this campaign previously and to make visible and purposeful actions to improve this situation.

Governance or Legal Issues

Discrimination means treating you unfairly because of who you are. The Equality Act 2010 protects individuals from discrimination by focusing upon the protected characteristics in this case this is disability.

The Care Act introduces a single law to replace existing complex legislation around adult social care, new duties for local authorities and partners, and new rights for service users and carers. These include new rules on who qualifies for publicly funded care and support, a stronger focus on wellbeing and prevention and new a safeguarding framework to protect from abuse and neglect.

Care and support services, such as practical assistance at home and support engaging in the community, are often vital in enabling the independence and wellbeing of people with Learning Disability and or Autism.

The Care Act requires councils to make sure any adult with an appearance of care and support needs, and any carer with an appearance of support needs, should receive a needs assessment. If an individual requests an assessment they should receive one regardless of where they (or the person they care for/support) are on the Learning Disability service, their IQ or financial situation.

The Act also requires councils to undertake ‘transition assessments’ if a child, young carer or adult caring for a child is likely to have needs when they, or the child they care for, turns 18. This is regardless of whether the individual currently receives any support from children’s services. This should be a holistic offer meeting all Health care needs, known as the Health Care Plan.

Public Sector Equality Duty & Equality Impact Risk Analysis The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).	
There are no adverse effects on people with protected characteristics (REGARDS).	
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	

Actions to Mitigate/Minimise Identified Risks

- There are approximately 193,707 children of school age in the UK who have a learning disability. Our children's and CAMHS (Child and Adolescent Mental Health Services) services are seeing a rise in individuals requiring our services and help.
- Having a profound Learning Disability is part of the picture, but a number of our services are also supporting Special educational needs (SEN) can affect a child or young person's behaviour, reading and writing, concentration levels, ability to understand things, or their physical ability. (Gov.uk 2016) our current waiting list in the Paediatric service may adversely affect some individuals more than others if there are delays in safe and effective access to assessment.
- In England in 2015, 8% of pupils with SEN (Special Educational Needs) attended special schools. Department for Education (2015) there are risks to our special school services who are seeing increasing demand and pressure.
- Children and young people with a learning disability are at an increased risk of bullying. A review of research on bullying and disability found much variation in reported rates of bullying between different studies, but the majority of studies have found that children and young people with a disability – including those with a learning disability or SEN – are more likely to be bullied than those without a learning disability (Rose 2011; Fink et al. 2015). This can lead to psychological distress and social exclusion, leading to increases chances of mental illness in later life in Derbyshire.
- Children and young people with a disability are more likely to live in poverty than those without a disability (Contact a Family 2012). A lot of data on money and poverty is not broken down into different disability types, and so the research in this section refers to all children and young people with a disability or special educational needs (SEN). This can lead to psychological distress and social exclusion, leading to increases chances of mental illness in later life in Derbyshire.
- Adults with Associative Discrimination already applies to race, religion or belief and sexual orientation. This is now extended to cover age, disability, gender reassignment and sex. It means direct discrimination against someone because they associate with another person with a protected characteristic. Therefore carers and parents of individual may have associate discrimination and potentially indirect discrimination.
- The health inequalities experienced by people with a learning disability are partly caused by poor quality healthcare. In addition, there are a number of

health conditions that people with a learning disability are more likely to experience, including epilepsy, dementia and respiratory disease.

- Additional monitoring of physical healthcare of individuals with Learning Disability or Autism is required on our services, through support teams and in all settings because of this known risk and significant risk of premature mortality.

Recommendations

The Board of Directors is requested to:

1) Receive the paper and be briefed on the treat me well campaign understand the connection with new reviewed clinical standards in Learning Disability services in all settings
2) Be assured that the Learning Disability services are in receipt of these new standards and this is working its way through governance groups to assess against the new standards
3) Understand the connection between the Treat Me Well campaign and the newly issues standards and awaiting further intelligence from the Quality committee and sub structures on current levels of assurance against new standards and improvement plans to meet any gaps in service standards
4) Sign the Treat Me Well campaign and give due regard to our role in influencing and representing the voice of individuals with Learning Disabilities in wider system changes to accept our leadership responsibilities as a large provider of this care pathway for Children's and Adult services.

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

What is Treat Me Well?

- A campaign aimed at NHS Services, predominantly Hospitals but includes any service provided by or on behalf of the NHS. Launched 15 February 2018
- Led by Mencap
- Treat me well, calls on NHS staff to make reasonable adjustments for people with a learning disability which can help to save lives

https://www.mencap.org.uk/get-involved/campaign-mencap/current-campaigns/treat-me-well

Resources currently available

- Survey report completed with NHS staff and people with LD (identifies need for mandatory LD training)
- Short (funny) video to highlight jargon and complicated instructions used by NHS
- A short video to highlight 4 reasonable adjustments that the NHS can make
- Stories about people with LD and their experience of Healthcare
- Easy read materials about rights and the law

Why should DHCFT sign up?

- NHS service
- Requirement to provide an equitable service
- Non LD staff legal requirement to understand and implement reasonable adjustments
- A higher percentage of the LD population also have mental health difficulties than in the ordinary population, therefore many will be seen by MH services
- Also can be applied to people with Autism and other disabilities
- CQC announced that they will include the Accessible Information standard as part of their inspections from October 2017 onwards
- This campaign is not about LD services, therefore is **applicable to the majority of DHCFT**
- DHCFT employ the LD Acute Liaison Nurse at Derby Teaching Hospitals, it would be ironic for them to sign up and not DHCFT
- DHCFT currently employ a number of people with LD who miss out on opportunities provided to other staff due to the lack of reasonable adjustments
- DHCFT provides a specialist LD service; sign up would demonstrate commitment and values of the population they work with
- Demonstrates the values of the organisation
- Supported by Healthwatch Derbyshire

What is the expectation from DHCFT?

- Sign up as an organisation
- Leadership
- All staff learn about reasonable adjustments for people with Learning Disabilities
- Implement reasonable adjustments
- Improved communication
- Include LD information at revalidation

What Law & Policy does this support?

- Equality Act 2010
- Accessible Communication Standard (law since July 2016)
- Mental Capacity Act
- Green light toolkit
- CQC expectations
- Person Centred Care
- Health Literacy (61% of the population struggle to understand health information)

Jackie Fleeman
Learning Disability, Lead Strategic Health Facilitator

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MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Tuesday 5 June 2018

MEETING HELD IN PUBLIC	
Commenced: 9.30	Closed: 12:35

PRESENT	Caroline Maley	Trust Chair
	Dr Julia Tabreham	Deputy Trust Chair and Non-Executive Director
	Margaret Gildea	Senior Independent Director
	Geoff Lewins	Non-Executive Director
	Dr Anne Wright	Non-Executive Director
	Richard Wright	Non-Executive Director
	Ifti Majid	Chief Executive
	Claire Wright	Director of Finance & Deputy Chief Executive
	Dr John Sykes	Medical Director
	Mark Powell	Chief Operating Officer
	Samantha Harrison	Director of Corporate Affairs
	Amanda Rawlings	Director of People & Organisational Effectiveness
	Gareth Harry	Director of Business Improvement & Transformation
IN ATTENDANCE	Donna Cameron	Assistant Trust Secretary (minutes)
	Mo Hussain	Integration Director, Derby Hospitals (Shadowing Ifti Majid)
	Anna Shaw	Deputy Director of Communications & Involvement
Items 076 - 082	Vikki Taylor	STP Director/NHS England
	Darryl Thompson	Deputy Director of Nursing & Quality Governance (on behalf of Carolyn Green)
VISITORS	Melanie Dickson	Liaison Software Corporation
	Gillian Hough	Public Governor – Derby City East
	Moira Kerr	Public Governor – Derby City West
	John Morrissey	Lead Governor & Public Governor – Amber Valley
	Lynda Langley	Public Governor – Chesterfield
	Denise Robson	Support Worker for Moira Kerr
APOLOGIES	Carolyn Green	Director of Nursing & Patient Experience

DHCFT 2018/076	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** The Trust Chair, Caroline Maley, welcomed all to the meeting. Introductions were made to Mo Hussain, Integration Director from Derby Hospitals who had been invited to shadow Ifti Majid, Chief Executive. Vikki Taylor was welcomed from the Joined Up Care Derbyshire Board/NHS England. Gareth Harry, Director of Business Improvement & Transformation was welcomed to his first official Trust Board meeting.

	Apologies for absence were noted as above. The Declaration of Interests register, as included in the Board papers, was noted.
DHCFT 2018/077	**MINUTES OF BOARD OF DIRECTORS MEETING HELD ON 1 MAY 2018** With minor amendments, the minutes of the previous meeting, held on Tuesday 1 May 2018, were accepted as a correct record.
DHCFT 2018/078	**MATTERS ARISING – ACTIONS MATRIX** The Board agreed to close all completed actions. Updates were provided by members of the Board and noted on the actions matrix. All completed 'green' actions were scrutinised to ensure that they were fully complete and actions that were not complete were challenged with Executive Director leads.
DHCFT 2018/079	**QUESTIONS FROM GOVERNORS OR MEMBERS OF THE PUBLIC** No questions had been received from members of the public or governors in advance of the meeting.
DHCFT 2018/080	**CHAIR'S UPDATE AND UPDATE FROM REMUNERATION & APPOINTMENTS COMMITTEE HELD 16 MAY 2018** Caroline Maley provided her report on her activity with and for the Trust since the previous Board meeting held on 1 May 2018, highlighting the following areas. A visit to Cubley Court (female) to attend a Multidisciplinary Team Meeting demonstrated excellence in integrated working for the benefit of patients. Voting had closed in the governor elections. A good response had been received and all vacancies are expected to be filled. One exception is the nominated governor from Derby City Council; this is vacant as the previous post holder had stood down at the last local elections. The City Council is to nominate a new governor. Board Development during May included focus on preparedness for the forthcoming CQC inspection and awareness of Equality & Diversity issues and progress within the Trust. Chairs of the Midlands and East Mental Health Trusts had met and continue to share experiences. The Trust shared how it had prepared for the Workforce Race Equality Standard (WRES). The Chairs had also shared their experience of managing Associate Hospital Managers. The Chair reported that she had been unable to attend the Joined Up Care Derbyshire (JUCD) Board meeting due to annual leave. Julia Tabreham offered to cover such meetings in future if required. A discussion followed on the use and application of the Public Sector Equality Duty & Impact Risk Analysis section in Board report cover sheets. Amanda

	Rawlings and Sam Harrison confirmed that further work is being undertaken to develop and support completion of this section. **RESOLVED: The Board of Directors noted the activities of the Trust Chair throughout the month of May.**
DHCFT 2018/081	**<u>CHIEF EXECUTIVE'S UPDATE</u>** The Chief Executive's report provided the Board of Directors with an update on developments occurring within the local Derbyshire health and social care community. The report also updated the Board on feedback from external stakeholders such as commissioners and feedback from staff. Ifti Majid highlighted to the Board that the Government's proposed Green paper on Transforming Children and Young People's Mental Health has been criticised nationally for lack of pace and substance of recommendations. Early findings of the independent review of the Mental Health Act 1983 (MHA) are outlined in the Chief Executive's report. The Mental Health Act Committee will continue to have oversight of this. NHS England (NHSE) and NHS Improvement (NHSI) have published a report that sets out details of how NHSI intends to shift its focus from regulating trusts to supporting improvement and how the two bodies intend to provide a more joined up and effective leadership of the NHS. The Board will be kept updated as more details emerge. Internally, the Trust has had a busy month with two successful inclusion events (LGBT+ conference and annual BAME conference). The CQC have undertaken unannounced visits and the inspection process is planned to continue until mid-July. Formal feedback is expected after the summer. Ifti Majid continues his 'on the road' visits and reflected that more people are coming to see him and take the opportunity to share with him innovative work and thinking. **RESOLVED: The Board of Directors scrutinised the Chief Executive's update, noting the risks and actions being taken.**
DHCFT 2018/082	**<u>UPDATE ON JOINED UP CARE DERBYSHIRE</u>** Vikki Taylor, STP Director, presented the Joined Up Care Derbyshire (JUCD) Sustainability and Transformation Partnership (STP) report to provide a quarterly update regarding progress. The Board was reminded that the JUCD Board is a partnership of health and social care organisations to drive forward both clinical and financial sustainability of the system to improve services for patients. Since the establishment of STPs there has been a shift in focus from long term redesign of services to a balance between long term development and the 'here and now' – oversight that as a system we are delivering currently. There remains significant financial pressure in the Derbyshire system but this has led to strong partnership working, particularly amongst system leaders supporting this work. Since the STPs were created two years ago a stronger commissioning landscape of Strategic Commissioners has evolved. In Derbyshire the four Clinical Commissioning Groups (CCGs) will be moved into one single Strategic Commissioner with one leadership team. Provider alliances are expected to be developed where

	providers work together to break down barriers to improvement and help support delivery of a more locally provided service. Linked to that is the need to develop leadership and the way system leaders and organisations are working together. John Sykes, Medical Director, asked how the system considers the impact of additional winter funding for provision of additional acute beds when there is a need to support the growing number of elderly people, not just with dementia but with physical health needs, in the community. Vikki Taylor acknowledged the tension and challenge in achieving strategic alignment for delivery of services in priority areas such as those described by Dr Sykes. It is anticipated that the development of Strategic Commissioners would be able to progress development of Patient-Led Assessments of the Care Environment (PLACE) and community delivery. Ifti Majid added that more evidence-based conversations are required on the impact of failing to promote mental health pathways that can prevent hospital admissions which in turn may improve patient flow in a hospital setting. Julia Tabreham, Deputy Trust Chair, asked how provider alliances and Strategic Commissioners can be sure they are providing the services patients need. Vikki advised that provider alliances will not take responsibility for commissioning but focus on how services are delivered. Gareth Harry, Director of Business Improvement and Transformation, added that the Derbyshire CCGs had carried out a significant consultation on a model of care in Derbyshire over a four year period that included engagement with patients and stakeholders; the results suggested a need for greater co-ordination of services and care planned around individuals which is in line with the integration and coordination route being taken forwards by JUCD. Vikki added that an engagement strategy has been developed for JUCD with Communication Leads from provider and commissioner organisations which will be rolled out in the coming weeks. A schedule of meetings will be planned to engage with patients and stakeholders and those dates will be promoted by each organisation. Margaret Gildea, Senior Independent Director, enquired how concerns are escalated from JUCD. Vikki advised that as a Derbyshire system, JUCD has a voice through providers talking to NHS Improvement and Commissioners talking to NHS England. In addition, Vikki's substantive role is with NHS England so she has direct line of communication to NHS England on policy, finance, strategic direction and can feed messages both ways. Following comment regarding workforce leadership and development, Margaret Gildea asked how this would impact on the Trust. Vikki responded that leadership events are available to staff at all levels in organisations and provide opportunities to meet staff, develop leadership skills and network across the system. The wider workforce community is also working to bring leaders together and maximise use of resource. Richard Wright, Non-Executive Director, asked how much money was spent on commissioning health prevention. It was noted that the STP strategy initially focussed on prevention but that this has reduced and should be prioritised going forwards. Mark Powell, Chief Operating Officer, shared with the Board his observations as a member of four work streams; each appears to operate differently with various levels of productivity. He suggested a re-framing of the work streams and membership of them would be beneficial to re-set the core purpose and

	direction. Ifti Majid emphasised the importance of members of the work streams operating in an organisationally agnostic way in order to have full conversations regarding the whole pathway. Caroline Maley added that as a Trust Chair on the JUCD Board she currently did not feel she had overall insight of what is happening in each of the work streams and would benefit from this overview going forwards. **RESOLVED: The Board of Directors thanked Vikki Taylor for attending the meeting and noted the JUCD STP update.** Vikki Taylor left the meeting.
DHCFT 2018/083	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT** Mark Powell presented the Integrated Performance Report (IPR) to provide the Board of Directors with an integrated overview of performance as at the end of April 2018. The focus of the report is on workforce, finance, operational delivery and quality performance. This is the first iteration of a simplified IPR which formed two parts; regulatory performance and performance against Trust strategy. The information is triangulated with other data as presented to Board Committees. Component sections will be presented at Board Committees and performance discussions will continue to take place at Performance Review Meetings with Divisions. The Board was invited to discuss how this report presents effectiveness and identify any further changes for improvement. Ifti Majid agreed that the revised format indicates activity hot spots in the organisation, supporting the current narrative. He supported the addition of more 'people first' metrics and inclusion of information on raising concerns. Geoff Lewins, Non-Executive Director, welcomed the inclusion of data quality kite marks and requested that where they are not applicable that this should be indicated. Richard Wright and Julia Tabreham welcomed the revised format. Julia Tabreham would like to see the issues that impact strategic delivery related to system issues reflected so connectedness can be highlighted. On the matter of a delayed transfer of care (DTOC) that is in excess of six months, Ifti Majid expressed concern for the level of patient experience. Mark Powell confirmed that this DTOC had been escalated to the Director of Social Services and committed to further follow up. In relation to areas where performance is reducing, eg supervision, Mark Powell confirmed that this continues to be a focus in Performance Review Meetings and are also part of the data presented to Board Committees for scrutiny. It was agreed to add information to the Board IPR on the actions being taken to address 'hotspots'. Agency spend continues to be a concern, particularly in light of the pace of recruitment of doctors. Mark Powell confirmed that scrutiny levels remain high and following national guidance on reporting agency spend, the Board can expect to remain informed of this. In relation to doctor recruitment, Amanda Rawlings, Director of People & Organisational Effectiveness, advised that the Trust had been impacted by the national issue of rejection of visas but this is expected to resolve. However, progress in doctor recruitment remains an issue and bolder workforce modelling solutions are under consideration. The issue of data quality in relation to doctor appraisals is to be discussed at Quality Committee later in the month. Ifti Majid requested assurance by the next Board meeting that these issues had been resolved.

	ACTIONS: **1. John Sykes to update the July Board meeting regarding the resolution of data quality issues related to doctor appraisals.** **2. Mark Powell to incorporate suggestions into the next version of the IPR, to be presented to the July Board.** **RESOLVED: The Board of Directors considered the Integrated Performance Report and obtained limited assurance on current performance across the areas presented.**
DHCFT 2018/084	**<u>RATIFICATION OF NOTES OF MEETING HELD 27 APRIL TO APPROVE OPERATIONAL PLAN SUBMISSION</u>** Claire Wright, Deputy Chief Executive & Finance Director, presented the minutes of the above meeting for approval. A verbal update had been provided at the last Public Trust Board meeting. **RESOLVED: The Board of Directors ratified the minutes as an accurate representation of the meeting.**
DHCFT 2018/085	**<u>RADBOURNE UNIT DEEP DIVE</u>** Mark Powell offered apologies on behalf of the Radbourne Team who were not able to attend the Board meeting due to staffing challenges. The Board is aware of the ongoing risks on the Unit, particularly associated with staffing. There remain circa 25 vacancies on the Radbourne Unit. Linked to that are the ongoing challenges linked to capacity for patient flow when caring for people with very complex needs. However, the team continues to explore areas of improvement and has introduced some effective methods that have created greater unity and improved understanding of the needs of the unit and its patients. The Board debated the links between staffing, extended lengths of stay (LOS) and sickness absence, with which there is correlation. The ward environment is rarely at full establishment on any shift which does cause the staff to be frustrated that they are unable to provide all of the therapeutic care they would wish to. A new influx of staff is expected but the impact of delivering their training and support will need to be absorbed in the short term. The skill mix on the Unit has been considered and positive changes made but there is still the need to underpin with sufficient Registered Mental Health Nurses (RMN). Review of staffing movements show that RMNs move internally from the Radbourne Unit so there is a piece of work underway to develop rotational posts so that internal moves are managed, and which in turn will help manage the vacancies. In responding to a question from Margaret Gildea, Mark Powell confirmed that staff are involved in finding solutions to recruitment problems with a wide range involved in all aspects from designing adverts, supporting open days and participating in panels. They are also involved in the selection of agency staff. Learning from those experiences is also incorporated. Leadership opportunities exist in the Unit and suitability for those roles is part of the development process. The importance of supporting the staff on the Radbourne Unit was agreed to be a priority for the Board. In spite of the challenges faced, the Unit performs well

	in the Staff Survey. Staff are invited to speak at national events on the work of the Unit and there is a downward trend in the IPR in reducing LOS; these are all good indicators and a positive narrative. In the meantime, consideration will be given to a variety of options on how pressure can be relieved on staff, although the preference is to improve staffing levels. Support will continue from the Executive Leadership Team and Trust Management Team. Organisational Development support will be supporting leadership in the Unit more closely and the focus on recruitment will continue. **ACTION: Sam Harrison and Mark Powell to agree a future date for the Radbourne Team to present their deep dive to Trust Board.** **RESOLVED: The Board of Directors:** **1. Was assured that the vacancy situation on the Radbourne Unit is not the result of financial pressures and encouraged the continued focus on recruitment and support of staff on the Unit.** **2. Agreed to arrange another opportunity for staff from the Radbourne Unit to attend, noting it may be necessary to have a confidential session.** **3. Supported and will promote a positive narrative on the Radbourne Unit.**
DHCFT 2018/086	**BOARD COMMITTEE ASSURANCE SUMMARIES AND ESCALATIONS** Assurance summaries were received from the Board Committees below, and highlights provided by the respective Non-Executive Chair. **Audit & Risk Committee – Geoff Lewins** The majority of work in the last two meetings had been related to the finalisation of the Annual Report & Accounts, which had been signed off and positive audit findings received on all aspects. John Morrissey, Lead Governor, had attended the meeting when the sign off had taken place. The quality indicator chosen by the Council of Governors (COG) in the meeting held on 21 March 2018 could not be audited because the national data set was not available. The second indicator, also discussed at the same COG meeting, was therefore audited. Internal audit reports had been received on Data Quality and Mental Health Act Committee giving partial and significant assurance respectively. The counter fraud annual report was received which provided significant assurance. Two policies were approved (Accessing Legal Advice and Raising Concerns / Speaking up at Work). The Committee received significant assurance from the Information Governance (IG) Q4 Report. The Trust had received notification that following submission of the IG Toolkit it had been notified as scoring as the top mental health trust in the country and third nationally amongst all trusts. **Quality Committee – Julia Tabreham** The Committee had reviewed preparatory work for the CQC inspection. The Quality Impact Assessment Policy had been approved. A retrospective audit of actions impacting quality of care had been received, providing assurance. Significant assurance had been received on the investigation into and report of the fire alarm incident on the Radbourne Unit in January 2018. **Safeguarding Committee – Anne Wright** Following the attendance of the Director of Public Health at the February Trust Board meeting where there was a discussion around new and emerging

	communities, the Trust has been commissioned to provide a team to support them. Full assurance was received in the last Safeguarding Committee for SEND compliance and adult PREVENT training. **Finance & Performance Committee – Richard Wright** Month 1 reporting was ahead of plan, giving significant assurance on the financial position. The commissioning position compared to last year is improved, as is Improving Access to Psychological Therapies. The new perinatal contract has been received. Work to improve the Cost Improvement Programme position is ongoing. Caroline Maley thanked the Committee Chairs for their scrutiny and focus . **RESOLVED: The Board of Directors received and noted the Board Committee Assurance Summaries**
DHCFT 2018/087	**<u>REPORT ON EFFECTIVENESS OF BOARD COMMITTEES</u>** Sam Harrison, Director of Corporate Affairs & Trust Secretary, presented the report to provide the Board of Directors with assurance on the effectiveness of Board Committees, following the review of year-end reports by the Audit and Risk Committee at its meeting held on 3 May and subsequent discussions at the Board Committee chairs meeting held on 16 May 2018. The report demonstrates how the Trust is sustaining and building upon good governance practice as exemplified through the year-end exercise undertaken by each Committee. Each Committee was also encouraged to set clear developments objectives and a forward plan. A learning point for next year is to have more clarity on how the surveys are included in the year-end reports. Terms of Reference are in place although some movement is expected in Executive Director membership following the appointment of the Director of Business Improvement and Transformation. Membership changes have occurred in-year, including the move to attendance by members only (with exceptions for attendance of individuals presenting papers by invitation). This ensures that challenge and assurance comes via Executive Directors. The Board was asked to note that the suggestion from the Deloitte Phase 1 Well Led Review that Safeguarding Committee and Mental Health Act Committee may be subsumed into Quality Committee has been discussed, and will continue to be regularly reviewed, but the conclusion at this time is that this is not a suitable approach for the Trust. **RESOLVED: The Board of Directors:** **1. Received significant assurance on the effectiveness of Board Committees during 2017/18, as recommended by the Audit and Risk Committee, following the submission of year-end effectiveness reports and review of feedback from qualitative surveys undertaken.** **2. Noted that Terms of Reference for all Committees are under review and will be presented to the Board of Directors once membership is clarified.**
DHCFT 2018/088	**<u>IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK</u>** No issues were highlighted in the meeting for update or inclusion in the Board

	Assurance Framework.
DHCFT 2018/089	**<u>MEETING EFFECTIVENESS</u>** Attendees and visitors were thanked for their attendance and asked to leave the meeting. Board members reflected on their experience of the discussions held. Comments from members of the Board confirmed that assurance had been received on the governance processes and controls. The balance of strategic versus operational debate was welcomed. The debate in the meeting was felt to be improved as a result of not holding a confidential Board meeting, however, it was acknowledged that there will continue to be a need, from time to time, to hold some confidential meetings. Members of the public had mentioned they were not able to hear the meeting clearly. Amanda Rawlings is investigating an equipment upgrade to provide sound projection. Mo Hussain observed that the meeting felt collegiate, showed movement and progress of issues. Papers were concise and impactful. He agreed that the addition of information to the IPR on actions to address hotspots would help members of the public understand how the Trust is responding to those challenges.
DHCFT 2018/089	**<u>FOR INFORMATION</u>** The Board noted the forward plan and the report from the Council of Governors meeting held on 1 May 2018.

The next meeting of the Board to be held in public session will take place at 9.30 on Tuesday 3 July 2018.

The location will be Conference Rooms A & B, Centre for Research & Development, Kingsway, Derby, DE22 3LZ

Date	Minute Ref	Item	Lead	BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - JUNE 2018 Action	Completion Date	Current Position	
28.2.2018	DHCFT 2018/024	Deep Dive – Joint Eating Disorders Service	Carolyn Green	**Transferred to Quality Committee** Introduction of a combined initiative with specialist areas to be captured in the new Eating Disorders Strategy	Nov-18	A revised eating disorder strategy will be submitted to the Quality Committee within a six month delivery date - scheduled for October 2018. **Action transferred to Quality Committee and captured on Quality Committee actions matrix. Quality Committee to confirm when action is complete (due November 2018).**	Yellow
28.3.2018	DHCFT 2018/042	Board Assurance Summaries and Escalations	John Sykes Ifti Majid	**Transferred to Quality Committee** Age discrimination breach within the Equalities Act to be raised with commissioners on behalf of the Quality Committee	1.5.2018	Letter regarding age discrimination breach within the Equalities Act has been sent to commissioners and will be progressed through the Quality Committee and will also be addressed by ELT. **Action complete from the Board's perspective and transferred to Quality Committee and captured on Quality Committee actions matrix. Quality Committee to confirm when action is complete** **Upate from Quality Committee (John Sykes):** Commissioners have confirmed that they will invest in crisis teams this year and that an ageless service is essential to comply with the law. They wish to engage with the Trust to determine the priority of this development against others that have been identified.	Green
5.6.2018	DHCFT 2018/083	Integrated Performance & Activity Report	John Sykes	John Sykes to update the July Board meeting regarding the resolution of data quality issues related to doctor appraisals.	03.07.18	The medical appraisal process is fully compliant with NHS England regional and national requirements. This allows for appraisal to be deferred if, for example, a doctor is unavailable due to long term absence or has just started their first consultant post and needs time to collect the necessary information and feedback. Against these standards the appraisal rate is 100%. The lower figure is drawn from ESR which does not allow for deferment.	Green
5.6.2018	DHCFT 2018/083	Integrated Performance & Activity Report	Mark Powell	Mark Powell to incorporate suggestions into the next version of the IPR, to be presented to the July Board. To include actions being taken to address 'hotspots',	03.07.18	IPR has been enhanced to include further detail on hot spot areas and associated actions. No specific additions have been requested by Board Members. Report remains the same format as last month	Green
5.6.2018	DHCFT 2018/085	Radbourne Unit Deep Dive	Mark Powell & Sam Harrison	Sam Harrison and Mark Powell to agree a future date for the Radbourne Team to present their deep dive to Trust Board.	03.07.18	Provisional date set for September Board. Focus to be further discussed with Trust Chair.	Green

Resolved	GREEN	4	80%
Action Ongoing/Update Required	AMBER	0	0%
Action Overdue	RED	0	0%
Agenda item for future meeting	YELLOW	1	20%
		5	100%

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 3 July 2018

Trust Chair's report to the Board of Directors

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on my activity with and for the Trust since the previous Board meeting on 5 June 2018. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

1. I have made a point of visiting as many front line services as possible, so that my leadership is grounded on the reality of what our staff face every day, and also to ensure that I have a good understanding of the services provided by the Trust.

2. On 15 June, I was pleased to welcome Pauline Latham, MP, Jacci Woodcock, and Rob Johnstone, from the TUC to witness the Trust signing up to the Dying to Work Charter. The Charter sets out how we will support, protect and guide staff throughout their employment, following a terminal diagnosis. This event was attended by a number of members of the Board, staff and staff–side representatives, Governors and public members. Jacci Woodcock started up this campaign after she received a terminal diagnosis and was not supported by her employer. I am very pleased that we have been able to make this commitment on behalf of the Trust to our staff.

