NHS
Derbyshire Healthcare
NHS Foundation Trust

# Meeting of the Board of Directors 24 May 2017

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Better together

**WEDNESDAY 24 MAY 2017 TO COMMENCE AT 1.00 PM IN CONFERENCE ROOMS A&B**
**CENTRE FOR RESEARCH & DEVELOPMENT, FIRST FLOOR,**
**RESEARCH & DEVELOPMENT CENTRE, KINGSWAY, DERBY DE22 3LZ**

| | TIME | AGENDA | ENC | LED BY |
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| **1.** | 1:00 | Chair's welcome, opening remarks and apologies for absence | **-** | Caroline Maley |
| **2.** | 1:05 | Service Receiver Story | **-** | Carolyn Green |
| **3.** | 1:30 | Declarations of Interest | **A** | Caroline Maley |
| **4.** | 1:30 | Minutes of Board of Directors meeting held on 26 April 2017 | **B** | Caroline Maley |
| **5.** | 1:35 | Matters arising – Actions Matrix | **C** | Caroline Maley |
| **6.** | 1:40 | Acting Chair's Update | **-** | Caroline Maley |
| **7.** | 1:50 | Acting Chief Executive's Update<br>- Joint Integration Programme Committee Update | **D** | Ifti Majid<br>Chris Sands |
| **OPERATIONAL PERFORMANCE, QUALITY AND STRATEGY** | | | | |
| **8.** | 2:10 | Integrated Performance and Activity Report | **E** | Mark Powell/Claire Wright/Amanda Rawlings/Carolyn Green |
| **9.** | 2:40 | Control of Infection Report | **F** | Carolyn Green |
| **10.** | 2:50 | Position Statement on Quality | **G** | Carolyn Green |
| **3:00 B R E A K** | | | | |
| **11.** | 3:15 | Deep Dive – Pediatrician CAMHS Wait Times | **H** | Mark Powell |
| **GOVERNANCE** | | | | |
| **12.** | 3:35 | Board Committee Assurance Summaries and Escalations: Audit & Risk Committee 27 April, Safeguarding Committee 5 May, Quality Committee 11 May 2017 | **I** | Committee Chairs |
| **13.** | 3:45 | Governance Improvement Action Plan Update | **J** | Sam Harrison |
| **14.** | 4:00 | Information Governance Update | **K** | John Sykes |
| **15.** | 4:10 | Fit and Proper Person Declaration | **L** | Sam Harrison |
| **16.** | 4:20 | Report from the Audit & Risk Committee on the effectiveness of the Board Committees | **M** | Sam Harrison |
| **17.** | 4:30 | Report from Council of Governors Meeting | **N** | Sam Harrison |
| **18.** | 4:40 | NHS Improvement Year-End Self-Certification | **O** | Sam Harrison |
| **CLOSING MATTERS** | | | | |
| **19.** | 4:50 | Any Other Business | **-** | Caroline Maley |
| **20.** | 4:55 | 2017/18 Board Forward Plan | **P** | Caroline Maley |
| **21.** | 5:00 | - Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework<br>- Meeting effectiveness | **-** | Caroline Maley |

*Questions that are applicable to the agenda, and at the Chairman's discretion, can be sent by email to the Board Secretary up to 48 hours prior to the meeting for a response provided by the Board at the meeting. Email: sue.turner2@derbyshcft.nhs.uk*
*The 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.*

**The next meeting will be held at 1.00 pm on 28 June 2017**
**in Conference Rooms A & B, Centre for Research and Development, Kingsway, Derby DE22 3LZ**
*Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.*
***Participation in meetings is at the Chairman's discretion.***

## Declaration of Interests Register 2016-17

| NAME | INTEREST DISCLOSED | TYPE |
|---|---|---|
| **Margaret Gildea**<br>Non-Executive Director | Director, Organisation Change Solutions Limited<br>Non-Executive Director, Derwent Living | (a, b) |
| **Ifti Majid**<br>Acting Chief Executive | Board member, North East Midlands Leadership Academy Board<br>Kate Majid (spouse) Assistant Chief Commissioning Officer, NHS North Derbyshire CCG | (a, d) |
| **Caroline Maley**<br>Acting Trust Chair | Director – C D Maley Ltd<br>Trustee – Vocaleyes Ltd. | (a)<br>(a, d) |
| **Barry Mellor**<br>Non-Executive Director | Non-Executive Director, Rotherham NHS Foundation Trust<br>Trustee, Rotherham Hospital Charity<br>Mrs Mellor is a befriender with Age UK | (a, d) |
| **Amanda Rawlings**<br>Director of People and Organisational Effectiveness (DHcFT) | Director of People and Organisational Effectiveness, Derbyshire Community Healthcare Services (DCHS)<br>Co-optee Cross Keys Homes, Peterborough | (a, d) |
| **Dr Julia Tabreham**<br>Deputy Trust Chair and Non-Executive Director | Non-Executive Director, Parliamentary and Health Service Ombudsman<br>Director of Research and Ambassador Carers Federation<br>Leads the Parliamentary and Health Service Ombudsman's contribution to establishing NHS complaints advocacy support in Ireland | (a, d) |
| **Lynn Wilmott-Shepherd**<br>Interim Director of Strategic Development | Substantive post – Director of Commissioning and Delivery, NHS Erewash CCG | (d) |
| **Richard Wright**<br>Non-Executive Director | Director, Sheffield Chamber of Commerce<br>Chair, The Sheffield College Multi Academy Trust<br>Chair Sheffield University Technical College<br>Member of Advisory Board of Sheffield National Centre for Sport and Exercise Medicine | (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 share holdings in organisations likely or possibly seeking to do business with the NHS.
(d) A position of authority in a charity or voluntary organisation in the field of health and social care.
(e) Any connection with a voluntary or other organisation contracting for NHS services.

# DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

## MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

**Held in Training Rooms 1 and 2**
**Research and Development Centre, Kingsway, Derby DE22 3LZ**

**Wednesday 26 April 2017**

**MEETING HELD IN PUBLIC**

Commenced: 1pm Closed: 4:45pm

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| **PRESENT:** | Caroline Maley | Acting Trust Chair |
| | Margaret Gildea | Senior Independent Director |
| | Barry Mellor | Non-Executive Director |
| | Dr Anne Wright | Non-Executive Director |
| | Richard Wright | Non-Executive Director |
| | Ifti Majid | Acting Chief Executive |
| | Claire Wright | Executive Director of Finance |
| | Carolyn Green | Executive Director of Nursing & Patient Experience |
| | Dr John Sykes | Executive Medical Director |
| | Samantha Harrison | Director of Corporate Affairs & Trust Secretary |
| | Mark Powell | Acting Chief Operating Officer |
| | Amanda Rawlings | Director of People & Organisational Effectiveness |
| | Lynn Wilmott-Shepherd | Interim Director of Strategic Development |
| **IN ATTENDANCE:** | Anna Shaw | Deputy Director of Communications & Involvement |
| | Sue Turner | Board Secretary (Minutes) |
| For item DHCFT 2017/053 | Jill | Service Receiver Carer |
| For item DHCFT 2017/053 | Jenny | Service Receiver Carer |
| For item DHCFT 2017/053 | Julie Cooper | Senior Nurse, Radbourne Unit |
| For item DHCFT 2017/057 | Dr Beth Masterson | Junior Doctor |
| For item DHCFT 2017/063 | Acute Inpatients Team | |
| **APOLOGIES:** | Dr Julia Tabreham | Deputy Trust Chair and Non-Executive Director |
| **VISITORS:** | John Morrissey | Lead Governor, Public Governor, Amber Valley South |
| | Gillian Hough | Public Governor, Derby City East |
| | Shelley Comery | Public Governor, Erewash North |
| | Kevin Richards | Public Governor, South Derbyshire |
| | Carole Riley | Public Governor, Derby City East |
| | Melissa Castledine | Derbyshire Mental Health Alliance |
| | Mark McKeown | Derbyshire Mental Health Alliance |

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| **DHCFT 2017/052** | **ACTING CHAIR'S WELCOME, OPENING REMARKS AND APOLOGIES**<br><br>Acting Trust Chair, Caroline Maley, opened the meeting and welcomed everyone. Apologies were noted from Julia Tabreham who was attending the NHSI Networking Event on Caroline Maley's behalf. Questions received from Julia Tabreham relating to the reports supporting today's agenda items would be addressed as the meeting progressed. |
| **DHCFT** | **SERVICE RECEIVER STORY** |

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| **2017/053** | Nicola Fletcher introduced Jill, her daughter Jenny and Julie Cooper, Senior Nurse from the Radbourne Unit. Jill told a very moving story as the mother of a son who had experienced drugs and homelessness. She described the difficulties she and her family had experienced in locating her son and in getting help for him when he became very ill.<br><br>Jill's son was eventually sectioned and admitted to the Radbourne Unit on Ward 36 which was a very distressing time for her and the family. Jill spoke very positively about the way Julie Cooper and the team worked together showing them kindness and compassion and treating them with the utmost respect. Jill and her daughter were invited to go to a carers meeting run by the ward where they were given help and reassurance from people going through the same sort of problems with their own loved ones. They found it helpful having other people to talk to and it gave them hope. Jill finished her story by telling the Board that her son has continued to improve at Audrey House and she is continuing to be involved in helping him with his journey to recovery.<br><br>Carolyn Green thanked Jill for sharing her story. She explained that the Trust was aware of the impact that caring has on parent and family carers and she was pleased that support from the carers group had helped. She assured Jill that the Board would work to make people aware of the carers group and the Trust would work with other agencies to make these support services more available. Carolyn Green explained that the Trust also recognised the need to involve the family in a patient's care and patients are encouraged to have the family involved. Work is also taking place with community groups to help people understand what happens when you have to stay in hospital.<br><br>The Board thanked Jill and Jenny for bringing to life their experience which emphasised the importance of carer involvement and support which had enabled thought to be given to improving the information that is made available to carers and to publicise the work of the carers group that was of great value in this case.<br><br>**RESOLVED: The Board of Directors expressed thanks to Jill for sharing her experience and appreciated the opportunity to hear at first hand the service the Trust had provided.** |
| **DHCFT 2017/054** | **MINUTES OF THE MEETING DATED 1 MARCH 2017**<br><br>The minutes of the previous meeting, held on 1 March were agreed and accepted. |
| **DHCFT 2017/055** | **MATTERS ARISING AND ACTIONS MATRIX**<br><br>The Board agreed to close all completed actions. Updates were provided by members of the Board and were noted on the actions matrix. |
| **DHCFT 2017/056** | **QUESTIONS FROM A PUBLIC GOVERNOR**<br><br>A question relating to the merger/acquisition with DCHS had been received from the public governor for Derbyshire Dales, Ruth Greaves asking if the Trust had an alternative plan to the merger by acquisition proposals.<br><br>Ifti Majid responded that the Strategic Options Case (SOC) presented to governors in October set out the reasons behind improving clinical outcomes for residents of Derbyshire and clarified that if integration with DCHS proves unsustainable, the Trust is not under pressure to merge with any organisation and would continue as at present. The Trust already works in partnership with other organisations in Derbyshire for specialised services and if necessary will extend these partnerships to other organisations further.<br><br>**RESOLVED: The Board of Directors noted and responded to questions raised by** |

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| | **the public governor for Derbyshire Dales.** |
| **DHCFT 2017/057** | **ACTING CHAIR'S VERBAL REPORT**<br><br>Caroline Maley reported that during the last month she had attended meetings with other chairs of organisations and providers and with Clinical Commissioning Groups and she had also met with the Chair of Nottinghamshire Healthcare. The Joint Integration Programme Committee (JIPC) met on 8 March. This project is gathering momentum as the Trust and DCHS works towards consideration of the Outline Business Case OBC at the end of July.<br><br>A significant amount of work has been carried out with the Council of Governors. Additional meetings have now been established to focus on issues related to the proposed process of the acquisition. The Governance Committee continues to deliver good work and the Governors Nominations & Remuneration Committee met last week and received the annual report of the Committee as well as the appraisal for Maura Teager, Non-Executive Director on her departure from the Trust. Regular meetings have also taken place with the Lead Governor as well as other governors.<br><br>National meetings have also taken place which enabled Caroline Maley to understand the progress being made in the system of mental health. This was particularly evident during a meeting that focused on the effects that BREXIT will have on the mobility of staff.<br><br>During March Caroline Maley and the Non-Executive Directors attended an excellent training session facilitated by the Trust's Mental Health Act Office that covered the Mental Health Act and the Mental Capacity Act. She also attended a meeting with hospital managers which gave her a good understanding of their work. Caroline Maley also attended an excellent Board development session on equality, diversity and inclusion.<br><br>Caroline Maley also attended the NHS induction for chairs and chief executives which gave her an opportunity to talk about the challenges other trusts are facing around the recruitment of medical staff.<br><br>Internal meetings involved carrying out Ifti Majid's appraisal which resulted in them having a very good discussion. Caroline Maley also worked with John Sykes to recruit consultants and she also attended the TMAC (Trust Medical Advice Committee) meeting.<br><br>Reference was made to the Deloitte review of well led outcomes. The final report received from Deloitte LLP reflected significant progress in all areas within the Trust's scope. The Trust now meets the NHSI (NHS Improvement) benchmark associated with organisations rated as amber-green which places the Trust alongside other well performing trusts. The Trust will continue to keep on improving and thanks were made to all staff involved in this process.<br><br>**RESOLVED: The Board of Directors noted the Acting Chair's verbal report.** |
| **DHCFT 2017/057** | **ACTING CHIEF EXECUTIVE'S REPORT**<br><br>The Acting Chief Executive's report provided the Board of Directors with feedback and an update on developments occurring within the local Derbyshire health and social care community.<br><br>Ifti Majid gave an overview of the key points contained in his report. He drew particular attention to the work that has taken place to enter into a jointly delivered People and Organisational Effectiveness function with DCHS. It is expected that the number of other HR organisations involved in this joint venture may grow over time and will evolve into a single HR function supporting a number of organisations. Amanda Rawlings explained |

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| | that as part of the management of change process staff provided input into this structure and that this has enabled a full business case to be developed into the governance process. This business case was received by the Finance & Performance Committee and was referred to the Board as it is an important case for the future that will support staff as well as key leaders. This is a fully inclusive process and staff will be supported by trade union colleagues throughout and the process which is expected to be completed towards the end of September.<br><br>Amanda Rawlings also explained that integrating the teams of both organisations is separate to the integration work between the two Trusts and would have gone ahead regardless of that work. This is the future of the NHS working towards building a strong team for the future in Derbyshire. Amanda Rawlings told how HR team welcomed this opportunity. Margaret Gildea added that the Board can take assurance from this business case because it supports the HR function and will provide a larger and common talent pool that all stakeholders can benefit from.<br><br>Caroline Maley thanked Amanda Rawlings for her excellent summarisation of the business case. She recognised that governors would be very interested to know that this business case has been scrutinised by the Finance & Performance Committee and the People & Culture Committee. The Trust is following due process in terms of steps for change and this business case will be discussed further at the meeting of the Council of Governors on 2 May.<br><br>**ROYAL COLLEGE OF PSYCHIATRISTS TRAINEE-LED REVIEW INTO MORALE AND TRAINING WITHIN PSYCHIATRY**<br><br>The second part of this report included a report from the Royal College of Psychiatrists. Ifti Majid introduced Beth Masterson one of the Trust's CT3 Doctors who gave a presentation on the key points contained in the Royal College of Psychiatrists trainee-led review into morale and training within psychiatry.<br><br>The Board heard first-hand about the pressure that junior doctors work under and how they feel about the conditions they work in. The presentation set out the problems in recruiting to psychiatric training and Beth Masterson talked about the work of the focus groups that have taken place nationwide to establish what trainee doctors valued most about their work life and training. The presentation also provided an opportunity for the Board to acknowledge the importance of ensuring that the basic needs of trainees are met and for the Trust to become a good employer and educationalist as well as a more attractive employer for all staff.<br><br>The Board thanked Dr Masterson for making the Board aware of the importance of the Royal College of Psychiatrists report and the issues psychiatric trainees are experiencing and agreed to support all the core recommendations contained in the report.<br><br>Julia Tabreham's question relating to the Chief Executive's report, raised in her absence, related to how the Trust would measure the impact on estate closure on the people who are less mobile was responded to by Ifti Majid and Claire Wright who undertook to ensure that a written update on estate closure would be addressed within the next Estates Strategy report that will be brought to the Finance & Performance Committee.<br><br>**RESOLVED: The Board of Directors noted the Acting Chief Executive's update and supported the recommendations contained in the report from the Royal College of Psychiatrists.** |
| **DHCFT 2017/058** | **INTEGRATED PERFORMANCE AND ACTIVITY REPORT (IPR)**<br><br>Mark Powell, Acting Chief Operating Officer, opened discussions on the integrated overview of performance in workforce, finance, operational delivery and quality |

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| | performance as at the end of March 2017. He drew attention to the challenge in achieving priority metric compliance by the end of the financial year around the collection of patient record data and explained that this is being worked through the Trust Management Team meetings to see how we can best operate this metric.<br><br>The report identified a concern in the waiting time for Early Intervention in Psychosis referral to treatment. Mark Powell explained that a number of vacancies have resulted in a service capacity gap which will result in April and May being quite challenging until staff are recruited into post. This gap means that the 50% referral to treatment target has not been met and is unlikely to be met until June 2017 when new recruits start in post. In the meantime early intervention staff are being used flexibly from across the county to address these issues.<br><br>Claire Wright focussed on the outturn position for the financial year. She was pleased to report that the Trust has achieved its control total which was improved by £32k. As a result NHS Improvement (NHSI) have committed to make an incentive payment to organisations who delivered their 2016/17 control totals. This has resulted in a £906k payment that will be added to our control total during this financial year which will be used to benefit our patients.<br><br>Barry Mellor asked what assurance can be provided that the CIP (cost improvement plans) for this year will be a better plan to deliver. Mark Powell acknowledged that there is still a gap in the plan. A number of plans have been identified and internal discussions are taking place to invigorate a robust programme delivery approach that will be followed up along with any increasing risks associated with our CIP position through the Finance & Performance Committee.<br><br>Carolyn Green drew attention to bed occupancy and reported that the Trust was currently operating above the national target set by the Royal College of Practitioners. This may result in 12 hour A&E breaches and will affect people getting access to beds and work is taking place to mitigate this risk. Anne Wright asked whether the increase in bed occupancy levels was due to increasing demands or length of stay. Carolyn Green explained that length of stay has returned to average and has reduced compared to when the Trust was an outlier. The increase in bed occupancy is due to an increase in demand in the community. She assured the Board that staff make sure that patients are discharged appropriately and not too early.<br><br>Carolyn Green also referred to levels of restraint and seclusion and reported that for the first time there appears to be more restraint being applied to women and older adults, both men and women. She assured the Board that the Quality Committee is receiving a detailed breakdown of all cases in order to monitor these levels.<br><br>Amanda Rawlings was pleased to report that a slight improvement has been made in recruitment levels and in the uptake of staff appraisals. Results received for the first of the quarterly staff pulse checks has shown an improvement in participation. She felt encouraged by this trend and has shared these results with the Engagement Forum and the Executive Leadership Team (ELT).<br><br>Julia Tabreham's question, raised in her absence, related to the worrying upward trend for complaints within the Trust. She asked when the new complaints investigators were due to start work, what is the most worrying aspect of performance and how will their workload be prioritised? When can the Board expect to see an improvement in the position? Carolyn Green responded that these newly created posts will enable the team to improve the flow of mitigations and an improved performance is expected to be seen by September.<br><br>Ifti Majid referred to the ward staffing levels section of the report and asked how this information was being used to help fill rates and bed occupancy rates. Mark Powell |

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| | responded that this information is used to understand fill rates and staff requirements for the coming weeks. This information was also seen as an indicator of potential safety issues and did not show the detail about the individuals working on shifts. This will be looked at further along with bed occupancy and length of stay to see if there is a link and will be captured as an enhanced narrative in the next month's report.<br><br>**ACTION: Specific areas will be investigated where bed occupancy is high to establish any links and incorporated into an enhanced narrative in the next report.**<br><br>**RESOLVED: The Board of Directors considered the Integrated Performance Report and obtained a good level of assurance on current performance across the areas presented.** |
| **DHCFT 2017/059** | **<u>QUALITY POSITION STATEMENT</u>**<br><br>Carolyn Green provided the Board of Directors with an update on the organisation's continuing work to improve the quality of services that are provided in line with the Trust Strategy, Quality Strategy and Framework and strategic objectives.<br><br>Julia Tabreham's question, raised in her absence, referred to the retrospective case record reviews following the deaths of those with severe mental illness and learning disability and asked if the Trust has modelled the impact this will have on its resources and are there plans in place to achieve what is required? John Sykes advised that the report summarised the process involved and explained that although it is not necessary to review every death in detail the Trust is required to identify and scrutinise any deaths that are connected to our services. This work will be quite intensive because some of the review systems have not yet been developed. Work is taking place to quantify the impact on staff capacity for this work and work plan is being developed.<br><br>In response to Anne Wright challenging the capacity issues, John Sykes explained that a mortality technician will carry out some of this work and that reviewing individual caseloads will be substantial piece of work over and above the normal SIRI (serious investigation) work. He assured the Board that the Quality Committee has oversight of the investigation work and any issues will be escalated to the Board.<br><br>John Sykes also talked about safety planning and how the Trust was now using a bespoke safety planning approach developed by our own clinicians. Training has taken place in the use of this system and feedback from the training is enabling clinicians to drive this change and this is being monitored through the Quality Committee.<br><br>Carolyn Green drew attention to the Care Quality Commission Comprehensive Inspection revisit results and was very pleased to report that the Trust's warning notice has been lifted and services have been positively re-graded.<br><br>**RESOLVED: The Board of Directors:**<br>**1) Received and noted the Quality Position Statement**<br>**2) Gained assurance in quality leadership strategy and engagement as shown in the report** |
| **DHCFT 2017/063** | **<u>DEEP DIVE – ACUTE INPATIENTS</u>**<br><br>The Acute Inpatients team joined the meeting and provided the Board with an insight into some of the key achievements.<br><br>The Board heard how the reinstatement of Schwartz rounds to support supervision in inpatient areas has been very beneficial especially in gaining peer support. Schwartz rounds will now be introduced in the Radbourne Unit and the Hartington Unit. |