3. On 21 June, I visited the Learning Disabilities Team and the Older Adults Community Team in Swadlincote. I was made very welcome by Donna Dyke, Kim West, and Sarah Seale, and I had a brief opportunity to talk to other staff members in the office. Once again I was impressed by the passion and commitment that our staff have for the work that they do and what they do for our service users and carers, the latter being really important to the way that we work. The challenging themes continue to reflect the pressure on our services, the space in which we accommodate staff and access to IT systems. However, it was also an opportunity to reflect on the specialist nature of the skills of staff who look after patients with really challenging needs – and how long it takes to train people to take on these roles. I believe that it is important in looking forward to our services of the future to ensure that we have a pipeline of training for staff to be able to deliver these services as our staff with longer tenure retire. I have raised this with the Executive Leadership Team.

Council of Governors

4. The elections for our new governors ended on Friday 1 June, and I am delighted to be welcoming a number of new governors (both appointed and elected – public and staff) to the Trust over the next few weeks. Formal induction takes place on 26 June, after the completion of this report.

5. The Governance Committee of the Council of Governors met on 12 June. The Committee is chaired by Gillian Hough, and they are doing a lot of work to address the means of engagement with the community, and holding NEDs to account, in terms of framing the questions that they need answers for.

6. On 26 June I am meeting with John Morrissey and Carole Riley, lead and deputy lead Governors, as part of our regular one to one meetings. These are important meetings to ensure that we share information and that there are no surprises.

7. The next meeting of the Council of Governors will be on 3 July following the public Board meeting. The next Governance Committee takes place on 21 August.

Board of Directors

8. On 5 June, I attended the People and Culture Committee to observe how it is in the process of reconfiguring its membership and attendance to become more of an assurance board. There is more to do with the new People Services function settling in, and I am confident that it is on the right path to deliver its objectives.

9. I attended the Mental Health Act Committee on 7 June. One of the important areas that was considered was the work of the Associate Hospital Managers who perform an important role for the Board. It is important that we reconfigure how this group of volunteers is supported, trained and managed to do the role that we need them to do. I look forward to seeing the outcome of the benchmarking and development work that is required to support these people to do the best for our service users.

10. On 7 June I met with Avtar Johal, our NeXT director placement with us, to review his experience so far and his objectives on the scheme. Avtar has also been attending the Board and Council of Governors, as well as the Mental Health Act Committee and Quality Committee as part of his placement. The placement is to help people who want to become NEDs in the NHS to gain exposure to the work of a NED, and our Trust agreed to focus on those form a BAME background. The placement will be reviewed again at the end of September.

11. On 20 June Board Development looked at a psychometric tool called Lumina Spark – both identifying our own working types as well as that of the Board as a whole, Executives and NEDs – helping us to understand the findings from this tool and how they relate to the context of our Trust and culture. It was an important day spent working on our own behaviours and I am sure that we have taken away some valuable actions from the day.

12. I continue to meet with Non-Executives on a one to one basis quarterly. There have been no such meetings in the last month.

System Collaboration

13. The Joined Up Care Derbyshire (JUCD) Board meeting took place on 21 June, and I attended this along with Ifti Majid. Once again there was a focus on the financial gap that the system has in the current financial year and a briefing on

the actions that are being taken to minimise these. However, it seems at times that this is almost an impossible task. We also received updates on the requirements for the system progression towards a Derbyshire Integrated Care System and how the development of the strategic commissioner is progressing, including joint commissioning teams and joint governance and decision making. More detail will be included in the CEO report to this Board.

14. The system has agreed to progress to the appointment of a substantive Sustainability and Transformation Partnership (STP) director, and interviews will be taking place on 6 July. Our Trust has offered to host this important role, and other roles that are appointed to support the development of JUCD.

Regulators: NHS Providers and NHS Confederation and others

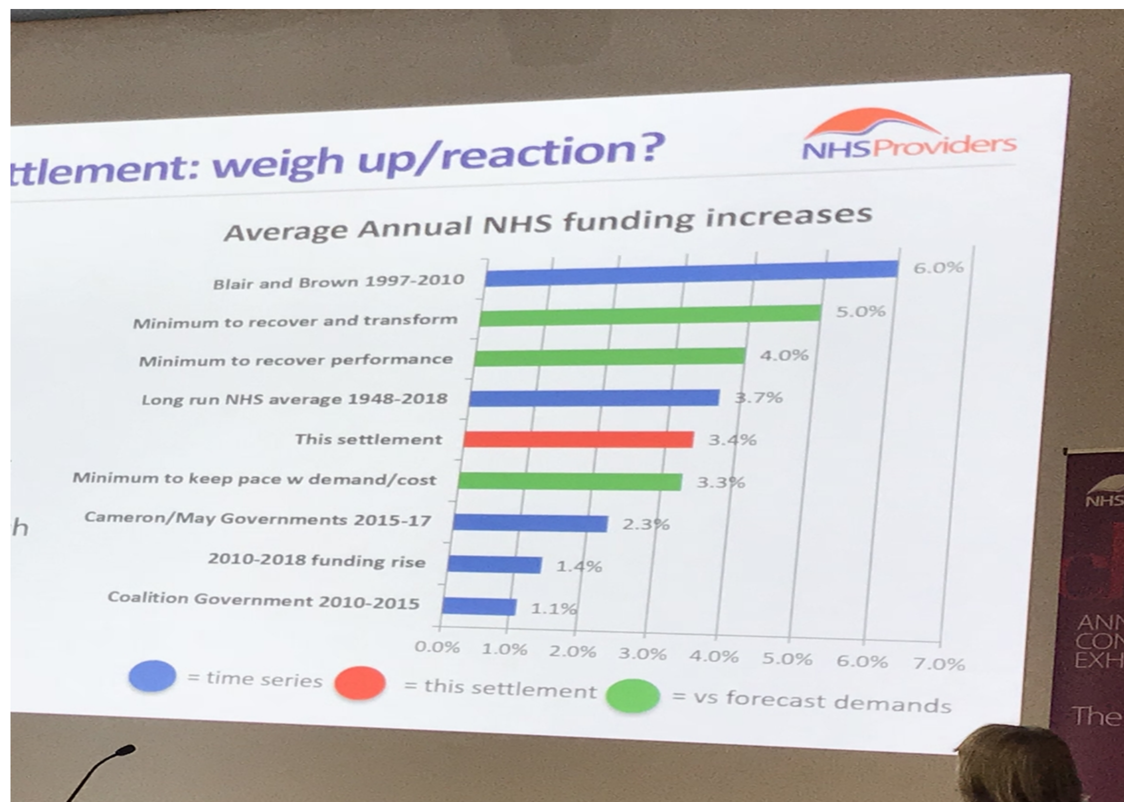
15. Together with Ifti Majid, Claire Wright and Richard Wright, I attended the NHS Confederation annual conference held in Manchester. The conference had a packed agenda, with opportunities to hear from Simon Stevens and Ian Dalton on the coming together of NHS Improvement (NHSI) and NHS England (NHSE), from Jeremy Hunt on the future of the NHS funding - although of course this was before the announcement on 17 June and many other speakers covering a range of important topics. One of the benefits from attending the conference is to meet up with colleagues from trusts all around the country and to compare notes on developments in their systems and performance challenges.

16. On 19 June I attended the quarterly meeting of NHS Providers of Chiefs and Chairs. The meeting heard from David Behan as he nears retirement as CEO of CQC (Care Quality Commission) and what he has learned from his time in charge. He structured his presentation around the following, which I think are all relevant to us today:

    - Purpose - why is your organisation there - this is not the same as its vision;
    - Values and behaviour – the behaviours deliver the purpose, and leaders are judged by what they say and do;
    - Staff engagement – a firm believer that a happy staff delivers great service and improvement starts and ends with staff;
    - Culture of learning, openness and transparency - a just culture is one that recognises that people make mistakes, does not blame but recognises the learning; it requires trust and organisational improvement;
    - Collaboration – no single organisation can meet the needs to the complex comorbidity that we see today; collaboration is about behaviours and not documents or governance.

    We also heard from Chris Hopson, the CEO of NHS Providers, with perspectives including the financial settlement that was announced on 17 June, and the role that the regions being developed by NHSI and NHSE will play in the future.

    There is a sharp reminder that the new money will not solve all the issues that we wish and that we still need significant transformation in the NHS. It is also clear that the new ten year plan to be developed over the next few months will include mental health waiting targets.



Jeremy Hunt also attended in the afternoon, and recognised the importance of the commitment of the government to the NHS, but also recognised the challenges that remain without Social Care receiving any additional funds / being considered as part of the next spending review.

Beyond our Boundaries

17. There is no activity to report this month.

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

Assurances

- The Board can take assurance that the Trust level of engagement and Influence is high in the health and social care economy.
- Feedback from staff and other stakeholders is being reported into the Board.

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

None

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).

There are no adverse effects on people with protected characteristics (REGARDS).	x
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	

Actions to Mitigate/Minimise Identified Risks

The report outlines the Trust signing up to the Dying to Work charter which is a direct commitment to support those with a terminal diagnosis and to ensure that there is no discrimination to these individuals within the Trust and that a colleague with a life limiting condition is supported throughout their employment with compassion and the provision of reasonable adjustments as required (based on individual needs).

Governor Elections - We work actively to encourage a wide range of nominees to our governor elections, and strive that our Council of Governors is representative of the communities they serve. We also provide support to any current or prospective governors to enable them to carry out their role to address any specific needs they may have. This includes providing transport for those who may not be able to access public transport due to physical needs, accommodating communication requirements and providing support workers at meetings. We currently have 16 publically elected governors representing our local demographic population.

The Board Development session on 20 June looked at a psychometric tool called Lumina Spark – both identifying our own working types as well as that of the Board as a whole. This will have a positive impact in terms of enabling an inclusive culture which embraces different perspectives, fostering good relationships and support by

valuing individual diversity and individual needs/preferences (neurodiversity).

Demonstrating inclusive leadership at Board level

Through the Trust's involvement in the NeXT Director scheme, hosting a placement for Avtar Johal, we are supporting the development of those who may find it more difficult to be appointed as a NED in the NHS. This placement will run to the end of September, when we will review the effectiveness of our support for Avtar and the scheme before deciding on our next steps.

Recommendations

The Board of Directors is requested to consider the content of this report, and to ask for any clarification or further information.

Report prepared and presented by: **Caroline Maley**
Trust Chair

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 July 2018

Chief Executive's Report to the Public Board of Directors

Purpose of Report

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

National Context

1. On 18 June the Prime Minister, Theresa May, announced a new five year funding settlement for the NHS starting from 2019/20, giving the service real terms growth of more than 3%for the next five years. In addition she has also tasked the NHS with producing a ten year plan to improve performance, specifically on cancer and mental healthcare, and unpick barriers to progress. The key points the Board should be aware of from this announcement include:

    - The average annual uplift is 3.4% per year above inflation – based on Office for Budget Responsibility projections. The funding is frontloaded, meaning the annual rates of growth are: 3.6%; 3.6%; 3.1%; 3.1%; 3.4%.
    - This will equate to £20.5bn more revenue in real terms compared with 2018-19.
    - A further £1.25bn has been found to deal with an increase in pensions costs associated with the new Agenda for Change pay deal.
    - The funding is for the NHS England commissioning budget only.
    - In an appearance in front of the Public Accounts Committee and in his speech at Confederation 2018, Simon Stevens said there was an explicit commitment from the government that the adult social care budget would be set to not put further pressure on the NHS.
    - Simon Stevens has told MPs the extra money does include funding for an increase in Agenda for Change salaries from next year.
    - How the increase will be funded is unclear. While the prime minister has emphasised that some of it will come from monies no longer being paid to the European Union, along with tax and borrowing rises, the "Brexit" element has been disputed by economists.

    In return for the increase in funding, the NHS has been tasked to develop a ten year plan, via an "assembly" convened by national leaders that I referred to in my report to Board last month. The Prime Minister has emphasised that this should have strong clinical input.

    The ten year plan, which will likely be delivered by the autumn budget, should set out how the service intends to deliver major improvements in mental health and cancer care.

    Ministers may be considering legislative reform: the Prime Minister described the number of contracts held between NHS organisations as a "problem", and said she wanted the service to suggest ways of breaking down any barriers that might hold up progress, including in the regulatory framework.

The Prime Minister set out five priorities for the NHS:

- Putting the patient at the heart of how care is organised
- A workforce empowered to deliver the NHS of the future
- Harnessing the power of innovation
- A focus on prevention
- "True parity of care" between mental and physical health.

The Prime Minister said she would like to see the ten year plan set out ambitious "clinically defined access standards" for mental health and, she said clinicians should confirm the NHS is focused on the right performance targets for both physical and mental health – indicating that ministers may be willing to reconsider key performance standards.

From our Trust's perspective the five year funding settlement is good news, it may be below what economists have said the NHS requires, however it is in line with the average settlements other public sector organisations have seen since 2010. It is good news the pension increases will be funded separately although more understanding is needed around the general agenda for change pay award funding from next year. Equally of concern is the lack of clarity about any settlement for our Children's Universal and Specialist Services and Substance Misuse Services funded by Public Health as these are excluded from the settlement announced by the Prime Minister.

It is very positive to see mental health playing a strong part in the narrative associated with the announcement. I welcome the opportunity to look again at how we develop meaningful targets and will be urging they are a mixture of short term and longer term mental health prevention based measures. The mental health/physical health agenda is clearly in urgent need of targeted investment but it is important that some other core areas that have suffered due to austerity measures start to be built up again such as primary care mental health services and the wide range of guided and self-help facilities provided by the voluntary and independent sector. Finally I note the focus in some of the content of the Prime Minister's enhancements to digital and its use to support capacity. This is something we must look more at in our organisation both around efficiency of support services as well as direct clinical care delivery but note it is not a replacement for adequately staffed services.

2. At the beginning of June 2018 NHS Improvement released the performance of the Foundation Trust and Trust sector for 2017/18. The key headlines include:

    - The Q4 deficit for the sector is £960m compared to the £791m figure reported the previous year. Board members will remember the sector start plan deficit was £496m
    - The Q4 actual position does however show an in quarter improvement against the Q3 deficit of £1.28bn
    - The CCGs ended the year £251m in deficit but commissioning as a whole finished underspent by £955m due to NHS England central underspends)
    - 44% of Trusts finished the year in deficit (89 Acute Trusts and 13 Community / MH / Ambulance)
    - The sector deficit position was driven by
        - Unprecedented winter pressures
        - Non delivery of CIP (achievement was £3.2bn however underachievement was £477m)
        - £1.49bn over spend on pay costs including £976m on bank overspend. Agency spend reduced by 18% resulting in an overall reduction in

temporary staffing of £67m (1.2%). I think it important to see this real reduction in the context of the staffing shortages we as a Board have been very aware of and that have been replicated throughout the sector.

- Worth noting spend on non-pay increased during Q4 with increased spending on both clinical and non-clinical supplies, premises and spend on other providers (out of area placements for example). There is no doubt that with the operational productivity review for community and mental health services now being released we can expect to see increased focus on non-pay spend and measures to reduce.
- Only 22 trusts did not sign up to their control total and thus received no Sustainability Transformation Fund (STF) income either during the year or as part of the year end round up.
- Financial penalties imposed by commissioners fell during the year to £40m nationally.
- 5.34 million patients attended A&E this year of whom 84.97% were seen within 4 hours, a slight improvement from last year.
- 6.26 million non-elective admissions during the year 2.2% above plan and 3.5% above last year and is important as this relates to the regulators reluctance to allow growth to below national expectations.
- Sadly the elective waiting list has grown by 2.9% during the year with more patients waiting longer that 18 weeks and an increase in people waiting longer than a year for treatment.
- The NHS had 92,694 vacancies in NHS Trusts (8%)

As we review the integrated performance report it is important to view our Trust performance in the context of overall NHS performance.

Local Context

3. The Joined up Care Derbyshire (JUCD) Board met on 21 June. Key issues discussed included:

- Confirmation that the JUCD Assurance Board had met for the first time and would now be acting as the point of assurance for all programmes of work within the Sustainability Transformation Programme (STP) regardless of whether there was a financial benefit attached to the programme.
- The previously discussed strengthening of the core STP support Team is underway with the advert for a lead director closing on 22 June. Derbyshire Healthcare will be acting as the host organisation for these support teams with financial costs and risks being equally shared throughout the system. This demonstrates the system view of our Trust as a key advocate and supporter of the need to work in a different way, delivering the agreed programmes of work.
- A new JUCD website will go live on 11 July, replacing the existing website. In addition to support the increased focus on how we communicate with and engage residents of Derbyshire a video is being produced that will describe the case for change locally.
- Derbyshire has been allocated £508,000 to support new models of workforce to support the required transformation with expectations this will focus on areas such as extended roles (non-medical prescribing), apprenticeships, promoting prevention and health and wellbeing.
- Discussions about the development of Place Alliance Groups and how these support the development of the strategic commissioner by taking responsibility for developing and testing new local models of care and acting as the point of local integrated care delivery.
- Received an update about the wave 4 capital bids that had been prioritised by

Derbyshire in association with updating our Local Estates Strategy. The top three priorities are Buxton Community Hub, Bakewell Community Hub and Shirebrook Joint Service Centre.
- The JUCD received and approved an engagement strategy for the STP to support engaging local people around the proposed changes

4. On Monday 18 June I had the privilege of being part of the Derbyshire County Council recruitment panel to appoint the Director of Adult Social Care to replace Joy Hollister. Joy is retiring after the summer and her passion, drive and challenge in the way the system works and how it should prioritise community interventions will be missed. I am delighted at the new appointment which will be formally announced in the near future.

5. I was invited to attend a Workforce Race Equality Standard Roundtable event in Birmingham led by Yvonne Coghill who is the NHS England Lead. This event was a mixture of understanding national data patterns and developing an understanding about themes emerging around recruitment, disciplinary and disciplinary sanction and personal development. In addition we were able to share some actions attendees were taking to address those common themes. Since the meeting I have set up a task group to look at the development of 'Inclusion Guardians' who would be trained to sit on all recruitment (and possibly disciplinary)panels to ensure equity of opportunity for colleagues from all protected characteristics.

Within our Trust

6. During June I am absolutely delighted that myself and several Executive Directors took part in their first Reverse Mentoring for Diversity and Inclusion session being mentored by colleagues from different BME backgrounds at various levels within our organisation. As I mentioned in my report in April the process is closely governed and will follow a four domain framework model. In addition through links with the University of Nottingham this work will be part of a formal research study. The sessions are an exciting and alternative way to hear the voice of BME colleagues in our organisation as well as to support the development of both the Executive and the BME Mentor. I would add that this is a real 'power shift' with the sessions being led not by the Executive but by the BME Mentor.

7. On 15 June we held a ceremony attended by Pauline Latham MP, representatives from the TUC, Governors and Board members to sign the Dying to Work Charter – a vital pledge and call to action to ensure that people who are diagnosed with terminal illness are treated fairly and with dignity at work and ensuring that at a time of great need they are not taken advantage of by unscrupulous employers. It was particularly great to hear from Jacci Woodcock, the courageous individual who started the charter following her own battle with cancer and challenges with her employer.

8. Week commencing 11 June saw the CQC visiting Trust Services for the second in depth review as part of the revised comprehensive inspection. Services visited included Learning Disability, Crisis and Liaison, Adult Mental Health Community and In-Patient. It is too early to confirm full feedback for these services or revised ratings however on behalf of the Board I would like to thank colleagues involved for the confident and professional way the visits were managed particularly as they came at a time of increased pressure with regards capacity in many of the services visited. We still have the well led component of the visit to complete week commencing 9 July and I would hope to see the initial draft reports some 6 - 8 weeks after that.

9. I am delighted to inform the Board that congratulations are in order for our Community Perinatal Service as it has now received formal notification of it achieving accreditation via The Royal College of Psychiatrists. This means that we now have an accredited inpatient and community perinatal service which meet all the expected essential standards. This is great timing given the recent confirmation of national investment to support community service expansion

10. Since the last Board the Executive Team have been actively engaging colleagues through individual Director visits, *Ifti on the Road* engagement events and pre-ELT drop ins at:

    - St Andrews House, Derby
    - Rivermead, Belper
    - Learning Disability services as part of LD Awareness Week and included a letter of thanks to all staff for their support during change processes
    - IAPT Team Ilkeston Resource Centre
    - Derby City Mission
    - Century House, Long Eaton

    Key themes that emerged from these sessions included:

    - The importance of a welcoming reception environment and it was great to hear colleagues at St Andrews coming up with a number of good options for improvement.
    - The need for greater understanding about the impact that changes in Place may have on our community teams
    - Car parking, whilst improvements noted in some areas in others pressures continue
    - Some positive comments about safety planning and how it has supported and

enabled appropriate discharge from services.

Feedback from each visit has been logged on our engagement spreadsheet, actions allocated and shared with our freedom to speak up guardian. The Board may remember some feedback in relation to the environment at St Marys Gate, Chesterfield (Substance Misuse Service) two months ago. I am delighted to report that the requested bike sheds are now in place and work has been completed to increase air circulation within the building.

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

Assurances

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

Consultation

- The report has not been to any other group or committee though content has been discussed in various Executive meetings

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).

There are no adverse effects on people with protected characteristics (REGARDS).	
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	x

Actions to Mitigate/Minimise Identified Risks

This document is a mixture of a strategic scan of key policy changes nationally and locally that could have an impact on our Trust and the reporting of internal actions and feedback I have received relating to the strategy delivery.

Any implementation of national policy in our Trust would include a repeat Equality Impact Assessment even though this will have been completed nationally.

That said some of the reports both nationally and within the Derbyshire system have the potential to have an adverse impact on people with protected characteristics for example the work looking at current estate utilisation and prioritisation of some locality buildings over others whilst increasing access in some areas could by definition reduce access for some users of our service.

Any equality impact assessment carried out will determine a response to the three aims of the general equality duty:

- identifying barriers and removing them before they create a problem
- increasing the opportunities for positive outcomes for all groups, and
- using and making opportunities to bring different communities and groups together in positive ways.

The specific focus we have on hearing the views of colleagues from a BME background through our reverse mentoring programme supports our adherence with our Board equalities of colleagues from protected groups is complex as colleagues by definition will fall into several groups.

The signing of the Dying to Work Charter demonstrates the Trusts commitment to supporting those colleagues with a disability/Long Term Condition and is a positive contribution to inclusion within the workplace.

Recommendations

The Board of Directors is requested to:

1) Scrutinise the report, noting the risks and actions being taken
2) Seek further assurance around any key issues raised.

Report prepared and presented by: **Ifti Majid**
Chief Executive

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 July 2018

Integrated Performance Report Month 2

Purpose of Report

This paper provides Trust Board with an integrated overview of performance as at the end of May 2018. The focus of the report is on workforce, finance, operational delivery and quality performance.

Executive Summary

The Trust continues to perform well against many of its key indicators, with maintenance or improvements continuing across many of the Trust's services. These can be seen within the body of this report.

There are a number of areas where performance is below Trust standards or trends are showing an overall decline in performance. In order to ensure that there is a focused discussion on key issues these have been listed below.

1. Regulatory Compliance dashboard

- Sickness absence
- Appraisals
- Mandatory Training

2. Strategy Performance dashboard

- Cost Improvement Plan
- Agency Spend
- Delayed Transfers of Care (DTOC)
- Neighbourhood waiting times

At the end of the report further information is provided regarding some aspects of data quality assurance for a number of amber rated kitemarks and a rationale for why all finance measures are rated as green.

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

Assurances

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

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

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

Consultation

This paper has not been considered elsewhere however; some content supporting the overview presented is regularly provided to, Finance and Performance Committee, People and Culture Committee and Quality Committee.

Governance or Legal Issues

Information supplied in this paper is consistent with the Trust's responsibility to deliver all parts of the Single Oversight Framework and the provision of regulatory compliance returns.

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).

There are no adverse effects on people with protected characteristics (REGARDS).	
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	X

Actions to Mitigate/Minimise Identified Risks

This report reflects performance related to our whole staff and service receiver population and therefore includes members of those populations with protected characteristics in the REGARDS groups.

Any specific impact on members of the REGARDS groups is described in the report itself.

Recommendations

The Board of Directors is requested to;

1. Confirm the level of assurance obtained on current performance across the areas presented.
2. Determine whether further assurance is required and at which Committee this needs to be provided and by whom.

Report presented by:	**Mark Powell, Chief Operating Officer** **Claire Wright, Director of Finance/Deputy CEO** **Amanda Rawlings, Director of People and Organisational Effectiveness** **Carolyn Green, Director of Nursing and Patient Experience**
Report prepared by:	**Peter Charlton, General Manager, IM&T** **Rachel Leyland, Deputy Director of Finance** **Liam Carrier, Workforce Systems & Information Manager** **Rachel Kempster, Risk and Assurance Manager** **Peter Henson, Performance Manager**

Integrated Performance Report Month 2

1. Regulatory Dashboard

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	DQ
Finance	Finance Score	Finance Scorecard	YTD	2	1	G	→		
			Forecast	1	2	R	↑		
		Capital Service Cover	YTD	3	2	G	→		
			Forecast	2	2	G	→		
		Liquidity	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Income and Expenditure Margin	YTD	2	1	G	→		
			Forecast	1	1	G	→		
		Income and Expenditure variance to plan	YTD	1	1	G	→		
			Forecast	1	2	R	↑		
		Agency variance to ceiling	YTD	1	1	G	→		
			Forecast	1	2	R	→		
	Single Oversight Framework	Agency costs as % of total pay costs	YTD	2.9%	2.7%	G	→		
			Forecast	2.9%	3.4%	R	→		
		NHS I Segment	YTD	N/A	2		→		
Quality and Operations	KPIs	CPA 7 Day Follow-up (M)	May, 2018	95.00%	96.08%	G	↓		
			Apr, 2018		100.00%	G			
		Data Quality Maturity Index (DQMI) - MHSDS Data Score (Q)	May, 2018	95.00%	96.17%	G	→		
			Apr, 2018		96.49%	G			
		IAPT RTT within 18 weeks (Q)	May, 2018	95.00%	99.86%	G	→		
			Apr, 2018		99.85%	G			
		IAPT RTT within 6 weeks (Q)	May, 2018	75.00%	96.13%	G	↑		
			Apr, 2018		95.10%	G			
		Early Intervention in Psychosis RTT Within 14 Days - Complete (Q)	May, 2018	53.00%	82.76%	G	↓		
			Apr, 2018		100.00%	G			
		Early Intervention in Psychosis RTT Within 14 Days - Incomplete (Q)	May, 2018	53.00%	83.33%	G	↓		
			Apr, 2018		100.00%	G			
		Patients Open to Trust In Employment (M)	May, 2018		10.25%	G	→		
			Apr, 2018		10.44%	G			
		Patients Open to Trust In Settled Accommodation (M)	May, 2018		59.36%	G	↓		
			Apr, 2018		60.47%	G			
		Under 16 Admissions To Adult Inpatient Facilities (M)	May, 2018	0	0	G	→		
			Apr, 2018		0	G			
		IAPT People Completing Treatment Who Move To Recovery (Q)	May, 2018	50.00%	53.25%	G	↓		
			Apr, 2018		54.81%	G			
		Physical Health - Cardio-Metabolic - Inpatient (Q)							
		Physical Health - Cardio-Metabolic - EI (Q)							
		Physical Health - Cardio-Metabolic - on CPA (Community) (Q)							
		Out of Area - Number of Patients Non PICU (M)	May, 2018		8		↓		
			Apr, 2018		11				
		Out of Area - Number of Patients PICU (M)	May, 2018		26		↑		
			Apr, 2018		23				
		Out of Area - Average Per Day Non PICU (M)	May, 2018	9.7	3.7	G	↓		
			Apr, 2018	9.7	4.5	G			
		Out of Area - Average Per Day PICU (M)	May, 2018	24.6	15.6	G	↑		
			Apr, 2018	24.6	14.1	G			
		Written complaints – rate (Q)	Q4 2017/18		0.03		↑		
			Q3 2017/18		0.02				
		Staff Friends and Family Test % recommended – care (Q)	Q4 2017/18		73%		→		
			Q2 2017/18		73%				
		Occurrence of any Never Event (M)	May, 2018	0	0	G	→		
			Apr, 2018		0	G			
		Patient Safety Alerts not completed by deadline (M)	May, 2018	0	0	G	→		
			Apr, 2018		0	G			
		CQC community mental health survey (A)	2017		7.3/10		↑		
			2016		7.0/10				
		Potential under-reporting of patient safety incidents (M)							
Workforce and Engagement	KPIs	Turnover (annual)	May, 2018	10.00%	10.19%	G	→		
			Apr, 2018		10.42%	G			
		Sickness Absence (monthly)	May, 2018	5.04%	4.91%	G	→		
			Apr, 2018		4.82%	G			
		Sickness Absence (annual)	May, 2018	5.04%	5.40%	R	→		
			Apr, 2018		5.39%	R			
		Vacancies (funded fte)	May, 2018		11.94%		↓		
			Apr, 2018		13.18%				
		Appraisals All Staff (number of employees who have received an appraisal in the previous 12 months)	May, 2018	90.00%	79.06%	R	→		
			Apr, 2018		79.52%	R			
		Medical Appraisals (number of medical employees who have received an appraisal in the previous 12 months)	May, 2018	90.00%	100.00%	G	→		
			Apr, 2018		100.00%	G			
		Compulsory Training (staff in-date)	May, 2018	90.00%	85.67%	A	→		
			Apr, 2018		85.81%	A			
		NHS Staff Survey (A)	Work		60.92%				
			Treatment		72.77%				

Key:

Period Current Month / Previous Month

- Green: Achieving target
- Red: Not achieving target
- Amber: Within tolerance
- Blue: No Target Set

↑ → ↓ Trend compared to previous month/quarter with tolerance of 1%

1.1 Finance Position

The overall score of a '1' is better than plan year to date. The forecast of a '2' is worse than the plan. This is mainly due to two of the metrics:

- Income and Expenditure variance to plan – Plan was based on Income and Expenditure of £2.331m as a percentage of total income of £143.79m which is 1.62%. The forecast Income and Expenditure is as per the plan but the forecast income has increased to £144.7m which generates a margin of 1.61%, so a variance to plan of 0.01% which changes the score on that metric to a '2'.

- Comparing the actual expenditure on Agency to the ceiling, we are below the ceiling value by £62k (12%) at the end of May. This generates '1' on this metric within the finance score. Agency expenditure is forecast to be above the ceiling by 15.5% which is generating a score of '2' which is worse than the plan. Agency expenditure is forecast to be above the ceiling by £468k. Included in the forecast is a contingency of £450k.

1.2 Agency cost as % of total pay

The plan of 2.9% reflects the ceiling of £3.030m as a percentage of the total pay budget. The agency expenditure is forecast to be higher than plan and also the total pay expenditure is forecast to be less than the plan.

The forecast agency expenditure equates to 3.4% of the pay budgets (3.7% last month). National NHSI benchmarking information from 2017/18 showed agency expenditure at 4.5% of pay budgets with Midlands and East region at 5.2%.

1.3 Sickness Absence

The table below shows the main sickness absence hotspot service areas for May.

Sickness Absence May 2018	HC	%
RDH Ward 36 Adult Acute Inpatient IP	28	18.35%
Hartington Unit Tansley Ward Adult IP	24	16.34%
Patient Records	10	12.37%
Derby City Drug Team	18	12.15%
Derby City Early Intervention	14	11.98%
Nursing and Operations Management	12	11.29%
KillNthCfld Neighbourhood - Older Adult	10	10.93%
Hope & Resilience Hub	22	10.84%
Psychology LD	11	10.80%
Derby City Neighbourhood - Adult Team C	29	10.79%
County South Early Intervention	10	10.52%
Enhanced Care Ward IP	31	10.50%
Maintenance	21	10.45%
City & County South CRHT	32	10.19%
RDH Ward 33 Adult Acute Inpatient IP	26	10.01%
Amber Valley Neighbourhood - Adult	19	9.64%
RDH Ward 35 Adult Acute Inpatient IP	29	9.10%
LRCH Ward 1 OP IP	35	8.06%
District CAMHS Medical	12	8.03%
KillNthCfld Neighbourhood - Adult	22	8.02%

A main area of focus has been the Radbourne Unit where dedicated support has been provided by the People Services team during the last month looking at sickness. 22 staff were absent during May - 12 on short-term absence and 10 on long-term absence (4 weeks or more) some staff are now back at work. It has been agreed that ER Managers will pick up the long term (4 months and over cases) with managers to help work through bottlenecks.

A new attendance guide has been written and is currently being discussed with the unions regarding attendance. It is proposed that first care will send this out with their first letter.

1.4 Appraisals

The table below shows the main appraisal hotspot service areas for May.

Appraisal Compliance May 2018	HC	%
CfldCentral Neighbourhood - Adult	32	25.00%
CAMHS IAPT	11	27.27%
Amber Valley Neighbourhood - Adult	19	42.11%
Early Access	30	46.67%
Operational Support Admin	10	50.00%
Supported Care	28	57.14%
Nursing and Operations Management	12	58.33%
UPC Management	17	58.82%
County South Early Intervention	10	60.00%
Psychology Neighbourhood	35	62.86%
Pharmacy	36	66.67%
Derby City Drug Team	18	66.67%
IAPT	80	67.50%
Enhanced Care Ward IP	31	67.74%
Dynamic Psychotherapy Duffield Road	13	69.23%
In Reach + Home Treatment OP	13	69.23%
Neuro Developmental Team	10	70.00%
Medics Neighbourhood Sth	10	70.00%
County North Early Intervention	17	70.59%
Domestics MH Properties	14	71.43%

There are low completion rates in some areas where leaders have been under pressure due to staff shortages and sickness absence. There is some apathy noticed in the staff survey that staff do not feel the appraisal is of value, more of a tick box exercise, paperwork is lengthy and not easy to complete.

New appraisal paperwork to be rolled out (date tbc) which will be aligned to incremental progression as in Agenda for Change, this will provide for more meaningful and qualitative appraisals and will drive up completion rates.

New People Services, Divisional People Leads will be taking a lead with services to look at hot spots and provide support and guidance, new training to be rolled out as part of the leadership strategy which will raise the profile and importance of a good appraisal.

The number of Medical staff who have received an appraisal within the last 12 months is currently 100%

1.5 Training

The table below shows the main mandatory training hotspot service areas for May.

Compulsory Training Compliance May 2018	HC	%
CAMHS IAPT	11	32.99%
County South Training Grades	10	56.82%
UPC Management	17	66.67%
Domestics MH Properties	14	69.84%
Paediatric Medical	17	73.86%
Trainee Clinical Psychologist	10	74.44%
Medics Neighbourhood City	11	74.75%
Liaison Team North	23	75.36%
Chesterfield CRHT	25	77.33%
Sth DD Neighbourhood - Adult	24	78.24%
Supported Care	28	78.57%
The Lighthouse DH	14	78.57%
Derby City Early Intervention	14	79.37%
CAMHS Admin	23	79.61%
Medics Neighbourhood Nth	17	79.74%
Hartington Unit Morton Ward Adult IP	27	79.84%
CfldCentral Neighbourhood - Adult	32	79.86%
County South Early Intervention	10	80.00%
Domestic Kingsway	55	80.72%
Maintenance	21	81.48%

A deep dive will be in undertaken to understand which elements of mandatory and role specific training require additional resource.

In addition, now that People Services are in place colleagues are now available to work alongside operational colleagues to understand and address any barriers to completion. Moreover, supportive sessions are being conducted across the organisation to engage with staff and in particular bank staff to understand ESR and undertake eLearning.

2. Strategy Delivery

Category	Metric	Period	Target	Actual	Variance	Trend	Last 12 Months
Finance Scorecard	Finance Scorecard	YTD	2	1	G	→	
		Forecast	1	2	R	↑	
	Control Total position £000	YTD	164	395	G	↑	
		Forecast	2331	2331	G	→	
	CIP achievement £m	YTD	0.759	0.681	R	↑	
		Forecast	4.871	4.871	G	→	
		Recurrent	4.871	2.460	R	↓	
	Agency £m	YTD	0.506	0.443	G	↑	
		Forecast	3.030	3.498	R	↓	
	Cash £m	YTD	20.390	22.135	G	↑	
		Forecast	21.608	21.608	G	→	
Quality and Operations Scorecard	RTT Incomplete Within 18 Weeks (%)	May, 2018	92%	93.1%	G	↓	
		Apr, 2018		94.1%	G		
	CPA Review in last 12 Months (on CPA > 12 Months)	May, 2018	95%	95.1%	G	→	
		Apr, 2018		96.0%	G		
	Delayed Transfers of Care (%)	May, 2018	0.8%	2.1%	R	↑	
		Apr, 2018		0.9%	R		
	North Neighbourhood Average Wait (weeks)	May, 2018		8.0		↓	
		Apr, 2018		9.4			
	North Neighbourhood Current Waits (number)	May, 2018		1973		↓	
		Apr, 2018		1993			
	City Neighbourhood Average Wait (weeks)	May, 2018		8.1		↓	
		Apr, 2018		8.8			
	City Neighbourhood Current Waits (number)	May, 2018		1382		↑	
		Apr, 2018		1340			
	South Neighbourhood Average Wait (weeks)	May, 2018		10.1		↑	
		Apr, 2018		9.1			
	South Neighbourhood Current Waits (number)	May, 2018		1764		↓	
		Apr, 2018		1802			
	CAMHS Average Wait (weeks)	May, 2018		7.0		↓	
		Apr, 2018		8.0			
	CAMHS Current Waits (number)	May, 2018		344		↓	
		Apr, 2018		350			
	Community Paediatrics Average Wait (weeks)	May, 2018		15.9		↓	
		Apr, 2018		16.7			
	Community Paediatrics Current Waits (number)	May, 2018		923		↓	
		Apr, 2018		994			
	Number of Adult Acute Inpatients (Hartington and Radbourne) LoS > 50 Days	May, 2018		70		↑	
		Apr, 2018		60			
Workforce and Engagement Scorecard	RETAIN - Staff engagement score	2017 Annual	To see an improvement in the staff engagement score	3.740	G	↑	
		2016 Annual		3.690			
		Q4 Mar 2018		72%	G	↑	
		Q2 Sep 2017		70%			
	DEVELOP - Retention of preceptorship staff	Q4 Mar 2018	Percentage of preceptorship staff who stay with the Trust greater than 2 years	75%	R	↓	
		Q3 Dec 2017		80%	R		
		Q2 Sep 2017		82%	R		
		Q1 Jun 2017		84%			
	ATTRACT - Students who return substantively following their placement	Q4 Mar 2018	Number of students who return substantively following their placement	7		↓	
		Q3 Dec 2017		24			
		Q2 Sep 2017		9			
		Q1 Jun 2017		n/a			
	LEADERSHIP & MANAGEMENT - Employee relations cases	Q4 Mar 2018	To see a reduction in the number of cases	48	R	↑	
		Q3 Dec 2017		45	R		
		Q2 Sep 2017		37	G		
		Q1 Jun 2017		38			

Key:

Period Month
Previous Month

Achieving target
Not achieving target
No Target Set

Target
Trend

Trend compared to previous month with tolerance of 1%

2.1 Cost Improvement Programme (CIP)

As at the end of May CIP of £4.1m has been actioned in the ledger (84% of target) leaving a balance of £775k. This is an increase from last month of £657k. Of the £4.1m assured 41% of it is recurrent.

The forecast assumes that the balance of the CIP will be found recurrently. The current gap without any identified schemes has reduced to £189k.

2.2 Delayed Transfers of Care (DTOC)

The number of occupied bed days each month is used as the denominator to calculate the rate of delayed transfers of care. The higher the number of occupied bed days, the lower the rate of delayed transfers. When NHS England set the Trust's target back in January 2017 they estimated that we would have 8384 occupied bed days a month. We have subsequently reduced bed numbers and in May our actual occupancy was 7524. This makes it very difficult to achieve the target.

There were 7 delayed transfers in May, 2 of which have now been resolved.

To put this into context, in the most recently published national data we were 18th lowest of all organisations for delayed transfer bed days.

Delayed Transfers of Care April 2018

https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/statistical-work-areas-delayed-transfers-of-care-delayed-transfers-of-care-data-2018-19/

2.3 Neighbourhood Waits

There has been an increase in demand in Derby City neighbourhood during May, predominantly for community mental health services. Service Managers have local systems for monitoring their waiting lists and receive weekly waiting list reports from IM&T in order to support this process. In addition, the waiting list policy is being reviewed to ensure that it clearly sets out the need for colleagues to communicate effectively with referrers and those on the waiting list. This is turn being underpinned by having a consistent approach to managing waiting lists.

In the South team we continue to experience difficulties with obtaining consistent locum cover for the vacant consultant post, with the latest locum leaving at short notice. This is impacting on average waits for outpatients.

The review of neighbourhood services continues to be undertaken with specific outcomes seeking to address current issues across community mental health services. The conclusion of this work is expected after the summer period.

Workforce and engagement measures

The staff engagement score is taken from the annual staff survey and the quarterly Trust pulse check (Q1, Q2 & Q4). The maximum score for the annual staff survey is 5.00 and the maximum score for the pulse check is 100%.

The percentage of preceptorship staff who started between two and five years before the end of each quarter and who have stayed with the Trust for more than 2 years.

The number of students who return substantively following their placement. This measure will change to a percentage from the next reporting period and the reporting period will also be reviewed.

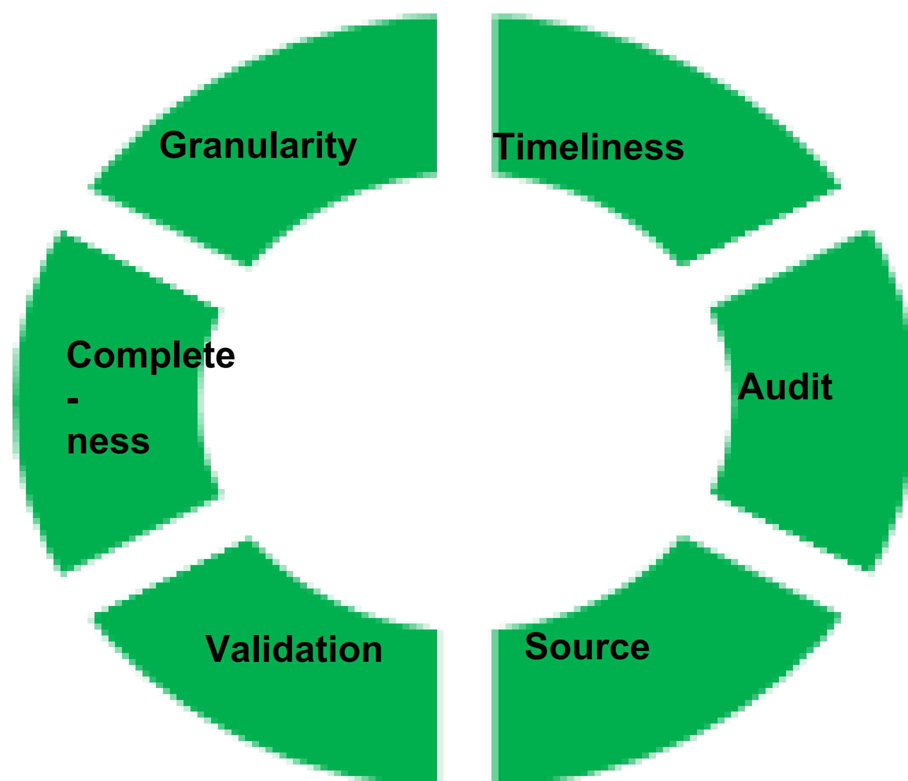
Number of open cases 'as at' the end of each quarter. At the end of Q4 there were 19 disciplinaries cases, 15 dignity at work cases and 14 grievance cases.

Data Quality Kitemark

Background

A number of Trusts prepare data quality kitemarks to support members' review and assessment of performance indicator information reported in integrated performance reports (IPRs). Alternative methods include a simpler data quality scoring in a range, such as 1-5 which are more reliant on judgement. The kitemark is used to assess the system against six domains: timeliness; audit; source; validation; completeness; and granularity to provide assurance on the underlying data quality.

Approach



The Trust has adopted this Data Quality Kitemark. The assessment of each domain will be based on the following criteria;

Data Quality Indicator	Definition	Not yet assessed	Sufficient	Insufficient
Timeliness	Is the data the most up to date and validated available from the system?	Not yet assessed	The data is the most up to date available.	Data is not available for the current month due to the time taken to extract / prepare from the system.
Audit	Has the system or processes used to collect the data been subject to audit (Internal Audit/ External Audit / self-audit) in the last 12 months?	Not yet assessed	The system and processes involved in the collection, extraction and analysis of the data have been audited and presented to the oversight committee.	No formal audit has taken place in the last 12 months. Exceptions have been identified and corrective action has not yet been implemented.
Validation	Prior to publication, is the data subject to validation, e.g. spot checks, random sample checks, involvement of a clinician, the associated service or approval by Executive Director?	Not yet assessed	The data is validated against a secondary source. The indicator owner can assure the data is a true reflection of performance, supported by a sign off process and underlying information.	No validation has taken place. The information owner cannot assure that the data truly reflects performance. A random sample may reveal errors.
Source	Is the source of the data fully documented and understood?	Not yet assessed	All users understand how to extract the data in line with the indicator definition. The data source is well documented in the event that there is a change in personnel producing the indicator.	The data source is poorly documented and could be inconsistently extracted.
Completeness	Is the indicator a reflection of the complete performance of the Trust	Not yet assessed	All the appropriate activity has been included within the indicator	A material amount of activity has not been included within the indicator that may alter the Trust level performance.
Granularity	Can the data be disaggregated into smaller parts? E.g. evaluated at a division or ward level as well as a Trust level.	Not yet assessed	Data can be drilled down to a division or ward level in order to understand and drive performance improvement.	Data is only available at a Trust level.

Each indicator on the Operational component of the NHSi Dashboard has been reviewed and rated against these dimensions. As issues are identified and addressed, the ratings will change to reflect the work undertaken.

KPI Data Quality Reviews

A review will be undertaken every 6 months of 5 to 10 indictors to review their compliance with the defined indicators of quality. This will be done to complement any reviews undertaken by internal or external audit. The results will be shared with the Finance and Performance Committee together with any remedial action required.

Amber ratings on the current NHSi Dashboard

8 indicators are currently rated Amber for validation on the NHSi Dashboard. This is because processes are not yet in place to share the granular detail of those records included and excluded from the calculation of the indicators. Plans are in place to develop a suite of reports which will allow the teams to review the information on a monthly basis.

The assessment of the Finance rating is categorised as sufficient across all elements. This is because the finance information is the most up to date information taken from the ledger and the monthly compliance return to NHSI. The finance system processes under goes regular internal audits and also NHS Business Services who provide the ledger system also send copies of their audits to their clients each year. The data reported is validated against the ledger and the NHSI monthly return and signed off by Deputy Director of Finance following those checks. There are procedure notes in place so staff know how to extract the data, with at least 4 core members of the team who can complete this reporting. The information is extracted from the ledger in each of the relevant categories and can be reconcile back to the ledger. It can also be drilled down to cost centre and account code level and is also reported to teams at that level in order for them to manage their budgets.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 July 2018

Infection Prevention & Control Annual Report 2017/18

Purpose of Report

This paper was received by the Quality Committee in June 2018 and summarises the activity over the preceding twelve months of work related to infection control.

The Health Act 2009 requires NHS bodies must, in accordance with regulations made by the Secretary of State, publish in respect of each reporting period a document containing prescribed information relevant to the quality of Infection Prevention & Control in the Public domain therefore the annual report is formally made in public in addition to the responsible committee, which in this case is the Quality Committee.

Executive Summary

- The Quality Committee reviewed and analysed the data presented and confirmed that the Trust teams continue to provide a consistent level of performance against infection control standards and related management activities
- Our number of reported cases of key alert organisms is very low
- As in 2016/17 we have seen very little interruption to service delivery due to infection control matters
- Inspection of clinical areas remains of a good standard and PLACE scores continue to show we perform at a higher than national average level with some improvements on last year's scoring
- Clinical staff compliance with training has dropped for e-learning due to a systems issue effecting access toward the end of the financial year. This is now resolved
- We have maintained our five-star rating for kitchen cleanliness awarded by the local authority.

Overall the Quality Committee was assured and confirmed significant assurance of the infection control systems and processes in the Trust. This standard of performance has been stable and meeting required standards.

The Quality Committee did accept the operational challenges and improvement work that are still faced by the team and the mitigations which are in active implementation.

- Acknowledging a recommendation to support the infection control lead nurse post, the current post holder has had their hours increased to 0.8 wte until September 2018 to manage this period was agreed by the responsible team
- Ongoing monitoring of compliance data for training has seen infection control training numbers begin to rise after the dip in completion rates following system issues last year; this is being monitored on an on-going basis to

maintain performance
- Revised Infection Control training packages (electronic and taught) are being explored through the extended training department
- Amendments to the Toy cleaning policy have been proposed from Children's services and are being addressed through governance processes
- Diabetes care and management is an area of focus for the nutrition steering group as this has associated infection control risk and susceptibility
- Developing improved training for SEPSIS recognition and management with training department for 2018/19 in line with required Sepsis policy standards
- Infection Control Committee has combined with Physical healthcare Committee and the revised meeting has been increased in frequency to bi-monthly to enable issues to be dealt with more swiftly and to widen attendance and representation.

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

Assurances

- We have reviewed the current audit programme against National infection control guidance and it is contemporaneous and compliant
- There are evidently robust cleanliness measures in place
- There is strong oversight of any infection control incidents or outbreaks
- Overview of national picture has identified areas for focus for 2018/19 for CPE (Carbapenemase Producing Enterobacteriaceae).

Consultation

For discussion at Quality Committee June 2018, then as part of a report to the Trust Board of Directors.

Governance or Legal Issues

This paper brings update on regulatory aspects – around standards which may form part of a CQC inspection or enquiry. These would be around patient safety, leadership, responsiveness and effectiveness. Standards are set in the Healthcare Associated Infections Code of Practice for Infection Prevention & Control 2015. There is a governance and contractual element to the emergency preparedness planning and work.

The Health Act 2009 requires NHS bodies must, in accordance with regulations made by the Secretary of State, publish in respect of each reporting period a document containing prescribed information relevant to the quality of Infection Prevention & Control ion the Public domain.

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).

There are no adverse effects on people with protected characteristics (REGARDS).	x
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential gaps/inequalities are outlined below, with the appropriate action to mitigate or minimise those risks.	

Actions to Mitigate/Minimise Identified Risks

This policy does impact upon people however there are no known specific protected characteristic issues which this report would like to single out or bring to the attention of the Trust Board.

There is no evidence of any specific groups being significantly adversely affected.

Recommendations

The Board of Directors is requested to:

1) Receive and accept the Annual report and recommendations of the Quality committee. Note the reporting of key areas, such as surveillance of healthcare associated infections – alert organisms, outbreaks of infection, staff training.
2) Receive assurance on standards of cleanliness of clinical areas and food preparation areas
3) Approve this report.

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

Report prepared by: **Richard Morrow**
Assistant Director of Public and Physical Health
Julie Carvin
Infection Prevention & Support Nurse
Liz Bates
Deputy Head of Facilities

Infection Prevention & Control Annual Report – 2017/18

Report prepared by Richard Morrow Assistant Director of Public and Physical Health (lead for Infection Prevention & Control), on behalf of Carolyn Green – Executive Director of Nursing & Patient Experience, Director for Infection Prevention & Control.

1.0 Introduction

1.1 Preventing the spread of infection has been a key focus in healthcare for a number of years, with a statutory requirement to fulfil mandated standards for all healthcare providers. The Health and Social Care Act 2008 enabled a code of practice to be established with standards which are overseen by the Care Quality Commission (CQC).

1.2 The Code of Practice: Prevention and Control of Healthcare Associated Infections (2015) provides the framework for the standards we are required to achieve, and this report will detail the actions and on-going work which underpins the achievement of this. The regulation of this activity falls as part of the inspection programme undertaken by the CQC. Infection Prevention & Control considerations are part of the ongoing framework of improvements undertaken by the organisation.

1.3 Preventing the spread of infection is an integral aspect of both patient safety and patient experience, providing assurance and a visible marker of standards and the quality of care service users should expect to receive. Derbyshire Healthcare NHS Foundation Trust is proud of the high standards we continue to achieve and the comparatively low rates of infection we see.

2.0 National context

2.1 Over the past five years, through sustained progress against challenging expectations, the rates of healthcare associated infection reported nationally have continued to fall (source Public Health England 2014, updated 2016). Recent focus on the impact of healthcare associated infection has now shifted somewhat from MRSA bacteraemia and *Clostridium difficile* to looking now at other emergent resistant organisms such as *Escherichia coli,* and the significant impact the communicable conditions such as Norovirus have on delivering healthcare. Cleanliness in healthcare facilities remains a high priority, with the well-established links between poor environmental standards and rates of infection. The emphasis on the speciality and related work is now much more proactive, rather than reacting to events after the fact. This has seen a considerable focus now on ‘zero tolerance’ of healthcare associated

infections, with healthcare associated infection now being seen as largely preventable. There is ongoing focus by NHS England on pandemic influenza preparedness.

3.0 Structures within Derbyshire Healthcare NHS Foundation Trust

3.1 The Chief Executive holds the responsibility for overall standards; however the Trust is required to designate a Director lead for Infection Prevention & Control (DIPC), Carolyn Green - Executive Director of Nursing & Patient Experience.

3.2 The Assistant Director of Public and Physical Health is responsible for the day to day delivery of the plan of work and ensuring this meets the required standards. This role is both strategic and also involved in delivery of training, clinical advice and planning.

3.3 Since September 2013, an Infection Control Support Nurse (currently 0.8wte, increased hours from last year) has been in post to assist the Assistant Director of Public and Physical Health in the delivery of clinical support, advice, training and audit of standards.

3.4 The Head of Estates and Facilities oversees the maintenance, cleanliness and support services which are vital aspect of meeting high standards.

3.5 The programme of work has been previously devised and delivered by the Infection Control Committee, which formed a key component of the Governance structure. This committee has been reporting via the Divisional Clinical Operational Assurance Teams (COAT) as required.

3.6 For 2018/19 the infection Control Committee and the Physical Healthcare Committee have combined in order to make better use of clinicians time and also to broaden the attendance of infection control Committee. The combined meeting will still rep[ort to the divisional COAT meetings as before.

4.0 Key achievements of 2017/18

4.1 Continued investment in the capital programme has seen sustained improvement in the care environment in a number of locations, through a dedicated capital expenditure allocation for Infection Control in 2017/18.

- Replacement furniture and flooring has been provided to Hartington Unit.
- The Peri-natal unit (The Beeches) have had two bathrooms refurbished
- Towel rails and shower curtains have been replaced and upgraded across sites.
- Erewash House and the Ritz at Matlock are having carpets replaced with more durable and sanitary hard flooring covers.
- Radbourne Unit have had some furniture replaced or recovered and some remedial works to improve their flooring and skirting.

- Ward 1 and the older adult wards at Kingsway site are currently having some replacement furniture delivered.

4.2 Continued delivery of a training programme for those clinical and support staff who are identified as requiring the training (target group March 2017 was 1941; staff 1822 staff in the target group in March 2017) saw a compliance position on 31/03/17 of 73.5%. Training sessions are largely delivered in a 'face to face' taught session, in a variety of locations and via the 'block' training methodology. There is also an e-learning option for staff to access. This will be reviewed alongside packages available from DCHS as our training resources are merged to identify the most appropriate and accessible package for staff moving forwards.

4.3 There have been no ward closures related to outbreaks of Norovirus type illness during 2017/18. A small number of locally managed single cases have been, reported, well managed and prevented onward transmission.

4.4 Surveillance of healthcare associated infections (HCAI alert organisms) have seen no cases of MRSA bacteraemia between April 2017 – March 2018 – this has been the case for 5 consecutive years. Following on from last year's report there have been no cases of Clostridium Difficile.

4.5 Cleaning scores, measured against the national standards of cleanliness, have continued to meet the nationally defined 'excellent' standard in clinical areas across year (see detailed performance in the section 'Assurance').

4.6 Cleaning schedules remain consistent with national guidance, and are held at ward level for access by staff and patients / visitors.

4.7 Patient Led Assessment of the Care Environment (PLACE) inspections took place in Spring 2017and results released later in the year, with continued strong performance. The 2018 inspection programme has concluded at the time of writing this report; however the results will not be available until later in the year and are currently embargoed. The teams undertaking PLACE consist of Service User representatives, Estates, Nursing and Domestic Services as well as Infection Control representation. An action plan is drawn up after the assessments, which then feed into the allocation of capital funds, support for larger capital bids and in informing backlog maintenance priorities.

4.8 Continued development of the skills and leadership of the Infection Control Link Nurses programme brings a strong focus of clinical leadership and a conduit for information between the specialist team and clinical level. The infection control audit has been reviewed as the safety of sharps was highlighted last year by the infection control link nurses. The audit is derived from a national safety standards audit and is undertaken annually by all in-patient areas. The 2017 audits are uploaded centrally for assurance and accessibility and this year's schedule is well underway and due to concluded in July 2018. All clinical teams now have access to a range of safer sharps for

both blood taking and also injection administration. A trial of new safety insulin syringes is underway during March / April 2017.

5.0 Assurances

5.1 The Facilities team continue to deliver high standards of cleanliness. The annual cleaning score for the whole trust is 95.02% the means we are in the ‘excellent’ range which is supported by the findings in this year’s PLACE inspections. The highest standards and greatest cleaning services input are delivered in inpatient wards and patient facilities. Services to admin bases and bases where patients do not receive services have seen a reconfiguration of cleaning service, and the scores reflect their performance which as they receive a lower priority than the clinical areas.

The Hotel Services and Estates teams continue to undertake visits to the Community Mental Health unit’s premises to ensure all environmental standards and being met and to check that all planned maintenance is in accordance with the proposed works schedule. A number of improvements have been made following these visits and new flooring, replacement of carpets and furniture have improved the environment and reduced potential infection control risks.

5.2 The Heads of Nursing rounds have continued to provide assurance of key standards in the inpatient wards, where on a twice yearly basis, representatives from Infection Control, and Hotel Services join the Heads of Nursing to inspect the clinical areas from an environmental quality perspective. This provides a proactive way of looking at the environment, anticipating maintenance and quality issues at an early stage (and ensuring action is taken) and also the opportunity to seek informal feedback from patients on the wards as to the comfort and cleanliness of the wards.

5.3 Healthcare associated infection (HCAI) surveillance demonstrates our performance, as reported to the Commissioning organisation. We continue to show consistent performance here, with clinical focus on anticipation of possible infection risks and a swift, appropriate response, for example to suspected diarrhoeal illness. This has seen a significant emphasis on prevention of cross infection, and rising confidence in staff to deal with potential infection risks as they arise.

5.4 During 2017/18, there have been 0 ward closures as a result of diarrhoeal illness (suspected Norovirus).

All infection control issues are reviewed and whilst there have been no outbreaks of MRSA bacteraemia and Clostridium difficile, an incident of Amp C beta-lactamase was identified on one of our older adult wards and the team were delayed in informing relatives of the potential for cross infection. This was reviewed and the Medical Director wrote to the family as part of our duty of candour to apologise for the delay. As in previous years learning from incidents is shared through the Infection Control Committee (ICC) and

Physical Health Care Committee (PHCC) learning points are also be distributed via the Infection Control link nurses and via clinical training. These two committees have combined for 2018/19.