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| | A successful trip was made to Denmark to look at initiatives to develop a model on the safest way for staff to deal with conflict and aggression. This initiative is being implemented on both units and has been received very positively by both patients and staff and has helped to reduce their stresses and anxiety.<br><br>A "getting to know you" folder has been introduced on each ward which has helped staff get to know their patients and understand what they like such as taste in music, hobbies etc. This also helps with social inclusion on the wards and helps people feel they are listened to. Refurbishment of the de-escalation rooms on the Hartington Unit has also provided a quiet space for patients to spend their time.<br><br>The implementation of the Broset Violence Checklist pilot on the Enhanced Care Ward has resulted in a reduction in violence on the ward and a reduction in people who have potential for violence and aggression. This is managed through a care plan for each patient and has been very effective.<br><br>The team also talked about the challenges they face and how they are continually striving to improve both quality outcomes and patients experiences in services. Staffing levels and the reliance on bank and agency staff was a particular concern and the team are focussing on plans for future improvement in staff retention.<br><br>Compliance with supervision and staff appraisals was one of the elements highlighted by the CQC. The Board heard a personal experience of supervision from one of the team and was pleased to hear how this experience supported their work and how it had also been motivating and invigorating.<br><br>Resulting from the CQC visit last year the team was challenged to improve their seclusion pathway and rapid tranquilisation and they have now introduced a robust management process to manage seclusion. Work is taking place to improve the standard of reporting on the Mental Capacity Act and this is being monitored through the Mental Health Act Committee. Rapid tranquilisation is being managed more efficiently and patients are being monitored correctly.<br><br>The Board observed how the team has managed resources effectively and have developed themselves as a joined up service working across both the Radbourne Unit and the Hartington Unit. The Board acknowledged that staff retention is an important part of success and assured the team that Amanda Rawlings and her team are working hard to fill vacancies.<br><br>**RESOLVED: The Board of Directors considered and noted the presentation made by the Acute Inpatient Team.** |
| **DHCFT 2017/060** | **<u>EQUALITY DELIVERY SYSTEM2 (EDS2)</u>**<br><br>This report, presented by Amanda Rawlings provided the Board with an update against the goals of the EDS2, including actions to date, equality objectives and associated work streams. The document also set out the next steps in terms of governance and assurance to deliver the Trust's EDS2 performance grading for 2017/18, including Board Assurance Framework 3d. The report also included in Appendix 1 an update against the equality objectives, including EDS2 actions embedded in the People Plan.<br><br>A Board Development Session held on 12 April focused on Equality, Diversity and Inclusion which identified specific actions to improve the Trust's equality objectives. The Board acknowledged that EDS2 is part of the Trust's governance process and approved and noted the recommendations for EDS2 2016/17. The Board also noted the steps to progress outcomes of EDS2 Goal 4 Inclusive leadership and the proposal to present to the top six priority actions and SMART implementation plan at the Board meeting in May. |

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| | **ACTION: Top six priority actions and EDS2 SMART implementation plan to be received at the May 2017 Board meeting**<br><br>**RESOLVED: The Board of Directors:**<br>**1) Noted progress on equality and more specifically the undertaking of our annual EDS2 16/17 goals 1 & 2 including upward RAG improvement.**<br>**2) Noted and approved EDS2 2016/17 external validation for goals 1 & 2 and actions against the 9 outcomes (Appendix 3) and follow-up action to produce a 'You said, we did' report for publishing on website.**<br>**3) EDS2 Goal 4 Inclusive leadership – noted steps to progress outcomes and proposal to present (Draft) Board top six priority actions and SMART implementation plan at the May 2017 Board meeting.**<br>**4) Noted BAF 3d and controls (Equality Impact, data completion rates and engagement) to deliver EDS2 2017/18 implementation plan, including formal Board approval of EDS2 2017/18 plan on the 27 September, 2017 (as per nine step EDS2 process/ methodology).** |
| **DHCFT 2017/061** | **BOARD ASSURANCE SUMMARIES & ESCALATIONS**<br><br>Assurance summaries were received from the Board Committees that took place during February and March 2017. Committee Chairs summarised the escalations that had been raised and these were noted by the Board.<br><br>**RESOLVED: The Board of Directors received and noted the Board Committee Assurance Summaries and Escalations.** |
| **DHCFT 2017/062** | **MEASURING THE TRUST STRATEGY**<br><br>This report provided the Board with an update on year one of the Trust Strategy 2016/21 and an annual report will be received by the Board in April in the forthcoming years. The Integrated Performance Report is used for on-going monitoring of the strategy and the revised dashboard included in the report sets out the four strategic objectives and trajectory of the strategy over the next five years.<br><br>Lynn Wilmott-Shepherd was pleased to report that as the Trust has achieved its financial control total the trajectory of the Trust Strategy 2016/21 is on track. A report will be submitted to the Finance & Performance Committee setting out the detail of the partnerships that will enhance service delivery and foster a system wide approach in line with the Sustainability and Transformation Plan.<br><br>The Board accepted that the report was a useful snapshot of the progress that had been made during the past year and noted that an annual report on the five year Trust Strategy will be received at the April meeting in forthcoming years.<br><br>**RESOLVED: The Board of Directors:**<br>**1) Noted the achievements to date**<br>**2) Accepted that an annual update will be received at the April Board each year** |
| **DHCFT 2017/064** | **BUSINESS PLAN 2017-18**<br><br>This report provided the Board with a consolidated summary of each division and the corporate directorate's business plan for year two of the five-year Trust Strategy.<br><br>The Board was satisfied that the report covered the implications for clinical and corporate areas across the Trust and approved the Business Plan 2017/18. The business plan is driven by the Trust Strategy and NHSI and is in line with feedback received from Deloitte LLP and had previously been received by the Executive Leadership Team and it will be measured through the Trust Management Team. Quarterly progress reports on the |

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| | business plan are to be submitted to the Board and captured in the forward plan.<br><br>**ACTION: Quarterly update reports on the Business Plan 2017 to be incorporated into the Board forward plan.**<br><br>**RESOLVED: The Board of Directors:**<br>**1) Approved the business plan for 2017-18**<br>**2) Agreed to receive quarterly updates on progress** |
| **DHCFT 2017/065** | **ANNUAL REVIEW OF REGISTER OF INTERESTS**<br><br>This report provided the Trust Board with an account of directors' interests during 2016/17.<br><br>The Board reviewed the register of interests and it was noted that Ifti Majid had also declared his wife, Kate Majid's role as Assistant Chief Commissioning Officer, NHS North Derbyshire Clinical Commissioning Group. Lynn Wilmott-Shepherd's substantive role as Director of Commissioning and Delivery for NHS Erewash Clinical Commissioning Group is also to be listed.<br><br>**RESOLVED: The Board of Directors:**<br>**1) Approved and recorded the declarations of interest as disclosed and noted above. These will be recorded in the Register of Interests which is accessible to the public at the Trust Head Office and will be listed in the Trust's annual report and accounts for 2016/17.**<br>**2) Recorded that all directors have signed to confirm compliance with the NHS Codes of Conduct and Accountability and Nolan principles; no relevant audit matters have been declared.** |
| **DHCFT 2017/065** | **ANNUAL REIVEW OF TRUST SEALINGS**<br><br>This report provided the Trust Board with an account of the authorised use of the Foundation Trust Seal during 2016-17.<br><br>The Board noted the three entries made to the Register of Trust Sealings for 2016/17 as shown in the report.<br><br>**RESOLVED: The Board of Directors noted the authorised use of the Foundation Trust Seal during 2016-17.** |
| **DHCFT 2017/066** | **GOVERNANCE IMPROVEMENT ACTION PLAN (GIAP)**<br><br>Sam Harrison presented the Governance Improvement Action Plan (GIAP) report, providing the Board with an update on progress on delivery of the GIAP. She was pleased to report that all recommendations are now complete for Core areas 2, 5, 8, 9 and 10 and asked the Board to formally approve 14 'blue forms' to confirm that the recommendation within each form had been completed.<br><br>Sam Harrison pointed out that the Board approved several GIAP recommendations at extraordinary Board meeting held in confidential session on 29 March and this report would be made available on the Trust's website.<br><br>The Board scrutinised the blue forms and the following comments were noted:<br><br>As the recommendations contained in HR3 and HR4 were aligned these two blue forms were reviewed together:<br><br>***HR3 - Undertake an exercise to update the model for HR. Utilising the model as a*** |

***guide, expertise and best practice across the LHE, and beyond. As a priority the Trust should focus on establishing clear foundations, utilising key building blocks to create sustainability in the long term. HR4 - Define a new structure for HR and its related functions with a priority on operational efficiency and strategic impact taking into account the refreshed People Strategy and revised model for HR and related functions:*** Amanda Rawlings assured the Board that the new shared service structure for the HR/Workforce team is now in place. The Board was satisfied with the detail that supported HR3 and HR4 and approved recommendations HR3 and HR4.

Recommendations GLING1 and CORPG7 are also aligned and these two recommendations were considered together:

***CLING1 - Refresh the role of Quality Leadership Teams to increase their effectiveness as core quality governance forums. CORPG7 - In light of the changing governance and accountability structures (such as neighbourhoods, campuses and QLTs) an accountability framework should be designed to fully engage staff in how these changes will affect ways of working, performance management structures and desired behaviours moving forward:*** The Board received assurance that a very detailed effectiveness review had been carried out by the Quality Committee and approved CLING1 and CORPG7

***WOD5 - Consider a range of development interventions for the operational HR team to ensure employment law risks are mitigated:*** The Board obtained assurance that a series of training programmes has been undertaken across the HR directorate and the team has also received updates from a variety of legal sources. The Board approved WOD5 on the understanding that the blue form would be updated with narrative to reflect this work.

***WOD6 - Consider mechanisms to regularly seek feedback from the HR function on the extent to which the candour, openness, honesty, transparency and challenge to poor performance are the norm, e.g. through monthly pulse checks:*** The results of the first monthly pulse checks have been received. Following the challenge that took place at the March meeting of the People & Culture Committee the blue form has been updated to reflect how staff feedback from the HR function can be captured. The Board agreed that this recommendation was now complete.

***M2 - The Governance Improvement Action Plan will be updated to reflect material matters arising from the HR investigation:*** It was acknowledged that this recommendation formed the development of the GIAP and was signed off by the Board in April 2016 and it was agreed that this recommendation was now complete.

***M4 - The Trust will implement programme management and governance arrangements to ensure the delivery of the Governance Action Plan:*** The governance and delivery framework was agreed in April 2016. The Board was satisfied that this has been effectively followed throughout 2016/17 with reporting regularly to oversight Board Committees, the Board, Council of Governors and regulators and approved recommendation M4.

***M5 - The Trust will provide regular reports to Monitor:*** The Board accepted that reports have been provided to NHSI (previously known as Monitor) as part of regular performance review meetings and approved recommendation M5.

***M6 - The Licensee will, by 18 March 2016 or such other date as agreed with Monitor, develop and submit to Monitor a timetable for making permanent appointments to all director roles which are currently vacant and/or filled on an interim basis. It will, by a date to be agreed with Monitor, revise that timetable in response to any comments made on it by Monitor:*** The Remuneration and Appointments Committee agreed the timetable for recruitment of all Board level posts

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| | outlined and these were recruited to successfully. The Board agreed closure of this recommendation at its April 2016 meeting and accepted that this recommendation was now complete.<br><br>***RR1 – Implement proposals to improve succession planning at Board level, including ensuring that Governors are adequately engaged in this process. Alongside this, develop processes for succession planning for Senior Leader positions.*** This was discussed at the Remuneration and Appointments Committee and it was agreed that this recommendation would be include reference to governors in their role in succession planning for Non-Executive Directors. The Board was satisfied that there was a process in place to develop succession planning requirements and approved recommendation RR1.<br><br>***RR2 - Agree a programme of Board development work which includes a mix of internal and externally facilitated sessions, is clearly aligned to the combined governance action plan. CQC 3 - The trust should ensure that all Board members and the council of governors undertake a robust development plan:*** The Remuneration & Appointments Committee confirmed receipt of a report outlining the completed development programme for 2016/17 and agreed at the February 2017 meeting that the development of this programme for 2017/18 is to be taken forward as business as usual. The Board was satisfied that recommendation RR2 is now complete.<br><br>***RR3 - Complete the full process of 360 feedback for all Board Members and utilise the outcome to set clear objectives in relation to portfolio areas (for Executive Directors) as well as in relation to the role of the corporate director and contribution to the Board:*** The Board was assured that that appraisals for outgoing Non-Executive Director, Maura Teager and outgoing Interim Chairman, Richard Gregory had been presented to governors through the Nominations and Remunerations Committee. The Board was satisfied that work on 360 degree appraisals has been implemented and this has helped progress personal and team development and it was agreed that this recommendation RR3 is now complete.<br><br>***RR5 - The Trust should ensure that training passports for directors reflect development required for their corporate roles:*** Mandatory training will be overseen by the Executive Leadership Team and Caroline Maley will regularly review training and development with Non-Executive Directors. The Board was agreed that recommendation RR5 is now complete.<br><br>The Board understood that two recommendations remain outstanding, M1 and M3, which are subject to external assurance and these will be submitted to the next meeting in May for completion. The focus will now shift to embedding and monitoring the work undertaken.<br><br>**RESOLVED: The Board of Directors:**<br>**1) Noted the progress made against addressing GIAP recommendations**<br>**2) Formally approved the 14 blue forms as presented and confirmed that they provided assurance of completion, namely:**<br>• **HR3**<br>• **HR4**<br>• **CLING1**<br>• **CORPG7**<br>• **WOD5**<br>• **WOD6**<br>• **M2**<br>• **M4**<br>• **M5**<br>• **M6**<br>• **RR1** |

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| | • **RR2**<br>• **RR3**<br>• **RR5**<br>**3) Agreed at the end of the Board meeting that no further changes are required to the GIAP following presentation of papers, outcomes of item specific discussions and/or other assurances provided throughout the meeting** |
| **DHCFT 2017/067** | **<u>REPORT FROM COUNCIL OF GOVERNORS MEETING</u>**<br><br>Sam Harrison presented the report which provided a summary of issues discussed at the meeting of the Council of Governors held on 7 March 2017. The Board noted the report and was assured on the breadth of key topics presented to and discussed by the Council of Governors.<br><br>**RESOLVED: The Board of Directors noted the report from the Council of Governors meeting held on 7 March 2017.** |
| **DHCFT 2017/068** | **<u>CLOSURE OF BOARD ASSURANCE FRAMEWORK 2016/17 AND ISSUE OF BOARD ASSURANCE FRAMEOWRK 2017/18</u>**<br><br>Sam Harrison presented this report detailing the final issue of the Board Assurance Framework (BAF) for 2016/17 and the first issue of the 2017/18 BAF.<br><br>The Board acknowledged that the BAF was very carefully scrutinised by the Audit & Risk Committee in March. The BAF was also reviewed by ELT and amendments arising from both these meetings have been incorporated into the final version of the BAF for 2016/17. Since Issue 4 of the BAF for 2016/17 was reviewed by the Board in February 2017, the risk rating of three risks has been further reduced.<br><br>• Risk 1e) 'Lack of compliance with the Civil Contingencies Act as a category 2 responder. Risk identified through 2016/17 EPRR Assurance Process' has reduced from high to moderate due to mitigation in place and CCG formal notification of compliance<br>• Risk 3b) 'Risk of a loss of confidence by staff in the leadership of the organisation at all levels' has reduced from high to moderate due to stability in senior leadership team and increased confidence of regulators, and<br>• Risk 4a) 'Failure to deliver short term and long term financial plans could adversely affect the financial viability and sustainability of the organisation' has reduced from high to moderate due to confidence in year-end financial forecast.<br><br>As a result at year-end, five risks remain graded as high risk and five as moderate risk to the achievement of the Trust's strategic objectives.<br><br>The report also included the first issue of the BAF for 2017/18. Following feedback from Board Committees and KPMG this version of the BAF has been amended in terms of format and content. The risks in this first issue 2017/18 have been scrutinised by the Executive Leadership Team and Audit and Risk Committee. As a result further changes have been made and are reflected in the BAF as presented.<br><br>Carolyn Green questioned whether risk 3b '*There is a risk to staff engagement and wellbeing by the Trust not having supportive and engaging leaders*' correctly articulated the risk of lack of capacity within leadership. Amanda Rawlings responded that good quality leadership staff will support the change process. This risk was concerned with working towards ensuring consistency of good leadership across the whole of the Trust.<br><br>Julia Tabreham's final question, raised in her absence, referred to the risk of cyber-attack on the Trust. This was acknowledged to be an ill-understood risk and she asked if any development had been made on any further analysis into this risk. This will be the |

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| | subject of a Board Development session. Mark Powell will brief the Finance & Performance Committee on the arrangements that are in place and any issues will be escalated to the Board.<br><br>The Board approved the final version of the BAF for 2016/17. The content and format of the first issue of the BAF for 2017/18 was also approved and it was noted that deep dives of BAF risks will take place at various Board Committees and Audit & Risk Committee.<br><br>**RESOLVED: The Board of Directors:**<br>**1) Approved the final issue of the BAF for 2016/17**<br>**2) Approved the content of this first issue of the BAF for 2017/18, including the revised format and additional fields**<br>**3) Approved ongoing reporting and monitoring arrangements as outlined** |
| **DHCFT 2017/069** | **2017/18 BOARD FORWARD PLAN**<br><br>The forward plan was noted by the Board.<br><br>**RESOLVED: The Board of Directors noted the forward plan for 2017/18.** |
| **DHCFT 2017/070** | **IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK OR GIAP**<br><br>It was agreed that no further changes are required to the GIAP or to be updated or included in the BAF or the GIAP. |
| **DHCFT 2017/071** | **MEETING EFFECTIVENESS**<br><br>A lot of issues have been closed at today's meeting. Caroline Maley asked that the May agenda be formulated so it is more manageable so that time can be used to enable more challenge. |

The next meeting of the Board held in Public Session will take place at 1pm on Wednesday, 24 May 2017.

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

| | | | | BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - MAY 2017 | | | Enc C |
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| **Date** | **Minute Ref** | **Item** | **Lead** | **Action** | **Completion Date** | **Current Position** | |
| 1.3.17 | DHCFT 2017/046 | Board Assurance Summaries & Escalations | Amanda Rawlings | Workforce Plan to be submitted to the April Board meeting | 28.6.2017 | Deferred to June meeting | Yellow |
| 26.4.17 | DHCFT 2017/058 | Integrated Performance And Activity Report | Mark Powell | Specific areas will be investigated where bed occupancy is high to establish any links and incorporated into an enhanced narrative in the next report | 28.6.2017 | Owing to IT downtime this has not been possible, an enhanced narrative within the IPR will be provided in June's report. | Yellow |
| 26.4.17 | DHCFT 2017/060 | Integrated Performance And Activity Report (EDS2) | Amanda Rawlings | Top six priority actions and EDS2 SMART implementation plan to be received at the May 2017 Board meeting | 28.6.2017 | Deferred to June meeting | Yellow |
| 26.4.17 | DHCFT 2017/064 | Business Plan 2017-18 | Sam Harrison | Quarterly update reports on the Business Plan 2017-18 to be incorporated into the Board forward plan | 24.5.2017 | Business Plan 2017-18 featured in forward plan on a quarterly basis ACTION COMPLETE | Green |

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| **Resolved** | **GREEN** | 1 | 25% |
| **Action Ongoing/Update Required** | **AMBER** | 0 | 0% |
| **Action Overdue** | **RED** | 0 | 0% |
| **Agenda item for future meeting** | **YELLOW** | 3 | 75% |
| | | 4 | 100% |

**Derbyshire Healthcare NHS Foundation Trust**
Report to Public Board of Directors 24 May 2017

## Acting 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. During May it was Mental Health Awareness Week and this year the theme was "Surviving or Thriving".


Headed up by the Mental Health Foundation, the nationwide Mental Health Awareness Week (MHAW) campaign took place 8-14 May

With many people struggling to cope with the demands of life and stuck on getting through the day, rather than ask why, so many people are living with mental health problems, the Mental Health Foundation sought to uncover why too few of us are thriving with good mental health.

The many events of the week for us included an interview with Dr Rais Ahmed on BBC Radio Derby; raising awareness and hopefully helping listeners to know ways to seek help if they need.

The Workforce & OD, IM&T and Communications teams have also worked together to launch 'Work Perks' to coincide with MHAW and to provide better information to staff on the support available to them. Work Perks is a micro-site that staff can access from any device, as it is part of our (external) website. It seeks to help improve staff health and wellbeing by giving staff a one-stop shop for all information, advice and benefits.

2. The Mental Health Policy Group (a coalition of six organisations working for better mental health. Colleagues from Mind, Rethink Mental Illness, Royal College of Psychiatrists, Mental Health Foundation and the Centre for Mental Health and the Mental Health Network) launched their Manifesto for Better Mental Health supporting the parties in the general election in the process of finalising their manifesto policies. In order to try to make sure that mental health remains high on the agenda during this time.

   Of particular importance, is focus on asking all parties to re-commit to the full implementation of the Five Year Forward View for Mental Health as well as a funding settlement post-2020 which will provide vital increases in investment for mental health services.

3. The media have reported this month that since 2010, the total number of NHS mental health nurses in England has dropped by 15% - in parts of London, about 20% of job vacancies are unfilled. The nursing shortage is caused partly by an ageing workforce that is not being replaced quickly enough. In 2013, more than 32% of mental health nurses were aged over 50, and the abolition of bursaries for student nurses may also have had an adverse effect on the number of new recruits. This is resulting in individual nurses taking on higher caseloads. Research last year found that some mental healthcare coordinators – not all of whom are nurses – have caseloads as high as 50 patients. Community-based teams care for 97% of mental health patients, and nurses play a pivotal role in building up trust between patients and families.

   As we have regularly reported, these types of staffing and workload pressures are being felt by our own teams. We have been regularly reporting in the Integrated Performance Report on our staffing levels and actions to improve recruitment for example. The People and Culture Committee are taking keen oversight of the delivery of our People Plan and recruitment plans which seek to address this and other staffing pressures that we are experiencing.

   We regularly benefit from teams coming to Board to tell us more about their services in our ‘Deep Dives’. In recent months we have heard loud and clear from our Crisis and Home Treatment teams and from our Community teams about the staffing pressures as described in the type of media reports this month.

4. The media also reported that new figures show that the number of patients absconding from NHS mental health units has risen by up to 64% since 2014. Freedom of information requests to 19 mental health trusts revealed that incidents in which patients we missing from units, or failed to return from authorised periods of leave, rose by 28% between 2014 and 2016. Only four of the 19 trusts show a decrease in incidents of absenteeism.

   Numbers of incidences of absconsions for our Trust can be found regularly reported in the Quality Dashboard section of our Integrated Performance Report and would also feature in the Quality Position Statement and narrative if and when we had exceptions to report.

**Local Context**

5. With regard to progress with the Derbyshire Sustainability and Transformation Planning (STP) there is a strong commitment to develop a local Accountable Care System (ACS). The System Management Executive (SME) met 18th May where they considered progress and the best way forward with the deliverables associated with an accountable care system, specifically:
   - the core governance structure
   - a revised system financial plan and
   - implementation plan

   I will be able to provide a verbal update on progress at the Board meeting. I will also provide a more formal update on progress with the STP/ACS at the June meeting.

6. On the 10 May I sent a letter to commissioners expressing our serious concerns regarding the requirement to plan for the impact of the release to Derbyshire of Indeterminate Imprisonment for Public Protection (IPP) Prisoners.

   Our Trust is unfortunately one of the very few Trusts which is not commissioned to provide a community forensic mental health care service and so we believe this places the Derbyshire community and system at higher risk of not being well-prepared to respond to this policy decision.

   Our Executives and other leaders will work with their counterparts and commissioners across the system to plan the management of risks related to the complex needs of these individuals: Scoping the number of Derbyshire prisoners and assessing the risks to the system and the community is key to effective and safe community management.

   We have added this risk to our Board Assurance Framework as one of our highest risks.

**Within our Trust**

7. We have been notified of some more one-day CQC visits:
   - 7th June where the visit will be on Mental Health with regard to Community Treatment Orders (CTOs)
   - 12th July where the visit will be a multi-agency visit looking at the Mental Health Act Assessment and Application for Detention and Admission, looking at the whole pathway

Staff are already planning support to the visiting teams from CQC

8. In our Spotlight on Leaders event in conversation with Claire Wright my deputy on the 11 May, leaders talked openly about how to further improve our pulse check scores, which are showing some good improvement about how staff feel working for this Trust.

   Every team should be working on their top three actions for improvement. They also discussed ways in which to better hear <u>everyone's</u> voice.

As with all leadership events we ask that leaders reflect on what they have learned and implement change to best suit them and their teams and we will follow up on progress at future events and pulse checks.

9. Joint staff events for engagement with both governors and staff of DHCFT and DCHS have continued this month. The focus has been on developing the clinical case for change, undertaking due diligence and on discussion of vision and values.

   I recognise that this is a very intensive time and is having a significant adverse impact on staff capacity and I am very grateful for staff who I know are doing their utmost to juggle the priorities of STP, DCHS integration, as well as key priorities for our 'business as usual' and our governance priorities such as CQC action plan delivery.

10. The month of May also sees the formal sign-off our statutory annual report and accounts at our Audit and Risk Committee on behalf of the Trust Board.

    Improving our governance and broader service quality in response to the well led reviews and the CQC has been a key focus and priority for the year and I am pleased that I feel increasingly positive about our performance across a wide range of indicators – operational, quality, finance and our workforce.
    The annual accounts report that we have met our control total and have qualified for £906k of NHSI incentive funding on top of the control total which will benefit us in 2017/18.

11. Looking ahead to early next month, on the 7 June my Executive team will be doing their reverse mentoring masterclass – this is a strategy for improving the capacity and capability of leaders in the UK health sector to be truly inclusive and to increase the potential for reverse mentoring to raise the confidence and profile of BME staff in organisations and to consider the contribution this might make to increasing the diversity of the leadership of the UK health sector.

    I truly believe that this will make a real difference to our leadership being able to hear the voice of our BME community (and is one of the commitments I made to our BME colleagues at the BME conference last month).

12. As part of an ongoing dialogue with some of our Trusts Junior Doctors I have now had some expressions of interest from a number of them who are very interested in taking part in some two way shadowing, to understand a little more about how the Board operates, our strategic priorities but importantly also to enable Board members to understand more about the challenges and opportunities junior doctors have when placed in our Organisation. I am keen for Executive and Non-Executive Board members who might be also interested in taking part in this innovative approach to developing a shared understanding as well as supporting the development of our future clinical leaders.

13. It was commonly reported in the media on Friday 12th May that the NHS had been subject to a cyber-attack. The response from staff at many levels in out Trust was simply superb! Our IT Team worked to quickly and effectively isolate our Network and systems from the wider web environment as a purely precautionary measure as we did not suffer any direct infection. Business continuity plans were implemented and our

clinical and front line staff very effectively kept services running. We quickly developed confidence in our internal resilience and were able to get clinical information services back up and running by Saturday evening, a great response. Our email systems and shared folders took much longer as these were potentially the highest risk to attack from the malware. There will be a formal debrief and lessons learnt process and this will be presented to the next public Board meeting in June. I would like to express my sincere thanks to all of our staff who worked so hard during this time to ensure the quality of our services was not compromised in any way

14. I understand that on May 22 there was an NHS Improvement meeting to consider the achievement of our Governance Improvement Action Plan and the independent report from Deloitte, with a view to approving the satisfactory achievement of our licence undertakings.

    At the time of writing we await news of what impact this has on our licence conditions and any date for a return to normal licence conditions. If there are any update I will provide a verbal update at the meeting.

| **Strategic considerations** | |
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| 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
- There is a new risk for the BAF related to IPP – this will require mitigations

**Consultation**

- The report has not been to any other group or committee

**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**<br>The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people). | |
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| 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 regionally have the potential to have an adverse impact on people with protected characteristics (REGARDS).

Internal Trust and wider system transformation schemes all need to involve an appropriate equality impact assessment in order to mitigate any risks that are identified in actions being proposed

That equality impact assessment needs to 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.

Transformation done well has the potential to *improve* our delivery of equality, by for example, increasing the opportunity for communities to come together in more positive ways than those that exist in the way we currently deliver services

The Reverse Mentoring training is a specific example where the outcomes will positively impact on all three aims of the Equality Act for groups of staff, i.e. the BME staff community, in helping the executive to identify barriers and remove them, increase the opportunities for positive outcomes for BME groups, and support the creation of opportunities to bring communities and groups together in positive ways.

**Recommendations**

The Board of Directors is requested to:

1) Scrutinise the report, noting the risks and actions being taken
2) Challenge myself or the Executive on the content therein.

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| **Report presented by:** | **Ifti Majid**<br>**Acting Chief Executive** |
| **Report prepared by:** | **Ifti Majid**<br>**Acting Chief Executive and**<br><br>**Claire Wright**<br>**Deputy Chief Executive** |

Derbyshire Healthcare NHS Foundation Trust

Derbyshire Community Health Services NHS Foundation Trust

# Summary Report from the Joint Integration Programme Committee

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| **Meeting:** | DCHS & DHcFT Joint Integration Programme Committee | | | | | |
| **Date of Meeting:** | 3 May 2017 | | | | | |
| **Presenter/Title:** | Caroline Maley | | | | | |
| **Author/Title:** | Sukhi Mahil, Joint Integration Programme Manager | | | | | |
| **Document is for:** (more than one box can be ticked) | **Information** | X | **Decision** | | **Assurance** | X |

| **Executive Summary** |
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| The DCHS & DHcFT Joint Integration Programme Committee met on 3 May 2017. This report provides a summary of the key discussions and highlights any issues which Boards need to be aware of. |

**Key issues discussed at meeting**

| Summary | Risks identified | Decisions made and actions to be taken |
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| **<u>Programme Director's Report</u>**<br><br>A significant increase in activity since the previous meeting was reported; the first due diligence session had taken place with a further one scheduled for 8 May. Clinical Pathways workshops and vision and values workshops were also in place and dates circulated to all staff. | | The Programme Director report and workstream updates were noted. |
| ***Workstream Updates***<br><br>Progress was being made in each of the workstream areas. The strategy workstream was reported as amber this month because of the outstanding clarity in relation to competition and choice. Liaison with NHSI was continuing as this was a key issue as Boards would be required to make a decision whether to evoke a CMA review at OBC stage. | There was a risk of continued lack of clarity from NHSI in relation to the CMA position; in the absence of the NHSI report internal information was being developed as a contingency and independent advice would also be sought to guide the Boards in their decisions | |
| Capacity was highlighted as a concern as there was a challenge in terms of releasing people to engage in the pathway development work and vision and values sessions in a meaningful way. | There was a risk that the same people were supporting the programme and this could impact on their 'day jobs' which in turn could result in deliverables being compromised on both fronts. | The challenges were noted and it was agreed the test would be whether or not people attend the planned sessions; if not then this was a reality as opposed to a perceived challenge, which would require further consideration.<br><br>The JIPC recognised there were challenges that needed to be closely monitored but agreed that the risk of slowing down the timescales and pace of |

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| | | work would inevitably prolong uncertainty for staff which wouldn't be helpful. |
| An issue was highlighted in the IM&T workstream update in relation to the extension of the PARIS contract; this in turn raised concerns with regards to decisions being taken as individual organisations and the need to consider the impact on the integration proposals. | There was a risk the extension could impact on benefits realisation in relation to the clinical pathways workstream as one of the key emerging benefits was single patient records. | The committee were informed that DHcFT needed to ensure that safe systems were in place during the transition period and had taken the longer term implications into account when taking the decision and appropriate break points had been factored in. Therefore it was reported that there would not be a risk. However the JIPC agreed that there needed to be a line of sight for any similar long term decisions each organisation makes and the joint Exec meeting would be the appropriate forum for such considerations. |
| **OBC critical issues and impact on timeline**<br><br>A revised OBC framework had been developed to reflect the critical issues as agreed at the last JIPC; these requirements had also been factored into the revised timeline. Within this timeline a joint session for both Boards had been factored in w/c 19th June to go through the OBC content and allow the opportunity for feedback to be incorporated prior to formal Board approval in July.<br><br>The OBC would go to public Boards in July and therefore the two meeting dates needed to be aligned to fall on the same day. | | The JIPC agreed with the suggested approach and timeline. |
| There was considerable discussion in relation to the role of the Governors at OBC and FBC stage. The Trusts Boards were responsible for approval of the business case and transaction itself and the CoG would need to be assured of the process undertaken to enable them to approve formal submissions of the transaction to NHSI. | There was a risk that the language used could cause confusion in terms of the governor role in the transaction which needed to be made explicit throughout the process. This would also need to be balanced with the risk of governors not being assured at FBC stage. Therefore, assurance of on-going commitment was required and this was necessary at OBC stage to mitigate against the risk of continuing through to FBC approval, which would incur significant transaction programme costs. | The JIPC agreed there was a need to seek assurance from both Boards and CoGs at OBC stage to confirm full support and commitment to the direction of travel post OBC so the subsequent costs incurred are not wasted. This would not replace the respective roles and there was a need to be clear about the distinction.<br><br>The approach agreed was for both CoGs to consider the OBC individually, with a joint governor session to be held to go through the process and content in the same way as was planned for the Boards. The aim would be to provide the necessary assurances in terms of the process. |

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| **Clinical workstream update**<br><br>It was reported that progress was being made in relation to the four priority areas (LD, Children's, OPMH and PLACE). Groups with representatives from both organisations had begun coming together to develop the current position and clinical workshops were taking place on the 9th and 11th May to develop the future potential models. The focus of the sessions would be the integration specific benefits to demonstrate what would be better together. | | It was agreed that the benefits would need to draw out those things that could only be delivered through formal integration. There was also a second category of things which could be delivered through closer collaboration but in practice these things would be far harder to implement such as shared patient information due to information governance rules across two organisations. |
| **Due Diligence**<br><br>It was reported that the due diligence work was now underway and there were two sessions taking place with Exec leads their respective support; the first of which was on the morning of the 3rd May and a further one on 8th May.<br><br>This work was intended to identify 'red flags' which would then enable mitigation through the implementation planning. | | The update was noted. |
| **Culture Development**<br><br>It was reported that the culture survey was due to go live as part of the cultural due diligence work which EY were leading on. The survey was intended to be light touch at this stage but it would give sufficient insight to inform the on-going work, as the intention was to gather momentum and a wider reach through the FBC stage.<br><br>As part of the culture due diligence, leadership interviews and focus groups were also in the process of being arranged.<br><br>These focus groups were in addition to the joint vision and values sessions that were being held w/c 15th May. | | The progress and approach was noted. The JIPC agreed that NEDs and Governors should also be invited to complete the survey. Furthermore it was agreed the EY leadership interviews would also include NEDs.<br><br>It was agreed the vision and values sessions would also be opened up to NEDs. |

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| **Risk & Issues Register**<br><br>The JIPC received the risk report.<br><br>The red risks to be specifically reported to the Boards this month were:<br>• The risk of issues arising from the due diligence resulting in delay in getting the OBC / FBC approval – this risk is unchanged from the previous month. The risk would be mitigated through the work that both organisations will start with due diligence in May. To support this work, EY will be facilitating 2 sessions in early May to ensure key staff understand the principles of due diligence, and understand the specific work required in each functional area (R010)<br><br>• The risk of lack of clarity on the CMA position in relation to competition resulting in potential delay to the process and additional cost – this risk has increased from 12 to 16 in month. The reason for the increase in the risk is the lack of clarity received from NHS Improvement around the CMA position. A teleconference was being arranged with NHSI to take stock of the current position, and understand the timelines for a CMA view. Contingency arrangements have been discussed by the Core Group. Since increasing the risk to 16, we have had conformation that discussions with CMA have now taken place, and that the informal view is that the transaction is low risk. We intend to keep the risk at 16 until formal confirmation has been received, or assurances are received through further discussions (G001)<br><br>• The risk that governors of either or both organisations are not in agreement with the proposals, resulting in the transaction not proceeding, benefits not being achieved, and resources wasted – this risk has been increased from 15 to 20 following discussions at | | It was agreed that the JIPC should give greater consideration to the risk register at the start of future meetings with a check back at the end to ensure there are no further risks or changes based on the discussions.<br><br>It was agreed that there was a need to collectively understand the issues and the planned joint governor session on 10th May could help start to work through but it was noted that further work and support would be required to ensure concerns were addressed. |

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| the DHcFT Board and concerns that current actions were not mitigating Governor anxieties around the transaction. Further actions are required, and JIPC were asked to discuss this risk further in the meeting (G002) | | |
| A new risk was identified, that the staff unions may not fully support the integration resulting in potential delays to the process and / or challenging employee relationships. Further discussions were required with union colleagues to understand the specific concerns, to inform the actions and mitigations that need to be put in place (G005) | This risk had been identified due to DHcFT collective staff side concerns; DCHS staff side confirmed no concerns had been raised. | It was agreed that in the spirit of openness it was important to collectively understand the underlying issues and to work through these together to confirm whether there was anything that could be done to address the concerns. Therefore it was agreed these would be shared with the JIPC for discussion at the next meeting. |

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| **Issues to be escalated/ decisions required by Trust Boards** |
| None at this stage. |
| **Recommendations** |
| The Trust Boards are requested to:<br>1. Note the summary report. |

**Derbyshire Healthcare NHS Foundation Trust**
Report to Board of Directors – 24 May 2017

# Integrated Performance Report Month 1

## Purpose of Report

This paper provides Trust Board with an integrated overview of performance as at the end of April 2017. The focus of the report is on workforce, finance, operational delivery and quality performance.

## Executive Summary

The Trust continued to perform well against many of its key indicators during April. This Executive Summary provides an overview of the some of the key issues during the month, assurance in a number of challenged areas and a forward view of some future risks and/or issues Board members need to be aware of.

Owing to the IT downtime during w/b 15th May, reporting of data was delayed affecting the level of narrative that has been able to be provided within the report. As a result of this, quality, workforce and operational sections will require greater scrutiny by Board members to establish key performance issues and to seek assurance on mitigating actions being undertaken in these areas.

Financial Performance

In surplus terms, the Trust is slightly ahead of plan in the month by £21k and is forecast to achieve the control total at the end of the financial year.

With regard to other financial performance factors, the Use of Resources (UoR) metrics is a 1 in month and is forecast to be a 2 at the end of the financial year. In terms of the year end forecast, four of the five metrics are strong at 2, 1, 1 and 2, but the fifth metric, agency spend against ceiling is forecast at a 3.

Planning continues for cost improvement action that is required to achieve 2017/18 control total financial plan. Whilst early plans exist for some of the Trust CIP of £3.85 million (at our risk), the commissioner driven QIPP disinvestment schemes that require £3.05 million income and cost reduction (at commissioner risk) are not yet agreed.

## Strategic considerations

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

## Board Assurances

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

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

**Consultation**

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

**Governance or Legal issues**

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

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

**Equality Delivery System**

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

**Recommendations**

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

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

## Financial Perspective

Highlights
- Surplus slightly ahead of plan year to date
- Forecast achievement of control total
- Cash better than plan

Challenges
- Delivery of Cost Improvement Programme
- Containment of agency expenditure within ceiling set by NHSI

## Operational Perspective

Highlights
- Incomplete waits for Early Intervention in Psychosis RTT Within 14 Days has been achieved this month

Challenges
- Achieving Priority Metric compliance
- Clustering
- Outpatient cancellation compliance
- Outpatient letters sent in 10 working days
- Breastfeeding targets

## People Perspective

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

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

## Quality Perspective

Highlights
- The data relating to incidents has been refreshed so that 'plan' data for month and quarter is now based against 2016/17 average, rather than 2015/16 average shown previously
- Quarterly data remains the same as last month as relates to Q4 16/17 data, therefore highlights/challenges have been previously included for quarterly indicators . This will be updated with Q1 17/18 for the report Jul 17
- No of incidents involving physical assault and prone restraint have decreased compared with the previous last month
- No of falls has decreased, as has no of absconsion incidents. These and the indicator above should be seen alongside a reduction in in-patient beds, from where the highest numbers of incidents are reported
- Again, all seclusion forms have been received by the MHA office for April 2017

Challenges
- No of episodes of patients held in seclusion and no incidents involving patients held in seclusion has increased this month
- No of patients with a safety plan has increased, but still remains low at 15.10%
- No of patients with a VTE assessment has increased, but again still remains low at 8.91% compliance
- No of complaints has again increased

# FINANCIAL OVERVIEW – April 2017

| Category | Sub-set | Metric | Period | Plan | Actual | Rating | Key Points |
|---|---|---|---|---|---|---|---|
| Governance | Use of Resources (UoR) Metric | Overall Use of Resources Metric | YTD | 1 | 1 | G | In April the Use of Resources Rating is an overall '1' as per plan.<br>Forecast is a rating of '2' which is slightly worse than the plan of '1'. This is mainly driven by the agency metric which is forecast at a '3' for the end of the financial year. |
| | | | Forecast | 1 | 2 | G | |
| | | Capital Service Cover | YTD | 2 | 2 | Y | |
| | | | Forecast | 2 | 2 | Y | |
| | | Liquidity | YTD | 1 | 1 | G | |
| | | | Forecast | 1 | 1 | G | |
| | | Income and Expenditure Margin | YTD | 1 | 1 | G | |
| | | | Forecast | 1 | 1 | G | |
| | | Income and Expenditure variance to plan | YTD | 1 | 1 | G | |
| | | | Forecast | 1 | 2 | G | |
| | | Agency variance to ceiling | YTD | 1 | 2 | G | |
| | | | Forecast | 1 | 3 | A | |
| | Single Oversight Framework | NHS I Segment | YTD | | 3 | n/a | |

| | | | | Plan | Actual | Variance | |
|---|---|---|---|---|---|---|---|
| I&E and profitability | Income and Expenditure | Control Total position £'000 | In-Month | 178 | 199 | G | In April the surplus is slightly ahead of plan by £21k and is forecast to achieve the control total at the end of the financial year.<br><br>EBITDA is slightly behind plan in month £23k and forecast £76k. This is offset by small underspends below the line on depreciation and Public Dividend Capital payments. |
| | | | YTD | 178 | 199 | G | |
| | | | Forecast | 2,765 | 2,765 | G | |
| | | Underlying Income and Expenditure position £'000 | In-Month | 138 | 160 | G | |
| | | | YTD | 138 | 160 | G | |
| | | | Forecast | 1,971 | 1,971 | G | |
| | | Normalised Income and Expenditure position £'000 | In-Month | 138 | 200 | G | |
| | | | YTD | 138 | 200 | G | |
| | | | Forecast | 1,971 | 2,375 | G | |
| | Profitability | Profitability - EBITDA £'000 | In-Month | 830 | 807 | R | |
| | | | YTD | 830 | 807 | R | |
| | | | Forecast | 10,159 | 10,083 | R | |
| | | Profitability - EBITDA % | In-Month | 7.4% | 7.1% | R | |
| | | | YTD | 7.4% | 7.1% | R | |
| | | | Forecast | 7.6% | 7.3% | R | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Liquidity | Cash | Cash £m | YTD | 12.998 | 13.103 | G | Cash is ahead of plan year to date and is forecast to be ahead of plan at year end. This mainly relates to additional STF income from 2016/17 that will be received during 2017/18. This additional income may be spent on capital bids, but this is not yet included in the capital or cash forecast.<br>Net Current Assets are less than plan due to the removal of an Asset Held for Sale. |
| | | | Forecast | 12.193 | 12.769 | G | |
| | Net Current Assets | Net Current Assets £m | YTD | 7.213 | 4.165 | R | |
| | | | Forecast | 8.345 | 4.661 | R | |
| | Capex | Capital expenditure £m | YTD | 0.049 | 0.033 | A | |
| | | | Forecast | 3.338 | 3.338 | G | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Efficiency | CIP | CIP achievement £m | In-Month | 0.321 | 0.132 | R | CIP is currently behind plan. An additional amount of savings has been included in the forecast. However work continues to fully assured the CIP in totality. |
| | | | YTD | 0.321 | 0.132 | R | |
| | | | Forecast | 3.850 | 2.443 | R | |
| | | | Recurrent | 3.850 | 1.080 | R | |

Key:

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

**Plan** In-month or Year end Trust plan

Achieving plan
Not achieving plan

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

# OPERATIONAL OVERVIEW – APRIL 2017

| Category | Sub-set | Metric | Period | Plan | Actual | Variance | Trend | Key Points |
|---|---|---|---|---|---|---|---|---|
| Performance Dashboard | NHSI | CPA 7 Day Follow-up (M) | Month | 95.00% | 97.50% | G | ↑ | All NHSi metrics are all compliant except "Priority Metrics" which is a new indicator since April 2017. Plans are being formulated to address the under-performance. For each metric we have indicated if it is monitored by NHSi Quarterly (Q) or Monthly (M). |
| | | | Quarter | 95.00% | 97.22% | G | → | |
| | | Data completeness - Identifiers (M) | Month | 95.00% | 99.45% | G | → | |
| | | | Quarter | 95.00% | 99.45% | G | → | |
| | | Data completeness - Priority Metrics (M) | Month | 85.00% | 72.17% | R | → | |
| | | | Quarter | 85.00% | 71.05% | R | → | |
| | | Crisis Gatekeeping (Q) | Month | 95.00% | 100.00% | G | ↑ | |
| | | | Quarter | 95.00% | 100.00% | G | ↑ | |
| | | IAPT RTT within 18 weeks (Q) | Month | 95.00% | 100.00% | G | → | |
| | | | Quarter | 95.00% | 99.90% | G | → | |
| | | IAPT RTT within 6 weeks (Q) | Month | 75.00% | 92.72% | G | ↑ | |
| | | | Quarter | 75.00% | 93.23% | G | ↑ | |
| | | Early Intervention in Psychosis RTT Within 14 Days - Complete (Q) | Month | 50.00% | 82.35% | G | ↓ | |
| | | | Quarter | 50.00% | 78.79% | G | ↓ | |
| | | Early Intervention in Psychosis RTT Within 14 Days - Incomplete (Q) | Month | 50.00% | 64.71% | G | ↑ | |
| | | | Quarter | 50.00% | 57.14% | G | ↓ | |
| | | Patients Open to Trust In Employment (M) | Month | N/A | 9.10% | | → | |
| | | | Quarter | N/A | 8.94% | | → | |
| | | Patients Open to Trust In Settled Accommodation (M) | Month | N/A | 60.47% | | → | |
| | | | Quarter | N/A | 59.08% | | → | |
| | | Under 16 Admissions To Adult Inpatient Facilities (M) | Month | 0 | 0 | G | → | |
| | | | Quarter | 0 | 0 | G | → | |
| | | IAPT People Completing Treatment Who Move To Recovery (Q) | Month | 50.00% | 55.88% | G | ↑ | |
| | | | Quarter | 50.00% | 54.84% | G | → | |
| | | Physical Health - Cardio-Metabolic - Inpatient (Q) | Month | N/A | | | | |
| | | | Quarter | N/A | | | | |
| | | Physical Health - Cardio-Metabolic - EI (Q) | Month | N/A | | | | |
| | | | Quarter | N/A | | | | |
| | | Physical Health - Cardio-Metabolic - on CPA (Community) (Q) | Month | N/A | | | | |
| | | | Quarter | N/A | | | | |