The catheter passport is being introduced by the infection control lead nurse and aims to reduce the potential for catheter related infection such as Amp C Urinary tract infections. This will be evaluated later in the year for effectiveness.

5.5 Clinical audit specifically to infection control has looked at 2 key areas during the year:

- Infection control general standards (hand hygiene, sharps, decontamination equipment). Thematic review of the general infection control audit saw areas of work needed recording of cleaning of equipment. The audit tool has been revised and is now an electronic solution following feedback from Clinical teams and also from the Infection Control committee that the current system needed a refresh. Electronic system went live in April 2015, which will produce ease of recording and thematic review. The link nurses continue to undertake audits and have been involved in the revision of the tool.
- Last year an audit of toy cleaning highlighted some challenges for the clinical team in evidencing after each play contact that toys had been cleaned. This has been amended in the current protocol to show that toys are being cleaned in accordance with the policy but recorded weekly. This is to ensure that the clinical team are not spending a disproportionate amount of time recording cleaning schedule rather than engaging with the children directly.

5.6 Clinical compulsory training continues to take place for those staff who are required to attend, as identified as part of the training framework, and administrated via the training passport system. Compliance is monitored via the Infection Control Committee at a strategic level, and attendance is managed by each of the Divisions. Frequency of attendance is currently agreed as every 2 years, and these are largely taught sessions via the ‘block training’ method. The compliance ‘as at’ 31/03/18 was 73.5%, this is a drop in last year’s figures. There have been some challenges in regards to accessibility of our e-learning system which although resolved have created a backlog of staff who need to update their training passports. This is a focus for 2018/19.

5.7 An influenza vaccination campaign was delivered for staff and patients who met the criteria. The final staff uptake figures remain low but significantly increased to 50.2% (was 38.4% in previous year). We delivered or had access in excess of 96 clinic sessions in a variety of locations and for the first time trained and supported a group of 12 ‘peer vaccinators’ to deliver the vaccine in local areas, in particular campus where staff release can be difficult. The peer vaccination scheme was well received by staff, and the peer

vaccinators have agreed to continue into this year and will be provided with an update to refresh skills. They were acknowledged at the Annual Awards evening for their commitment beyond their existing role, and we will aim to recruit more colleagues to participate. Of note the Derbyshire campaign was nominated and received the Flu Fighter's innovative campaign of the year for the game of thrones inspired approach taken by our communications department. This is against a backdrop of a CQUIN target of 75% (of frontline clinical staff) for the forthcoming year.

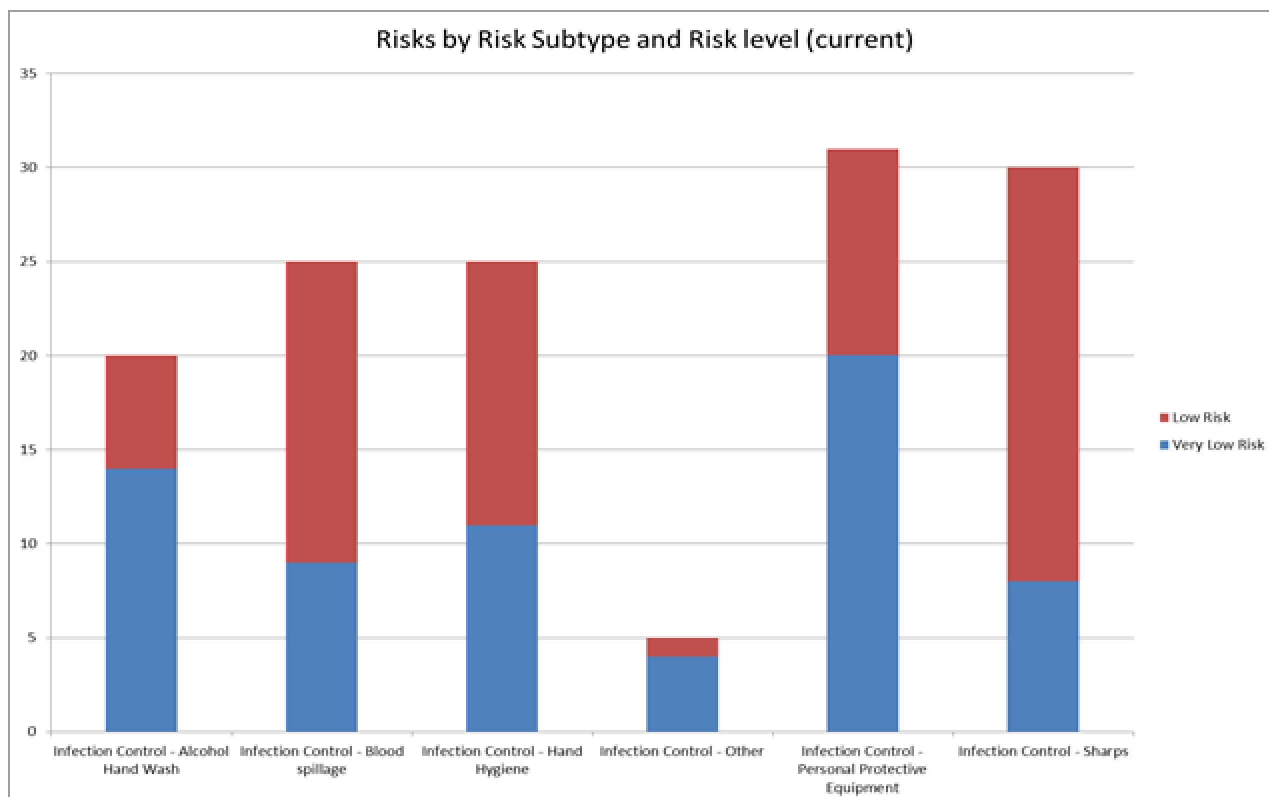
5.8 Hotel services continue to provide assurance on key service delivery areas, such as food hygiene, pest control, laundry and linen supplies, and the duty of care audits required under the NHS Waste Management regulations. A full review of the laundry contract has taken place as a joint venture, with a single provider in place. The kitchens at Kingsway and Radbourne sites have had had environmental health inspections and were once again awarded 5 star ratings by Derby City Council. This is a very public method of demonstrating quality, as it is used across all food preparation establishments. We continue to gain additional assurance by using an independent Environmental Health officer to undertake inspections and guidance, as well as the local authority inspections. Pest control contractors call outs totalled 30, with the majority being for wasps or ants. The large outdoor bins have been replaced on our Radbourne unit site as part of vermin prevention and the drains are baited on a monthly basis due to a small cluster of incidents earlier this year, this appears to be effective at present.

Planned inspections of kitchen areas taking place as a preventative measure measures this year and the estates team have been very proactive in dealing with the small number of incidents reported in order to ensure that issues are addressed quickly and effectively to maintain confidence from the people who access and work with our services.

5.9 Estates continue to provide a monitoring system and maintenance programme to maintain safe water quality. Focussed work in ensuring proactive flushing records are maintained have been a recent focus of the Estates planned, proactive management. A water safety group has recently been established to focus on prevention of Legionella and also other issues with potable water such as Pseudomonas.

5.10 Risks relating to infection control are recorded on the DATIX risk register against each Ward/Team in line with the Risk Assessment Policy and Procedures. This identifies a number of 'required' risk assessments that wards/teams must complete and review at least annually.

There are currently 136 risks on DATIX relating to infection control, all of which are currently rated as low or very low risk (see table below)



Between 1/4/2017 and 31/03/2018, 2 new risks were added to DATIX in relation to infection control.

A risk (21166) was raised in relation to the Section 136 suite toilet being out of commission due to a broken flexible soil pipe resulting in the seepage into plasterboard and an adjoining wall. The suite was closed until the issue rectified. This has now been completed and the risk therefore closed to further review.

A risk 21182 was raised in relation to the national shortage of Hepatitis B vaccine, resulting in staff no longer being offered prophylactic vaccination following an inoculation incident. This issue has been considered by the Health and Safety Committee and a range of controls identified and discussed. The risk is currently rated as low, and will be monitored on an annual basis.

6.0 Next steps and priorities

6.1 The organisation continues to place prevention of infection, along with prevention of harm, as a central feature of clinical service delivery. A focus on continuing to equip the workforce is pivotal to this. The delivery of a compulsory training requirement means that staff are equipped to deliver care in a way that prevents the spread of infection, and provides them with the clinical leadership to seek advice where required. Audit and ownership of the results by clinical teams through the infection control leads is a key part to

improve safety and encourage curiosity in emerging areas such as antimicrobial resistance.

6.2 Continued focus on strong, visible clinical leadership will continue to see practice at the highest standards, with staff empowered to seek advice and support where needed. Strong leadership also brings consistency of standards.

6.3 Continued commitment in capital expenditure on the Estate will ensure that environmental risk is kept to a minimum (for example on-going replacement schedule for furnishings), upgrade of ward and community facilities reduces the risk of poor environment and enhances patient experience. Work is underway and requires continued commitment to support safe practice. Monitoring of external contracted services ensures the highest standards are achieved on our behalf. This is an important aspect of quality assurance.

6.4 On-going support for the delivery of high standards of hotel services, and specialist infection control advice when needed.

6.5 Commitment to working with other providers, to ensure we play our part as a health economy in reducing the burden of healthcare associated infections, such as Norovirus, *Clostridium difficile* and MRSA. In addition we are also looking at regional and national guidance related to SEPSIS and Carbapenemase Producing Enterobacteriaceae (CPE) whilst the rates are low within our organisation the national figures for these infections are increasing and we are keen to keep abreast of best practice in these areas.

6.6 Ongoing support for the developmental work undertaken to meet Nutritional standards, much of which is reported via the Physical Care Committee, but crosses over with this work plan due to governance of food preparation and storage. This year's focus is on improving diabetes care and management.

6.7 A continued commitment to the provision of high standards of cleanliness in our premises with the ability to have highly trained and flexible staff helps us meet clinical need.

7.0 Potential risks in delivery

7.1 Operational support for the infection control support nurse role is pivotal in the ability to deliver the programme of work and level of clinical support and responsiveness needed to meet clinical demand.

7.2 The relatively low uptake of the influenza vaccination by staff should be considered as a key protective and public health responsibility of the organisation, and requires continued support to improve uptake.

7.3 Continued operational support to achieve compliance with compulsory training.

7.4 Any impact on ability to deliver cleaning services to the current high standard in the inpatient areas and clinical bases would have an impact on existing infection control standards.

7.5 The organisation needs to ensure that we maintain monitoring of externally provided contracts, such as laundry, cleaning (north county units), pest control and maintenance to ensure that that standards are not allowed to slip in challenging operating environments.

7.6 The organisation needs to remain focussed that Hotel Services remain equipped to be able to continue to maintain the high standards of cleanliness we currently achieve.

Richard Morrow
30 May 2018

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 July 2018

Learning from Deaths - Mortality Report

Purpose of Report

To meet the requirements set out in the 'National Guidance on Learning from Deaths[1]' which outlines that the Trust is required to collect and publish on a quarterly basis specified information on deaths.

Executive Summary

In line with the CQC's recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a new national framework for NHS Trusts - *'National Guidance on Learning from Deaths'*. The purpose of the framework is to introduce a more standardized approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and improved embedded learning.

Progress to date includes:

- From 1 April 2017 to 29 May 2018, 248 deaths were reported through the Trust incident reporting system (Datix). Of these, 242 were reviewed through the process of the Untoward Incident Reporting and Investigation Policy and Procedure of which 80 warranted a further investigation. 46 reported incidents were closed by the Serious Incident Group
- As a way to access a national database for cause of death, our application for NHS Digital continues and the Trust is currently awaiting an outcome. This continues to be a slow process to ensure that the Trust meets all of NHS Digital legal requirements
- The Mortality Review Group has amended the current form used in case note reviews in line with a pilot currently being undertaken by the Royal College of Psychiatrists. This form is very similar to the Trust's and will be adopted if required once the final version of the form has been approved by the Royal College of Psychiatrists although delays in establishing cause of death would currently be a problem
- We have audited to ensure compliance with policy and process in that we are conducting cases note reviews. Two have been referred for further investigation.

Challenges include:

- Undertaking a case note review of all deaths as outlined in the national guidance, within available time. This is impossible without substantial additional resources
- Delay in obtaining cause of death. If we can obtain a complete data set from

[1] National Guidance on Learning from Deaths. National Quality Board. March 2017

NHS Digital we will identify “hotspots” against the background population and target case reviews against these

- Medical colleague availability to undertake case note reviews at a time when we have a significant number of vacancies
- The sensitivity of our incident recording system means that the total numbers of deaths are potentially higher than comparable trusts.

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

Assurances

Our approach to ensuring that we’re meeting the guidance supports Board Assurance risks. Failure to achieve the clinical quality standards required by our regulators with regards to learning from deaths may lead to harm to service users.

This report provides assurance that the Trust is following recommendations outlined in the National Guidance on learning from Deaths – *A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care.*

Since this report has been prepared further work has been ongoing regarding an analysis of deaths of patient on waiting lists which will feature in the next report.

Consultation

Deputy Director of Nursing and Quality Governance and Medical Director.

Review at Quality Committee in June 2018. Benchmarking of approach against other trusts requested plus ethnicity breakdown for city/county deaths to both be included in next report.

Governance or Legal Issues

There are no legal issues arising from this Board report.

The Care Quality Commission Regulations this report provides assurance to are as follows:

- Outcome 4 (Regulation 9) Care and welfare of people who use services
- Outcome 14 (Regulation 23) Supporting Staff
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
- Regulation 20 Duty of Candour

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).

There are no adverse effects on people with protected characteristics (REGARDS).	x
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	

Actions to Mitigate/Minimise Identified Risks

We are making an assertive effort to ensure that there is attendance from the multi-disciplinary team to attend Case Note Reviews to ensure quoracy. This is being monitored through the Mortality Review Group and Executive Serious Incident Group

Recommendations

The Board is requested to accept this Mortality Report as assurance of our approach, and note that the report is required to be published on the Trust website prior to end of June 2018, as per national guidance.

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

Report prepared by: **Rachel Williams**
Lead Professional for Patient Safety and Patient Experience
Aneesa Alam
Mortality Technician & Legal Services Support

Learning from Deaths - Mortality Report

1. Background

In line with the CQC's recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a new national framework for NHS Trusts - 'National Guidance on Learning from Deaths[2]'. The purpose of the new framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and improved embedded learning.

The Guidance has outlined specific requirements in relation to reporting requirements. From April 2017, the Trust is required to collect and publish every quarter specified information on deaths. This is through a paper and Board item to a public Board meeting in each quarter, to set out the Trust's policy and approach (by end of Q2) 2017-2018 and publication of the data and learning points by Quarter 3 2017/18. The Trust should include the total number of inpatient deaths and those deaths that the Trust has subjected to case record review. Of these deaths subject to review, we are asked to consider how many of these deaths were judged more likely than not to have been due to problems in care.

The report presents the data so far from April 2017 incorporating new data for the periods March, April and May 2018.

2. Current position and progress

- As a way to access a national database for cause of death, our application for NHS Digital continues and the Trust is currently awaiting an outcome .This continues to be a slow process to ensure that the Trust meets all of NHS Digital legal requirements.
- The Mortality Review Group has amended the current form used for case note reviews in line with the pilot undertaken by the Royal College of Psychiatrists. This form was very similar to the Trusts and will be amended if required once the final version of the form has been approved by the Royal College of Psychiatrists.
  We have audited 25 records and plan to audit 25 more, and this will be ongoing to ensure compliance with policy and process.

[2] National Guidance on Learning from Deaths. National Quality Board. March 2017

3 Data Summary of all deaths

Month	2017-04-01	2017-05-01	2017-06-01	2017-07-01	2017-08-01	2017-09-01	2017-10-01	2017-11-01	2017-12-01	2018-01-01	2018-02-01	2018-03-01	2018-04-01	2018-05-01	*Total*
Total Deaths Per Month	196	212	230	177	204	194	183	169	226	260	203	219	174	140	*2787*
Total Deaths On Waiting List	1	0	0	0	1	1	0	0	3	7	2	13	48	29	*105*
Inpatient Deaths	0	2	0	4	0	1	0	1	1	1	3	1	1	0	*15*
LD Referral Deaths	2	1	1	2	4	4	0	5	4	4	3	3	2	0	*35*

Correct as at 29.05.2018

Since April 2017 the Trust has received 2787 death notifications of patients who have been in contact with our service. The figure elsewhere in this paper (3,551) is for all deaths from 1 January 2017. Initially, the Trust recorded all deaths of patients who had contact within the last 12 months but this was changed after discussion with Commissioners to contact within the last 6 months. This took effect from 20 October 2017.

4. Review of Deaths

Total number of Deaths from 1 April 2017 – 29 May 2018 reported on Datix?	248 Incidents were reported as DEATH
Number reviewed through the Serious Incident Group	242
Number investigated by the Serious Incident Group	80
Number of Serious Incidents closed by the Serious Incident Group?	46

The Trust has recorded 15 inpatient deaths, of all which have been reviewed under the Untoward Incident Reporting and Investigation Policy and Procedure.
Only deaths which meet the criteria below are reported through the Trust incident reporting system (Datix) and these are also reviewed using the process of the *Untoward Incident Reporting and Investigation Policy and Procedure*;
Any patient open to services within the last 6 months who has died and meets the following:

- Homicide – perpetrator or victim.
- Domestic homicide - perpetrator or victim
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatient who died within 30 days of discharge from a DHCFT hospital
- Death following an inpatient transfer to acute hospital
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLs) authorisation
- Death of patient following absconsion from an inpatient unit
- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family / carer / The Ombudsman, or where staff have raised a significant concern about the quality of care provision
- Death of a child (this will also be subject to scrutiny by the Child Death Overview Panel)

- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death
- Death of a patient with historical safeguarding concerns, which could be related to the death
- Death where a previous Coroners Regulation 28 has been issued
- Death of a staff member whilst on duty
- Death of a child under the age of 18 of a current or previous service user who has died in suspicious circumstances
- Where an external organisation has highlighted concerns following the death of a patient whether they were open to the Trust at time of death or not

5. Learning from Deaths Procedure

As of 29.05.18, the Trust has 121 deaths to review under the mortality process that meet the criteria defined below. The Mortality Review Group has currently case reviewed 41 deaths. This was undertaken by a multi-disciplinary team and it established that of the 41 deaths reviewed, 34 have been classed as unavoidable, 7 are on hold pending cause of death and 2 of these 7 have been sent for further investigation under the Untoward Incident Reporting and Investigation Policy and Procedure. The Mortality Review Group is currently reviewing deaths of patients who fall under the following 'red flags':

- Patient on end of life pathway, subject to palliative care
- Patient prescribed anti-psychotic medication
- Referral made, but patient not seen prior to death
- Death of patient on Clozapine

Initial analysis of death notification information shows the most prevalent causes of death are:

- Alzheimer's / Dementia
- Old Age
- Pneumonia

Undertaking Case Note Reviews of deaths remains a challenge due to lack of medical colleague availability. This lack of availability has resulted in a number of Case Note Reviews being cancelled.

Guidance

The Royal College of Psychiatrists is currently piloting a Case Record Review Tool which has been adapted from the Structured Judgement Review tool developed by the Royal College of Physicians, to make it suitable for supporting mortality reviews in patients in receipt of mental health services.

The Case Record Review Tool has been designed to support Trusts to respond to concerns from carers and families about any aspect of their care. In addition, the process has the potential to identify cases where, although a Serious Incident Investigation was not initially deemed necessary, concerns when completing the care note review suggests that a Serious Incident investigation might be appropriate.

The tool has two sections:

- ❖ The screen (section 1**) should be completed within three days** of the patient's death.
- ❖ For deaths 'red flagged' as needing further review, section 2 **should be completed within 60 days** of the death being reported.

The Case Record Review Tool has been developed to look at care at different phases of a patient's contact with mental health services, and good care should be recognised, judged and recorded in the same detail as problematic care.

Piloting of the tool has been arranged via members of the Expert Reference Group and is scheduled for April – June 2018. The final version of the tool and care review process will be launched in September 2018.

There is a concern if this is adopted by the Trust that it will be very difficult to complete the relevant sections within 3 days and 60 days respectively due to the current delay in notification of deaths.

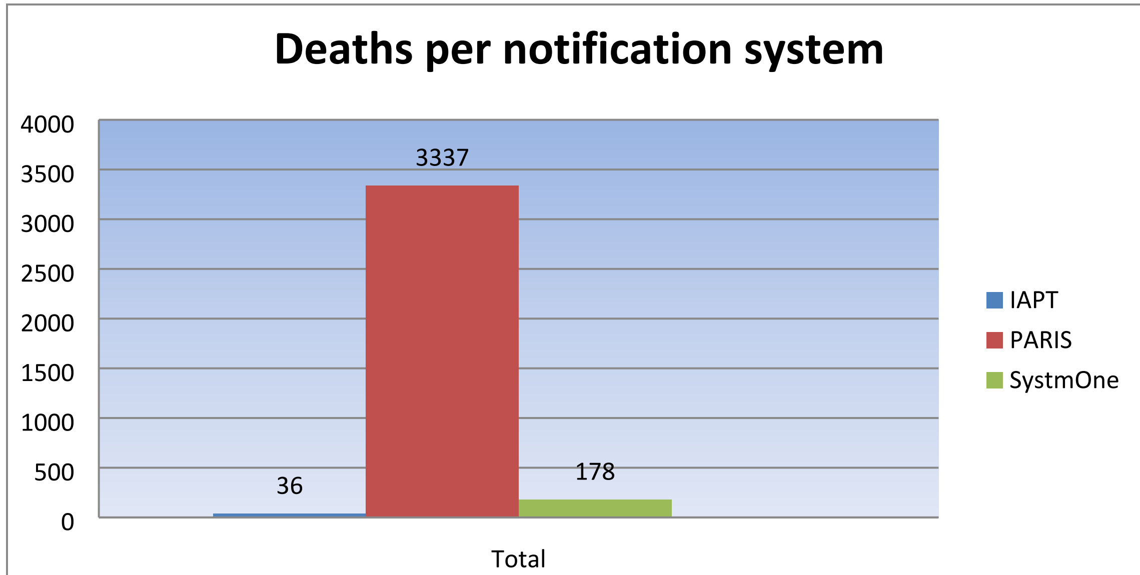
As well as the above pilot, NHS Improvement (NHSI) has published draft guidance: 'Learning from Deaths Workstream 3 – Working with Families'

The purpose of this guidance is to provide information and direction for NHS trusts regarding best practice on how to engage and work effectively with families following the death of a family member. The guidance has been informed by the work of the Workstream 3 steering group, alongside the families, carers, stakeholder organisations and NHS trusts that participated in events to help develop this guidance.

At the current time, the members of the Trust's Mortality Review Group have made the decision that following a case note review if concerns are raised, then the incident will be reviewed through the Serious Incident Process. At this point the family will be contacted to advise that an investigation is being undertaken.
Once the NHSI guidance has been finalised, it will be reviewed by the Trust and an update will be provided in the next Mortality Report.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 Jan 2017

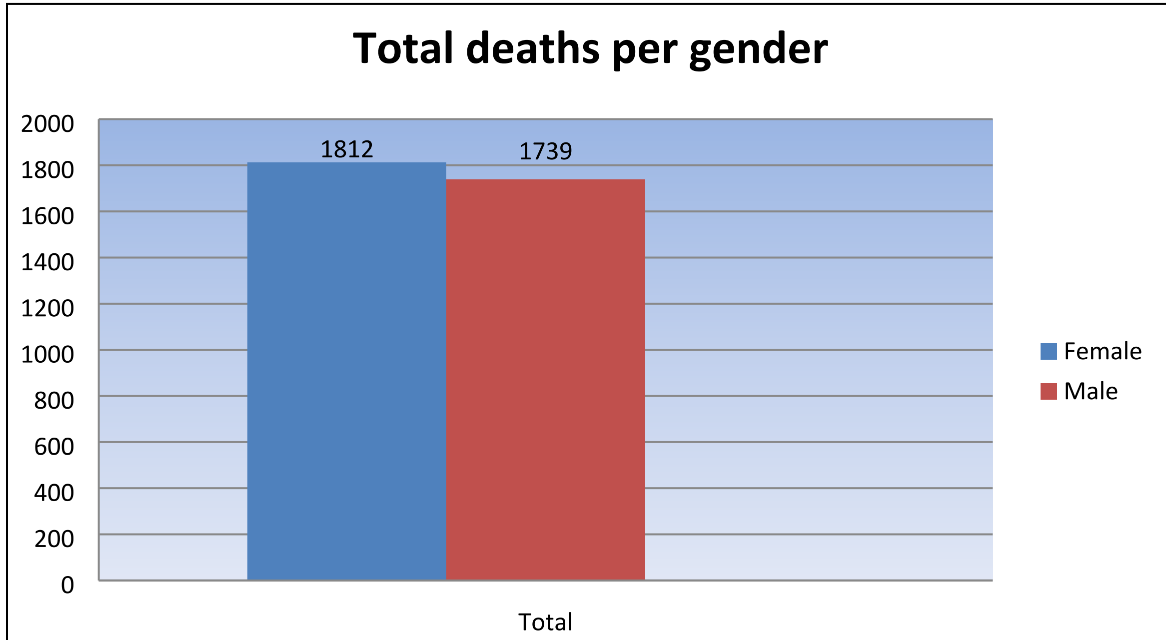


	IAPT	PARIS	SystmOne	Grand Total
Count of Source System	**36**	**3337**	**178**	**3551**

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from PARIS, as we would expect as this clinical record system is aligned to our largest population of patients and a population at greatest risk of death due to the proportion of older people in our care. 178 death notifications were pulled from SystmOne and 36 from IAPT.

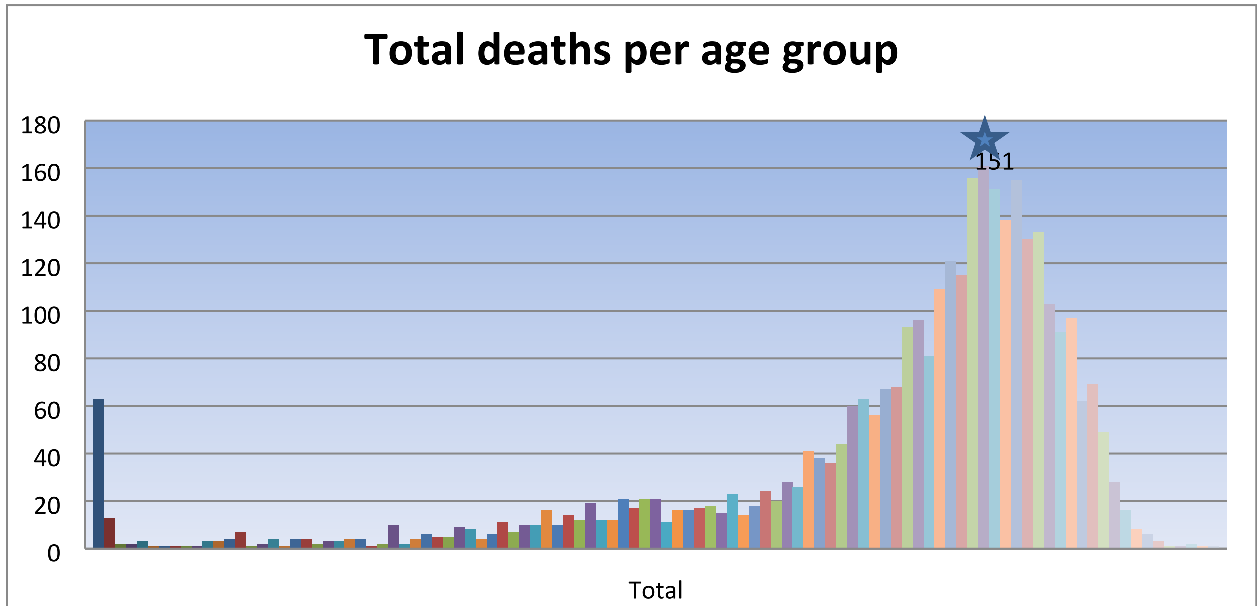
6.2 Deaths by gender since 1 Jan 2017

The data below shows the total number of deaths by gender since 01 Jan 2017. There is very little variation between male and female deaths; 1739 male deaths were reported compared to 1812 female.



	Female	Male	Grand Total
Count of Gender	1812	1739	3551

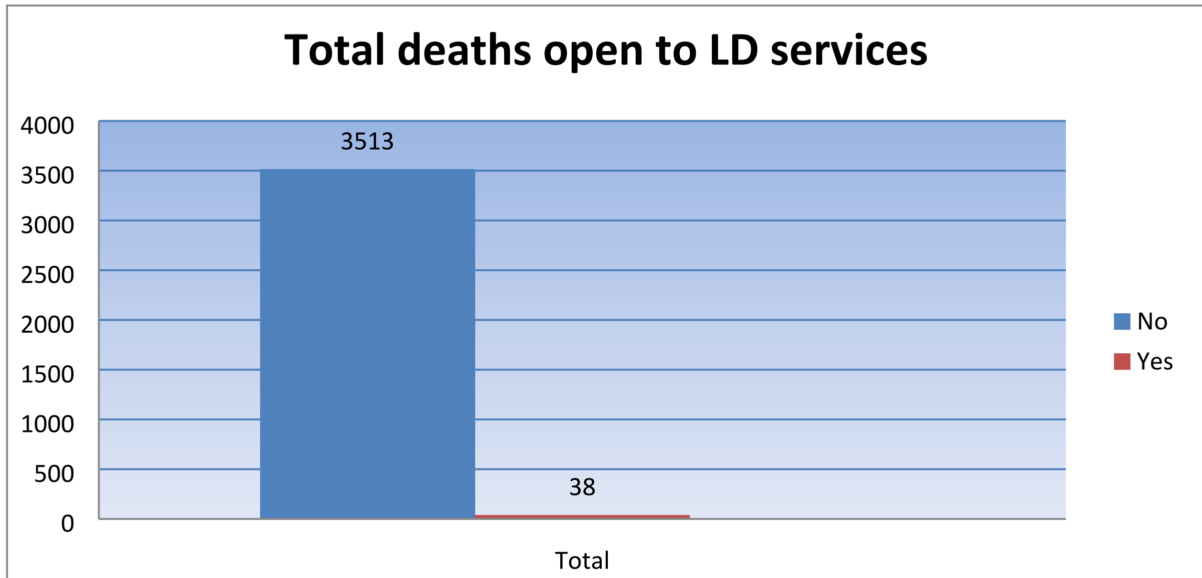
6.3 Death by age group since 1 Jan 2017



The youngest age was classed as 0 and the oldest age was 107 years. Most deaths occur within the 82-87 age groups (indicated by the star); in the last report most deaths occurred between 85-90 age group.