Key:

**Period**

Month — Current Month

Quarter — Current Quarter

Achieving target

Not achieving target

↑ → ↓ Trend compared to previous month/quarter

# OPERATIONAL OVERVIEW – APRIL 2017

| Category | Sub-set | Metric | Period | Plan | Actual | Variance | Trend | Key Points |
|---|---|---|---|---|---|---|---|---|
| Performance Dashboard | Locally Agreed | CPA Settled Accommodation | Month | 90.00% | 96.01% | G | → | An action plan has been implemented. We should be able to start evaluating the impact of the actions as each is completed over the next few months. |
| | | | Quarter | 90.00% | 96.01% | G | → | |
| | | CPA Employment Status | Month | 90.00% | 97.10% | G | → | |
| | | | Quarter | 90.00% | 97.10% | G | → | |
| | | Data completeness - Identifiers | Month | 99.00% | 99.45% | G | → | |
| | | | Quarter | 99.00% | 99.45% | G | → | |
| | | Data completeness - Outcomes | Month | 90.00% | 94.16% | G | → | |
| | | | Quarter | 90.00% | 94.16% | G | → | |
| | | Patients Clustered not Breaching Today | Month | 80.00% | 78.63% | R | → | |
| | | | Quarter | 80.00% | 78.27% | R | → | |
| | | Patients Clustered regardless of review dates | Month | 96.00% | 94.07% | R | → | |
| | | | Quarter | 96.00% | 93.98% | R | → | |
| | | 7 Day Follow-up - all inpatients | Month | 95.00% | 96.15% | G | ↓ | |
| | | | Quarter | 95.00% | 96.09% | G | ↓ | |
| | | Ethnicity coding | Month | 90.00% | 92.57% | G | → | |
| | | | Quarter | 90.00% | 92.57% | G | → | |
| | | NHS Number | Month | 99.00% | 99.98% | G | → | |
| | | | Quarter | 99.00% | 99.99% | G | → | |
| | | CPA Review in last 12 Months (on CPA > 12 Months) | Month | 95.00% | 95.09% | G | ↓ | |
| | | | Quarter | 95.00% | 95.09% | G | ↓ | |
| | | Community Care Data - Activity Information Completeness | Month | 50.00% | 94.37% | G | → | |
| | | | Quarter | 50.00% | 94.37% | G | → | |
| | | Community Care Data - RTT Information Completeness | Month | 50.00% | 92.31% | G | → | |
| | | | Quarter | 50.00% | 92.31% | G | → | |
| | | Community Care Data - Referral Information Completeness | Month | 50.00% | 73.97% | G | ↓ | |
| | | | Quarter | 50.00% | 73.25% | G | ↓ | |
| | | Early Interventions New Caseloads | Month | 95.00% | 100.00% | G | ↓ | |
| | | | Quarter | 95.00% | 100.00% | G | ↓ | |
| | | Clostridium Difficile Incidents | Month | 7 | 0 | G | → | |
| | | | Quarter | 7 | 0 | G | → | |
| | | 18 Week RTT Greater Than 52 weeks | Month | 0 | 0 | G | → | |
| | | | Quarter | 0 | 0 | G | → | |

# OPERATIONAL OVERVIEW – APRIL 2017

| Category | Sub-set | Metric | Period | Plan | Actual | Variance | Trend | Key Points |
|---|---|---|---|---|---|---|---|---|
| Performance Dashboard | Schedule 6 | Consultant Outpatient Trust Cancellations | Month | 5.00% | 11.67% | R | ↓ | The most common reason was clinician absent from work. |
| | | | Quarter | 5.00% | 11.38% | R | ↓ | |
| | | Consultant Outpatient DNAs | Month | 15.00% | 13.90% | G | → | |
| | | | Quarter | 15.00% | 15.16% | R | → | |
| | | Under 18 admissions to Adult inpatients | Month | 0 | 0 | G | → | |
| | | | Quarter | 0 | 0 | G | → | |
| | | Outpatient letters sent in 10 working days | Month | 90.00% | 88.69% | R | ↓ | |
| | | | Quarter | 90.00% | 91.53% | G | ↑ | |
| | | Outpatient letters sent in 15 working days | Month | 95.00% | 95.84% | G | → | |
| | | | Quarter | 95.00% | 97.13% | G | ↑ | |
| | | Inpatient 28 day readmissions | Month | 10.00% | 9.01% | G | → | |
| | | | Quarter | 10.00% | 6.63% | G | → | |
| | | MRSA - Blood stream infection | Month | 0 | 0 | G | → | |
| | | | Quarter | 0 | 0 | G | → | |
| | | Mixed Sex accommodation breaches | Month | 0 | 0 | G | → | |
| | | | Quarter | 0 | 0 | G | → | |
| | | Discharge Fax sent in 2 working days | Month | 98.00% | 100.00% | G | ↑ | |
| | | | Quarter | 98.00% | 100.00% | G | ↑ | |
| | | Delayed Transfers of Care | Month | 0.80% | 0.55% | G | → | |
| | | | Quarter | 0.80% | 0.79% | G | → | |
| | | 18 Week RTT Less Than 18 Weeks - Incomplete | Month | 92.00% | 97.15% | G | → | |
| | | | Quarter | 92.00% | 96.86% | G | → | |

# OPERATIONAL OVERVIEW – APRIL 2017

| Category | Sub-set | Metric | Period | Plan | Actual | Variance | Trend | Key Points |
|---|---|---|---|---|---|---|---|---|
| Performance Dashboard | Fixed Submitted Returns | 18 weeks RTT greater than 52 weeks | Month | 0 | 0 | G | → | Compliant with Fixed Targets |
| | | | Quarter | 0 | 0 | G | → | |
| | | 18 Week RTT incomplete | Month | 92.00% | 96.89% | G | ↑ | |
| | | | Quarter | 92.00% | 96.89% | G | ↑ | |
| | | Mixed Sex accommodation breaches | Month | 0 | 0 | G | → | |
| | | | Quarter | 0 | 0 | G | → | |
| | | Completion of IAPT Data Outcomes | Month | 90.00% | 96.04% | G | → | |
| | | | Quarter | 90.00% | 96.04% | G | → | |
| | | Ethnicity coding | Month | 90.00% | 92.87% | G | → | |
| | | | Quarter | 90.00% | 92.87% | G | → | |
| | | NHS Number | Month | 99.00% | 99.99% | G | → | |
| | | | Quarter | 99.00% | 99.99% | G | → | |
| Other Dashboards | Health Visiting | % 10-14 Day Breastfeeding coverage | Month | 98.00% | 97.50% | R | → | Not Compliant with Health Visiting Targets |
| | | | Quarter | 98.00% | 97.50% | R | ↓ | |
| | | % 6-8 Week Breastfeeding coverage | Month | 98.00% | 96.97% | R | ↓ | |
| | | | Quarter | 98.00% | 96.97% | R | ↓ | |
| | IAPT | Recovery Rates | Month | 50.00% | 55.69% | G | ↑ | Compliant with IAPT Targets |
| | | | Quarter | 50.00% | 55.69% | G | ↑ | |
| | | Reliable Improvement Rates | Month | 65.00% | 72.77% | G | ↑ | |
| | | | Quarter | 65.00% | 72.77% | G | ↑ | |
| | Safer Staffing | Inpatient Safer Staffing Fill Rates | Month | 100.00% | 99.4% | G | → | Detailed ward level information shows specific variances |
| | | | Quarter | 100.00% | 99.4% | G | ↑ | |

# WORKFORCE OVERVIEW – April 2017

| Category | Sub-set | Metric | Period | Plan | Actual | Variance | | Trend | Key Points |
|---|---|---|---|---|---|---|---|---|---|
| Workforce Dashboard | NHSI Key Performance Indicator (KPI) | **Turnover** (annual) | **Apr-17** | 10% | **10.16%** | ↘ | G | ↓ | Annual turnover remains within the Trust target parameters and is below the regional Mental Health & Learning Disability average of 12.65% (as at June 2016 latest available data). The monthly sickness absence rate is 1.25% lower than the previous month and compared to the same period last year (April 2016) it is 0.83% lower. The annual sickness absence rate is running at 5.58% (as at March 2017 latest available data). The regional average annual sickness absence rate for Mental Health & Learning Disability Trusts is 5.14% (as at October 2016 latest available data). Anxiety/stress/depression/other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 31.51% of all sickness absence, followed by surgery at 12.26% and other musculoskeletal problems at 11.43%. The Funded Fte vacancy rate has decreased to 8.04% mainly due to a large reduction in Funded Fte in this years budget. The number of employees who have received an appraisal within the last 12 months has decreased by 0.43% to 74.71%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £2k. Compulsory training compliance has decreased slightly by 0.56% to 88.17% but remains above the 85% main contract non CQUIN. |
| | | | Mar-17 | | 10.44% | | G | | |
| | | **Sickness Absence** (monthly) | **Apr-17** | 5.04% | **4.45%** | ↘ | R | ↓ | |
| | | | Mar-17 | | 5.70% | | R | | |
| | | **Vacancies** (including funded fte flexibility / cover) | **Apr-17** | | **8.04%** | | | ↓ | |
| | | | Mar-17 | | tbc | | | | |
| | | **Appraisals** (all staff - number of employees who have received an appraisal in the previous 12 months) | **Apr-17** | 90% | **74.71%** | ↘ | R | ↑ | |
| | | | Mar-17 | | 75.14% | | R | | |
| | | **Appraisals** (medical staff only - number of employees who have received an appraisal in the previous 12 months) | **Apr-17** | 90% | **81.37%** | ↘ | R | ↑ | |
| | | | Mar-17 | | 86.11% | | A | | |
| | | **Qualified Nurses** (to total nurses, midwives, health visitors and healthcare assistants) | **Apr-17** | 65% | **68.79%** | ↘ | G | ↓ | |
| | | | Mar-17 | | 69.08% | | G | | |
| | | **Agency Usage** (£ year to date level of agency expenditure exceeding the ceiling set by NHSI) | **Apr-17** | £0 | **£0.352m** | | R | | |
| | | | Mar-17 | | £1.972m | | R | | |
| | | **Agency Usage** (% year to date level of agency expenditure exceeding the ceiling set by NHSI) | **Apr-17** | 0% | **0.51%** | | R | | |
| | | | Mar-17 | | 65.08% | | R | | |
| | Other KPI | **Compulsory Training** (staff in-date) | **Apr-17** | 90% | **88.17%** | ↘ | A | ↑ | |
| | | | Mar-17 | | 88.73% | | A | | |

Key:

**Period** Current month and previous month
**Plan** Trust target
↗ Variance to previous month

Achieving target/within target parameters
Approaching target/approaching target parameters
Not achieving target/outside target parameters

Trend based on previous 4 months
Turnover parameters (8% to 12%)
Vacancy parameters (5% to 10%)

# QUALITY OVERVIEW – APRIL 2017

| Category | Sub-set | Metric | Period | Plan | Actual | Variance | Trend | Key Points |
|---|---|---|---|---|---|---|---|---|
| Quality | Safe | No of incidents of moderate to catastrophic actual harm | Month | 29 | 24 | | | Plan: average last fin yr 2016/17 (month). |
| | | | Quarter | 88 | 102 | | | Plan: average last fin yr (Qtr) 2016/17. Actual: 2016/17 Q4 data |
| | | No of deaths of patients who have died within 12 months of their last contact with DHcFT | Month | 104 | 118 | | | |
| | | | Quarter | 312 | 458 | | | Plan: average last fin yr (Qtr). Actual: 2016/17 Q4 data. *Alert as data for Qtr not complete* |
| | | No of serious incidents reported to the CCG | Month | 5 | 3 | | | Plan - average last fin yr (month) |
| | | | Quarter | 16 | 10 | | | Plan: average last fin yr (Qtr). Actual: 2016/17 Q4 data |
| | | No of episodes of patients held in seclusion | Month | 10 | 14 | | | |
| | | | Quarter | 30 | 21 | | | Plan: average last fin yr (Qtr). Actual: 2016/17 Q4 data |
| | | No of incidents involving patients held in seclusion | Month | 16 | 17 | | | |
| | | | Quarter | 47 | 39 | | | Plan: average last fin yr (Qtr). Actual: 2016/17 Q4 data |
| | | No of incidents involving physical restraint | Month | 48 | 30 | | | |
| | | | Quarter | 143 | 170 | | | Plan: average last fin yr (Qtr). Actual: 2016/17 Q4 data |
| | | No of incidents involving prone restraint | Month | 10 | 8 | | | Month plan based on average from 1/7/16 when prone restraint collected on Datix as defined field |
| | | | Quarter | 29 | 46 | | | Qtr plan based on average for Q2/Q3/Q4. Actual 2016/17 Q4 data |
| | | No of incidents of physical assault - patient on patient | Month | 12 | 5 | | | |
| | | | Quarter | 37 | 31 | | | Actual: 2016/17 Q4 data |
| | | No of incidents of physical assault - patient on staff | Month | 19 | 12 | | | |
| | | | Quarter | 56 | 42 | | | Actual: 2016/17 Q4 data |
| | | No of falls on in-patient wards | Month | 32 | 23 | | | |
| | | | Quarter | 96 | 94 | | | Actual: 2016/17 Q4 data |
| | | No of incidents of absconsion | Month | 33 | 28 | | | |
| | | | Quarter | 99 | 120 | | | Actual: 2016/17 Q4 data |
| | | No of patients with a clinical risk plan (FACE or Safety Plan) | Month | 100% | 77.41% | | | |
| | | | Quarter | 100% | 77.77% | | | |
| | | Of above, no of patients with a Safety Plan | Month | 90% | 15.10% | | | Safety Plan replaced FACE from 1/4/2017 |
| | | | Quarter | 90% | 7.90% | | | |
| | | % of staff compliant with Level 3 Safeguarding Children training | Month | 85% | 81.04% | | | Target reduced to 85% |
| | | | Quarter | 85% | NA | | | Qtr comparison not available |
| | | % of staff compliant with Think Family training | Month | 85% | 82.43% | | | Target reduced to 85% |
| | | | Quarter | 85% | NA | | | Qtr comparison not available |
| | | % of staff compliant with Clinical Safety Planning eLearning | Month | 95% | 94.99% | | | |
| | | | Quarter | 95% | NA | | | Qtr comparison not available |
| | | No of people with LD or Autism admitted without a CTR (Care & Treatment Review) | Month | 0 | NA | | | Data quality confirmation syill underway, to be completed for May 2017 data |
| | | | Quarter | 0 | NA | | | |
| | | % of compliance with inpatients VTE assessment | Month | 95% | 8.91% | | | |
| | | | Quarter | 95% | NA | | | |
| | | HCR20 assessment completed, Low Secure | Month | 100% | 8.30% | | | No of patients with HCR20 assessment completed in time. |
| | | | Quarter | 100% | NA | | | |

# QUALITY OVERVIEW – APRIL 2017

| Category | Sub-set | Metric | Period | Plan | Actual | Variance | Trend | Key Points |
|---|---|---|---|---|---|---|---|---|
| Quality | Caring | No of complaints opened for investigation | Month | 12 | 23 | | | |
| | | | Quarter | 37 | 43 | | | Actual: 2016/17 Q4 data |
| | | No of concerns received | Month | 35 | 34 | | | |
| | | | Quarter | 104 | 84 | | | |
| | | No of compliments received | Month | 100 | 79 | | | |
| | | | Quarter | 300 | 236 | | | |
| | | No of investigations by the Parliamentary Ombudsman | 2016/17 | NA | 10 | | | |
| | | | 2017/18 | NA | 0 | | | |
| | | % of complaints upheld (full or in part) by the Parliamentary Ombudsman | 2016/17 | 2 | 0 | | | 2 ongoing and 4 NFA (no further action) |
| | | | 2017/18 | 0 | 0 | | | |
| | | % of responded to (orange) complaint investigations completed within 40 working days, opened after 01/04/2016 | Year | 100% | 18% | | | As at 26/04/2017, 158 (orange) complaints. 62 not responded to within 40 working days. 67 ongoing |
| | | | Year | 100% | 0% | | | As at 26/04/2017, 7 (red) complaints. 3 not responded to within 60 working days. 4 ongoing. |
| | | No of incidents requiring Duty of Candour | Month | 1 | 1 | | | These figures will fluctuate based on the outcome of investigations. |
| | | | Quarter | 2 | 2 | | | |
| | Effective | % of in-patients with a recorded capacity assessment | Month | 100% | 91.09% | | | |
| | | | Quarter | 100% | 91.00% | | | |
| | | % of patients who have had their care plan reviewed and have been on CPA > 12months | Month | 90% | 95.00% | | | |
| | | | Quarter | 90% | 95.95% | | | |
| | | No of seclusion forms not received by MHA Office | Month | 0 | 0 | | | |
| | | | Quarter | 0 | 2 | | | Actual: 2016/17 Q4 data |
| | | % of CTO rights forms received by MHA Office | Month | 100% | 92.8% | | | |
| | | | Quarter | NA | NA | NA | NA | |
| | | % of in patient older adults rights forms received by MHA Office | Month | 100% | 91% | | | |
| | | | Quarter | NA | NA | NA | NA | |
| | Responsive | % of staff uptake of Flu Jabs | Month | 45% | 38.40% | | | Data to end of 30/11/16 |
| | | | Year | 45% | 22.70% | | | Relates to 2015.16 compaign |
| | | % of policies in date | Month | 95% | 96.30% | | | |
| | | | Quarter | NA | NA | NA | NA | |
| | Well Led | % of staff who have received Clinical Supervision, within defined timescales | Month | 90% | 45.06% | | | |
| | | | Quarter | 90% | NA | NA | NA | |
| | | % of staff who have received Management Supervision, within defined timescales | Month | 90% | 60.20% | | | |
| | | | Quarter | 90% | NA | NA | NA | |
| | | No of outstanding actions following serious Incident investigations | Month | 0 | 43 | | | Total overdue actions as at 30/04/2017 |
| | | | Quarter | 0 | NA | | NA | |
| | | No of outstanding actions following complaint investigations | Month | 0 | 52 | | | Total overdue actions as at 30/04/2017 |
| | | | Quarter | 0 | NA | NA | NA | |
| | | No of outstanding actions following CQC comprehensive review report | Month | 0 | 69 | | | Figure as at 03/05/2017 |

# Financial Section

## Governance – Use of Resources (UoR) Rating

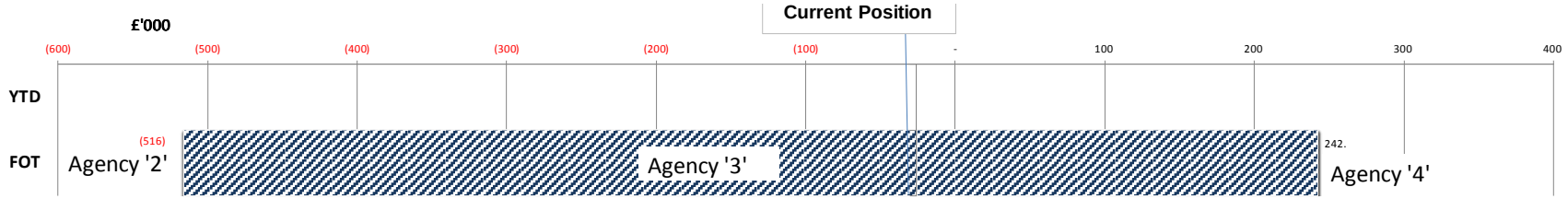
The Use of Resources rating at the end of April is a ‘1’, with Capital Service Cover and the Agency metrics being at a ‘2’. The forecast rating is an overall ‘2’ which is due to the agency metric moving to a 3’ and the Income and Expenditure Margin Distance from Plan moving to a ‘2’.

The I&E Margin distance from plan starts to move from a ‘1’ to a ‘2’ at the end of quarter 2. This is because the actual I&E margin (2.3%) is -0.15% different to the planned I&E margin (2.4%). This is mainly driven by income being forecast higher than the plan due to the forecast assumptions for QIPP (in the forecast QIPP income has not been removed from the contract).

| | Apr-17 | | YTD @ Quarter 1 | | YTD @ Quarter 2 | | YTD @Quarter 3 | | YTD @ Quarter 4 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Capital Service Capacity rating | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Liquidity rating | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| I&E Margin rating | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Distance from Financial Plan | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 2 | 1 | 2 |
| Agency distance from Cap | 1 | 2 | 1 | 2 | 1 | 3 | 1 | 3 | 1 | 3 |
| **UoR** | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 2 | 1 | 2 |
| **4 on any metric** | No Trigger | No Trigger | No Trigger | No Trigger | No Trigger | No Trigger | No Trigger | No Trigger | No Trigger | No Trigger |
| **UoR** | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 2 | 1 | 2 |

As most of the metrics are in a healthy position and it is the agency metric that is driving the lower rating, this is the area of focus from a headroom perspective.

The agency metric is currently forecast at a ‘3’ for the end of the financial year. In order to reduce that metric down to a ‘2’ at the end of March then we need to reduce agency expenditure by £516k. However if we spend an additional £242k above the current forecasted levels then this would move the metric to a 4 and trigger an override.



# Income and Expenditure

## Statement of Comprehensive Income — April 2017

| | Current Month | | | Year to Date | | | Forecast | | |
|---|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | Variance Fav (+) / Adv (-) | Plan | Actual | Variance Fav (+) / Adv (-) | Plan | Actual | Variance Fav (+) / Adv (-) |
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Clinical Income | 10,420 | 10,539 | 120 | 10,420 | 10,539 | 120 | 124,871 | 127,747 | 2,876 |
| Non Clinical Income | 751 | 789 | 38 | 751 | 789 | 38 | 9,329 | 10,239 | 911 |
| Employee Expenses | (7,968) | (8,161) | (193) | (7,968) | (8,161) | (193) | (95,932) | (99,170) | (3,238) |
| Non Pay | (2,373) | (2,360) | 13 | (2,373) | (2,360) | 13 | (28,108) | (28,733) | (624) |
| **EBITDA** | **830** | **807** | **(23)** | **830** | **807** | **(23)** | **10,159** | **10,083** | **(76)** |
| Depreciation | (278) | (270) | 8 | (278) | (270) | 8 | (3,338) | (3,315) | 24 |
| Impairment | 0 | 0 | 0 | 0 | 0 | 0 | (300) | (300) | 0 |
| Profit (loss) on asset disposals | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Interest/Financing | (215) | (181) | 34 | (215) | (181) | 34 | (2,146) | (2,120) | 26 |
| Dividend | (159) | (157) | 2 | (159) | (157) | 2 | (1,910) | (1,884) | 26 |
| **Net Surplus / (Deficit)** | **178** | **199** | **21** | **178** | **199** | **21** | **2,465** | **2,465** | **0** |
| Technical adjustment - Impairment | 0 | 0 | 0 | 0 | 0 | 0 | (300) | (300) | 0 |
| **Control Total Surplus / (Deficit)** | **178** | **199** | **21** | **178** | **199** | **21** | **2,765** | **2,765** | **0** |
| Technical adjustment - STF Allocation | 40 | 40 | 0 | 40 | 40 | 0 | 794 | 794 | 0 |
| **Underlying Net Surplus / (Deficit)** | **138** | **160** | **21** | **138** | **160** | **21** | **1,971** | **1,971** | **0** |

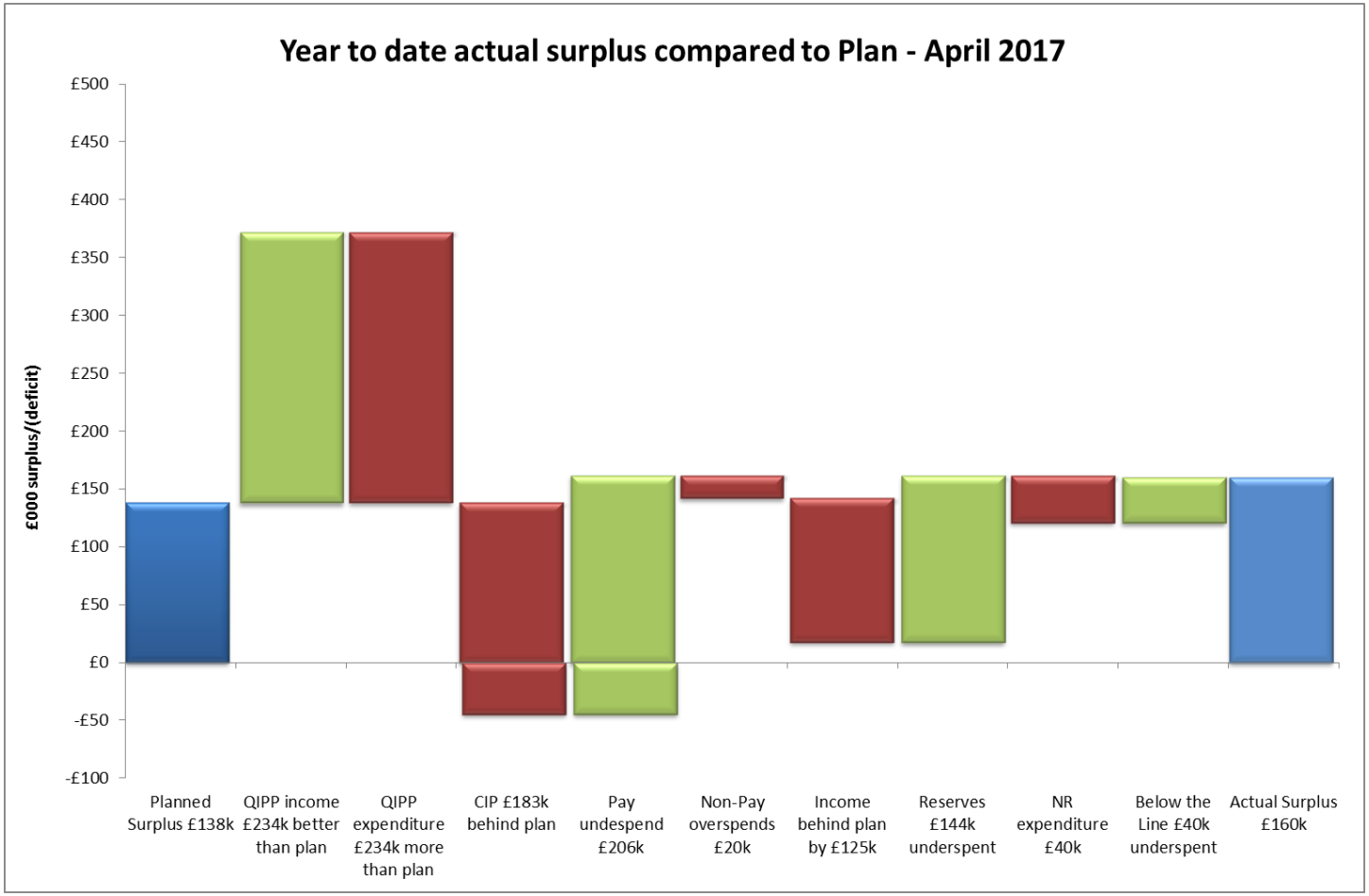
The Statement of Comprehensive Income shows both the control total surplus of £2.77m which includes the Sustainability Transformation Fund (STF) income and the underlying surplus / (deficit) against the underlying plan with the STF income excluded £1.97m.

Clinical Income is £120k more than plan in month and at the end of the year is forecast to be £2.9m ahead of plan. This is due to the income related to QIPP disinvestments not being removed from the contract as currently no further disinvestments have been identified (offsetting expenditure).

Non Clinical income is ahead of plan in the month by £40k and has a forecast outturn of £911k ahead of plan. £498m relates to 0.5% CQUIN reserve, where the plan assumed the income would be held back but the current forecast assumes the income is received. The remainder relates to secondments and training which is offset by expenditure.

Pay expenditure is £193k more than the plan in the month and forecast £3.2m worse than plan. This relates to costs not yet being released relating to QIPP disinvestments (offsetting income) and CIP not yet fully delivered.

Non Pay is underspent in the month by £13k but is forecast to be £624k worse than plan at the end of the year which mainly relates to the overspend on the Acute Out of Area budget partly offset by other underspends.

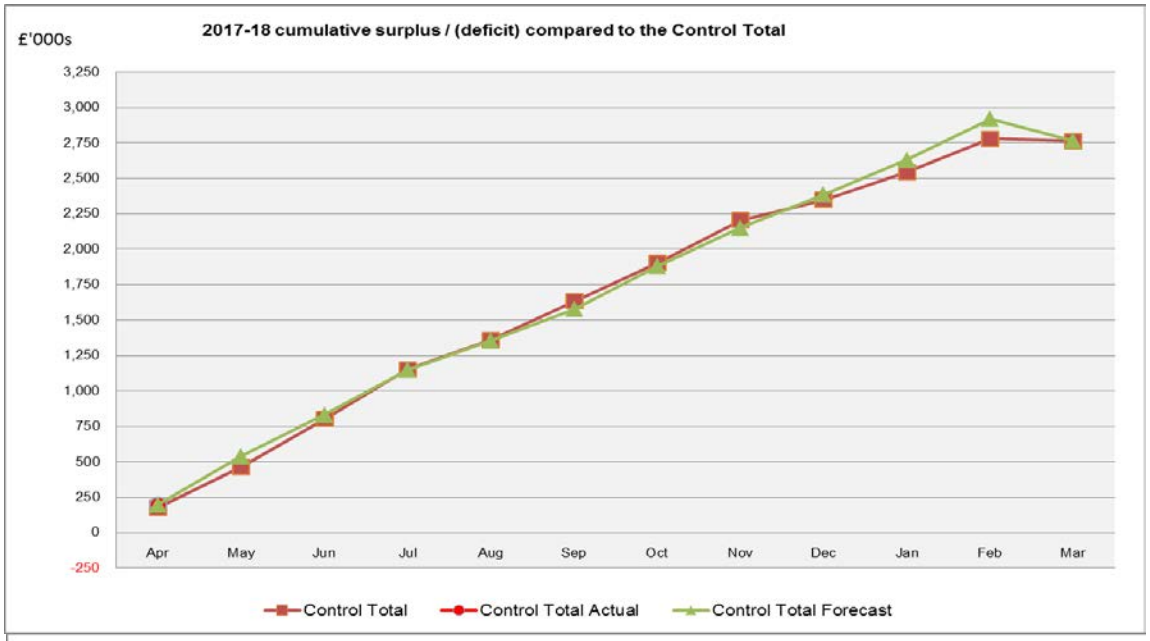


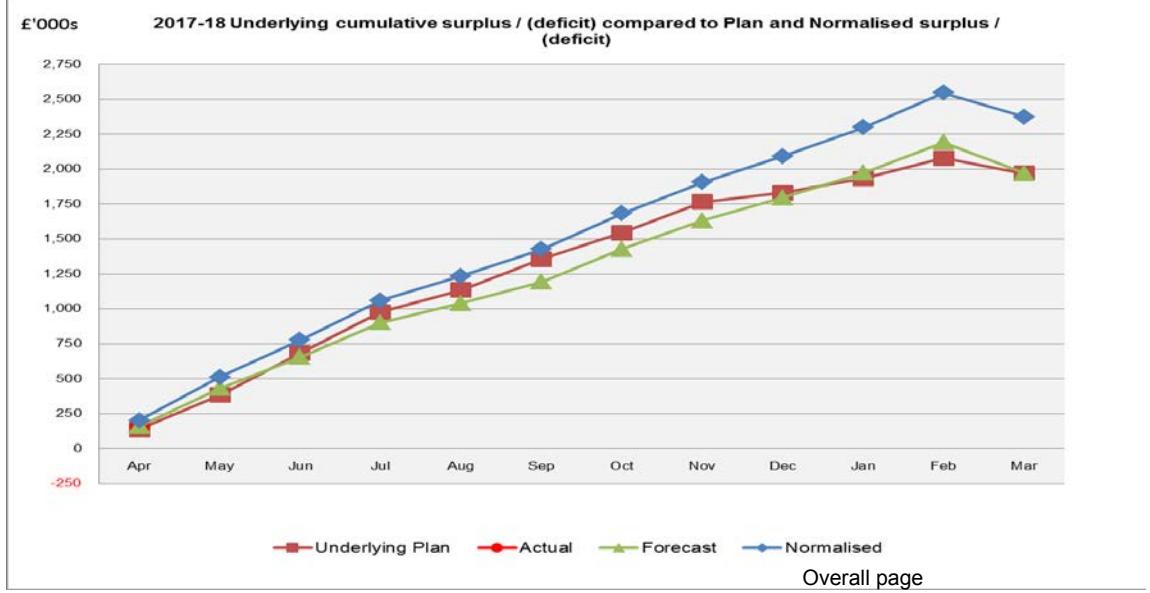

**Summary of key points for YTD variances**

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

- QIPP income is more than plan which is equally offset by expenditure being more than plan . This is due to the disinvestment not yet being fully agreed with Commissioners.
- CIP is currently behind plan in the month.
- Underlying pay underspends due to various vacancies across the Trust, partially offset by bank and agency expenditure.
- Income behind plan which is mainly related to activity and occupancy levels in cost per case services.
- Reserves are underspent mainly due to the contingency reserves not fully committed.
- Non-recurrent expenditure related to some temporary posts along with non-recurrent transaction costs.

# Normalised Income and Expenditure position



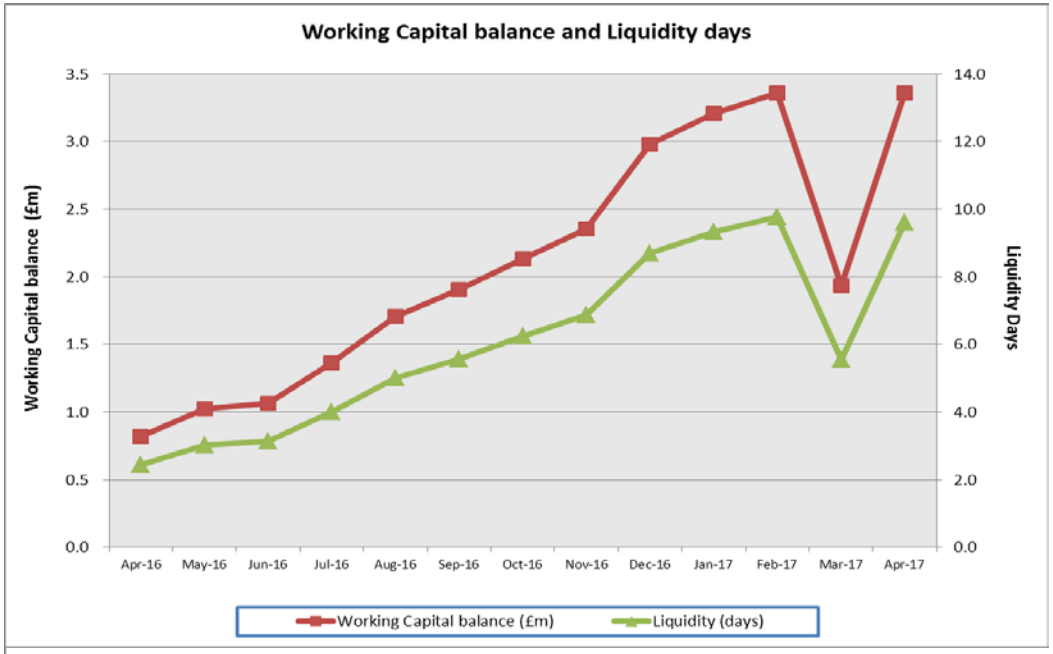



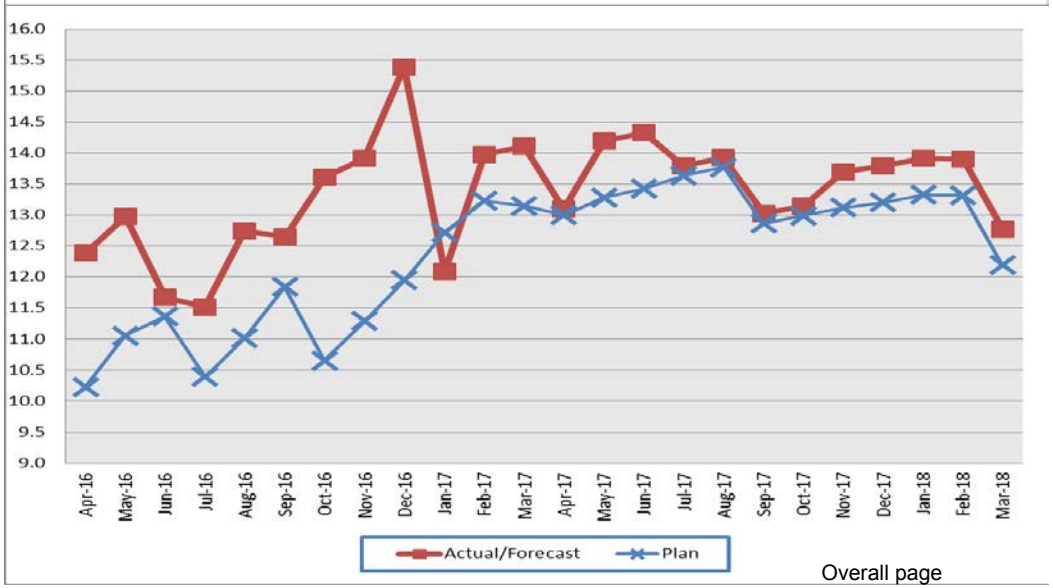

The first graph shows the actual cumulative surplus against the control total (including the Sustainability Transformation Fund (STF).
The second graph shows the underlying actual surplus against the underlying plan excluding the STF.

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

There is some additional non-recurrent expenditure in the position related to temporary staff posts for part of the financial year, along with non-recurrent transaction costs. In the normalised position these have been removed.
As shown in the graph if these non-recurrent costs were not incurred then the forecast outturn would be higher than the plan.

# Liquidity



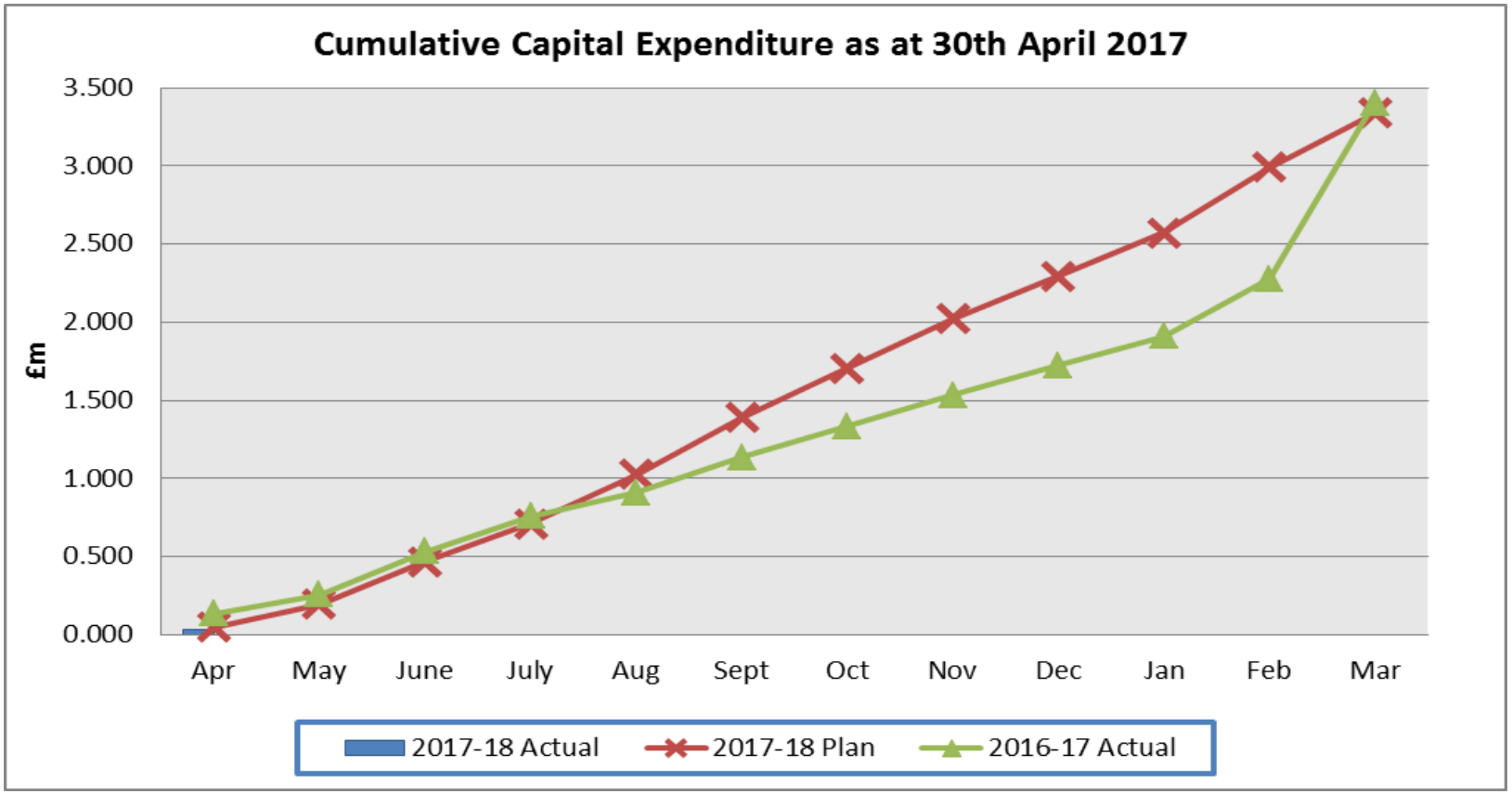

The first graph shows the working capital balance for the last 12 months (net current assets less net current liabilities adjusted for assets held for sale and inventories) and how many days of operating expenses that balance provides.

During this financial year working capital and liquidity continues to improve due to higher cash levels. The downturn at the end of March is reflective of the increase in year end transactions such as provisions, along with an increase in payables mainly related to capital as works have concluded at the end of March.
The liquidity at April is just under 10 days which still gives a rating of 1 (the best) on that metric (-7days drops to a rating of 2).

The Trust Board is reminded that sector benchmarking information recently provided by external auditors illustrates that the peer average continues to be around +19 days, therefore our liquidity must remain a strategic priority for us to continue to improve and protect.

Cash is currently at £13.1m which is £100k better than the plan at the end of April.

## Capital Expenditure

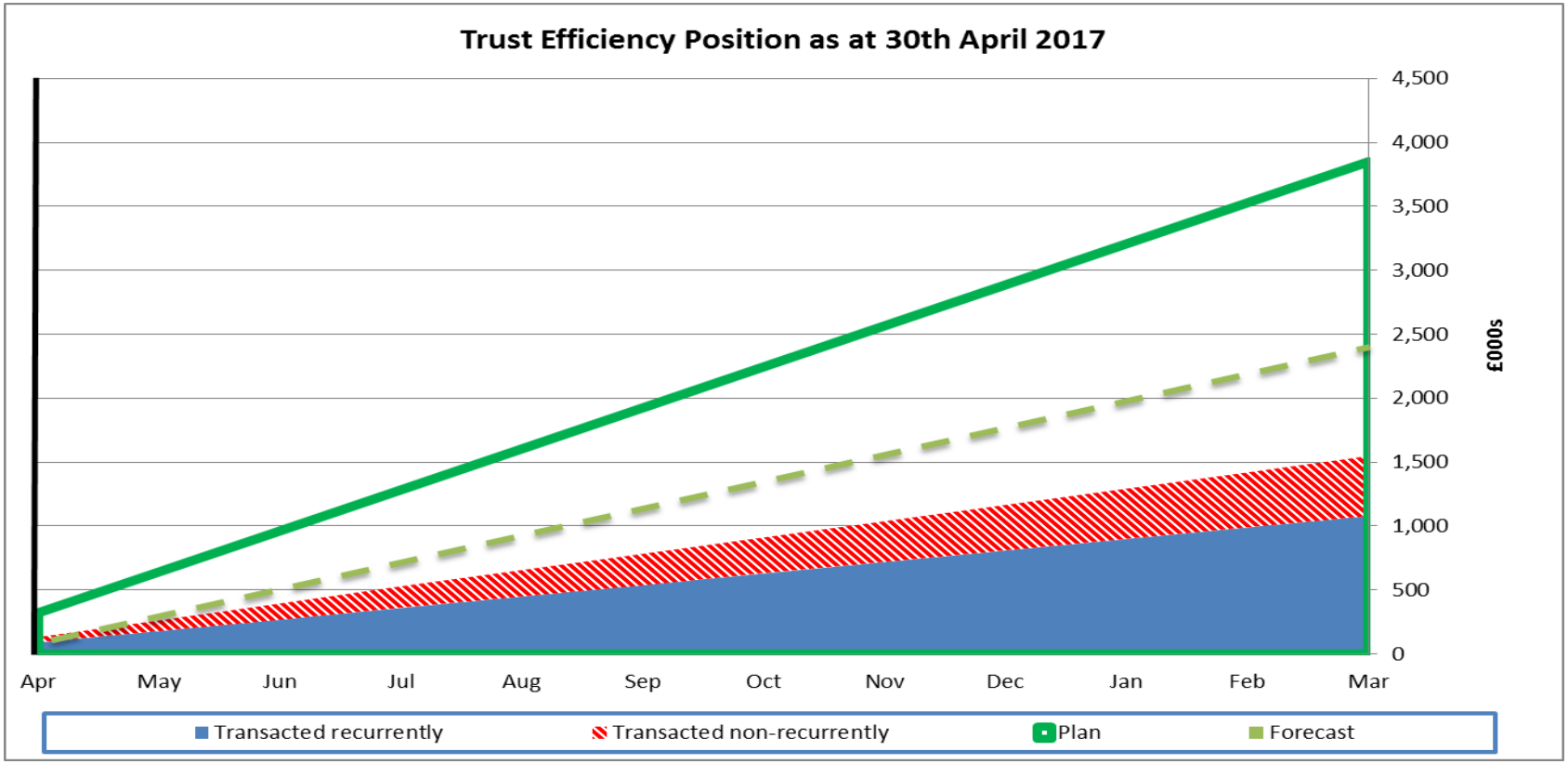



Capital Expenditure is slightly behind plan by £16k in the first month of the financial year. There is a fully committed plan which may need to be re-prioritised in year to take into account any urgent bids that arise, which will be monitored by the Capital Action Team.