Since April 2018 there were 25 deaths discussed and closed in the period and 2 of these had been referred for Serious Case Review or Learning Review.

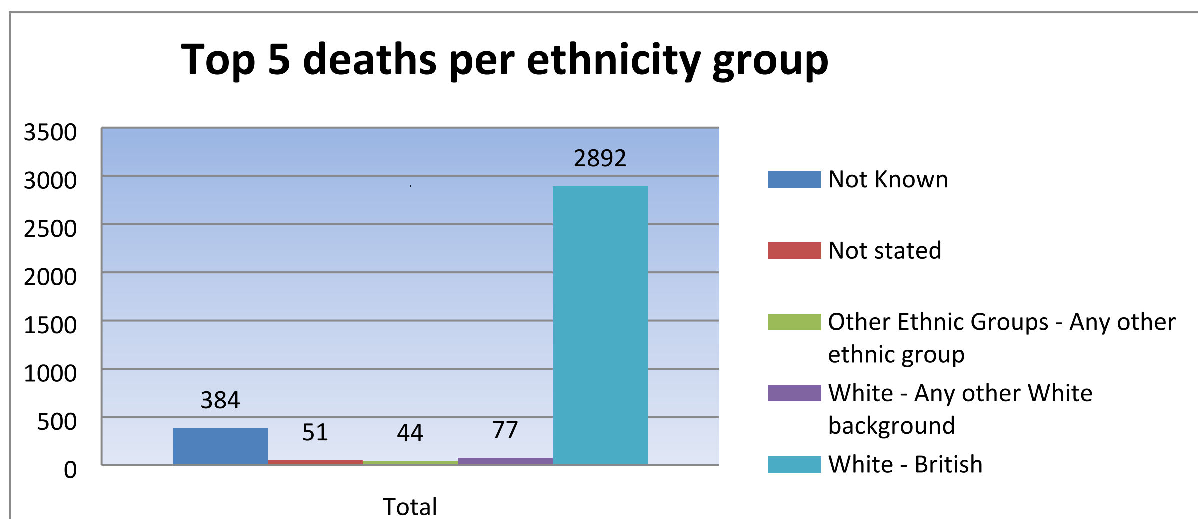
6.4 Learning Disability Deaths since 1 Jan 2017



	No	Yes	Grand Total
Count of Known To LD	**3513**	**38**	**3551**

The Trust reviews all Learning Disability deaths. The Trust also currently sends all Learning Disability deaths that have been reported through the Datix system to the Learning Disabilities Mortality Review (LeDeR) Programme. However, we are unable to ascertain how many of these deaths have been reviewed through the LeDeR process as LeDeR only look at a sample of overall deaths, and are unable to tell us if our patients have been part of that sample.

6.5 Death by Ethnicity since 1 Jan 2017



The top 5 recorded deaths per ethnicity group are highlighted above. White British is the highest recorded group with 2892 recorded deaths, 384 deaths had no recorded ethnicity assigned and 51 people did not state what their ethnicity was. The chart below outlines all ethnicity groups.

Ethnicity	Death Count
Asian or Asian British - Any other Asian background	7
Asian or Asian British - Bangladeshi	2
Asian or Asian British - Pakistani	7
Caribbean	20
Indian	19
Mixed - Any other mixed background	7
Mixed - White and Black Caribbean	6
Not Known	384
Not stated	51
Other Ethnic Groups - Any other ethnic group	44
Other Ethnic Groups - Chinese	2
Pakistani	9
White - Any other White background	77
White - British	2892
White - Irish	24
Total	**3551**

7. Recommendations and learning

Below are examples of the recommendations that have been undertaken following the review of deaths either through the *Untoward Incident Reporting and Investigation Policy and Procedure* or *Learning from Deaths Procedure.* These recommendations are monitored by the Patient Safety Team and are allocated to specific team and individuals to be completed. This is not an exhaustive list.

Learning / action log

- Consideration of formal management training for development, support use of IT systems to inform operational decision-making
- Review of blood-borne virus policy
- Review and audit of Safety Box use on the Paris electronic patient record system.
- Review of communication practices between inpatient areas and community teams
- Review standards, training and audit relapse prevention plans with community mental health teams
- Explore with commissioners, the commissioning of a community forensic team and the potential risks and benefits of this model of practice
- Advice to be provided for nursing and medical staff in relation to patients suffering from health anxiety and referral for CBT
- Discussion with commissioners regarding specific services / pathways for individuals with a diagnosis of personality disorder
- Review the number of funded care programme approach co-ordinators in community teams benchmarked against comparable trusts per hundred thousand population
- Review expected standards of practice for patients on a Community Treatment Order. Complete a Trust-wide audit of these revised standards and then monitor via a six monthly audit cycle
- Education/information on the referral process to IAPT for inpatient areas
- All services contracted to provide IAPT services should be given training and read only access to PARIS
- For interagency communication to be improved so information can be shared in a timely manner
- Review of home leave care-plan to include explicit completion of parent/carer contact or to actively state why not required

8. Mortality prevention work undertaken by the Trust;

Summary of Acute Liaison work – Dental day case only – The Royal Derby Hospital

NHS Choices outlines the importance of good oral health and the implications to health

The state of someone's teeth affects their overall health, with gum disease linked to lots of serious health problems in other parts of the body and increasing risk to other health complications, including stroke, diabetes and heart disease. Gum disease has even been linked with problems in pregnancy and dementia.

The dental day cases are held every other Wednesday for essential assessment and treatment if necessary, for individuals where it is apparent that primary health care services would not be able to meet the needs of this group of people. These sessions offer:

- Case by case situations. Organised visits to the dental day case clinic if required as part of any **desensitisation programme**
- Many service users require accessible **information** around coming into hospital which is issued prior to admission.
- Service users are **met upon arrival** at hospital, and are provided with an offer of **support during any outlined procedure**, including administration of anaesthetic / treatment. This support is available throughout the whole process, not just 'booking in'.
- Support is provided in a variety of ways and is tailored to the needs of the individual.

Supporting post–operatively and the discharge process is also invaluable within the dental day case. Whilst it is essential that observations are monitored post-operatively, these can be extremely distressing to some individuals. Being able to support adjustments within this can be of extreme benefit in the recovery process / procedure. Use of an iPad has at times, provided distraction and focus during periods of high anxiety.

Offering this type of **bespoke** service in hospital enhances the positive outcomes for many, as essential treatment is unlikely to be achieved through primary health care services alone.

Working with Chesterfield FC: a short history of 'Active Spireites'

Summary

In 2013, in a chance meeting, the chair of the Chesterfield FC Community Trust (John Croot) was at a networking meeting which included clinicians from the Trust. The two organisations decided to meet to explore opportunities to develop a joint Mental Health Strategy. The Trust was already working on a Healthy Body Healthy Mind programme that ran with Public Health, looking at how people with severe mental health problems improved their physical health. As part of our recovery approach, the Trust wanted to collaborate with the football club to run sessions targeting improving fitness and mental wellbeing using the motivation of football as that therapeutic tool.

In the five years since the initial meeting, several programmes have developed and the Core Active Spireites programme continues on a rolling basis.

Associated projects have included:

- Healthy lifestyle course at the stadium co-facilitated by mental health Occupational Therapists, football coaches and volunteer Peer Supporters (The Core Active Spireites Programme)
- A similar programme targeted particularly at people with substance misuse problems
- Football coaching sessions and competitive football matches facilitated by Chesterfield FC community Trust and Peer Supporters
- Walking for health project
- In-reach work to acute mental health unit from Chesterfield FC Community Trust
- 'Time to change' match events at Chesterfield FC stadium (Twice a year)
- Establishing links with national projects promoting football and mental health projects and presenting details of the programme at national meetings

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 July 2018

A Framework of Quality Assurance for Responsible Officers and Medical Revalidation

Purpose of Report

To provide the Board with an overview of medical appraisal and revalidation

Executive Summary

The report provides the necessary assurance that the Trust has fully achieved all the standards stated in the statement of Compliance required by NHS England by 28/9/2018.

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

Assurances

- 100% of available doctors completed appraisals or had approved postponement.
- Major reason for deferment – new starters
- Quality of appraisals is improving
- Appraiser numbers are healthy
- Final assurance is given regarding recruitment checks so compliance statement can be signed off (Appendix E)

Consultation

Feedback has been taken from appraisers and appraises. This report has been scrutinised at the Quality Committee – but without Appendix E.

Governance or Legal Issues

1. The Annual Organisational Audit was submitted to NHS England on time
2. The Board is required to provide a Statement of Compliance to NHS England by 28 September 2018

Public Sector Equality Duty & Equality Impact Risk Analysis The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).	
There are no adverse effects on people with protected characteristics (REGARDS).	X
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential gaps/inequalities are outlined below, with the appropriate action to mitigate or minimise those risks.	
Actions to Mitigate/Minimise Identified Risks – not applicable	

Recommendations

The Board of Directors is requested to:

1) Accept the report and note it will be shared along with the annual audit with the higher Responsible Officer
2) Approve the Statement of Compliance for submission to NHS England in September 2018

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

Report prepared by: **Dr Edward Komocki**
Medical Appraisal Lead

NHS England

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – DHCFT Annual Board Report 2017-2018

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	**03551**
Document Purpose	Guidance
Document Name	A Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D - Annual Board Report Template
Author	Gary Cooper, Project Manager Quality and Assurance, Professional Standards Team
Publication Date	16 June 2015
Target Audience	All Responsible Officers in England
Additional Circulation List	Foundation Trust CEs , NHS Trust Board Chairs, Medical Appraisal Leads, CEs of Designated Bodies in England, NHS England Regional Directors, NHS England Directors of Commissioning Operations, All NHS England Employees, Directors of HR, NHS Trust CEs
Description	A template board report for use by designated bodies to monitor their organisation's progress in implementing the Responsible Officer Regulations.
Cross Reference	The Medical Profession (Responsible Officers) Regulations, 2010 (as amended 2013) and the GMC (Licence to Practise and Revalidation) Regulations 2012
Superseded Docs (if applicable)	A Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D - Annual Board Report Template, version 4 April 2014.
Action Required	Designated Bodies to receive annual board reports on the implementation of revalidation and submit an annual statement of compliance to their higher level responsible officers.
Timing / Deadlines (if applicable)	**From June 2015**
Contact Details for further information	england.revalidation-pmo@nhs.net http://www.england.nhs.uk/revalidation/

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet. **NB:** The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Annual Board Report Template

Version number: 2.0

First published: 4 April 2014

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Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

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1. Executive summary

Appraisals –

- 100% of DHCFT doctors either completed a successful appraisal or had an approved reason for a postponement during the 2017-18 appraisal cycle
- Although there were a relatively high number of appraisals deferred during the 2017-18 appraisal cycle (24 from a total of 108 doctors), 13 were "new starters" and thus not eligible to undertake an appraisal at this stage of their medical career
- The quality of appraisals has again improved since the previous appraisal cycle both in terms of the number of successfully completed entries and the quality of reflection
- Appraisers participated in a refresher programme during 2017-18 to maintain and enhance their roles and have individual appraiser dashboards to be able to review their progress.
- Two new appraisers have been trained and at least three other doctors within DHCFT are applying to take on this role – the total number of appraisers for 2018-19 will therefore be at least 16
- An analysis and comparison between the DHCFT revalidation/appraisal process and the findings of the 2018 GMC's evaluation of the first five years of revalidation supports the assertion that DHCFT is able to promote good professional practice through the central role of high quality formative appraisal.

2. Purpose of the Paper

This report serves to provide the Board with an overview of appraisal and revalidation within the Trust during the appraisal year and assure the Board that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer
2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained
3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners
4. Medical appraisers participate in on-going performance review, training and development activities, including peer review and calibration of professional judgements
5. All licensed medical practitioners have an annual appraisal in keeping with GMC requirements or, where this does not occur, there is full understanding of the reasons why and suitable action taken
6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners, which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal
7. There is a process established for responding to concerns about any licensed medical practitioner's fitness to practise
8. There is a process for obtaining and sharing information of note about any licensed medical practitioners" fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work

9. The appropriate pre-employment background checks (including for Locums) are carried out to ensure that all licenced medical practitioners have qualifications and experience appropriate to the work performed; and
10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations

3. Background and 2018 GMC Revalidation Update

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that provider boards / executive teams will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

On 1 May 2018, the GMC published the findings of its three-year UK Medical Revalidation Evaluation Collaboration's (UMbRELLA) study into the impact of revalidation. The key findings were –

- Overall, most doctors working within existing governance structures have been brought into a governed system of medical revalidation and this has led to a rise in participation by doctors in annual appraisal – locum doctors however can find this problematic
- Although there may be inconsistencies at the appraisal level for all doctors, the requirement to submit supporting information across six defined categories during the five-year cycle has resulted in a strong focus within the appraisal process on the collection of and reflection on a doctor's efforts during the appraisal year.
- Appraisal and appraisers can and do identify some concerns about doctors, particularly in relation to workplace and health issues, and many concerns identified through appraisal are addressed successfully within that process
- Responsible officers have three options available for revalidation

recommendations (revalidate; deferral; and non-engagement) – there are some concerns that this may not adequately cover all circumstances.

- Both doctors' and patients' engagement with patient feedback is inconsistent and at times problematic. A need for current patient feedback tools to be refined was repeatedly expressed from both patient and doctor perspectives.
- Ultimately, revalidation's ability to promote good professional practice is through the central role of high quality formative appraisal.

In response to this report, it can be stated that the revalidation/appraisal system within DHCFT –

- Ensures all doctors (including locums) are participating effectively in the revalidation and appraisal process, having access to relevant electronic systems, a bank of suitably trained appraisers and individual support through the Lead Appraiser
- Provides assurance through audit of appraisals to confirm that all doctors are submitting appropriate supporting information and reflecting upon this effectively
- Highlights any relevant concerns about a doctor's practice and through a feedback system of appraisers and the Lead Appraiser, will provide details to DHCFT's Responsible Officer
- Provides the Responsible Officer with appropriate information to allow him to reach effective decisions with regard to a doctor's revalidation recommendation
- In conjunction with the Royal College of Psychiatrists' 360 degree appraisal process, allows the provision of suitable colleague and patient feedback for reflection during the appraisal discussion meeting
- Through the process of audit is demonstrating evidence of improvement in both the quantity and quality of appraisal returns

4. Governance Arrangements

Appraisal and Revalidation is overseen by the Trust's Responsible Officer, Dr John Sykes. He is supported in discharging his responsibilities by Medical Appraisal Lead, Dr E C Komocki. Administrative support is provided by Mrs Pam Wardynska. The DHCFT HR department provide details of medical new starters and leavers.

Electronic appraisal and revalidation systems have been in place for several years with a new format (MAG 4.2) being utilised for the first time during this appraisal cycle.

Appraisees and appraisers are provided with reminder emails in advance of theappraisal cycle. The Medical Appraisal Lead arranges refresher courses for all appraisers, introductory appraisal sessions for appraisees and direct individual support for both when requested. Uncompleted appraisals are chased regularly. Deferral of appraisals is decided by both the Trust's Responsible Officer and Medical Appraisal Lead.

The Framework for Quality Assurance suggests that Responsible Officers may wish to have a monthly monitoring process. It is felt, at this time, that the relatively small size of the Trust and the regular communication between the Responsible Officer, Medical Appraisal Lead and members of the HR Department is sufficient to ensure that any problems are highlighted and acted upon in a timely manner and that additional reporting processes would be unnecessarily burdensome.

The Framework for Quality Assurance requires quarterly reporting on appraisal rates to be provided to the higher level Responsible Officer, this information being provided by the Medical Appraisal Lead.

DHCFT Medical Appraisal Policy is kept under constant review in light of national updates and changes are discussed and agreed with the Responsible Officer and communicated directly to the Medical Staff.

The Trust is fully compliant with the regulations and practice surrounding appraisal and revalidation, as reported to NHS England in the Annual Organisational Audit.

An independent verification of the DHCFT's processes was successfully undertaken by representatives of the NHS Revalidation Team in 2015.

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

The outcomes for Appraisal Year 2017-18 are summarised in the following table –

Section 2		Appraisal					
2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2015 should be included. Where the answer is 'nil' please enter '0'. **See guidance notes on page 2 for assistance completing this table**		**1a**	**1b**	**2**	**3**	
		Number of Prescribed Connections	**Completed Appraisal (1a)**	**Completed Appraisal (1b)**	**Approved incomplete or missed appraisal (2)**	**Unapproved incomplete or missed appraisal (3)**	**Total**
2.1.1	**Consultants** (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	78	38	25	15	0	78
2.1.2	**Staff grade, associate specialist, specialty doctor** (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff).	26	15	2	9	0	26
2.1.3	**Doctors on Performers Lists** (for NHS England area teams and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).	0	0	0	0	0	0
2.1.4	**Doctors with practising privileges** (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).	0	0	0	0	0	0
2.1.5	**Temporary or short-term contract holders** (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	4	3	1	0	0	4
2.1.6	**Other doctors with a prescribed connection to this designated body** (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).	0	0	0	0	0	0
2.1.7	**TOTAL** (this cell will sum automatically 2.1.1 – 2.1.6).	108	56	28	24	0	108

These figures show an improvement from the 2016/16 appraisal year –

- Doctors eligible to complete an appraisals increased from 97% to 100%
- Approved incomplete/missed of appraisals being reduced from 11% to 10%
- Unapproved incomplete/missed appraisals being reduced from 3% to 0%

Of the 24 approved incomplete/missed appraisals, 13 were deferred for reasons of being "new starters" so doctor not due an appraisal at this stage of their career.

Details of exceptions i.e. missed appraisals and reasons, incomplete appraisals etc. are included in **Annual Report Template Appendix A;** Audit of all missed or incomplete appraisals audit. All postponed appraisals were reviewed and agreed by both the Responsible Officer and the Medical Appraisal Lead.

b. Appraisers

- Number of active appraisers = 14 (although 20 trained appraisers exist within the Trust). So DHCFT ratio appraisers: doctors = 14:108 =1:7.7. NHS England recommended ratio is between 1:20 and 1: 5
- New appraiser training = takes place external to the DHCFT on NHS England recognised/approved courses. Fees for the course paid either through DHCFT study budget or by medical staff themselves.
- Further appraiser training support = arranged by Medical Appraisal Lead. External appraiser refresher course on External teaching on "Challenging Appraisals and Encouraging Optimum Appraisal Performance", successfully run in November 2017. Immediate advice provided as required during process of individual appraisal by Medical Appraisal Lead on direct contact.
- Training offered is a combination of update information disseminated by the Revalidation Team of NHS England, from issues raised on the doctors' post-appraisal feedback forms (as provided by the NHS England Revalidation Team- see attached document) and through issues identified by the appraiser themselves during contact with the Lead Appraiser.
- Standardised feedback is obtained from as many appraisees as possible and used in the "appraiser dashboard" provided for each appraiser
- The Medical Appraisal Lead attends the quarterly East Midlands Regional Appraisers' Network Meeting and offers feedback to all medical staff both through DHCFT TMAC and by "all-staff" emails.
- Potential future appraisal development plans include –
    - the development of DHCFT "in-house" new appraiser refresher training
    - an "Introduction to Appraisals" course for doctors new to both DHCFT and the appraisal process
    - a DHCFT Appraisers' Support Group

c. Quality Assurance

A random selection of 40 appraisal forms are audited by the Medical Appraisal Lead and submitted to NHS England as part of the Annual Organisational Audit. This audit addresses -

- Appraisal folders to provide assurance that the appraisal inputs, the pre-appraisal declarations and supporting information provided are available and appropriate
- Appraisal folders to provide assurance that the appraisal outputs, PDP, summary and sign offs are complete and to an appropriate standard
- Appraisal outputs to provide assurance that any key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal outputs
- Review of lessons learned from any complaints
- Review of lessons learned from any significant events
- An additional assessment of the quality of entries is also performed (Rating inputs 0 to 5)

Individual appraisers also participate in the following quality assurance processes -

- An on-going process reflection on their own appropriate continuing professional development as an appraiser and the development of a relevant PDP to enhance their appraisal skills
- Attendance at a yearly Appraiser Refresher Course – this was held in November 2017
- 360 degree feedback from doctors for each individual appraiser – collected utilising post-appraisal feedback forms, reviewed, collated and fed back to the appraiser by the Medical Appraisal Lead as part of their individualised Appraiser Dashboard. (See **Appendix F – a redacted example of an Appraiser Dashboard**)
- Provision of DHCT, local and national appraisal audit data as part of their individualised Appraiser Dashboard.
- Examples of good practice both from individual appraisers within DHCFT and those obtained from quarterly East Midlands Regional Appraisers' Network Meetings are then shared with all active appraisers for their learning and use in future appraisals.

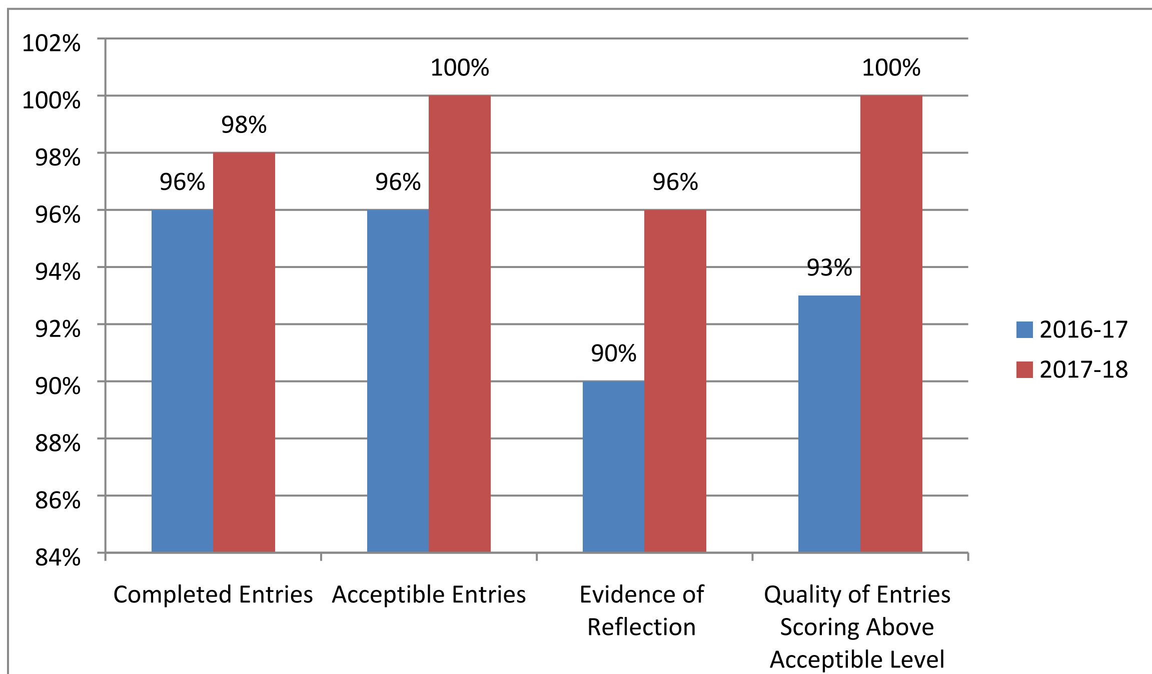
For the organisation

- The Responsible Officer has already submitted DHCFT's completed Annual Organisational Audit to NHS England in time for the deadline of 8th June 2018
- This document (**Annex d**) is to be presented to the DHCFT Board within a timeframe that allows it to be ratified and the required Statement of Compliance completed and returned to NHS England by 28th September 2018.

RESULTS OF NOTE OF 2017-18 QA AUDIT –

- Results of Appraisal Quality Assurance audit are included in **Annual Report Template, Appendix B;** Quality assurance audit of appraisal inputs and outputs.
- Of the mandatory entries on the appraisal form, appraisees scored 100% on all audit standards except three - Completed PDP (95%), Previous Appraisal attached(95%) and Achievements, Aspirations and Challenges (95%).
- All entries were deemed “acceptable”
- In those sections of the appraisal where reflection was requested, appraisers and appraisees performed this task on 95% of occasions or more
- The average scores measuring the quality of reflective entries was 3.6 out of 5 (range 2.7 – 4.2). This is a further improvement in quality in comparison to previous scores (2014-15 = 2.3, 2016-17 = 3.4)
- NOTE – those items marked (*) or (**) are optional entries and thus the scores recorded are not indicative of poor performance

Comparative figures for appraisal cycles 2016-17 and 2017-18 –



d. Access, Security and Confidentiality

Appraisal information is stored on a DHCFT shared drive with access restricted to those with a responsibility for the appraisal process. All appraisees retain copies of their individual electronic appraisal forms.

The Medical Appraisal Lead retains all appraisee feedback which is kept secure.

Appraisees and appraisers ensure confidentiality of all entries into the appraisal process. This is reinforced during refresher sessions, during appraiser appraisals and within the instructions of the MAG electronic appraisal form.

e. Clinical governance

The Medical Appraisal Lead co-ordinates with the DHCFT Patient Experience Department to review an annual report on all SIRI's and complaints. The Medical Appraisal Lead then performs a cross-check using this report to confirm each doctor has acknowledged and reflected upon any SIRI's or complaints in which they have been involved. For the 2017/18 appraisal year, **100%** of consultant and speciality grade doctors acknowledged and reflected upon SIRI's and/or complaints in which they have been involved.

6. Revalidation Recommendations

- *Recommendations between April 2017 – March 2018 - 16*
- *Recommendations completed on time - 16*
- *Positive recommendations - 16*
- *Deferral requests - 0*
- *Non-engagement notifications - 0*

See Appendix D

7. Recruitment and engagement background checks

See Appendix E

8. Monitoring Performance

Performance is monitored at a monthly Medical Management meeting attended by clinical directors and operational managers – chaired by Deputy Medical Director

9. Responding to Concerns and Remediation

The Trust Local Disciplinary Policy is consistent with the national approach to Maintaining Higher Professional Standards. A remediation policy has been agreed and used in the last 12 months.

10. Risks and Issues

Expertise and oversight is retained in a handful of individuals. It is planned to include RO training in Deputy Medical Director and Clinical Director development.

11. Board / Executive Team Reflections

Electronic job planning software will be procured to help ensure a fairer distribution of responsibility and enhance wider access to medical management/educational roles as part of a new Medical Strategy.

12. Corrective Actions, Improvement Plan and Next Steps

Quality Improvement cycles have been developed with successful outcomes.

13. Recommendations

1. The Board is requested to accept this report and note it will be shared along with the annual audit with the higher level Responsible Officer.

2. The Board is requested to approve the Statement of Compliance for submission to the higher level Responsible Officer at NHS England by 28 September 2018.

14. Reporting with small numbers

It is not considered that numbers reported in the appendices could result in breaches of confidentiality.

15. Annual Report Template Appendix A – Audit of all missed or incomplete appraisals

Doctor factors (total)	**Number**
Maternity leave during the majority of the 'appraisal due window'	*2*
Sickness absence during the majority of the 'appraisal due window'	*6*
Prolonged leave during the majority of the 'appraisal due window'	*1*
Suspension during the majority of the 'appraisal due window'	*0*
New starter within 3 month of appraisal due date	*0*
New starter more than 3 months from appraisal due date	*13*
Postponed due to incomplete portfolio/insufficient supporting information	*0*
Appraisal outputs not signed off by doctor within 28 days	*0*
Lack of time of doctor	*0*
Lack of engagement of doctor	*0*
Other doctor factors	*2*
(Undergoing retraining)	
Appraiser factors	**Number**
Unplanned absence of appraiser	*0*
Appraisal outputs not signed off by appraiser within 28 days	*0*
Lack of time of appraiser	*0*
Other appraiser factors (describe)	*0*
(describe)	
Organisational factors	**Number**
Administration or management factors	*0*
Failure of electronic information systems	*0*
Insufficient numbers of trained appraisers	*0*
Other organisational factors (describe)	*0*

16. Appendix B – Quality assurance of appraisal inputs and outputs

17. Appraisal inputs	Yes/No	Acceptable	Evidence of Reflection	Quality of Entries (0→5)
Personal details completed?	100%	Y		
Scope of work: Has a full scope of practice been described?	100%	Y	100% (*)	3.4
Previous year's appraisal attached?	95%	Y		
PDP review -				
PDP completed?	95%	Y	95%	3.2
Reasons for non-completion documented?	100%	Y	100%	3.0
General comments made?	90% (*)	Y (*)	100% (*)	3.0 (*)
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	100%	Y	100%	3.6
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	100%	Y	100%	4.0
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	100% (100%)	Y Y	100% (100%)	4.0 (3.8)
Patient feedback exercise: Has a patient feedback exercise been completed?	100%	Y	93% (**)	3.4
Colleague feedback exercise: Has a colleague feedback exercise been completed?	100%	Y	93% (**)	3.4
Review of complaints: Have all complaints been included?	100% (100%)	Y Y	100% (100%)	4.0 (4.4)
Achievements, aspirations and challenges documented?	95%	Y	100%	3.7
Health & Probity statements completed?	100%	Y		
Is there sufficient supporting information from all the doctor's roles and places of work?	100%	Y		
Additional information included?	80% (*)	Y (*)	52% (*)	3.6 (*)
Pre-appraisal preparation completed?	100%	Y	100%	3.5
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)?	100%	Y		
Appraisal Outputs				
Use of progressive appraiser comments	100%(*)	Y (*)	100% (*)	3.4 (*)
New PDP developed	100%	Y		
Summary of Appraisal Discussion	100%	Y	100%	3.4
Appraiser Statements	100%	Y		
Post –appraisal sign off completed?	100%	Y		

Key – (*) = this is not a mandatory entry requirement on the appraisal form
(**) = reflection documented in previous appraisal
Red = overall trust figures for all SIRI's and complaints

18. Annual Report Template Appendix C – Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level[1]	Medium level[2]	Low level[2]	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern				10
Capability concerns (as the primary category) in the last 12 months		2	5	7
Conduct concerns (as the primary category) in the last 12 months	1			1
Health concerns (as the primary category) in the last 12 months	2			2
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2015 who have undergone formal remediation between 1 April 2014 and 31 March 2015. Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice A doctor should be included here if they were undergoing remediation at any point during the year				2
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				2
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				0
General practitioner (for NHS England only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				0
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				0
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-				0

[1] http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

Concerns about a doctor's practice	High level[1]	Medium level[2]	Low level[2]	Total
term employment contracts, etc) All Designated Bodies				
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies				0
TOTALS				2
Other Actions/Interventions				
Local Actions:				
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included				0
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months				0
Number of doctors who have had local restrictions placed on their practice in the last 12 months?				3
GMC Actions: Number of doctors who:				
Were referred by the designated body to the GMC between 1 April and 31 March				2
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March				2
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March				1
Had their registration/licence suspended by the GMC between 1 April and 31 March				1
Were erased from the GMC register between 1 April and 31 March				1
National Clinical Assessment Service actions:				
Number of doctors about whom the National Clinical Advisory Service (NCAS) has been contacted between 1 April and 31 March for advice or for assessment				7
Number of NCAS assessments performed				1

19. Annual Report Template Appendix D – Audit of revalidation recommendations

Revalidation recommendations between 1 April 2014 to 31 March 2015	
Recommendations completed on time (within the GMC recommendation window)	16
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	16
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	Number
New starter/new prescribed connection established within 2 weeks of revalidation due date	Number
New starter/new prescribed connection established more than 2 weeks from revalidation due date	Number
Unaware the doctor had a prescribed connection	Number
Unaware of the doctor’s revalidation due date	Number
Administrative error	Number
Responsible officer error	Number
Inadequate resources or support for the responsible officer role	Number
Other	Number
Describe other	
TOTAL [sum of (late) + (missed)]	Number

20. Annual Report Template Appendix E – Audit of recruitment and engagement background checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	13
Temporary employed doctors	7
Locums brought in to the designated body through a locum agency - *** **all employment checks are undertaken by the relevant locum agency who is their employer**	46
Locums brought in to the designated body through 'Staff Bank' arrangements	0
Doctors on Performers Lists	0
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc	0
TOTAL	Number

For how many of these doctors was the following information available within 1 month of the doctor's starting date (numbers)

	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS investigations	Disclosure and Barring Service (DBS)	2 recent references	Name of last responsible officer	Reference from last responsible officer	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance concerns
Permanent employed doctors	13	13	13	13	13	13	13	13	13	13	13	13	13	13	13	13
Temporary employed doctors	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7

	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS investigations	Disclosure and Barring Service (DBS)	2 recent references	Name of last responsible officer	Reference from last responsible officer	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance concerns
Locums brought in to the designated body through a locum agency	46	***	***	***	***	***	***	***	***	***	***	***	***	***	***	***
Locums brought in to the designated body through 'Staff Bank' arrangements	0															
Doctors on Performers Lists	0															
Other (independent contractors, practising privileges, members, registrants, etc)	0															
Total	66															

Appendix F – a redacted example of an Appraiser Dashboard

APPRAISER DASHBOARD

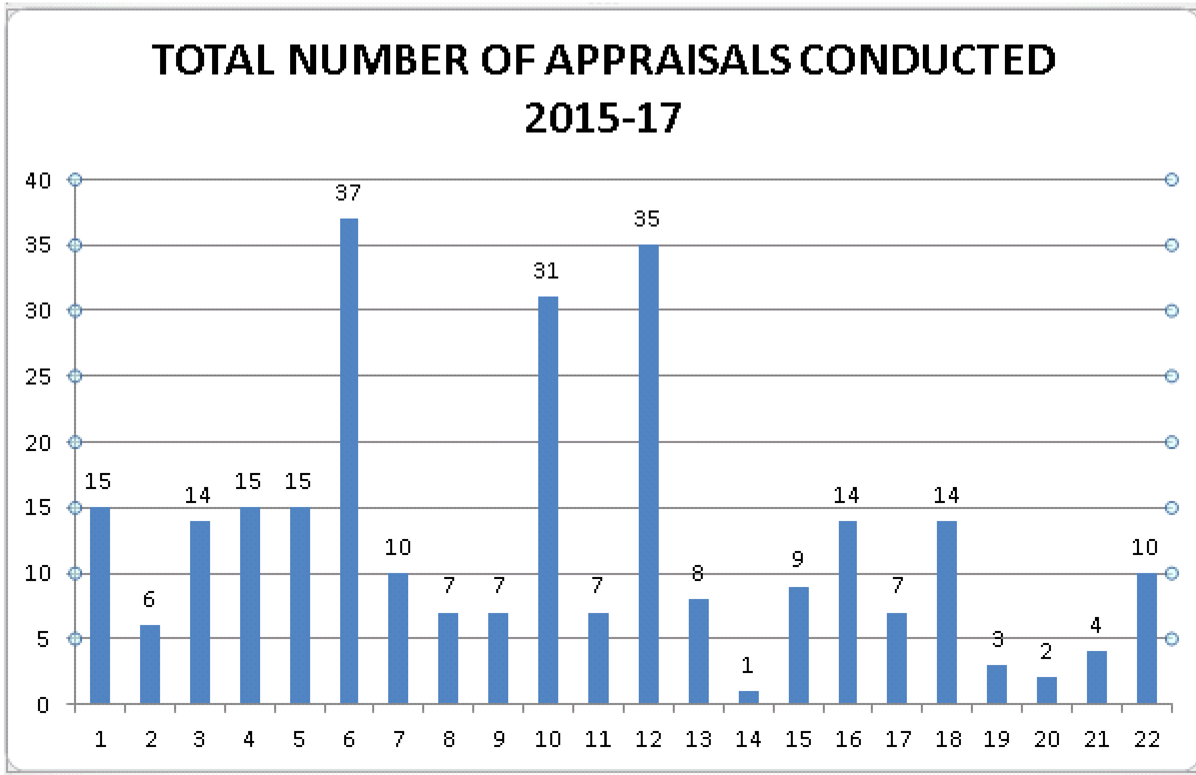
LOCAL & COMPARATIVE DATA
QUALITY ASSURANCE AUDIT
APPRAISEE FEEDBACK

COMPLIED BY DR E C KOMOCKI
MEDICAL APPRAISAL LEAD

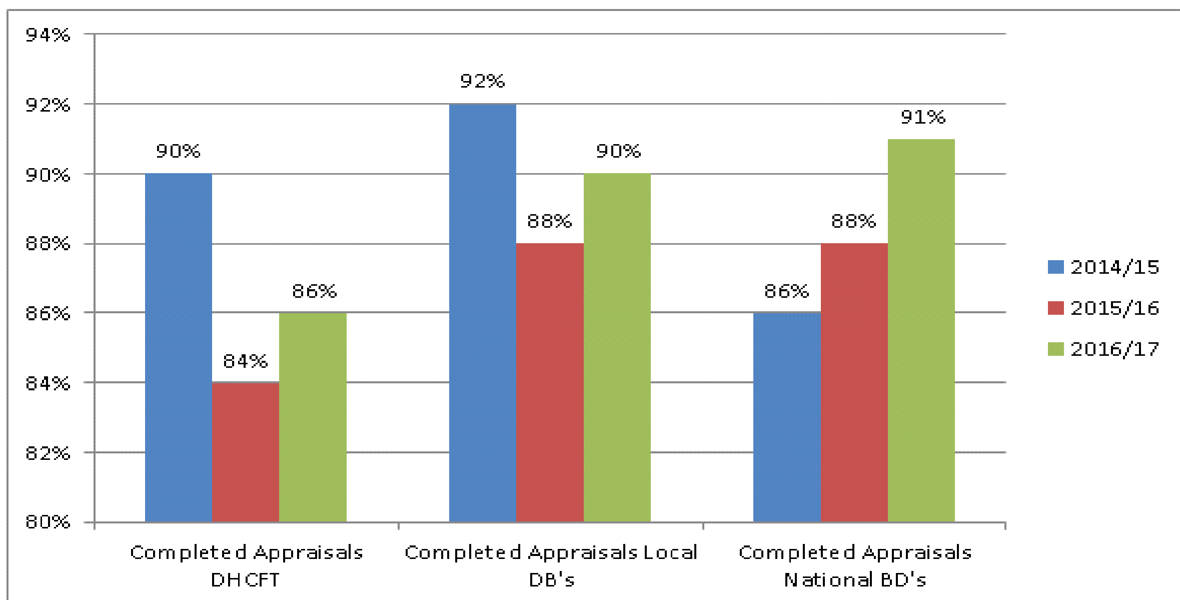
NOVEMBER 2017

APPRAISER – XXXXXXXXXXXXXXXXXX

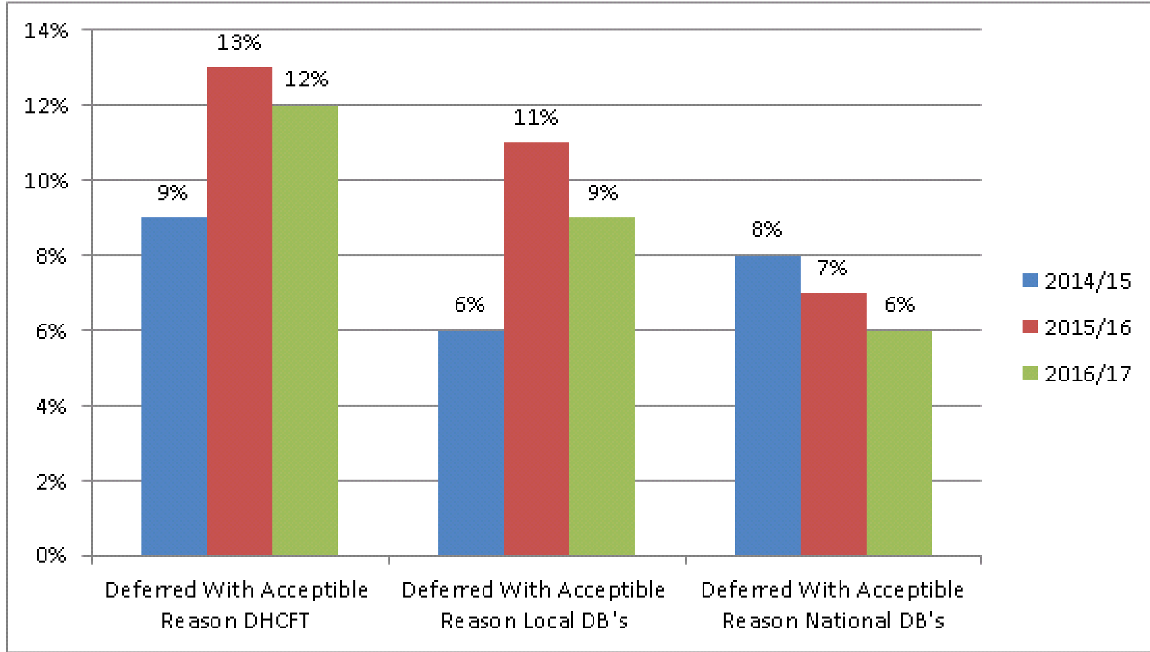
APPRAISAL PERIOD – 2014/15, 2015/16 & 2016/17



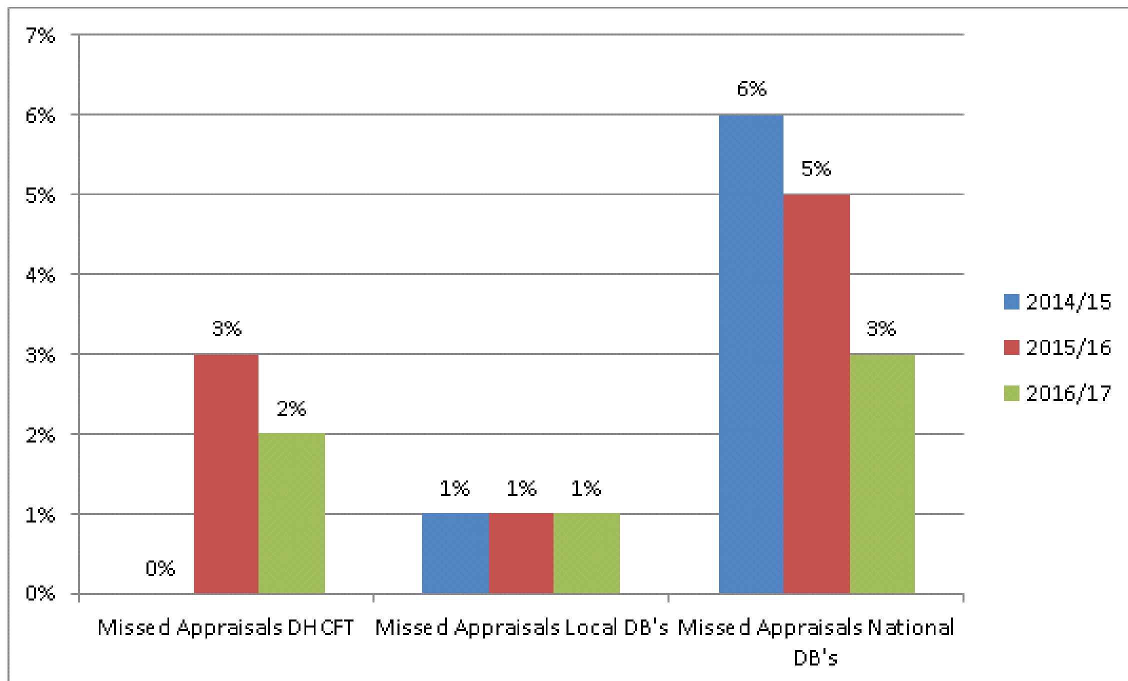
LOCAL & NATIONAL COMPARATIVE APPRAISAL RESULTS



1. SUCCESSFULLY COMPLETED APPRAISALS



2. DEFERRED APPRAISALS WITH ACCEPTABLE REASON



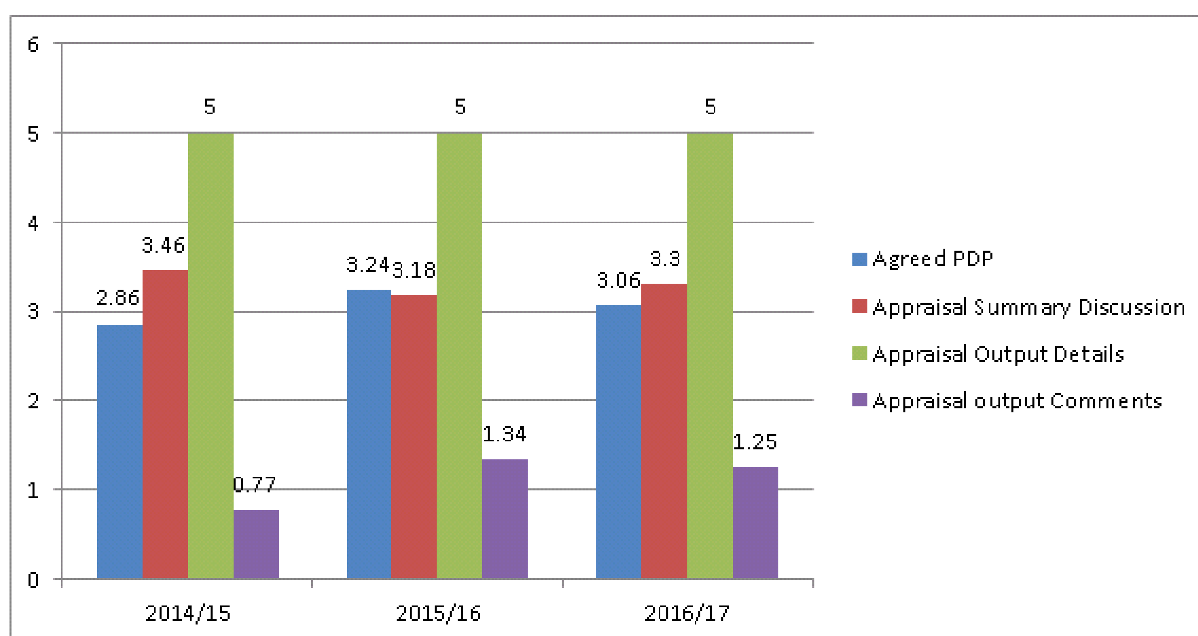
3. MISSED APPRAISALS

QUALITY ASSURANCE OF APPRAISERS ENTRIES 2015 – 2017

Entries by appraisers on sections 18, 19 & 20 ("Agreed PDP", "Summary of Appraisal Discussion" & "Appraisal Outputs") rated using an adapted ASPAT NHS Revalidation rating scale

(0 = no entry…..5 = excellent entry)

300 appraisal forms covering appraisal periods 2014-15, 2015-16 & 2016-17 reviewed



LEARNING POINTS

- **AGREED PDP –**
  - **Quality not quantity**
  - **Limit the number of CPD/Mandatory Training items**
  - **CPD/Mandatory Training items are "Actions/goals" not "Development needs"**
  - **Collaborative reflection in points 1 & 4 ("Developmental need" & "Demonstration of success")**
  - **Is "certificate" good enough?**
- **APPRAISAL SUMMARY DISCUSSION –**
  - **Quality not quantity**

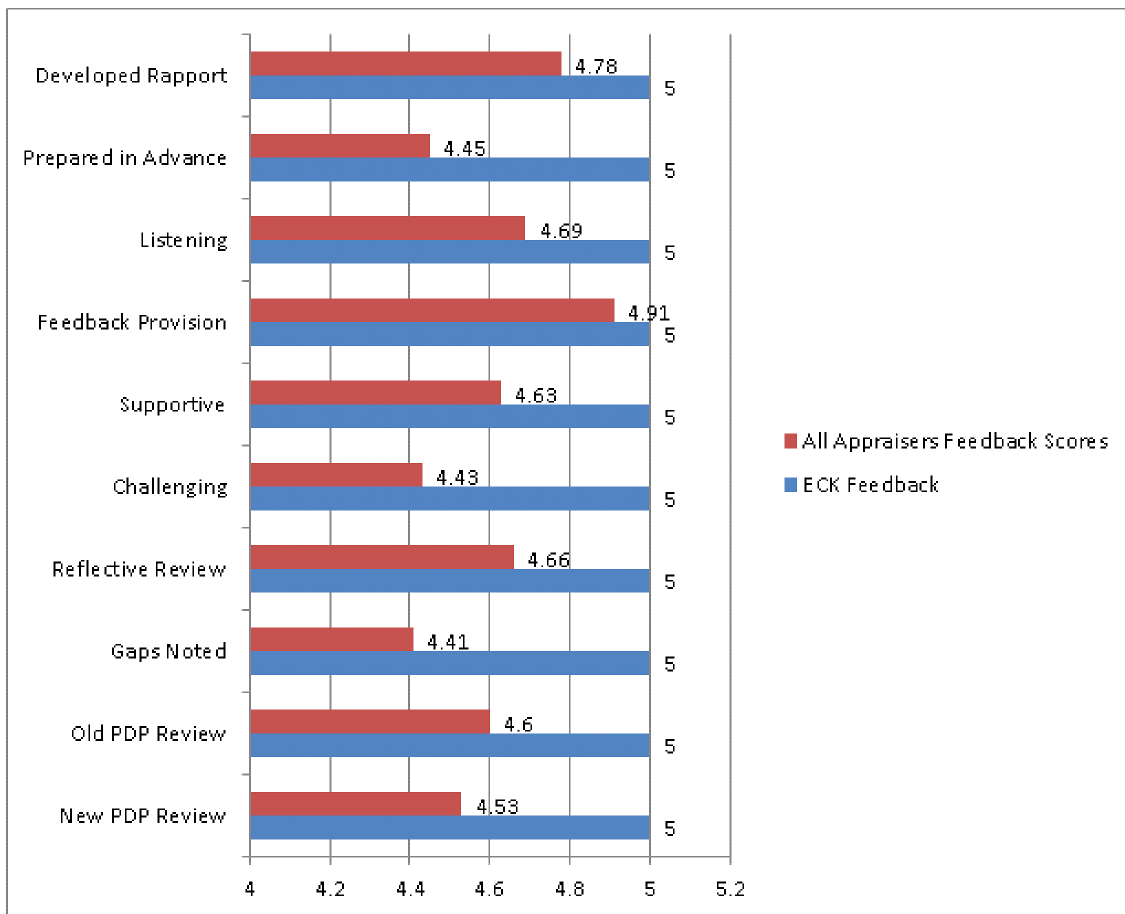
  - **Beware repetition of previously acknowledged CPD points – this IS improving since adoption of new MAG form thanks to the "Appraiser's review of portfolio"**
  - **Collaborative reflection – think "What? So what? What next?"**
- **APPRAISAL OUTPUT DETAILS –**
  - **Keep filling in the red boxes**
- **APPRAISAL OUTPUT COMMENTS –**
  - **Free text boxes ARE optional BUT they will help RO to reach a decision about doctor's potential for revalidation**
  - **Helpful to record appraisee's comments on the appraisal (may incorporate this into future feedback evaluations)**

FEEDBACK FOR APPRAISERS

Average scores for all appraisers calculated from 91 returned forms

XXX personal average score calculated from 6 returned forms

(Scoring range: 1 = poor to 5 = very good)



INDIVIDUAL COMMENTS FROM APPRAISEES –

- **"Supportive and challenging…met all my needs"**
- **"Experienced, comprehensive and useful"**
- **"Best appraisal ever….enjoyed the whole process"**
- **"Allowed space to reflect and fidelity in the process"**
- **"Clear explanations and didn't smother…uplifting and confidence building"**
- **"Has been a core part of my development"**

- **NB. All respondents commended the professionalism of the appraisal meeting, the usefulness of the process in assisting in both their professional development and their revalidation and stated that they would be happy to have the same appraiser again.**

NHS England

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex E - Statement of Compliance for DHCFT 2017-18

Statement of Compliance

Version number: 2.0

First published: 4 April 2014

Updated: 22 June 2015

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Publications Gateway Reference: 03432

NB: The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

Designated Body Statement of Compliance

The board of Derbyshire Healthcare Foundation Trust can confirm that

- an AOA has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

Yes – Dr John R Sykes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

Yes - Maintained and updated by DHCFT HR Department and utilised by the Medical Appraisal Lead to monitor and record appraisal rates

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

Yes - 14 trained appraisers presently functioning within DHCFT with two more doctors having now undergone training to adopt this role

4. Medical appraisers participate in on-going performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent);

Yes – On-going review of appraiser practice co-ordinated by Medical Appraisal Lead with refresher training/ feedback meetings and Appraiser Dashboards launched for 2017-18 appraisal cycle

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

Yes - All medical staff with a link to DHCFT have an annual appraisal utilising the updated MAG form to satisfy GMC requirements of "Good Medical Practice". Locum doctors also offered appraisal depending on need and strength of links to DHCFT. Review of all doctors unable to complete appraisal performed by Responsible Officer and Medical Appraisal Lead – the latter ensures follow up of all postponed appraisals to ensure doctors complete these when their circumstances are more favourable.

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

that information about these matters is provided for doctors to include at their appraisal;

Yes - Medical Appraisal Lead co-ordinates and audits appraisals to ensure all appropriate components are completed effectively. All complaints and SIRI's are cross-referenced with completed appraisals and the appropriate trust departments to ensure adequate reflection and learning from adverse events.

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

Yes – There are regular meetings with the GMC Liaison Officer when all concerns/cases are reviewed.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;[3]

Yes – all new appointments are asked to supply a reference from their RO. The Medical Director contacts ROs directly if he is concerned about a locum or another doctor who has left the Trust.

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners[4] have qualifications and experience appropriate to the work performed;

Completed by HR

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

Compliance rates are reviewed monthly at a Medical Management meeting and scrutinised at Trust Board.

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Derbyshire Healthcare Foundation Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _   Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Derbyshire Healthcare NHS Foundation Trust
Report to the Trust Board 3 July 2018

Freedom to Speak Up Self-Review Report

Purpose of Report

The purpose of this report is to outline the Trust's position following completion of the self review of Freedom to Speak Up (FTSU) as required by NHS Improvement (NHSI).

Executive Summary

NHSI self- assessment review

In May 2018 NHSI issued guidance which introduced the requirement for trusts to complete a self-review of Freedom to Speak Up. The guidance and review tool published is aligned with the good practice set out in the well-led framework which contains references to speaking up (KLOE 3) and will be shared with Inspectors as part of the CQC's assessment framework for well-led. The aim of the self review is for trust Boards to consider the leadership and governance arrangements in relation to FTSU and reflect on any areas to develop and improve. Completion of the self-assessment will act as a benchmark for our work going forwards.

The self-review tool is very comprehensive, and sets out a number of questions in each of the following areas exploring themes to assess whether:

- Leaders are knowledgeable about FTSU
- Leaders have a structured approach to FTSU
- Leaders actively shape the speaking up culture
- Leaders are clear about their role and responsibilities
- Leaders are confident that wider concerns are identified and managed
- Leaders receive assurance in a variety of forms
- Leaders engage with all relevant stakeholders
- Leaders are focused on learning and continual improvement

In addition there is a section of individual responsibilities including:

- Chief Executive and Chair
- Executive lead for FTSU
- Non-executive lead for FTSU
- Human resource and organisational development directors
- Medical Director and Director of Nursing

The self review was completed by the Director of Corporate Affairs who is the Executive Lead for FTSU on behalf of the Board, with contribution from the Freedom to Speak Up Guardian and the Governance lead.

Please note that when the review refers to senior leaders, NHSI have defined this term as Executive and Non-Executive Directors.

Summary of outcomes from the self–review

The self review was completed against all 69 questions, the template required each question:

- To be RAG rated - that we defined as e.g. RED – not met and no plan to address AMBER – partially met and with plan to address GREEN – fully met
- To state the principal actions required for development
- To list the evidence of how is the board assured it is meeting the expectation

Number of Red rated questions	Number of Amber rated questions	Number of Green rated questions
0	12	57

In terms of development areas identified there is much overlap in the actions underway to address recommendations set out in the report published in January 2018 by Deloitte, following their external independent well-led review which included KLOE3. Work that overlaps with existing Deloitte actions are:

- Implementation of Board engagement (Deloitte phase 2 action)
- Implementation of Leadership Management and Development strategy (phase 3 Deloitte)
- Six monthly reporting to Board on progress with Strategy (Deloitte phase 3)
- Implementation and focus on learning and continuous improvement (methodology) (Deloitte phase 2).

Additional actions for further development not included in previous work include:

- An annual Board development session for senior leaders to include sharing of guidance and discussion on Freedom to Speak Up
- To repeat the exercise in the 2018 Quality Visit programme to ask staff if they feel able to raise concerns
- Plans already in place to extend the CEO 'on the road' model to the wider Executive Leadership Team to increase visibility of senior leaders
- Integrated performance report to be developed to include Raising Concerns
- CEO report to be developed to include reference to issues raised with wider Executive Leadership Team
- Internal reviews of Board and Committees planned during 2018/19 to include review of robust challenge on patient safety, continuous improvement, openness and honesty
- To include the handling of speaking up cases on the internal audit programme for later in the year
- Further development of the continuous improvement agenda and learning is an organisational priority and will encompass identifying and sharing learning from concerns raised
- CEO to oversee six month review of FTSU Guardian role (FTSUG) June/July 2018

Actions for further development highlighted in the self-review are included in the work programme of the FTSUG over the next six months and include:

- As a long term goal, the FTSUG will consider options to develop 'champions' to ensure a wide network of individuals who can help support staff on our many sites and signpost them when raising concerns
- As part of the development of the FTSU Guardian role plans are in place to develop a programme of engagement with staff to include hard to reach/vulnerable staff groups
- Examples of learning and action taken from concerns raised to be communicated to staff
- FSUG report to Board to include evidence relating to staff confidence in speaking up and fair treatment
- Peer review of sample of cases
- Ongoing promotion and awareness activity to include examples of positive outcomes from raising concerns
- Learning from case reviews from the national guardian's office will be included in reports to the Audit and Risk Committee and People and Culture Committee.

The self-review confirmed that a great deal of work has been completed across all the areas of FTSU agenda and that the baseline assessment was overall very positive. There were no areas where we could not provide evidence of assurance. The increasing profile of Freedom to Speak Up Guardian in developing leaders' focus on learning and continual improvement is key to this work.