Additional STF income which was notified to us in 2016/17 and will be paid in this financial year is expected to be added to the capital plan. This could be invested in schemes that will drive further efficiencies across the Trust.

# Efficiency

## Cost Improvement Programme (CIP)

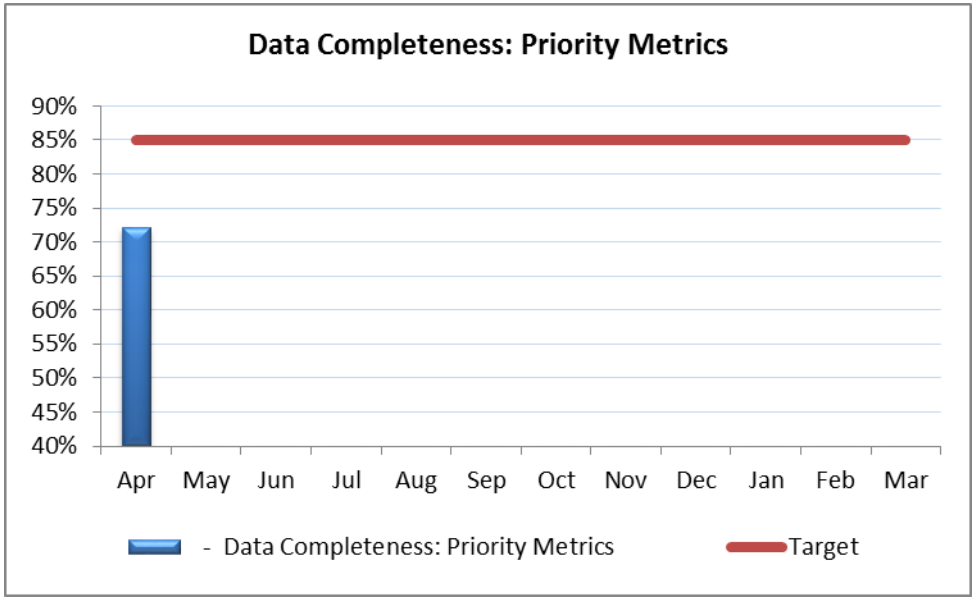



At the end of April there was £1.5m of assured CIP against a plan of £3.8m, which left a gap of £2.3m. Of this £1.5m assured CIP, £0.47m was assured non-recurrently. In order to achieve the control total the forecast assumes that a further £0.9m of cost reduction is required by the end of the financial year. This currently leaves a forecast of unfound CIP at £1.4m. There are some current underspends that will be allocated to CIP going forward and work continues to fully assure the savings programme in totality.

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

# Operational Section

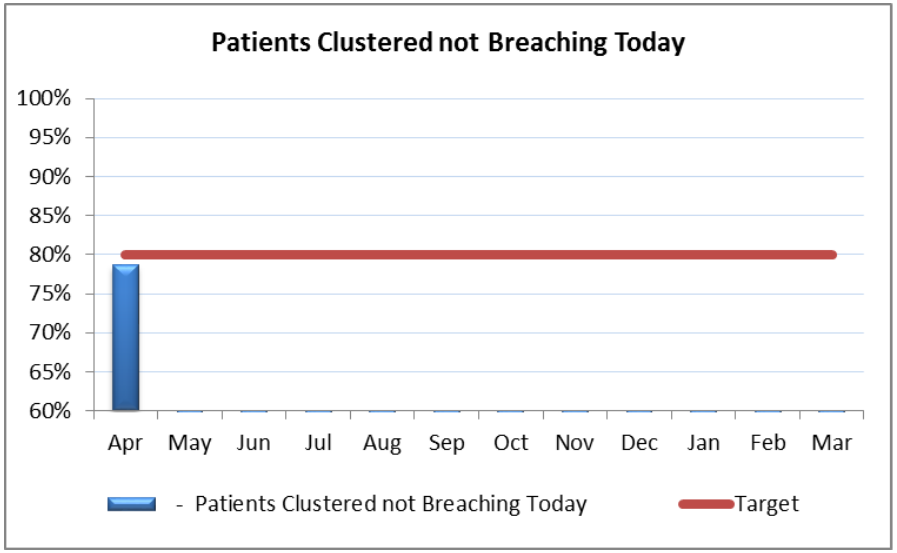
# Data Completeness: Priority Metrics

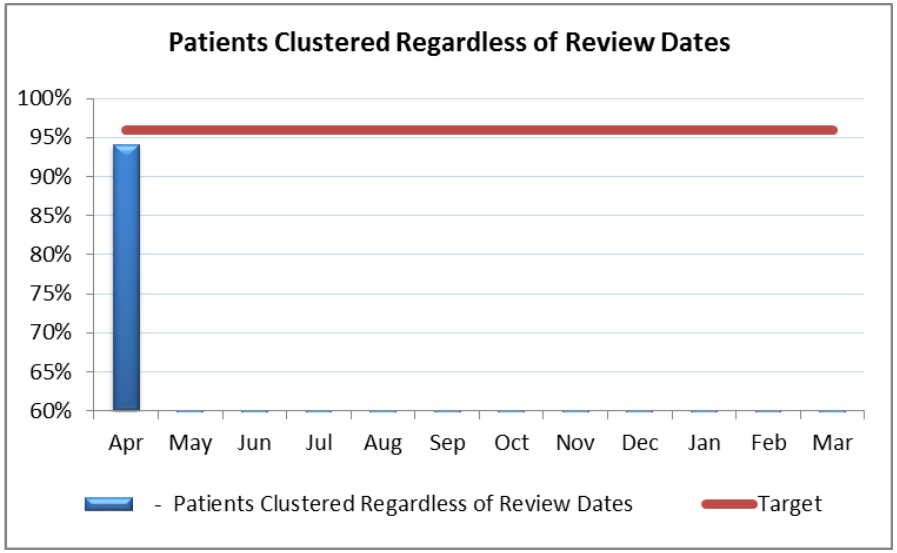



As previously reported, the performance dashboard was amended on 1st December 2016 to reflect the NHS Improvement Single Oversight Framework targets which came into force from 1st October 2016. The national requirement is to achieve the priority metrics target of 85%. Achieving this target will be extremely challenging without additional resource. There are currently 14,139 bits of additional patient information relating to 9,283 distinct patients that need sourcing and inputting into the patient records concerned. We are briefing teams to prioritise this and should see a gradually improving picture.

Action: Deputy Director of Operations and Performance Manager to prepare a paper detailing strategies for addressing the data deficit to be considered at TMT.

# Patients Clustered not Breaching Today and Patients Clustered regardless of review dates

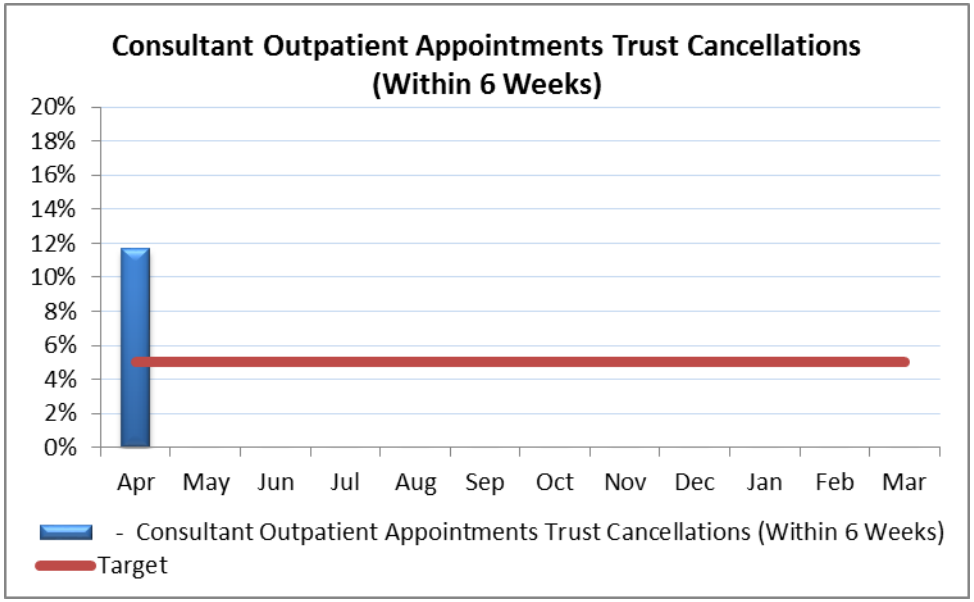



For a lot of consultants large outpatient caseloads, large clustering caseloads and the associated volume of cluster reviews required pose a significant challenge to the achievement of the clustering targets. – The targets developed several years ago, in themselves, no longer provide the level of information required to monitor good quality care.

Action: Head of Clinical & Operational Care Currencies & Outcomes to propose that the 2 clustering targets be replaced with the quality indicators, agreed with commissioners.

# Consultant Outpatient Appointments Trust Cancellations (within 6 weeks)



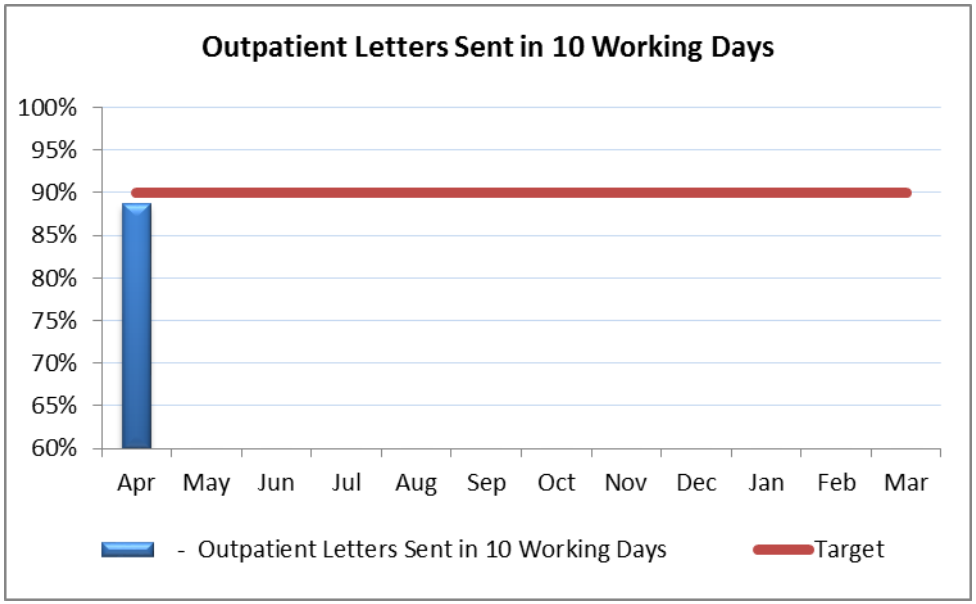

The most common reason was clinician absent from work.

Despite previous action for the Associate Clinical Directors to review cancellations with a reason of annual leave to establish whether enough notice was given and if not, to reiterate that at least 6 weeks' notice is required for annual leave, to ensure patients are not inconvenienced, the number of appointments cancelled for annual leave has increased significantly this month.

Action: Deputy Director of Operations is meeting with the Medical Director, Chief Operating Officer and newly appointed Deputy Medical Director

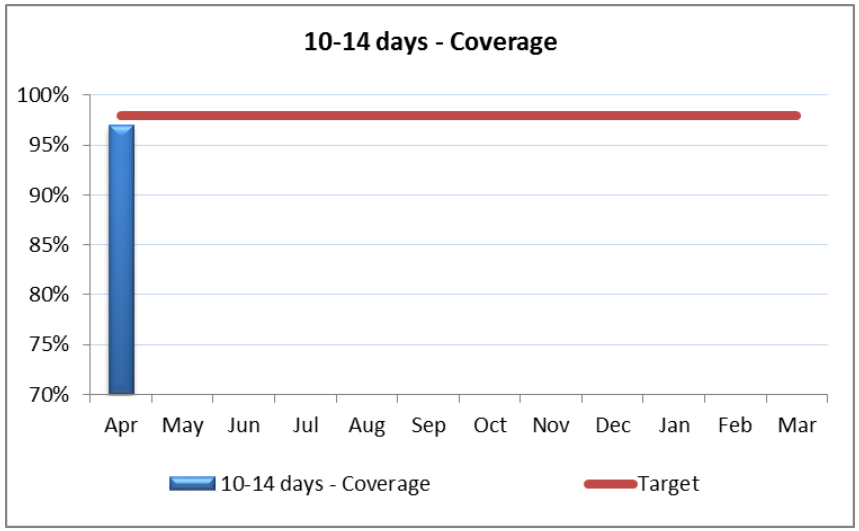
| Row Labels | n | % |
|---|---|---|
| Clinician Absent From Work | 145 | 30% |
| No Consultant | 110 | 23% |
| Moved - Staff Issue | 74 | 15% |
| Moved - Location Issue | 38 | 8% |
| Virtual Clinic | 38 | 8% |
| Moved - Clinic Cancelled | 22 | 5% |
| Moved - Trust Rescheduled | 20 | 4% |
| Clinician On Annual Leave | 15 | 3% |
| Clinic Booked In Error | 13 | 3% |
| Clinician Must Attend Meeting | 5 | 1% |
| ESTATES ISSUE OR SYSTEMS ERROR | 3 | 1% |
| CLINICIAN ON CALL / NIGHT DUTY | 2 | 0% |
| **Grand Total** | **485** | **100%** |

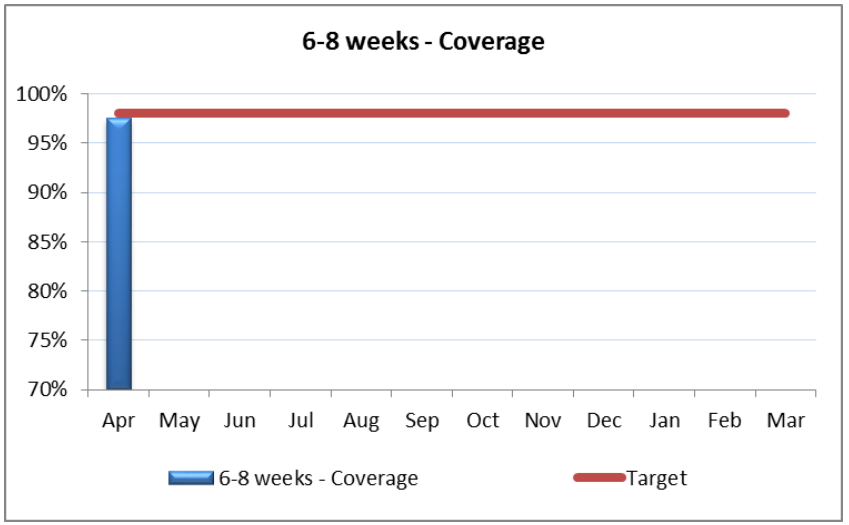
# Outpatient letters sent in 10 working days




In April we were 36 letters short of target. Delays have been experienced at all 3 stages of the process – appointment to uploading of dictation, upload to typed and typed to authorised. Medics are routinely emailed in relation to any late uploads, however this is not having the desired impact. April had 2 bank holidays which are not factored into the 10 working days calculation but are non-working days for consultants and typists. An issue has been identified re letter sign-off when a locum leaves with little or no notice. This issue has been discussed in depth at the recent Medical Management Committee. A procedure for signing letters was agreed and will be implemented to address this issue. In addition an action plan will be devised and implemented to address any potential for delays at all 3 stages of the letter generation process. Implementation of the action plan will be monitored by the Medical Management Committee.

# % 10-14 Day Breastfeeding coverage and % 6-8 Week Breastfeeding coverage

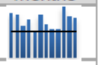


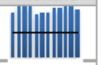
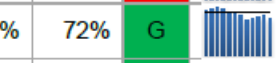
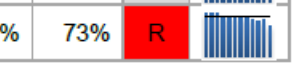



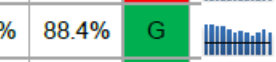
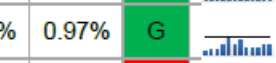

The 10-14 days coverage target of 98% was missed by 1 patient and the 6-8 weeks coverage target by 2 patients. This was as a result of high sickness levels and the Easter holiday impacting on capacity.

Action: service manager to liaise again with the teams who have not reached 98% coverage and also discuss the importance of accurate, timely recording and raise it with individual teams as well as at the Locality meetings

# Campus Division Performance Dashboard 2017/18 Month 1

| Quality, Safety and Experience | | | | | |
|---|---|---|---|---|---|
| Indicator | Period | Target | Actual | RAG | Previous months |
| CPA 7 day follow-up | Monthly | 95% | 98% | G |  |
| Crisis home treatment episodes | Monthly | N/A | 80 | N/A |  |
| Delayed transfers of care | Monthly | 0.8% | 0.7% | G |  |
| Never events | Monthly | 0 | 1 | R |  |
| Incidents | Monthly | N/A | 356 | N/A |  |
| Serious incidents reported to CCG via STEIS | Monthly | N/A | 2 | N/A |  |
| Crisis gatekeeping | Monthly | 95% | 100% | G |  |
| Mixed sex accommodation breaches | Monthly | 0 | 0 | G |  |
| Under 16 admissions to adult facilities | Monthly | 0 | 0 | G |  |
| New complaints opened for investigation | Monthly | N/A | 4 | N/A |  |
| New concerns | Monthly | N/A | 8 | N/A |  |
| Complaints upheld/partially upheld | Monthly | N/A | 3 | N/A |  |
| Compliments | Monthly | N/A | 32 | N/A |  |
| Friends and Family Test % positive | Monthly | N/A | 94% | N/A |  |
| Complaint response breaches (final response letter not sent in time) | Monthly | N/A | 5 | N/A |  |

| Performance | | | | | |
|---|---|---|---|---|---|
| Indicator | Period | Target | Actual | RAG | Previous months |
| Hartington Unit bed occupancy – including leave | Monthly | 85% | 99% | R |  |
| Hartington Unit bed occupancy – excluding leave | Monthly | 85% | 82% | G |  |
| Hartington Unit length of stay | Monthly | 36 | 66 | R |  |
| Radbourne Unit bed occupancy – including leave | Monthly | 85% | 103% | R |  |
| Radbourne Unit bed occupancy – excluding leave | Monthly | 85% | 92% | R |  |
| Radbourne Unit length of stay | Monthly | 36 | 52 | R |  |
| Kingsway bed occupancy – including leave | Monthly | 85% | 72% | G |  |
| Kingsway bed occupancy – excluding leave | Monthly | 85% | 68% | G |  |
| Kingsway length of stay | Monthly | N/A | 219 | N/A |  |
| Activity against contract – inpatient rehab. | Monthly | 95% | 73% | R |  |

| People | | | | | |
|---|---|---|---|---|---|
| Indicator | Period | Target | Actual | RAG | Previous months |
| Vacancy rate | Monthly | N/A | 2.4% | N/A |  |
| Turnover – rolling 12 months | Yearly | 10% | 12.7% | R |  |
| Sickness – in month | Monthly | 5% | 5.2% | R |  |
| Annual appraisals | Monthly | 90% | 79.4% | R |  |
| Mandatory training | Monthly | 85% | 88.4% | G |  |
| Agency staff use | Monthly | 1.9% | 0.97% | G |  |
| Bank staff use | Monthly | 5% | 15.3% | R |  |
| Clinical supervision | Yearly | 100% | 23% | R |  |
| Managerial supervision | Yearly | 100% | 47% | R |  |

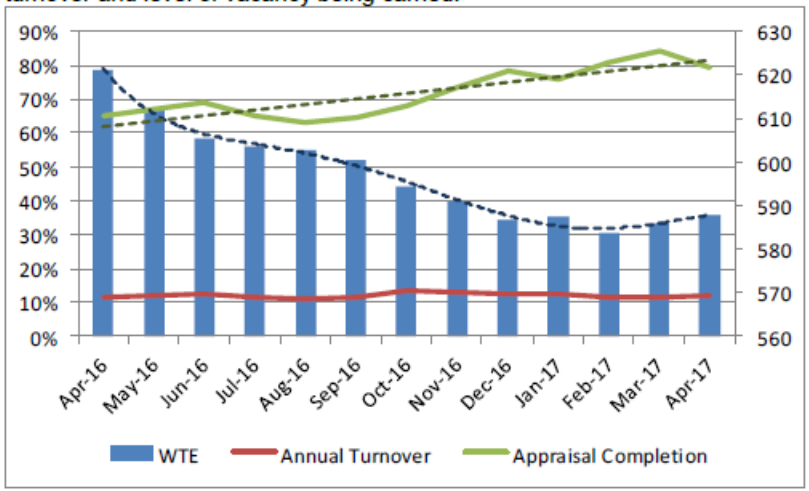
# Campus Division Performance Dashboard 2017/18 Month 1

| Pulse Check | | | | | |
|---|---|---|---|---|---|
| Indicator | Period | Target | Actual | RAG | Previous months |
| **Kingsway** | | | | | |
| Staff recommending as a place for care and treatment | Quarterly | N/A | 63% | N/A | |
| Staff recommending as a place to work | Quarterly | N/A | 39% | N/A | |
| Response rate | Quarterly | N/A | No data | N/A | |
| **Hartington Unit** | | | | | |
| Staff recommending as a place for care and treatment | Quarterly | N/A | No data | N/A | |
| Staff recommending as a place to work | Quarterly | N/A | No data | N/A | |
| Response rate | Quarterly | N/A | No data | N/A | |
| **Radbourne Unit** | | | No data | | |
| Staff recommending as a place for care and treatment | Quarterly | N/A | No data | N/A | |
| Staff recommending as a place to work | Quarterly | N/A | No data | N/A | |
| Response rate | Quarterly | N/A | No data | N/A | |

| Finance | | | | | |
|---|---|---|---|---|---|
| Indicator | Period | Target | Actual | RAG | Previous months |
| Performance against budget £'000s | In month | 2508 | 2506 | G | |
| Performance against budget £'000s | Year to date | 2508 | 2506 | G | |
| Out of area placement expenditure £'000s | Monthly | 40 | 124 | R | |