An audit of FTSU is proposed to be included on the internal audit programme for later in the year eg November/December 2018.

The Audit and Risk Committee will continue to receive updates on progress against these additional actions as part of the regular report by the Freedom to Speak Up Guardian.

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

Assurances

Much work has already been completed and embedded and there is further improvement planned.

Reporting on concerns raised is presented to the Trust Board six monthly and to the Audit and Risk Committee six monthly going forwards to provide assurance on progress made. The self-review provides a benchmark and assurance that our work to promote and respond to raising concerns/speaking up at work is progressing.

Consultation

This paper has not been previously presented.

Governance or Legal Issues

The Trust's Raising Concerns (Whistleblowing) policy addresses the main provisions of the Public Interest Disclosure Act 1998 which provides statutory protection to whistleblowers from victimisation and dismissal where they raise public interest concerns about misconduct or malpractice.

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).

There are no adverse effects on people with protected characteristics (REGARDS).	
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	x

Actions to Mitigate/Minimise Identified Risks

The FTSUG will review each concern raised to consider any potential impact on the person raising the concern or any associated services. It is outlined in the Trust's Raising Concerns policy that the Trust is committed to identifying colleagues (with protected characteristics or eg particular staff groups) where there may be barriers, and to provide support to ensure that all staff feel able to raise concerns.

Recommendations

The Board of Directors is requested to:

1) Review the outcomes from the self-review of Freedom to Speak Up
2) Receive significant assurance from the evidence outlined and ongoing reporting and oversight of established practice
3) To agree the future development work to be completed for oversight by the Audit and Risk Committee as lead Committee for ensuring robustness of implementation of the Trust's Raising Concerns /Speaking up at work (Whistleblowing) policy).

Report presented by: Sam Harrison, Director of Corporate Affairs

National Guardian
Freedom to Speak Up

NHS
Improvement

Freedom to Speak Up self-review tool for NHS trusts and foundation trusts

May 2018

How to use this tool
Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Our expectations			
Leaders are knowledgeable about FTSU			
1.1 Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office.	Green	**Board Development session** for senior leaders will include sharing of guidance and discussion on Freedom to Speak Up.	• **FSUG Reports to Board** six monthly • **Exec Lead reports to Audit and Risk Committee** six monthly • **FSUG six monthly updates to People and Culture Committee** • Director of Corporate Affairs attended 2017 national Freedom to Speak Up Guardian Day on 19 October 2017 and a Whistleblower's Hosting event on 23 October 2017. • Non-Executive is Senior Independent Director • Guidance from National Guardians Office referenced in reports and circulated as required.
1.2 Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up.	Green	Several areas of Board engagement have been developed and are being implemented and part of the Deloitte phase 2 action plan. In addition the following actions are to be developed. • To repeat the exercise in 2018 **Quality visit programme** to ask staff if they feel able to raise concerns. • To extend **the CEO 'on the road' model** to the wider	• FTSU vision is embedded in the **Trust's vision and values** refreshed in December 2017 • FTSU vision and key learning is reflected in the **Trust Strategy** which was refreshed in 2018 focus on 'people first' and sets out a clear vison to create a culture that supports continuous improvement, that learns from mistakes and promotes innovation Senior leaders regularly communicate the value of speaking up through the following channels of engagement with staff: • **CEO model of 'on the road'** and drop in

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
		executive team to increase visibility of senior leaders.	sessions. • The **Executive Leadership Team have scheduled meetings at venues across the Trust** and time is set aside prior to the formal meeting to meet with staff and give the opportunity for issues, ideas or concerns to be raised with Executive Directors. • Board members continue to lead **Quality Visits** which give valuable opportunity to meet with staff teams and listen to staff across the Trust. As part of this, in 2016 staff were asked if they feel able to raise concerns. • 'The **Staff Forum** commenced in September 2017 and includes representatives from across the Trust and provides the opportunity to raise issues with Executive Directors directly.
1.3 They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.	Amber	As part of the Deloitte phase 3 action plan, (comment 11) there are plans in place to review the approach to leadership development to include a focus on developing the skills for continuous improvement as outlined in the People Plan next steps.	• Leadership Strategy and development programme in development that emphases the importance of learning from issues.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
1.4 Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.	Green	The ongoing measures of success of the strategy will be reported to the Board annually as part of Deloitte phase 3 action plan in December 2018. (recommendation 1)	• Refreshed **Trust Strategy** developed by ELT including development session held on 8 November and presented to the Board in March 2018. • The Integrated Performance Report provides the Board with on-going assurance that the strategy is being delivered.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Leaders have a structured approach to FTSU			
2.1 There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.	Green	Work to implement continuous improvement methodology is part of the Deloitte phase 3 action plan. (comment 11)	• FTSU vision is embedded in the **Trust's vision and values** refreshed in December 2017 • FTSU vision and key learning is reflected in the **Trust Strategy** which was refreshed in 2018 focus on 'people first' and sets out a clear vison to create a culture that supports continuous improvement, that learns from mistakes and promotes innovation. • Report to Finance and Performance Committee 15 May 2018 setting out progress to date and actions planned to implement continuous improvement methodology.
2.2There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.	Green	Annual review of **Policy and procedures on Raising Concerns/Speaking Up at Work /Whistleblowing** as required to incorporate best practice, feedback from staff or new guidance.	• The Trust has in place a fit for purpose **Policy and procedures on Raising Concerns/Speaking Up at Work /Whistleblowing)**. This policy contains all elements as outlined in the NHS Improvement/NHS England standard integrated policy issued on 1 April 2016. Policy presented to Audit and Risk Committee May 2018 and confirmation reported to Board in assurance report on 5 June 2018
2.3 The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian) and it aligns with existing guidance from the National Guardian.	Green		• The **Trust Strategy** was refreshed and the draft was shared with a range of Stakeholders including staff forum to ensure it reflected the views of the whole organisation.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
2.4 Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.	Green	Integrated performance report to be developed to include Raising concerns. CE report to be developed to include reference to issues raised to wider executive team.	• Progress against the **Trust Strategy** is presented to the Board monthly in the Integrated Performance Report which provides the Board with on-going assurance that the Strategy is being delivered and uses a range of qualitative and quantitative measures. • Compliance with the policy is reported using a range of qualitative and quantitative measures in: • **FSUG Reports to Board** six monthly • **Reports to Audit and Risk Committee** six monthly • **FSUG six monthly updates to People and Culture Committee** • **CEO report includes issues raised through his engagement with staff**
Leaders actively shape the speaking up culture			
3.1 All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.	Green	**Board Development session** for senior leaders will include sharing of guidance and discussion on Freedom to Speak Up. **To extend the CEO 'on the road' model** to the wider executive team to increase visibility of senior leaders.	• Staff Engagement activities discussed and agreed at Board in November 2017. .
3.2 They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and	Green	Internal reviews of Board and committees during 2018/19 to include review of robust challenge	• Board minutes • Deloitte reviews of well led 2016, 2017 including observation of Board Committees.

Self review indicator **(Aligned to well-led KLOEs)**	**To what extent is this expectation being met?**	**What are the principal actions required for development?**	**How is the board assured it is meeting the expectation?** Evidence
honesty.		on patient safety, continuous improvement, openness and honesty	• CQC inspection 2016 report
3.3 Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers.	Amber	**To extend the CEO 'on the road' model** to the wider executive team to increase visibility of senior leaders.	• **CEO model of 'on the road' and drop in sessions**. • The **Executive Leadership Team have scheduled meetings at venues across the Trust** and time is set aside prior to the formal meeting to meet with staff and give the opportunity for issues, ideas or concerns to be raised with Executive Directors. • Board members continue to lead **Quality Visits** which give valuable opportunity to meet with staff teams and listen to staff across the Trust. As part of this, in 2016 staff were asked if they feel able to raise concerns. • 'The **Staff Forum** which commenced in September 2017 and includes representatives from across the Trust and provides the opportunity to raise issues with Executive Directors directly.
3.4 Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian.	Green		• Director of Corporate Affairs attended the 2017 national Freedom to Speak Up Guardian Day on 19 October 2017 and a Whistle-blower's Hosting event on 23 October 2017. • Non-Executive is Senior Independent Director • FTSU Guardian reports to Director of Corporate Affairs • Monthly 1:1 supervision meetings for FTSU Guardian and Director of Corporate Affairs • FTSU Guardian has **regular meetings with**

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
			the CEO and has direct access as required. • FTSU Guardian **has regular meetings with Senior Independent Director**
3.5 Senior leaders model speaking up by acknowledging mistakes and making improvements.	Amber	Examples of learning and action taken from concerns raised to be communicated to staff	• **CEO Board Report** includes feedback on issues raised and actions taken
3.6 The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.	Amber	**FSUG report to Board** to include evidence relating to staff confidence in speaking up and fair treatment.	• **Staff survey results** cover these areas – 2017 outcomes show this is area for further focus • **FSUG Committee/Board reports** include information on publicity on the options for staff to raise concerns and raising awareness initiatives. • **Audit and Risk Committee receive six monthly** reports on numbers of concerns and effectiveness of the raising concerns process. • The FTSUG has established links with the Senior Independent Non-Executive Director who reviews reports as devised by the Freedom to Speak up Guardian and works closely with the FTSUG to act as a conduit through which information is shared with the Board.
Leaders are clear about their role and responsibilities			
4.1 The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility.	Green		• Job descriptions of Director of Corporate Affairs and Senior Independent Director • 1:1 supervision sessions between Director of Corporate Affairs/ CEO and chair/SID • Annual Appraisals

Self review indicator **(Aligned to well-led KLOEs)**	**To what extent is this expectation being met?**	**What are the principal actions required for development?**	**How is the board assured it is meeting the expectation?** Evidence
4.2 They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.	Green		• **FSUG Reports to Board** six monthly • **Exec Lead reports to Audit and Risk Committee** six monthly • **FSUG six monthly updates to People and Culture Committee**
4.3 Other senior leaders support the FTSU Guardian as required.	Green		• FTSU Guardian has **direct access** to senior leaders as required • FTSU Guardian's job description
5.Leaders are confident that wider concerns are identified and managed			
5.1 Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns.	Green		• Data on staff speaking up is captured in a log and submitted quarterly to the NGO. • **FSUG Reports to Board** six monthly • **Audit and Risk Committee receive six monthly** reports • **FTSU guardian has access to staff survey results and Datix risk management information.** • **FSUG also links in with communications and involvement team on engagement issues**
5.2 The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.	Green		• FTSU Guardian has **direct access to senior leaders** as required
Leaders receive assurance in a variety of forms			

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
6.1 Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.	Amber	As a long term goal, the FTSUG will consider options to develop 'champions' to ensure a wide network of individuals who can help support staff on our many sites and signpost them when raising concerns. Ongoing promotion and awareness activity to include examples of positive outcomes from raising concerns	• The FTSUG role has been promoted and embedded in the Trust to support staff and patient care. • Visibility of the FTSUG is apparent through attendance at meetings, posters and electronic communications. • Presentations by FTSU Guardian to teams as outlined in regular reports to Board and Committees. • FTSU Guardian is involved in design and delivery of a range of training.
6.2 Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers	Amber	As part of the development of the FTSU Guardian role plans are in place to develop a programme of engagement with staff to include hard to reach/vulnerable staff groups i.e. Junior Doctors, LGBT group	• FTSU Guardian has made presentations to BME Network Meetings • Presented information in alternative formats to staff who may not access electronic systems i.e. Porters, Domestic Staff, Catering Staff
6.3 Speak up issues that raise immediate patient safety concerns are quickly escalated	Green		• The FTSU Guardian has **direct access** to the Director of Nursing and Deputy Director to discuss and receive personal support on clinical issues raised.
6.4 Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority	Green		• The **Raising Concerns/Speaking up Policy** has been updated to outline the role of the FTSUG and was presented to Audit and Risk Committee in May 2018 • The Dignity at Work Policy and Grievance Procedures has also been updated to include the support available to individuals through their FTSUG.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
			• No incidents of victimisation as a result of speaking up have been reported
6.5 Lessons learnt are shared widely both within relevant service areas and across the trust	Green	Examples of learning and action taken from concerns raised to be communicated to staff	• The FTSUG role is shared as part of the induction programme to new starters and an information sheet is added within induction packs that are issued to all new starters. • The Root Cause Analysis Training that is delivered in the Trust now incorporates a section on Whistleblowing which the FTSUG delivers to delegates attending the training. • The FTSUG maintains a central system of concerns which highlights themes and enables triangulation of data with other systems that exist and are accessible.
6.6 The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented	Green	To include the handling of speaking up cases on the internal audit programme for later in the year e.g. November/December	
6.7 FTSU policies and procedures are reviewed and improved using feedback from workers	Green	Annual review of **Policy and procedures on Raising Concerns/Speaking Up at Work /Whistleblowing** as required to incorporate best practice, feedback from staff or new guidance.	• **The Raising Concerns/Speaking up Policy** has been updated to outline the role of the FTSUG and was presented to Audit and Risk Committee in May 2018 • The Dignity at Work Policy and Grievance Procedures has also been updated to include the support available to individuals through their FTSUG.
6.8 The board receives a report, at least every six months, from the FTSU Guardian.	Green		• **FSUG Reports to Board** six monthly

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
7.Leaders engage with all relevant stakeholders			
7.1 A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.	Green		• The refreshed **Trust Strategy** included circulation of the draft to a range of stakeholders and to a range of staff through the Staff forum.
7.2 Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.	Green	Integrated performance report to be developed to include Raising concerns. CEO report to be developed to include reference to issues raised to wider executive team.	• Commissioners and NHSI have access to Board reports • FTSU Guardian met with CQC Inspectors on the 17/4/18 and will meet with CQC inspectors as part of inspection in summer 2018.
7.3 Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals).	Green		• **FSUG Reports to Board** six monthly in public session of the Board meeting
7.4 The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture.	Green		• Annual report 2017/18
7.5 Reviews and audits are shared externally to support improvement elsewhere.	Green		• Regional network provides platform for sharing externally learning and improvements made • Case reviews published by NGO
7.6 Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture	Green		• Director of Corporate Affairs attended the 2017 national Freedom to Speak Up Guardian Day on 19 October 2017 and a Whistle-blower's Hosting event on 23 October 2017. FTSU Guardian attends national and regional events

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
7.7 Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians	Green		• FTSU Guardian attends national and regional events • FTSU Guardian met with CQC Inspectors on the 17/4/18 and will meet with CQC inspectors as part of inspection in summer 2018. • Chair of FTSU Guardian Network on appointment panel in December 2017 for Trust FTSU Guardian • FTSU Guardian meets with regional FTSU Guardians on a quarterly basis. • FTSUG has an external mentor FTSUG who is the Chair of the Regional Network. • FTSUG attended the yearly FTSGU Conference in March 2018
7.8 Senior leaders request external improvement support when required.	Green		• **External reviews of complex cases** have been used when required. • **Audit and Risk Committee receive six monthly** reports

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
8.Leaders are focused on learning and continual improvement			
8.1 Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.	Amber	Work to implement continuous improvement methodology as part of the Deloitte phase 3 action plan. The measures of success of this will be reported to the Board annually as part of Deloitte phase 3 action plan progress report in December 2018. Further development of the continuous improvement agenda as part of organizational priority together with learning and transformation. The transformation team are working with OD to ensure that basic management principles are embedded within teams. Recognises that team managers provide sufficient focus on factors of safety, quality, workforce and finance as key to their role and that this is underpinned by an effective mechanism for supervision and support.	• **FSUG Reports to Board** six monthly • **Exec Lead reports to Audit and Risk Committee** six monthly • **FSUG six monthly updates to People and Culture Committee** • Report to Finance and Performance Committee 15 May 2018 setting out progress to date and actions planned to implement continuous improvement methodology

Self review indicator **(Aligned to well-led KLOEs)**	**To what extent is this expectation being met?**	**What are the principal actions required for development?**	**How is the board assured it is meeting the expectation?** Evidence
8.2 Senior leaders and the FTSU Guardian engage with other trusts to identify best practice.	Green		• Director of Corporate Affairs attended the 2017 national Freedom to Speak Up Guardian Day on 19 October 2017 and a Whistle-blower's Hosting event on 23 October 2017. • FTSU Guardian attends national and regional events
8.3 Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.	Green	**Board Development session** for senior leaders will include sharing of guidance and discussion on Freedom to Speak Up. Learning from **case reviews** from the national guardian's office will be included in reports to the Audit and Risk Committee and People and Culture Committee.	
8.4 Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.	Green	Work to implement continuous improvement methodology as part of the Deloitte phase 3 action plan. The measures of success of this will be reported to the Board annually as part of Deloitte phase 3 action plan progress report in December 2018. Further development of the continuous improvement agenda and learning from speaking up	• **FSUG Reports to Board** six monthly • **Exec Lead reports to Audit and Risk Committee** six monthly • **FSUG six monthly updates to People and Culture Committee** • **CEO reports to Board**

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
		cases. Is an organizational priority together with transformation. **Annual Board development programme for senior leaders** will include sharing of guidance and discussion on Freedom to Speak Up.	
8.5 The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.	Green		• **Trust Strategy** is reviewed and revised annually. • **FSUG Reports to Board** six monthly • **Exec Lead reports to Audit and Risk Committee** six monthly • **FSUG six monthly updates to People and Culture Committee**
8.6 The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.	Green	Annual review as set out in forward plan for Audit and Risk Committee of **Policy and procedures on Raising Concerns/Speaking Up at Work /Whistleblowing** as required to incorporate best practice, feedback from staff or new guidance.	• Revised **Policy and procedures on Raising Concerns/Speaking Up at Work /Whistleblowing** was presented to Audit and Risk Committee May 2018
8.7 A sample of cases is quality assured to ensure: The investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured • workers are thanked for speaking	Green		• All cases reviewed by Director of Corporate Affairs and Trust Secretary • **Case reviewed** by Senior Independent Director and external expert in 2017/18 • Revised **Policy and procedures on Raising Concerns/Speaking Up at Work**

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
up, are kept up to date though out the investigation and are told of the outcome • Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored			**/Whistleblowing** sets out timelines for feedback to staff who have spoken up • Independent investigation harnessed in 2017 for a complex case.
8.8 Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.	Amber	Newsletter to be devised to share anonymous data on speaking up	• FTSU Guardian delivers raising awareness presentations to teams • Evaluation forms are issued to individuals that have spoken up to receive feedback
9. Individual responsibilities			
Chief executive and chair			
9.1 The chief executive is responsible for appointing the FTSU Guardian.	Green		• CEO approved appointment of new a FTSU guardian who commenced in role on the 1 December 2017
9.2 The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust.	Green	CEO to oversee 6 month review of FTG role June/July 2018	• Regular meetings between FTSU guardian and CEO
9.3 The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.	Green		• Annual report 2017/18
9.4 The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office.	Green	Ongoing involvement in regional and national FTSU guardian networks.	• **FSUG Reports to Board** six monthly

Self review indicator **(Aligned to well-led KLOEs)**	**To what extent is this expectation being met?**	**What are the principal actions required for development?**	**How is the board assured it is meeting the expectation?** Evidence
9.5 Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.	Green		• FTSU Guardian has **direct access** and regular meetings with CEO and Chair
Executive lead for FTSU			
9.6 Ensuring they are aware of latest guidance from National Guardian's Office.	Green		• The Director of Corporate Affairs receives regular information from the National Guardians Office and meets regularly with the FTSU Guardian
9.7 Overseeing the creation of the FTSU vision and strategy.	Green		• FTSU vision is embedded in the **Trust's vision and values** refreshed in December 2017 • FTSU vision and key learning is reflected in the **Trust Strategy** which was refreshed in 2018 focus on 'people first' and sets out a clear vison to create a culture that supports continuous improvement, that learns from mistakes and promotes innovation Senior leaders regularly communicate the value of speaking up.
9.8 Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian.	Green		• FTSU Guardian role appointed to in December 2017 in line with Trust recruitment policy- open competition to all Trust staff. • Job description based on national template • External technical expert on panel.
9.9Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence.	Green		• 2 days per week are allocated as ring fenced time to the FTSU Guardian • FTSU Guardian receives monthly supervision from Director of Corporate Affairs. • The **Raising Concerns/Speaking Up at**

Self review indicator **(Aligned to well-led KLOEs)**	**To what extent is this expectation being met?**	**What are the principal actions required for development?**	**How is the board assured it is meeting the expectation?** Evidence
			Work /Whistleblowing policy identifies alternative contacts for staff in absence of FTSU guardian.
9.10 Ensuring that a sample of speaking up cases have been quality assured.	Amber	Peer review of sample of cases.	• Case reviewed by Senior Independent Director and external expert in 2017/18 • Independent investigation harnessed in 2017 for complex case
9.11 Conducting an annual review of the strategy, policy and process.	Green	To be included in forward plan for Audit and Risk committee on annual basis.	• Minutes of Audit and Risk Committee May 2018
9.12 Operationalising the learning derived from speaking up issues.	Amber	Further development of the continuous improvement agenda and learning from speaking up cases is an organizational priority together with transformation.	• Minutes of ELT • Minutes of TMT
9.13 Ensuring allegations of detriment are promptly and fairly investigated and acted on.	Green		• Revised **Policy and procedures on Raising Concerns/Speaking Up at Work /Whistleblowing** in place. • We are not aware of any cases of detriment.
9.14 Providing the board with a variety of assurance about the effectiveness of the trust's strategy, policy and process.	Green		• **FSUG Reports to Board** six monthly • **Exec Lead reports to Audit and Risk Committee** six monthly • **FSUG six monthly updates to People and Culture Committee** • **CEO report to Board.**

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Non-executive lead for FTSU			
9.15 Ensuring they are aware of latest guidance from National Guardian's Office.	Green	**Annual Board development programme for senior leaders** will include sharing of guidance and discussion on Freedom to Speak Up.	• Meetings with Director of Corporate Affairs • Meetings with FTSU Guardian • **FSUG Reports to Board** six monthly • **Exec Lead reports to Audit and Risk Committee** six monthly • **FSUG six monthly updates to People and Culture Committee**
9.16 Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.	Green		• **FSUG Reports to Board** six monthly • **Exec Lead reports to Audit and Risk Committee** six monthly • **FSUG six monthly updates to People and Culture Committee** • **CEO reports to Board**
9.17 Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement.	Green	Internal reviews of Board and committees during 2018/19 to include review of robust challenge on patient safety, continuous improvement, openness and honesty	• **FSUG Reports to Board** six monthly • **Exec Lead reports to Audit and Risk Committee** six monthly • **FSUG six monthly updates to People and Culture Committee**
9.18 Role-modelling high standards of conduct around FTSU.	Green		• Annual appraisal • 1:1 meetings with Chair
9.19 Acting as an alternative source of advice and support for the FTSU Guardian.	Green		• Meetings with FTSU Guardian • Role is defined in **Policy and procedures on Raising Concerns/Speaking Up at Work /Whistleblowing.**

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
9.20 Overseeing speaking up concerns regarding board members.	Green	Future concerns to be raised with NED lead	• Annual appraisal • 1:1 meetings with Chair
Human resource and organisational development directors			
9.21 Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up.	Green		• **FSUG Reports to Board** six monthly • **FSUG six monthly updates to People and Culture Committee** • FTSU Guardian receives Staff Survey results and works closely with HR colleagues to consider results and any barriers to speaking up.
9.22 Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust.	Green	Further development of the continuous improvement agenda and learning from speaking up cases is an organizational priority together with transformation..	• Leadership Strategy to be developed
9.23 Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.	Amber	Assess future results from Staff Survey	• Recruitment policy • HR policy and procedures • Training and development programme for managers • Staff Survey results
Medical director and director of nursing			
9.24 Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues.	Green		• FTSU Guardian has **direct access** to Director of Nursing and Deputy including opportunity to discuss and obtain personal support on clinical issues raised.

Self review indicator **(Aligned to well-led KLOEs)**	**To what extent is this expectation being met?**	**What are the principal actions required for development?**	**How is the board assured it is meeting the expectation?** Evidence
9.25 Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up.	Green		• FTSU Guardian has **direct access** to Director of Nursing and Deputy
9.26 Ensuring learning is operationalised within the teams and departments that they oversee.	Amber	Further development of the continuous improvement agenda and learning from speaking up cases is an organizational priority together with transformation.	• Minutes of ELT • Minutes of TMT • **Quality visit** programme

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 July 2018

Freedom to Speak Up Guardian

Purpose of Report
To present an update on the work of the Freedom to Speak Up Guardian (FTSUG) – as the first of scheduled six-monthly updates going forwards.

Executive Summary

The aim of this report is to enable the Board to maintain a good oversight of FTSU matters and issues, and no less than every six months. The report includes both quantitative and qualitative information, case studies and other information that will enable the Board to fully engage with FTSUG and to understand the issues being identified, areas for improvement, and take informed decisions about action.

The structure of the report follows that outlined in guidance issued by the National Guardian Freedom to Speak Up, and NHS Improvement in May 2018. This covers main themes of:

- Assessment of Issues
- Potential patient safety or worker experience issues
- Action taken to improve the FTSU culture
- Learning and Improvement
- Recommendations for action

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

Assurances
The report provides assurance on the frameworks in place to support Freedom to Speak Up

Consultation

None

Governance or Legal Issues

It is a requirement that all Trusts have a Freedom to Speak Up Guardian in post and best practice that they report periodically directly to the Trust Board.

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).

There are no adverse effects on people with protected characteristics (REGARDS).	
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	X

Actions to Mitigate/Minimise Identified Risks

Issues relating to providing additional support to groups or individuals who may find it more difficult to raise concerns are covered in both the Raising Concerns/speaking up at work (Whistleblowing) policy and also a key feature of the work plan of the Freedom to Speak up Guardian. Evaluation and feedback from staff will help us develop this further.

Recommendations

The Board of Directors is requested to:

1) Note this first report from the Freedom to Speak up Guardian
2) Receive assurance that the role is effective within the Trust, with a clear framework of policies, procedures and personal support to further develop this work
3) Note the planned work of the Freedom to Speak up Guardian as a key element of the Trust's aims to put People First and engender a culture of openness, transparency and learning.

Report presented by: **Kully Hans, Freedom to Speak Up Guardian**

Freedom to Speak Up Guardian (FSUG) Board Report covering recommended themes from the National Guardian's Office on Board reporting

The aim of this report is to enable the Board to maintain a good oversight of FTSU matters and issues, and no less than every six months. The report includes both quantitative and qualitative information, case studies and other information that will enable the Board to fully engage with FTSUG and to understand the issues being identified, areas for improvement, and take informed decisions about action.

Data and other intelligence are presented in a way that maintains the confidentiality of individuals who speak up.

1. Assessment of issues

1.1 What the Trust has learnt and what improvements have been made as a result of Trust workers speaking up.

In my experience in the FSUG role, where concerns raised do not fall under a formal process, managers can appear reluctant in dealing with the concern raised. For example, if it does not fall under an HR Process and there are no Terms of Reference to work to the manager may not see it is as their responsibility to look into the concern.

The Raising Concerns/Speaking up (Whistleblowing) Policy has been updated to ensure that the process to manage a concern that is raised is clearly defined. Where there is no requirement for Terms of Reference to be written, the practice of fact finding is defined to enable the concern to be considered against any corroborating evidence, which does not require Terms of Reference to be drawn up.

1.2 Information on the number and types of cases being dealt with by the FTSU Guardian and their local network.

A log is maintained of concerns that are received. These concerns are raised by individuals directly to the FTSUG, or through the Senior Independent Non-Executive Director, Chief Executive and Directors through their course of work and "On the Road" sessions undertaken throughout the Trust.

I commenced in the role on 1/12/2017 and have recorded a full quarter of data for year 2017/18 (1/1/2018 – 31/3/2018), which is shown in the table below.

Concerns are recorded by Service Divisions and categorised in accordance with the NGO guidance. At this time the NGO requires concerns relating to Patient Safety/Quality and Behaviours including Bullying and Harassment to be reported to them. However from a Trust perspective it is useful to recognise all concerns being reported to me under the speaking up route.

2017/18 Data from FTSUG	
Types of Concerns	**Q4 Jan – March 2018**
Patient Safety	7
Policy and Procedure	4
Attitude & Behaviours	5
Concerns by Areas	
Corporate	1
Campus	4
Central	7
Neighbourhoods	4
Other	0
Total No. of Concerns	**16**
Cases reported directly to the FTSUG	**11**
PIDA Cases	**7**

Note: in relation to the above table 1 person raised 2 concerns which were recorded separately as they related to different matters. So in respect of the number of individuals raising concerns in Q4 2017/18, this totals 15.

For the current year of data (2018/19), Q1 runs for the period 1/4/18 – 25/6/18 and data has been provided to the present date of this paper as the end of the quarter has not yet been reached.

2018/19 Data from FTSUG	
Types of Concerns	**Q1 April - June 2018**
Health and Safety (not patient related)	2
Patient Care	1
Policy and Procedure	5
Attitude & Behaviours	13
Cover Up	1
Unknown	1
Concerns by Areas	
Corporate	9
Campus	5
Central	4
Neighbourhoods	4
Other	1
Total No. of Concerns	**23**
Cases reported directly to FTSUG	**18**
PIDA Cases	**19**

Note: 2 people raised 3 concerns each on separate matters, so the total number of individuals that raised concerns during Q1 2018/19 was 16.

1.3 An analysis of trends, including whether the number of cases is increasing or decreasing; any themes in the issues being raised (such as types of concern, particular groups of workers who speak up, areas in the organisation where issues are being raised more or less frequently than might be expected); and information on the characteristics of people speaking up (professional background, protected characteristics)

With my commencement as FTSUG and ongoing promotion of the role, there has been an increase in concerns being reported. It is too early to identify a particular trend but some concerns shared have been due to the result of individuals that have already accessed support from myself have signposted colleagues to speak with me. Additionally individuals have made contact directly following the delivery of presentations I have made within teams to explain Trust commitment, policy and raise awareness of the importance of raising concerns. It is noted that concerns relating to "attitudes, behaviours and bullying" is prevalent and this is mirrored as a theme with all trusts. Individuals raising concerns with the FTSUG, often raise more than one concern at a time and dependent on the nature of the concern, these will be recorded separately.

2. Potential patient safety or workers experience issues

2.1 Information on how FTSU matters relate to patient safety and the experience of workers, triangulating data as appropriate, so that a broader picture of FTSU culture, barriers to speaking up, potential patient safety risks, and opportunities to learn and improve can be built.

Where matters of patient safety have been reported, I review Datix (risk management) systems to ensure the matter has been reported appropriately through incident reporting systems. I will cross check the Employee Relations Case Tracker to check if concerns have been raised through a formal Human Resource process. Additionally the Director of Nursing is also reporting matters of patient safety directly to myself. All three systems of reporting enable triangulation of data. Of the 7 Patient Safety concerns raised t in Q4, 2 concerns were recorded in the Datix system and 2 concerns were being dealt with under a HR process.

3. Action taken to improve FTSU culture

3.1 Details of actions taken to increase the visibility of the FTSU Guardian and promote the speaking up processes.

The role has been promoted through communication via the staff newsletters Weekly Connect and Monthly Newsletter, Trust wide email promotion with posters attached, payslip notification, screen saver and face to face meetings as well as team meeting presentations. There has also been direct communication by letter to service specific areas.

- Contracts of employment have been updated to include a section on speaking up and reference to the Raising Concerns/Speak up Policy has been included.
- The Trust Induction includes a section on FTSUG which is delivered by the CEO; information on the role of the FTSUG is incorporated into the induction handout packs.
- Human Resource Policies, Dignity at Work and Grievance Procedure have been updated to include the role of FTSUG.
- The Trust's Staff Handbook has been reviewed and updated to include the role of the FTSUG.
- The rolling programme for Junior doctor intake is attended to promote the role of FTSU. Equally I have engaged with the Guardian for Safeworking who has been recently appointed to support doctors in their roles and will look to work closely together.
- I have attended the BME Network meeting and asked if it would be appropriate to attend regularly in order to capture any concerns shared, or for Speaking up to be a regular agenda item for discussion between the group, which with agreement, the Chair will feed back to the FTSUG.
- I am member of the Staff Forum and attend agenda setting and forum meetings. Where agenda items do not progress to a Staff Forum meeting with Executive Directors following an agenda setting meeting, agreement has been given for these concerns to be picked up by me, so that these are not lost and may be progressed.

3.2 Details of action taken to identify and support any workers who are unaware of the speaking up process or who find it difficult to speak up.

There are a number of individuals within the Trust who may not be familiar with the Trust process on speaking up and may not be in the Trust long enough to be aware. These include individuals such as Agency Workers, Students, Junior Doctors on Rotation and Bank Workers.

- I have arranged to attend student Development Days throughout the year to promote the role of speaking up.
- I attend each Junior Doctor induction both North and South to promote speaking up.
- The Procurement Team have been updated to ensure an outline of the role is embedded in agency contracts.
- The bank workers agreement is presently being reviewed to ensure bank workers are aware of the support available through me in speaking up about any concerns.

3.3 Details of any assessment of the effectiveness of the speaking up process and the handling of individual cases.

Promotion of the FTSUG role in December 2017 resulted in a number of concerns being raised from 2 specific service areas. Since delivering presentations to teams, a trend is noted that people from those teams presented to, started to contact the FTSUG to raise concerns.

Concerns that have been raised to me in **Q4** identified that 11 of the concerns had been previously raised to other individuals, prior to me being approached.

In respect of **Q1**, 9 had been previously raised to other individuals.

3.4 Information on any instances where people who have spoken up may have suffered detriment and recommendations for improvement.

Delays in addressing a concern can cause a detriment and raise the anxieties of individuals. One individual that raised a concern to their manager and reported others had raised the same concern to the same manager, several times, came to me as a last resort. Following this, I raised the matter with the appropriate General Manager who was reluctant to take forward the matter and therefore this was not addressed in a timely manner. This resulted in the matter being escalated to the CEO. Since this time the individual who raised the concern has left the Trust. Whilst it cannot be factually established if the individual suffered a detriment as they did not complete the feedback form, part of the concerns that were raised are still outstanding and deemed to have had an impact, of which the line manager is aware.

A recommendation for improvement would be that an acknowledgement of concern should be issued as soon as a concern is raised. Communication on what is being considered or can or cannot be done to deal with the concern should be clearly stated without delay so that individuals remain engaged and feel listened to.

3.5 Information on actions taken to improve the skills, knowledge and capability of workers to speak up and to support others to speak up and respond to the issues they raise effectively.

I have devised a presentation that is delivered at team meetings to provide a background as to why the FTSU role was established and to outline how I can support individuals to speak up. The following teams have received a presentation so far:-

- Assessment Treatment Service, Learning Disabilities
- BME Network
- Catering Staff at Kingsway and Radbourne
- Childrens Service - Admin
- Cubley Court Male
- Derby City Drug and Alcohol Service
- Eating Disorders Service
- Erewash Community Learning Disabilities Team
- Junior Doctors Academic Review Meetings – North and South
- Pharmacy Team
- Practice Development Days – Nursing Staff
- South Derbyshire Community Learning Disabilities Team
- Substance Misuse St Mary's Gate, Erewash House and Swadlincote
- Staff Governors, paper presented at Council of Governors

Time with the Hotel and Facilities Porters Team has been requested, but is yet to be confirmed. Leaflets have been designed and planned to be issued to the team in order to promote speaking up.

Time has been requested with the Estates and Facilities team through their manager and dates for this are awaited.

Further meetings with teams planned in July 2018 include:-
Children's Services – All localities, 1, 2, 3, 4 and 5
Learning Disabilities Strategic Health
Morton Ward

For those finding it difficult to speak up or who may want to raise concerns confidentially/anonymously, a PO Box address had been communicated where they may choose to write to the FTSUG directly without exposure. This as yet had not been utilised, but will continue to be promoted.

A Trust wide newsletter is planned to be issued on a quarterly basis to regularly update individuals on matters relating to concerns and any positive outcomes. A draft copy of the first issue is attached.

4. Learning and improvement

4.1 Feedback received by FTSU Guardians from people speaking up and action that will be taken in response.

An evaluation feedback form is part of the Raising Concerns/Speaking Up At Work (Whistleblowing) policy and has previously been sent out to a number of individuals who had shared concerns but these were not returned. The feedback form has been revised along with the policy and will be used moving forward.

Verbal feedback has been received from a number of individuals and the comments have been as follows:

"***Grateful that you had listened and will be in touch if needs to contact.***"

"***Thanks for the support. Really glad of the opportunity to just share with someone. A lot of weight off my mind.***"

"***Thank you. Since I have spoken to you I feel totally different because you listened.***"

"***Thanks for the support, very welcomed.***"

4.2 Updates on any broader developments in FTSU, learning from case reviews, guidance and best practice.

The FTSGU receives regular updates from the National Guardian's Office on developments, best practice, guidance and case reviews. Two case reviews have been completed so far by the NGO and these have followed with recommendations

to the respective trusts. The FTSUG has reviewed these recommendations and cross checked them with DHCFT policy and practice and is assured the recommendations are incorporated.

5. Recommendations

5.1 Suggestions of any priority action needed.

The FTSUG would advise that training is provided to all managers, including individuals who may not manage staff but have the responsibility of supervision. The training needs to focus in on the role of the FTSUG and how I am the gatekeeper for capturing concerns and messenger for sharing concerns where individuals do not feel able to do so themselves. The training will need to incorporate levels of responsibility for each individual and outline the expectation of managers to investigate/fact find concerns whilst ensuring they regularly update me.

The FTSUG role is already embedded in a range of clinical mandatory training programmes.

There is an aim that the role of FTSUG will be incorporated into management and leadership training.

My role is well established in the Trust and now needs to be supported through the role of Champions. Champions may be appointed to support the work of the enabling individuals to speak up but also act as a listening ear in services where concerns maybe expressed but not raised to anyone in particular. It is imperative to have Champions due to the wide location of services in the Trust. This will help to engage individuals in hard to reach areas.

It would be useful to now take forward a pulse survey to check understanding of the role of FTSUG within the Trust. The Communications Team and I will work closely together to ensure this is actioned.

Derbyshire Healthcare
NHS Foundation Trust

Freedom to Speak Up Guardian

Newsletter 1 July 2018 Volume 1, Number 1

In This Issue

- Role of Freedom to Speak Guardian
- National Guardians Office
- Data for Q1 1/4/2018 to 30/6/2018
- Role of a Champion

Raising Concerns/Speaking Up Policy

Link to a Web page
Descriptive text that motivates the reader to click the link

Staff Survey

Link to a Web page
Descriptive text that motivates the reader to click the link

Link to a Web page
Descriptive text that motivates the reader to click the link

Link to a Web page
Descriptive text that motivates the reader to click the link

Role of Freedom to Speak up Guardian

Following the review of "Freedom to Speak Up" in 2015, the requirement for all Trusts to nominate a Freedom to Speak Up Guardian was introduced in October 2016 as part of every NHS contract. Trusts were expected to implement the role according to local need and resources. The aim of the role is to Support individuals to feel able to raise issues or concerns that they think might cause harm to our patients, the public or to themselves and/or colleagues; and Encourage speaking up without fear of any recrimination or comeback. Please refer to the Trusts Raising Concerns/Speak Up Policy.

- The FTSUG role has been promoted and embedded in the Trust to support staff and patient care.
- Visibility of the FTSUG is apparent through attendance at meetings, posters and electronic communications.
- Data on staff speaking up is captured in a central log and themes are planned to be communicated throughout the Trust, which will give assurance to staff that concerns are being heard and addressed.
- Data is also reported to the National Guardians Office on a quarterly basis.
- The FTSUG has established links with the Senior Independent Non-Executive Director who reviews reports as devised by the Freedom to Speak up Guardian and works closely with the FTSUG to act as a conduit through which information is shared with the board.
- The Trust also has a dedicated Director lead (Director of Corporate Affairs) to support the role.

Measuring Concerns

There are a number of ways to measure whether staff and patients are sharing concerns. Some of these include the Staff Survey, Patient Survey, Complaints Log, Incident Reporting Datix System, Family and Friends Test, HR Employee Relations Case Tracker. The FTSUG has identified key workers to link into to gather data from these systems and use as a means of identifying services, teams, staff groups that may benefit from more support through the FTSUG.

National Guardians Office

The National Guardians Office provides leadership and advice for Freedom to Speak Up Guardians based in NHS trusts. The office will also exercise its discretion to review cases referred to it where there is evidence that an NHS service has not responded appropriately to the safety concerns raised by individuals.

Contact Kully Hans

Freedom to Speak up Guardian at

Freedom2SUG@
derbyshcft.nhs.uk
OR
Tel: 07917 511699
OR
FAO FTSUG
Freepost, PO Box 6941
Derby DE1 9GY

All Freedom to Speak Up Guardians are required to report quarterly to the National Guardian's Office on the numbers and types of concerns raised with them. The National Guardians Office is regulated by the CQC.

Data for Quarter 4 (1st January 2018 – 30th April 2018)

Types of Concerns	Total Numbers
Quality and Safety	7
Policy and Procedure	4
Attitude & Behaviours	5
Total No. Of concerns	**16**
Cases reported to FTSUG	11

Data for Quarter 1(1st April 2018 to 25th June 2018)

Types of Concerns	Total Numbers
Quality and Safety (Not patient related)	1
Patient Care	1
Policy and Procedure	6
Attitude & Behaviours	13
Unknown	1
Total No. Of concerns	**23**
Cases reported to FTSUG	18

What's Next?

The FTSUG is looking to develop the role of Champions in the Trust to support the work of the FTSUG. Champions will, who will play an important role in encouraging staff in raising concerns at the earliest reasonable opportunity. They will act as ambassadors for the Trust Raising Concerns at Work (Whistleblowing) Policy and the FTSU work. Champions will receive training to support them in their role. If this is of interest to you then please contact Kully Hans Freedom to Speak up Guardian on Tel:07917 511699

NHS
Derbyshire Healthcare
NHS Foundation Trust

Board Committee Summary Report to Trust Board
People & Culture Committee – Meeting held 5 June 2018

Key items discussed

- Action matrix updates: Exit interview process update for end of July; on boarding guidance by end of July; PCC to set up a joint meeting with TU Reps and Staff Governors in 6 months' time; to finalise timeline for new appraisal process.
- Terms of reference to be agreed ahead of next meeting in July
- Staff Engagement deep dive back in October, Workforce plan back for December.
- Board Assurance Framework – to explore alternative medical workforce models to mitigate agency spend
- Leadership and Management strategy – Strategy is with Executive Leadership Team, to discuss at next PCC, strategy to be shared with the PCC members
- Employee relations update – to progress the actions into a SMART action plan
- Staff Engagement report – discussed key areas of work, top ten and bottom ten areas to focus on across the Trust
- Recruitment activity update – Progress noted, next meeting to focus on hot spots
- Training Compliance paper – Future focus on areas below 85% eg safeguarding adults, ILS changed delivery model eg Saturdays and Sundays and e learning, hub and bespoke model being developed. Apprenticeship levy and Learning Beyond Registration (LBR) funding to be a future area of focus due LBR reduced funding.
- Occupational Therapy Strategy – progress report presented.
- Workforce Equality and Diversity progress noted
- Workforce Performance report – Appraisal reminders going out to increase completion rates
- Medical Appraisal Policy and Procedure - Approved

Assurance/lack of assurance obtained

- Limited assurance - Employee relations, progress noted, further work on improving policy and process
- Limited assurance - Staff engagement progress and action plan noted
- Limited assurance - Recruitment activity paper, progress noted, to focus on hot spots in future reporting until vacancies are filled
- Limited Assurance - Training compliance paper – future reporting on hot spot areas

• Limited Assurance - Occupational Therapy Strategy, further work to follow • Significant assurance on progress - Workforce Equality and Diversity report • Limited Assurance - Workforce Performance report, more work to do on mandatory training and appraisal completion • Full Assurance to approve the Medical Appraisal Policy and Procedure	
Key risks identified • Recruitment hotspots • Reduced LBR funding • If national Pay deal is not approved and the impact on finances	
Decisions made • Future papers to focus on hot spots and mitigation plans	
Escalations to Board or other committee • Reduction in LBR funds	
Committee Chair: Margaret Gildea	**Executive Lead: Amanda Rawlings, Director of People Services and Organisational Effectiveness**

Board Committee Summary Report to Trust Board
Mental Health Act Committee - meeting held 8 June 2018

Key items discussed

- Trends reported in Operational group notes suggest people in ethnic minorities in the City may not access services in a timely way and are therefore over-represented in detention figures. Recommendations from Reverse Commissioning Group awaited.
- Three policies agreed and policy horizon scanned.
- "Big 5" recurrent themes identified:
  * patient involvement in their care plans
  * family/carer involvement in care plans
  * capacity assessment to underpin above
  * physical healthcare reporting
  * Section 17 (leave) process
- Terms of Reference for MHAC/Operational group agreed.
- Governance around MHA Associate Managers reviewed. Issues include recruitment, DBS checks, job description, code of conduct, appraisal (including 360°), training (including equality and diversity) and the infrastructure required to support all this. Operational issues highlighted the timeliness of reports.
- Use of 136 suite for seclusion was breach of Code of Practice. This is due to level of acuity on Radbourne Unit. Although no breaches of the new S136 timelines occurred this remains a high risk given the difficulty in accessing beds for CAMHS, LD/Autism cases and the lack of PICU provision in Derbyshire.
- Post incident debriefing and physical healthcare monitoring remains poor following seclusion/rapid tranquillisation. Pre-admission consideration of smoking cessation would help. Training/coaching input form Heads of Nursing noted.
- Section 41 re-audit – all cases now meeting acceptable level of monitoring.

  Section 5(2) re-audit – significant improvement noted.

  Capacity Assessment – Inpatients – steady state. Re-audit planned following further training including targeting of trainee doctors and specialist doctors.
- 90% training compliance probably unrealistic due to absentee factor but in contract for this year.

Assurance/lack of assurance obtained

- KPMG report gives significant assurance regarding processes but had limited scope.
- Significant assurance from MHA Manager's Quarterly Report
- CQC 2016 actions – Full assurance

- CQC 2017/18 actions – Significant assurance
- Rapid Tranquillisation/seclusion – Limited assurance
- Capacity assessments – inpatients – steady state audit noted. Limited assurance
- Training
  * significant for process
  * limited for rates achieved
  * do we have to count staff unavailable for figures? For further discussion at People and Culture Committee.
- Section 136 Group – significant assurance regarding process but residual risk noted.

Key risks identified

- LA delays in DoLS assessment remain a risk – add to BAF
- Governance around Associate Hospital Managers is weak
- Need to summarise likely risks/opportunities around proposed review of Mental Health Act

Decisions made

- To invite chair of Reverse Commissioning Group to MHAC
- Section 117 policy to be extended to avoid breach, pending review
- To discuss with Director of Operations how monitoring of "Big 5" themes can be included in Board IPR report and BAF. Likewise to link to performance management/job planning/appraisals
- To delete Chief Nurse/Deputy from MHAC Operational group
- To agree a proposal for the governance of MHA Associate Hospital Managers with a view to presenting a business case to ELT

Escalations to Board or other committee

- There is a high risk of new Section 136 waiting times given the difficulty accessing beds for CAMHS, LD/Autism cases, PICU places. To include in BAF risks and CEO to escalate to commissioners.

Committee Chair: Dr Anne Wright	**Executive Lead: Dr John Sykes, Medical Director**

Board Committee Summary Report to Trust Board
Quality Committee - meeting held 12 June 2018

Key items discussed

- **Board Assurance Framework (BAF) –** briefing on the changes and the revised version
- **Risk Assurance and Escalation quarterly report -** how we oversee quality risks, triangulation and monitoring risks to inform the BAF
- **Quality Dashboard –** this month's data for monitoring, triangulation and assurance. Clinical supervision remains below target in known target areas. Reporting for July to include a three month analysis in order to provide quality assurance of improvement in these areas.
- **Deloitte Well Led Framework Review Phase 3 Recommendations –** recommendations presented arising from the Phase 3 Deloitte review of the Trust's governance arrangements. Significant assurance received. Agreed proposals to provide assurance to the committee with the associated timeline of reporting back to the Committee on progress in two months' time.
- **Ligature Risk –** update provide in relation to ligature risk report. Significant assurance received. Areas to be targeted in 2018/2019 to be confirmed. Standardisation of beds across the Trust to be reviewed in due course, but initially focus to remain on bedrooms, bathrooms and doors which are the highest risk for ligatures.
- **Serious Incidents Annual Report –** Report presented relating to Serious Incidents occurring in 2017/2018. Inpatient deaths were discussed, mainly those with pneumonia and dementia. Limited assurance. Data to be obtained from NHS Digital on causes of death which would assist in identifying hot spots and a larger data set. Report requested for July meeting, to check national guidance that family liaison is occurring in all cases and to work on required standards
- **Quarterly Mortality / Learning from Deaths Report –** report presented to meet the national requirement to collect and publish data on a quarterly basis for publication on the Trust's website prior to the end of June 2018
- **Patient Experience Quarterly Report –** Report presented on themes and changes made to Trust services as a result of the feedback of incidents and complaints made to the Patient and Carer Experience committee. A revised patient experience report will be designed in due course revised with changes set by NHS improvement
- **Infection Prevention and Control Annual Report** – Report presented summarising activity through 2017/2018 related to infection prevention and control. Report to be presented to the Trust Board as per the statutory requirement of the Health Act.
- **EPRR Six Monthly Report** - A six monthly progress report for EPRR Core standards was presented. A full report will be produced later on this year. NHS England has offered to conduct some table top exercises in areas of the Trust's choices.
- **Serious Incident Bi-Monthly Report –** Report presented with information relating to Serious Incidents that had occurred during April and May 2018.
- **NICE Guidelines Update** – Report presented regarding progress of the NICE Steering Group in monitoring the effectiveness of implementation of National Institute for Health and Care

Excellence (NICE) Guidelines. The quality visit programme 2018/2019 will include evidence of NICE Guidelines implementation and outcomes.

- **Safety Needs Assessment and Management of Safety Needs –** Report presented to provide assurance to the committee that there is an upward trajectory on the percentage of safety plans being completed by the Mental Health teams for people open to neighbourhood services.

Assurance/Lack of Assurance Obtained

Board Assurance Framework – Substantial changes and improved. Changes were reviews and agreed. Significant assurance on the current process. Positive work – plans to mitigate / hold to account if executives fail to deliver. Review and analysis of the risk register.

Serious Incidents Annual Report – Possible gap in assurance that all risks are managed – limited assurance received. Data to be obtained from NHS Digital on causes of death which would assist in identifying hot spots. Report requested for July meeting to check national quality board required actions remain in place and that family liaison is occurring in all cases and work to improve on all on required standards.

Deloitte Well Led Framework Review Phase 3 Recommendations – this was reviewed. Significant assurance received. Agreed proposals to provide assurance to the committee with the associated timeline of reporting back to the committee on progress in two months' time.

Ligature Risk – Significant assurance received. Areas to be targeted in 2018/19 to be confirmed and standardisation of beds across the Trust to be reviewed, but not before focus remain on bedrooms, bathrooms and door which are the highest risk for ligatures.

Serious Incidents Annual Report – Possible gap in assurance that all risks are managed – limited assurance received. Data to be obtained from NHS Digital on causes of death which would assist in identifying hot spots. Report requested for July meeting, to check national guidance that family liaison is occurring in all cases and to work on required standards.

Quarterly Mortality / Learning from Deaths Report – Limited assurance received. Benchmarking exercise to be made to compare with other Trusts on run rate of mortality reviews. The report to be published on the Trust website prior to the end of June 2018 and will be shared with TMT and the SI Group

Patient Experience Quarterly Report – Trust is compliant with its statutory duties, but improvement is necessary on timescales. A revised patient experience report will be designed as agreed and due to operational service pressures and the release of new guidance and requirements, the newly designed model.

Infection Prevention and Control Report – Significant assurance received on standards of cleanliness of clinical areas and food preparation areas. Training standards re not being complied with, but this does not indicate actual harm. Report to be presented to the Trust board as per the statutory requirement of the Health Act.

EPRR Six Monthly Report – Significant assurance received. More training to be organised. NHS England has offered to conduct some table top exercise.

Serious Incident Bi-Monthly Report – Limited assurance received. The number of overdue actions to be implemented is at its highest for twelve months, further improvement in this area is required.

NICE Guidelines – Limited assurance received. Noted to be a BAF risk from 2017/2018 which had not been embedded. The quality visit programme for 2018/2019 will include evidence of NICE Guidelines and measuring outcomes.

Safety Needs Assessment and Management of Safety Needs – Lack of assurance. Assurance required for high risk inpatient areas and other services that Safety plan model is effective and in place. More pace required to ensure every patient has a safety plan and the revision to the model. Development is on-going but making progress. To provide an update after presentation to TMT in July 2018. To focus on hot spots and gaps in assurance, specifically targeted improvement.

Framework for Quality Assurance for Responsible Officers and Medical Re-validation – Final assurance is required regarding HR recruitment checks before the compliance can be signed off. People and Culture approved the Medical Appraisal Policy and Procedure at its meeting on 5 June 2018 which underpins this and gives assurance of the number of appraisals conducted. They also committed to make changes to ESR that reflect NHSE guidance so that the Trust figures match those submitted to NHSE. Report accepted noting that it will be shared along with the annual audit with the Higher Responsible Officer.

Meeting Effectiveness

- Challenge was effective
- Approach to restrict attendance to members only continues to prove successful.
- Meetings should not exceed 90 minutes with no detriment to discussion.
- Carolyn Green would have liked to have seen more focus on the new CQC actions and the re-emergence of the lack of embeddedness of any CQC action and one example being the Mental Capacity Act.

Decisions made

- Quorum confirmed and NEDS advised
- All completed actions closed
- Broader consultation approach is being taken regarding the policy status matrix
- Plans were identified for the committee to be linked to national requirements
- Use of the report cover sheet with executive summary was discussed
- One hour sessions to discuss how assurance can be provided, evidence of best practice from other organisations and focussed reporting will be scheduled
- Next updated BAF is in development
- Carolyn Green requested physical healthcare metrics and CQUIN is on the Quality Committee dashboard as previously agreed
- BAF risks requiring oversight by the committee will consider these in the context of subsequent committee decisions and review any discussions or decisions that affect the BAF (including Quality Committee specific risks as well as any other BAF risks) arising from the meeting which require inclusion or updating with the BAF.
- Deloitte Well Led – scope of actions noted to address this recommendation as outlined and the RAG rating proposed. Agreed proposals to provide assurance and report back to the committee in two months' time.
- Decision on beds to be taken to TMT.
- Data to be obtained from NHS Digital on causes of death which would assist in identifying hot spots and reported in July 2018.
- Benchmarking exercise to be made to compare with other Trusts regarding mortality and this will be published on the Trust website prior to the end of June 2018. This will also be shared with TMT and the SI Group.
- A revised patient experience report will be designed and due to operational service pressures and the release of new guidance and requirements, the newly designed model will be held back to assess new requirement once known.
- EPRR – more training to be organised and NHS England will offer some table top exercises in areas of the Trust's choices.
- NICE Guidelines update – the quality visit programme for 2018/2019 will include evidence of NICE Guidelines.
- Development needed to provide an update after presentation to TMT in July – to focus on hot spots and gaps in assurance relating to safety needs assessment and management of safety needs.

- Report accepted noting that it will be shared along with the annual audit with the Higher Responsible Officer for Framework for Quality Assurance for Responsible Officers and Medical Re-validation.

Escalations to Board or other committee

Escalation to Board – Summary of BAF risks for the Quality Committee

Escalation to other committees – one to TMT regarding Ligature risks

Escalation to ELT – None

Changes to the BAF: To review any discussions or decisions that affect the BAF (including Quality Committee specific risks as well as any other BAF risks) arising from the meeting require inclusion or updating of the BAF was completed.

Committee Chair: Dr Julia Tabreham	**Executive Lead: Carolyn Green, Director of Nursing & Patient Experience**

2018-19 Board Annual Forward Plan

Exec Lead	Item	1 May 18	5 Jun 18	3 Jul 18	4 Sep 18	2 Oct 18	6 Nov 18	4 Dec 18	5 Feb 19	5 Mar 19
		23 Apr	25 May	25 Jun	24 Aug	24 Sep	29 Oct	26 Nov	28 Jan	26 Feb
SH	Declaration of Interests	X	X	X	X	X	X	X	X	X
CM	Minutes/Matters arising/Action Matrix	X	X	X	X	X	X	X	X	X
CG	Actions and learnings from patient stories	X				X		X		X
CM	Board Forward Plan (for information)	X	X	X	X	X	X	X	X	X
CM	Board review of effectiveness of meeting	X	X	X	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE										
CM	Chair's Update	X	X	X	X	X	X	X	X	X
IM	Chief Executive's Update	X	X	X	X	X	X	X	X	X
MP/CW	NHSI Annual Plan - timing to be confirmed						X			
JS	Information Governance - annual declaration									A
AR	Staff Survey Results and Action Plan									X
AR	Equality Delivery System2 (EDS2) & Workforce Race Equality Standard (WRES) Submission	A			X				X Benchmarking report	
AR	Pulse Check Results and Staff Survey Plan				X					
SH	Corporate Governance Framework						A			
SH	Trust Sealings	X				X				
SH	Annual Review of Register of Interests	A								
SH	Board Assurance Framework Update	X			X			X		
SH	Raising Concerns (whistleblowing) and Freedom to Speak Up Guardian Report			X						
SH	Committee Assurance Summaries (following every meeting) - Audit & Risk Committee - Finance & Performance - Confidential - Mental Health Act Committee - Quality Committee - Safeguarding Committee - People & Culture Committee	X	X	X	X	X	X	X	X	X

2018-19 Board Annual Forward Plan

Exec Lead	Item	1 May 18	5 Jun 18	3 Jul 18	4 Sep 18	2 Oct 18	6 Nov 18	4 Dec 18	5 Feb 19	5 Mar 19
SH	Fit and Proper Person Declaration	X								x
MP	Emergency Planning Report (EPPR)						A			
SH	Board Effectiveness Survey									X
SH	Report from Council of Governors Meeting (for information)		X		X	X		X	X	
SH	Review of Policy for Engagement between the Board & COG									A
SH	Board Development Programme									X
GH	Business Plan 2017-18 Monitoring					X				X
GH	Measuring the Trust Strategy	X								
SH	Well Led Recommendations - update report on Phase 3 Deloitte recommendations to be received at the November 2018 Board meeting						x			
OPERATIONAL PERFORMANCE										
CG, CW, AR, MP	Integrated performance and activity report to include Finance, Workforce, performance and Quality Dashboard	X	X	X	X	X	X	X	X	x
QUALITY GOVERNANCE										
CG	Quality Position Statement (Incorporates Strategy and assurance aspects of Quality management) Quarterly publication of specified information on death in Jan/Mar/Jul/Sep/Dec/Mar Includes Annual Review of Recovery Outcomes in November and Annual Looked After Children Report in September			X	X	X	X	X	X	x
CG/JS	Safeguarding Children & Adults at Risk Annual Report				A					
JS	NHSE Return on Medical Appraisals sign off **				X					
CG	Control of Infection Report *			A						
JS	Re-validation of Doctors *			A						
CG	Annual Review of Recovery Outcomes *						X			
CG	Annual Looked After Children Report *				X					

* Incorporated in Quality Position Statement

** In line with Medical Appraisals Policy