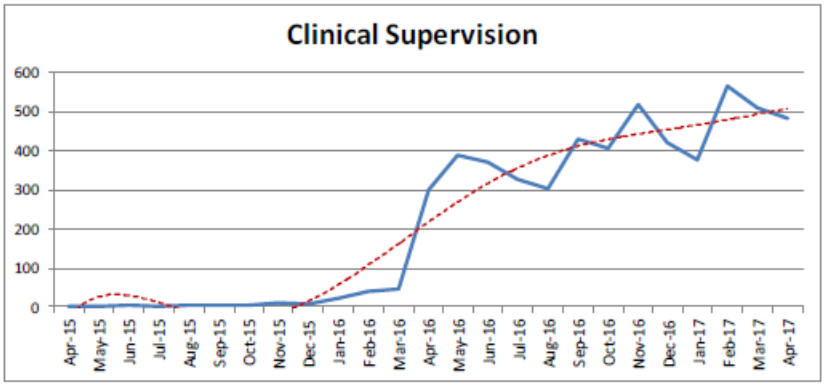
**General Manager Summary:**

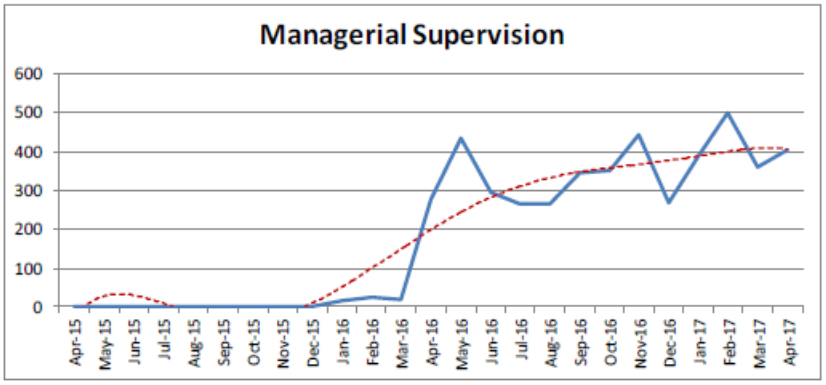
- **Never events**
  The never event related to administration of oral medication by a parenteral route. Action has been taken to prevent reoccurrence.
- **Adult acute inpatient occupancy and length of stay**
  Length of stay/ out of area placements project has commenced which is focusing on length of stay issues and will involve implementing a structured programme of improvement
- **Vacancies, turnover and sickness and associated bank and agency use**
  Recruitment and Retention group has been launched to focus on these issues
- **Inpatient rehabilitation**
  Audrey House: currently 8 of the 10 beds are occupied. 1 assessment is to take place on 8th May 2017. 3 patients from Kedleston Low Secure Unit have been deemed suitable for admission. All 3 patients from Kedleston are attending Audrey house for meaningful activity, lunch and assessment. This has been ongoing for 2-3 months in preparation for transfer. In-reach work to continue to source referrals.
  Cherry Tree: currently 16 of the 23 beds are occupied. There has been an overall reduction in referrals to rehabilitation services, leading to a drop in bed use.
  Rehab services are now actively engaging acute areas, attending ward and campus meetings to ensure ongoing dialogue and identification of appropriate individuals for referral.
- **Annual appraisals**
  The position has steadily been improving over time despite the rate of staff turnover and level of vacancy being carried.




- **Supervision**
  The charts below demonstrate the volume of supervision being completed each month has increased significantly each month since March 2016 and continues to move in the right direction. Owing to the way we currently report

compliance with supervision, this is not reflected in the overall compliance figures. A revision to the reporting methodology has recently been agreed and we should see an improvement once the system has been updated to reflect the change.




- **Liaison and Diversion**
  We have now commenced the new service model for Liaison and Diversion that covers increased hours and incorporates assessment across a boarder range of mental health and substance misuse issues

# Central Services Division Performance Dashboard 2017/18 Month 1

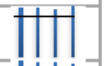
## Quality, Safety and Experience

| Indicator | Period | Target | Actual | RAG | Previous months |
|---|---|---|---|---|---|
| Never events | Monthly | 0 | 0 | G | |
| Incidents | Monthly | N/A | 37 | N/A |  |
| Serious incidents reported to CCG via STEIS | Monthly | N/A | 1 | N/A |  |
| New complaints opened for investigation | Monthly | N/A | 4 | N/A |  |
| New concerns | Monthly | N/A | 6 | N/A |  |
| Complaints upheld/partially upheld | Monthly | N/A | 0 | N/A | |
| Compliments | Monthly | N/A | 11 | N/A |  |
| Friends and Family Test % positive | Monthly | N/A | 100% | N/A |  |
| Complaint response breaches (final response letter not sent in time) | Monthly | N/A | 0 | N/A | |

## Performance

| Indicator | Period | Target | Actual | RAG | Previous months |
|---|---|---|---|---|---|
| Activity against contract – ASD assessments (cumulative) | Monthly | 100% | 100% | G |  |
| Activity against contract – perinatal inpatient bed days | Monthly | 100% | 44% | R |  |
| Activity against contract – perinatal south community contacts | Monthly | 158 | 108 | R |  |
| Activity against contract – eating disorder service contacts | Monthly | 191 | 108 | R |  |
| Waiting list - ASD assessment | Monthly | N/A | 372 | N/A |  |
| Waiting list - dietetics | Monthly | N/A | 9 | N/A |  |
| Waiting list – eating disorders | Monthly | N/A | 11 | N/A |  |
| Waiting list – LD speech and language therapy | Monthly | N/A | 159 | N/A |  |

## Performance

| Indicator | Period | Target | Actual | RAG | Previous months |
|---|---|---|---|---|---|
| Waiting list - physiotherapy | Monthly | N/A | 64 | N/A |  |
| Waiting list – psychological therapies | Monthly | N/A | 56 | N/A |  |
| Waiting list - psychology | Monthly | N/A | 604 | N/A |  |
| IAPT step 2 discharges | Monthly | N/A | 91 | N/A |  |
| IAPT step 3 discharges | Monthly | N/A | 515 | N/A |  |
| IAPT recovery rate | Monthly | 50% | 55.7% | G |  |
| IAPT reliable improvement & recovery rate | Monthly | 65% | 72.8% | G |  |
| **Substance Misuse City:** | | | | | |
| TOPS compliance - start | Quarterly | 80% | 98% | G |  |
| TOPS compliance - review | Quarterly | 80% | 91% | G |  |
| TOPS compliance - exit | Quarterly | 80% | 94% | G |  |
| Waiting time into treatment over 21 days | Quarterly | 0% | 0% | G |  |
| **Substance Misuse County:** | | | | | |
| TOPS compliance - start | Quarterly | 80% | 99% | G |  |
| TOPS compliance - review | Quarterly | 80% | 93% | G |  |
| TOPS compliance - exit | Quarterly | 80% | 96% | G |  |
| Waiting time into treatment over 21 days | Quarterly | 0% | 1% | A |  |

## People

| Indicator | Period | Target | Actual | RAG | Previous months |
|---|---|---|---|---|---|
| Vacancy rate | Monthly | N/A | 3.2% | N/A |  |

# Central Services Division Performance Dashboard 2017/18 Month 1

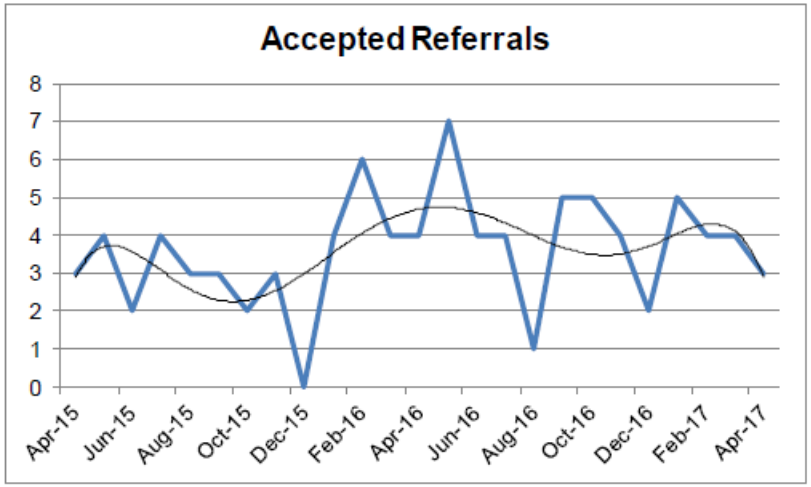
| People | | | | | |
|---|---|---|---|---|---|
| Indicator | Period | Target | Actual | RAG | Previous months |
| Turnover – rolling 12 months | Yearly | 10% | 8.6% | G | |
| Sickness – in month | Monthly | 5% | 4.3% | G | |
| Annual appraisals | Monthly | 90% | 76% | R | |
| Mandatory training | Monthly | 85% | 87% | G | |
| Agency staff use | Monthly | 1.9% | 1.3% | G | |
| Bank staff use | Monthly | 5% | 4.1% | G | |
| Clinical supervision | Yearly | 100% | 50% | R | |
| Managerial supervision | Yearly | 100% | 64% | R | |

| Pulse Check | | | | | |
|---|---|---|---|---|---|
| Indicator | Period | Target | Actual | RAG | Previous months |
| Staff recommending as a place for care and treatment | Quarterly | N/A | No data | N/A | |
| Staff recommending as a place to work | Quarterly | N/A | No data | N/A | |
| Response rate | Quarterly | N/A | No data | N/A | |

| Finance | | | | | |
|---|---|---|---|---|---|
| Indicator | Period | Target | Actual | RAG | Previous months |
| Performance against budget £'000s | In month | £1768 | £1757 | G | |
| Performance against budget £'000s | Year to date | £1768 | £1757 | G | |

**General Manager Summary:**

- **Perinatal inpatient bed days**
  There has been a drop in referrals over the last couple of months. Review of accepted referrals over time would indicate that the pattern is cyclical and we should start to see an increase in accepted referrals going forward.




- **Perinatal south community contacts**
  The full year target has been increased by 25% since 2016/17 and is set 9% higher than the level of activity achieved last financial year. Team to be briefed about the increased target and to consider ways to achieve compliance. A recent new starter is building up caseload under supervision, which should result in a positive impact on activity.
- **Eating disorder service contacts**
  The full year target has been increased by 64% since 2016/17 and is set 12% higher than the level of activity achieved last financial year. Team to be briefed about the increased target and to consider ways to achieve compliance. Sickness within the team has had an impact on the number of contacts during the month of April. 1 member of staff is on long term sick. The Manager of the team is now on sick leave. 2 other members of staff are on a phased return to work.
- **Supervision**
  Supervision is moving in the right direction. In a few months we should see a step change.

# Children's Services Division Performance Dashboard 2017/18 Month 1

## Quality, Safety and Experience

| Indicator | Period | Target | Actual | RAG | Previous months |
|---|---|---|---|---|---|
| Never events | Monthly | 0 | 0 | G | |
| Incidents | Monthly | N/A | 13 | N/A | |
| Serious incidents reported to CCG via STEIS | Monthly | N/A | 0 | N/A | |
| New complaints opened for investigation | Monthly | N/A | 6 | N/A | |
| New concerns | Monthly | N/A | 2 | N/A | |
| Complaints upheld/partially upheld | Monthly | N/A | 1 | N/A | |
| Compliments | Monthly | N/A | 6 | N/A | |
| Friends and Family Test % positive | Monthly | N/A | 100% | N/A | |
| Complaint response breaches (final response letter not sent in time) | Monthly | N/A | 2 | N/A | |

## Performance

| Indicator | Period | Target | Actual | RAG | Previous months |
|---|---|---|---|---|---|
| Paediatric current waits < 18 weeks | Monthly | 92% | 52% | R | |
| Paediatric waiting list | Monthly | N/A | 1024 | N/A | |
| Paediatric new referrals | Monthly | N/A | 255 | N/A | |
| Paediatric attended 1st appointments | Monthly | N/A | 188 | N/A | |
| CAMHS current waits < 18 weeks | Monthly | 92% | 96.6% | G | |
| CAMHS waiting list | Monthly | N/A | 321 | N/A | |
| CAMHS activity – attended contacts | Monthly | N/A | 1638 | N/A | |
| CAMHS caseload | Monthly | N/A | 1777 | N/A | |

## Performance

| Indicator | Period | Target | Actual | RAG | Previous months |
|---|---|---|---|---|---|
| CAMHS RISE – referrals from A&E seen same day | Monthly | N/A | 58% | N/A | |
| CAMHS RISE – discharges with completed ESQ | Monthly | N/A | 30% | N/A | |
| CAMHS RISE – discharges with completed SFQ | Monthly | N/A | 49% | N/A | |
| CAMHS RISE – A&E referral rate (as a percentage of total referrals) | Monthly | N/A | 74.5% | N/A | |
| Children in care health assessments – children aged under 5 | Monthly | N/A | 67% | N/A | |
| Children in care health assessments – children aged 5 and over | Monthly | N/A | 72% | N/A | |
| 10-14 day breastfeeding coverage | Monthly | 98% | 97.2% | R | |
| 6-8 week breastfeeding coverage | Monthly | 98% | 96.4% | R | |
| National child measurement programme (NCMP) | Quarterly | N/A | 1458 | N/A | |
| Audiology contacts | Quarterly | N/A | 878 | N/A | |
| SEND process – letter 1 responses within 15 days | Monthly | N/A | 100% | N/A | |
| SEND process – letter 2 responses within 42 days | Monthly | N/A | 73% | N/A | |

## People

| Indicator | Period | Target | Actual | RAG | Previous months |
|---|---|---|---|---|---|
| Vacancy rate | Monthly | N/A | 7.5% | N/A | |
| Turnover – rolling 12 months | Yearly | 10% | 12.6% | R | |
| Sickness – in month | Monthly | 5% | 3.5% | G | |
| Annual appraisals | Monthly | 90% | 76.6% | R | |

# Children's Services Division Performance Dashboard 2017/18 Month 1

| People | | | | | |
|---|---|---|---|---|---|
| Indicator | Period | Target | Actual | RAG | Previous months |
| Mandatory training | Monthly | 85% | 88.7% | G | |
| Agency staff use | Monthly | 1.9% | 2.9% | R | |
| Bank staff use | Monthly | 5% | 3.3% | G | |
| Clinical supervision | Yearly | 100% | 67% | R | |
| Managerial supervision | Yearly | 100% | 64% | R | |

| Pulse Check | | | | | |
|---|---|---|---|---|---|
| Indicator | Period | Target | Actual | RAG | Previous months |
| **Child Therapy & Complex Needs** | | | | | |
| Staff recommending as a place for care and treatment | Quarterly | N/A | 71% | N/A | |
| Staff recommending as a place to work | Quarterly | N/A | 50% | N/A | |
| Response rate | Quarterly | N/A | No data | N/A | |
| **Universal Children's Services** | | | | | |
| Staff recommending as a place for care and treatment | Quarterly | N/A | 80% | N/A | |
| Staff recommending as a place to work | Quarterly | N/A | 50% | N/A | |
| Response rate | Quarterly | N/A | No data | N/A | |

| Finance | | | | | |
|---|---|---|---|---|---|
| Indicator | Period | Target | Actual | RAG | Previous months |
| Performance against budget £'000s | In month | £1207 | £1140 | G | |
| Performance against budget £'000s | Year to date | £1207 | £1140 | G | |

**General Manager Summary**

- **Paediatric current waits < 18 weeks**
  This report was submitted to TMT and approved at meeting held on 10/04/17

  CMDG mar 17 (3) (3).docx (3).doc
- **Clinical supervision**
  Although significant progress has been made regarding recording, services are struggling to achieve required level. GM has generate a supervision and IPR dashboard for May 2017 and will ask each SLM to generate an action plan to address shortfall in performance. This will be monitored on fortnightly basis.
- **Managerial Supervision**
  See above.
- **10-14 day breastfeeding coverage**
  0.5% short of achieving this target. However target for prevalence of breastfeeding has been achieved for this month.
- **6-8 week breastfeeding coverage**
  1.03% short of achieving this target. However target for prevalence of breastfeeding has been achieved for this month.
- **Turnover – rolling 12 months**
  All services have been impacted by difficulty to recruit new staff. Recruitment Fair took place on 11th March 2017. Although awaiting final confirmation, all indications are that a large number of staff have been appointed and the vast majority of vacancies have been filled as a result of recruitment fair. Recruitment and Retention group has been launched to focus on these issues
- **Annual appraisals**
  See narrative for clinical supervision above.
- **Agency staff use**
  This issue is specifically impacting upon CAMHS Medical and Community Paediatrics. Recruitment plans are in place to reduce this over the next 3 months.

# Neighbourhood Services Division Performance Dashboard 2017/18 Month 1

| Quality, Safety and Experience | | | | | |
|---|---|---|---|---|---|
| Indicator | Period | Target | Actual | RAG | Previous months |
| Never events | Monthly | 0 | 0 | G | |
| Incidents | Monthly | N/A | 49 | N/A | |
| Serious incidents reported to CCG via STEIS | Monthly | N/A | 0 | N/A | |
| New complaints opened for investigation | Monthly | N/A | 9 | N/A | |
| New concerns | Monthly | N/A | 17 | N/A | |
| Complaints upheld/partially upheld | Monthly | N/A | 2 | N/A | |
| Compliments | Monthly | N/A | 30 | N/A | |
| Friends and Family Test % positive | Monthly | N/A | 77% | N/A | |
| Complaint response breaches (final response letter not sent in time) | Monthly | N/A | 4 | N/A | |

| Performance | | | | | |
|---|---|---|---|---|---|
| Indicator | Period | Target | Actual | RAG | Previous months |
| **North Derbyshire** | | | | | |
| Community caseload | Monthly | N/A | 4330 | N/A | |
| Community waiting list | Monthly | N/A | 1823 | N/A | |
| Community referrals | Monthly | N/A | 586 | N/A | |
| Community activity | Monthly | N/A | 4735 | N/A | |
| Community discharges | Monthly | N/A | 636 | N/A | |
| Outpatient memory assessment service caseload | Monthly | N/A | 1104 | N/A | |
| Outpatient caseload (exc. MAS) | Monthly | N/A | 5117 | N/A | |
| Outpatient waiting list < 18 weeks | Monthly | 92% | 100% | G | |

| Performance | | | | | |
|---|---|---|---|---|---|
| Indicator | Period | Target | Actual | RAG | Previous months |
| **South Derbyshire** | | | | | |
| Community caseload | Monthly | N/A | 3131 | N/A | |
| Community waiting list | Monthly | N/A | 1527 | N/A | |
| Community referrals | Monthly | N/A | 425 | N/A | |
| Community activity | Monthly | N/A | 3355 | N/A | |
| Community discharges | Monthly | N/A | 452 | N/A | |
| Outpatient memory assessment service caseload | Monthly | N/A | 549 | N/A | |
| Outpatient caseload (exc. MAS) | Monthly | N/A | 3389 | N/A | |
| Outpatient waiting list < 18 weeks | Monthly | 92% | 95.4% | G | |
| **Derby City** | | | | | |
| Community caseload | Monthly | N/A | 2364 | N/A | |
| Community waiting list | Monthly | N/A | 1117 | N/A | |
| Community referrals | Monthly | N/A | 338 | N/A | |
| Community activity | Monthly | N/A | 4057 | N/A | |
| Community discharges | Monthly | N/A | 368 | N/A | |
| Outpatient caseload | Monthly | N/A | 3213 | N/A | |
| Outpatient waiting list < 18 weeks | Monthly | 92% | 94.9% | G | |

| People | | | | | |
|---|---|---|---|---|---|
| Indicator | Period | Target | Actual | RAG | Previous months |
| Vacancy rate | Monthly | N/A | 13.2% | N/A | |

# Neighbourhood Services Division Performance Dashboard 2017/18 Month 1

| People | | | | | |
|---|---|---|---|---|---|
| Indicator | Period | Target | Actual | RAG | Previous months |
| Turnover – rolling 12 months | Yearly | 10% | 9.3% | G |  |
| Sickness – in month | Monthly | 5% | 7% | R |  |
| Annual appraisals | Monthly | 90% | 74% | R |  |
| Mandatory training | Monthly | 85% | 88% | G |  |
| Agency staff use | Monthly | 1.9% | 4.2% | R |  |
| Bank staff use | Monthly | 5% | 2.3% | G |  |
| Clinical supervision | Yearly | 100% | 46% | R |  |
| Managerial supervision | Yearly | 100% | 59% | R |  |

| Pulse Check | | | | | |
|---|---|---|---|---|---|
| Indicator | Period | Target | Actual | RAG | Previous months |
| **Locality 1** | | | | | |
| Staff recommending as a place for care and treatment | Quarterly | N/A | 70% | N/A |  |
| Staff recommending as a place to work | Quarterly | N/A | 47% | N/A |  |
| Response rate | Quarterly | N/A | 15% (74) | N/A |  |
| **Locality 2** | | | | | |
| Staff recommending as a place for care and treatment | Quarterly | N/A | 79% | N/A |  |
| Staff recommending as a place to work | Quarterly | N/A | 63% | N/A |  |
| Response rate | Quarterly | N/A | 11% (19) | N/A |  |
| **Locality 3** | | | | | |
| Staff recommending as a place for care and treatment | Quarterly | N/A | 100% | N/A |  |
| Staff recommending as a place to work | Quarterly | N/A | 0% | N/A | |
| Response rate | Quarterly | N/A | 19% (5) | N/A |  |
| **Locality 4** | | | | | |
| Staff recommending as a place for care and treatment | Quarterly | N/A | 42% | N/A |  |
| Staff recommending as a place to work | Quarterly | N/A | 42% | N/A |  |
| Response rate | Quarterly | N/A | 35% (12) | N/A |  |

| Finance | | | | | |
|---|---|---|---|---|---|
| Indicator | Period | Target | Actual | RAG | Previous months |
| Performance against budget £'000s | In month | £1910 | £1840 | G |  |
| Performance against budget £'000s | Year to date | £1910 | £1840 | G |  |

**General Manager Summary**

- A significant amount of work has gone into recruitment and overall the Neighbourhood services have recruited well. However we have a hotspot in South Derbyshire & South Dales where there are challenges in both recruitment and absence for other reasons and level of agency workers in this team is a risk. We have agreed over recruitment against absences and are trying hard to recruit. Derby City is also a hotspot, turnover here and the level of recruitment required at start of 2016/17 has meant sustained efforts are required and the pressure in the area threatens both recruitment and sickness levels. The situation is further compromised by lack of available agency staff, however the team are trying to improve the issue. this has a knock on impact on supervision, training and appraisal completion. The operational team are working with nursing directorate to try and mitigate these risks, but with a vacancy at Head of nursing for Neighbourhoods this is also difficult.
- The project office are about to commence supportive work in the City which it is hoped will help the overall efficiency, effectiveness and well-being of the teams
- We have exceeded target for use of agency staff and this has varied over the year, trajectories have been set repeatedly, but are undermined by changing situations however improving staff well-being and recruitment are key priorities for neighbourhood services through the next 6 months
- Recruiting to medical posts has been extremely challenging throughout the year, this is a national issue and we have worked with other Trust departments to try and resolve this. Similar to the nurse situation solutions are found in one

area but then crop up in another. However this does mean that we are able to refine our processes and have more speed about processing solutions where it is possible.

- Work has been done in all neighbourhoods to achieve the 18 week waiting for outpatients and this is reflected in our meeting the target.
- Recent further review of reporting procedures will enable improvement, however as mentioned above there are key areas where the infrastructure to deliver key targets is threatened – City and South specifically which we will need to support as much as possible to enable improvement.

# WARD STAFFING

| Ward name | | Day | | Night | | Comments Required | Analysis and Action Plan for 'Average fill rate' above 125% and below 90% |
|---|---|---|---|---|---|---|---|
| | Occupancy % Rate | Average fill rate - registered nurses / midwives (%) | Average fill rate - care staff (%) | Average fill rate - registered nurses / midwives (%) | Average fill rate - care staff (%) | | |
| AUDREY HOUSE RESIDENTIAL REHABILITATION | 70.00% | 147.7% | 74.9% | 170.0% | 33.3% | Yes | The attached staffing template is still set wrong we are now at 2 qualified each night shift and no unqualified so the temp[late is recording that we should only be at 1 qualified so when we actually work at 2 this will take us above our figures. |
| CHILD BEARING INPATIENT | 43.89% | 83.3% | 65.7% | 100.0% | 110.0% | Yes | Current fill rate tolerances on days for qualified staff broken due to backfilling maternity leave and care staff to support increased activity/observation levels. |
| CTC RESIDENTIAL REHABILITATION | 70.00% | 113.2% | 79.0% | 130.0% | 85.0% | Yes | The Ward has had some longer term sickness and occasions where an RN has been used to cover a HCA shift or vice versa. The Ward has also had a situation where we've low bed occupancy so haven't booked a bank shift to make 5 staff on an afternoon shift. it was discussed and cleared this with the SLM. |
| ENHANCED CARE WARD | 97.67% | 80.2% | 140.1% | 63.3% | 216.7% | Yes | The current staffing establishment for ECW is unable to meet the full demands for RN cover on each shift. In order to maintain safety and stability within the clinical areas, we have over recruited into HCA posts, hence the higher than required fill rates for unregistered staff.<br>The Trust and individual ward areas continue to proactively recruit into RN vacancies and staffing/ skill mix are reviewed on an ongoing basis at ward level, operational level and Trust level. |
| HARTINGTON UNIT - MORTON WARD ADULT | 94.31% | 103.6% | 147.7% | 61.7% | 270.0% | Yes | Currently on Morton ward we are carrying x7 Band 5 vacancies – these positions are recruited into but the start dates are not for some time.<br>We also have a Band 5 registered nurse and a Band 3 HCA currently on sick leave.<br>It is therefore difficult to reach safer staffing levels and have x2 qualified nurses on night shifts. Staff are prepare to work extra shifts so that where possible we can attempt to reach these requirements. |

# WARD STAFFING

| Ward name | | Day | | Night | | Comments Required | Analysis and Action Plan for 'Average fill rate' above 125% and below 90% |
|---|---|---|---|---|---|---|---|
| | Occupancy % Rate | Average fill rate - registered nurses / midwives (%) | Average fill rate - care staff (%) | Average fill rate - registered nurses / midwives (%) | Average fill rate - care staff (%) | | |
| HARTINGTON UNIT - PLEASLEY WARD ADULT | 103.00% | 111.2% | 81.0% | 52.2% | 160.0% | Yes | Some of the Care Staff shifts on days have been covered by Registered Nurses due to the need to cover short-term sickness and redeployment of Care Staff and also to address clinical need. The under safer staffing figures of Registered Nurses on nights is because we haven't always been able to cover the shifts with 2 Registered Nurses due to re-deployment to support other wards and to cover the Hartington Unit bleep holder role, these shifts have been back filled with Care Staff. |
| HARTINGTON UNIT - TANSLEY WARD ADULT | 99.44% | 93.5% | 108.8% | 45.0% | 200.0% | Yes | No comment received |
| KEDLESTON LOW SECURE UNIT | 69.83% | 92.3% | 83.9% | 98.3% | 100.0% | Yes | the unit has been running at 7-7-6 instead of 8-8-6 due to lower patient numbers and therefore reduced clinical activity. This accounts for the reduction in Nursing assistant shifts being filled. The unit is also carrying 5RN vacancies and 2NA vacancies which are in the recruitment process. Where possible we are aiming for 2RN's either side on early and late, however there are occasions where we have 3 RN's across both wards. |
| KINGSWAY CUBLEY COURT - FEMALE | 68.33% | 131.4% | 113.1% | 63.4% | 140.0% | Yes | Cubley female has failed to met requirement due to registered nurse vacancies, maternity, and cut on staff requirement due to reduced number of patients. There is recruitment process going on to employ into the registered post. |
| KINGSWAY CUBLEY COURT - MALE | 42.96% | 76.0% | 103.3% | 70.0% | 122.2% | Yes | Bed occupancy on Cubley male has been approximately 50% throughout the month of April 2017 therefore staff have been moved to support other wards on most shifts which has resulted in registered fill rates not meeting target despite all shifts being initially filled |

# WARD STAFFING

| Ward name | | Day | | Night | | Comments Required | Analysis and Action Plan for 'Average fill rate' above 125% and below 90% |
|---|---|---|---|---|---|---|---|
| | Occupancy % Rate | Average fill rate - registered nurses / midwives (%) | Average fill rate - care staff (%) | Average fill rate - registered nurses / midwives (%) | Average fill rate - care staff (%) | | |
| LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP | 102.59% | 93.8% | 103.8% | 100.0% | 148.4% | Yes | In relation to care staff this was increased from 2 to 3 to cover levels of observation and to meet demands /risk at night for high patient demand<br>We are carrying 4 NA vacancies and 3 additional NA's LTS and removed |
| RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT | 104.67% | 94.9% | 165.0% | 55.0% | 343.3% | Yes | Ward 33 have 8.2 Band 5 vacancies and the shifts are staffed with unqualified staff where we cannot achieve the current fill rate for Registered Staff. |
| RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT | 100.67% | 87.1% | 152.3% | 65.0% | 220.0% | Yes | Ward 34 continue to carry band 5 vacancies which has impacted on nursing assistant usage. Roster lines have now changed attempting to facilitate 2 qualified on nights. |
| RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT | 107.33% | 75.5% | 160.5% | 65.0% | 115.0% | Yes | We have exceeded current fill rates for unqualified nurses due to our level of vacancies for unqualified nurses. |
| RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT | 101.33% | 103.6% | 118.8% | 51.7% | 260.0% | Yes | The staffing levels on night duty are reflective of requiring extra staff to support people on an increased engagement level, also when there are peripatetic unqualified nurses they are often sent to work on ward 36. |

# Workforce Section

# WORKFORCE DASHBOARD

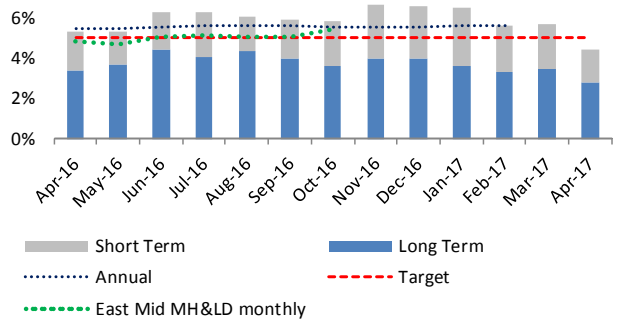
## Wellbeing

### Sickness Absence

(Monthly)

| Feb-17 | Mar-17 | Apr-17 |
|---|---|---|
| 5.61% | 5.70% | **4.45%** |

*Target 5.04%*



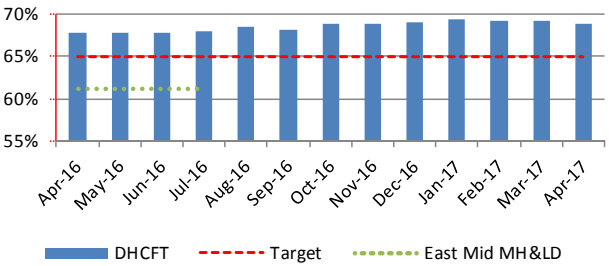

The monthly sickness absence rate is 1.25% lower than the previous month and compared to the same period last year (April 2016) it is 0.83% lower. The Trust annual sickness absence rate is running at 5.58% (as at Mar 2017 latest available data). Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 31.51% of all sickness absence, followed by surgery at 12.26% and other musculoskeletal problems at 11.43%. Compared to the previous month short term sickness absence has decreased by 0.59% and long term sickness absence has decreased by 0.66%.

### Qualified Nurses

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

| Feb-17 | Mar-17 | Apr-17 |
|---|---|---|
| 69.17% | 69.08% | **68.79%** |

*Target 65%*



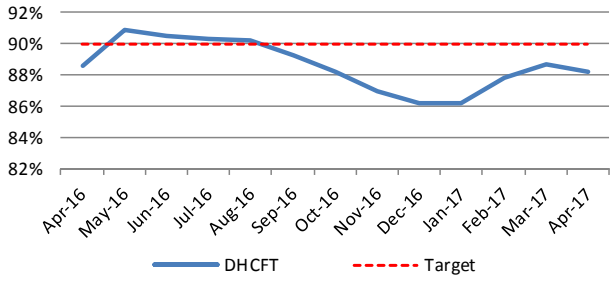

Contracted staff in post qualified nurses to total nurses, midwives, health visitors and healthcare assistants is running at 68.79%. Vacancy rates can impact on this measure. The average for East Midlands Mental Health & Learning Disability Trusts is 61.19%. Health Visitors represent 4.86% of the Trust total and are not included in the Qualified Nurses calculation. Healthcare Assistants and Nursing Support staff represent 26.35% of the total.

### Compulsory Training

(Staff in-date)

| Feb-17 | Mar-17 | Apr-17 |
|---|---|---|
| 87.83% | 88.73% | **88.17%** |

*Target 90%*



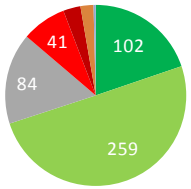

Compulsory training compliance continues to remain high running at 88.17%, which is a decrease of 0.56% compared to the previous month. Compared to the same period last year compliance rates are 0.41% lower. Compulsory training compliance remains above the 85% main contract commissioning for quality and innovation (CQUIN) target.

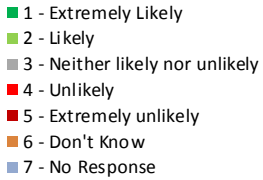
WORKFORCE DASHBOARD

Motivation

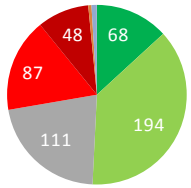
## Staff FFT Q4 2016/17 (516 responses, 22.4% response rate) & Staff Survey 2016

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




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

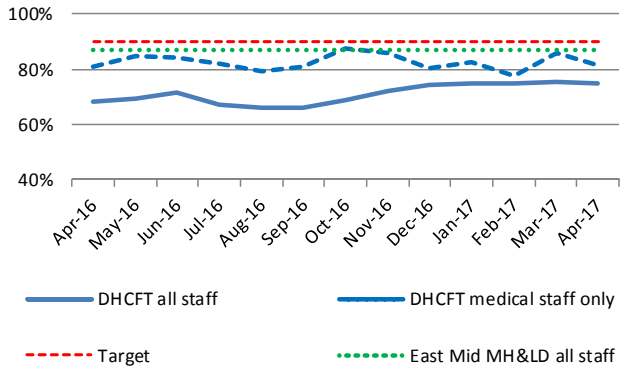



| | 2016 | National average 2016 | 2015 | National average 2015 |
|---|---|---|---|---|
| Overall staff engagement: | **3.69** | 3.84 | 3.73 | 3.81 |

## Appraisals

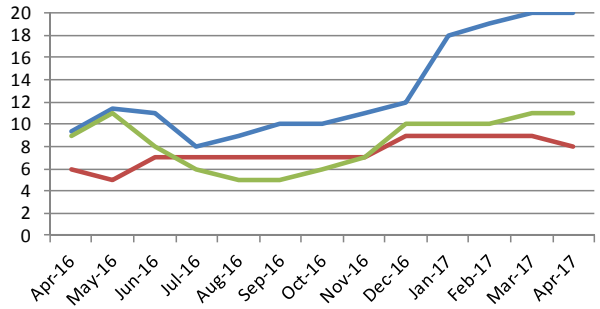
| | Feb-17 | Mar-17 | **Apr-17** |
|---|---|---|---|
| (All staff) | 74.62% | 75.14% | **74.71%** |

*Target 90%*

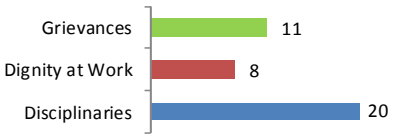



The number of employees who have received an appraisal within the last 12 months has decreased by 0.43% during April 2017 to 74.71%. Compared to the same period last year, compliance rates are 6.59% higher. Medical staff appraisal compliance rates are running at 81.37%. According to the 2016 staff survey results, the national average for Mental Health & Learning Disability Trusts is 88.79%. Local benchmarking data for a range of Trusts in the East Midlands shows an average completion rate of 82.86%.

## Grievances/Dignity at Work/Disciplinaries as at 30/04/2017



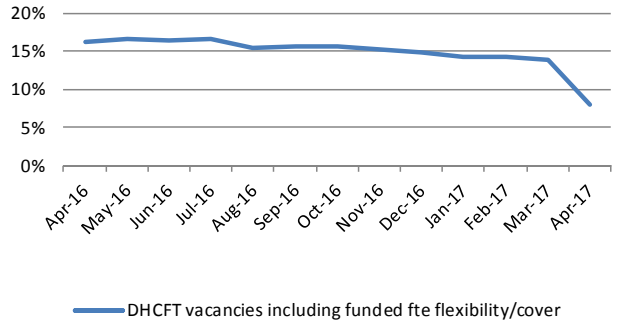

There are 11 grievance cases lodged at the formal stage. 1 new grievance has been lodged in the period and 1 was resolved. 1 new Dignity at Work case was lodged and 2 cases were resolved. One new Disciplinary case has occurred in the period and 1 was resolved.



WORKFORCE DASHBOARD

Attendance

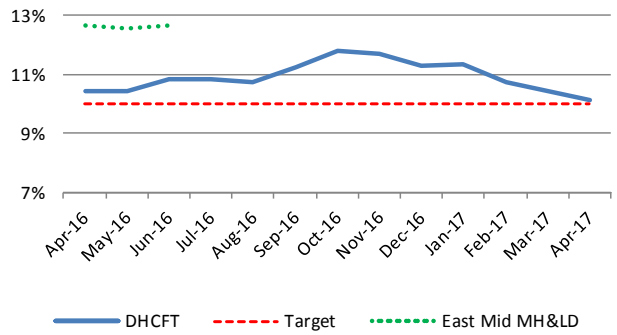
| Vacancy | Feb-17 | Mar-17 | Apr-17 |
|---|---|---|---|
| (Funded full time equivalent) Including funded fte flexibility/cover | tbc | tbc | **8.04%** ↘ |




The Trust vacancy rate includes funded Fte surplus for flexibility including sickness and annual leave cover in In-Patient areas. Funded vacancy rates have decreased to 8.04% in April 2017, however this has mainly been due to changes in the 2017/18 budget which included a large reduction in Fte from 2016/17 investment not materialising and Cost Improvement Programmes. During the previous four months, 69 employees have left the Trust and 108 employees have joined the Trust.

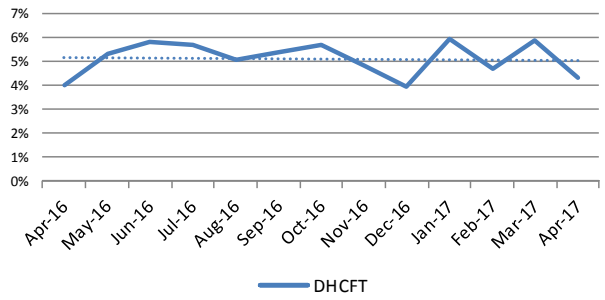
| Turnover | Feb-17 | Mar-17 | Apr-17 |
|---|---|---|---|
| (Annual) | 10.76% | 10.44% | **10.16%** ● ↘ |

*Target 10%*




Annual turnover remains within Trust target parameters at 10.16% and remains below the average for East Midlands Mental Health & Learning Disability Trusts. The average number of employees leaving over the last 12 months has decreased by 0.41 to 20.42. During April 2017 21 employees left the Trust which included 8 retirements.

| Agency Usage | Feb-17 | Mar-17 | Apr-17 |
|---|---|---|---|
| (Spend) | 4.70% | 5.86% | **4.31** ↘ |




Total agency spend in April was 4.31% (5.08% including medical locums). Of total agency and locum spend for all staff groups, Qualified Nursing represented 1.4%, Medical 2.3% and other agency usage 0.6%. Agency Qualified Nursing spend against total Qualified Nursing spend in April was 3.4%. Agency Medical spend against total Medical spend in April was 14.8%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £2.6

**Derbyshire Healthcare NHS Foundation Trust**
Report to Board of Directors 24 May 2017

# Infection Prevention & Control Annual Report 2016/17

**Purpose of Report** This paper summarises the activity in the safe management of Infection Prevention and Control over the preceding 12 months.

## Executive Summary

- This Annual report has been scrutinised by the Quality Committee and significant assurance was established.
- The safe management of Infection Prevention & Control is an important issue for members of the public to have confidence in the Board oversight of this key aspect of the Health Act.
- Performance against key standards of Infection Prevention & Control and related activities remains consistent.
- Reported cases of key alert organisms, and review of the Clostridium Difficile cases detected in year
- Interruption to services related to infection control incidents remains low
- Cleanliness of clinical areas remains consistently good, as were PLACE inspection results
- Clinical compulsory training of identified staff remains consistent
- Recent Environmental Health inspections of two of the Trust's kitchens has resulted in a five star rating by Derby City Council for the second consecutive inspection.

## Strategic considerations

- In order that standards remain high, organisational commitment is required
- Planning for transformation of services and buildings needs to include infection prevention and control as part of planning and delivery
- A commitment to supporting staff in delivery of high standards is required – attendance at training, supply of materials for example.
- A regional focus on emergency planning therefore pandemic influenza preparations will need to be considered as part of business continuity planning.
- CQUIN related activity with staff influenza vaccination targets will remain a significant challenge for the organisation.

## (Board) Assurances

- A clinical audit programme is developed and delivered
- Cleanliness assurance mechanisms
- Surveillance of health care associated infections (HCAI) alert organisms
- Compulsory training standards and compliance

**Consultation**

- Quality Committee April 2017, then as part of a report to the Trust Board of Directors in line with Health Act requirements.

**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 2010.
- There is a governance and contractual element to the emergency preparedness planning and work.

**Equality Delivery System**

This paper and the work of the Committee do not consider they disadvantage any group identified by REGARDS. There are no patterns of infections that adversely impact upon a specific group. Older people are generally more susceptible to infection; overall the incident level is too small to establish a statistical significance that would change existing systems or procedures. There are no other gender specific or other characteristics which are adversely affected.

**Recommendations**

The Board of Directors is requested to:

1) Note the reporting of key areas, such as surveillance of healthcare associated infections – alert organisms, outbreaks of infection, staff training.
2) Receive significant assurance on standards of cleanliness of clinical areas and food preparation areas
3) The report was approved by the Quality Committee and this report is presented to the Board and the public in line with legislation and in the public's interest.

**Report presented by:** **Carolyn Green, Director of Nursing & Patient Experience**
**Report prepared by:** **Hayley Darn, Julie Carvin (Infection Prevention & Support) and Liz Bates, (Deputy Head of Facilities)**

Derbyshire Healthcare
NHS Foundation Trust

# Infection Prevention & Control

# Annual Report – 2016/17

**Report prepared by Hayley Darn, Nurse Consultant (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.

1.2 The Code of Practice: Prevention and Control of Healthcare Associated Infections (2010) 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 Care Quality Commission (CQC). Infection Prevention & Control considerations formed part of the Trusts CCQ Preparedness work in the preceding year.

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). 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 now a renewed 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 Nurse Consultant (safety) 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 (0.6wte) has been in post to assist the Nurse Consultant 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 is devised and delivered by the Infection Control Committee, which forms a key component of the Governance structure, along with reporting via Quality Leadership teams (QLT) as required.

## 4.0 Key achievements of 2015/16

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 2016/17.

- Replacement furniture across areas in the inpatient wards at Hartington Unit and the Kedleston Unit.
- Some remedial flooring repairs and refurbishment at Hartington Unit.
- Replacement chairs for Corbar View (Buxton), The Old Vicarage (Bolsover) and the Resource Centre (London Rd).

4.2 The Infection Control team have been involved in the planning of the new of the seclusion suite at Radbourne Unit, as well as advising on refurbishments and the relocation of teams and services during the configuration of the Neighbourhoods.

4.3 Continued delivery of a training programme for those clinical and support staff who are identified as requiring the training (target group March 2016 was

1822; staff 1747 staff in the target group in March 2016) saw a compliance position on 31/03/17 of 79.1%. 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.

4.4 There have been no ward closures related to outbreaks of Norovirus type illness during 2016/17. Small locally managed single cases have been well managed and prevented onward transmission. Pleasley ward can be commended on this with swift use of source isolation where there was a potential to develop to an outbreak on 2 occasions, however all wards show a heightened awareness and response to diarrhoeal illness.

4.5 Surveillance of healthcare associated infections (HCAI alert organisms) have seen no cases of MRSA bacteraemia between April 2016 – March 2017 – this has been the case for 4 consecutive years. However, we identified three cases of Clostridium difficile in inpatient settings in the past year; prior performance saw no cases in the preceding 3 years. These have been fully reviewed and will be discussed later in the report.

4.6 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').

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

4.8 Patient Led Assessment of the Care Environment (PLACE) inspections took place in Spring 2016, with continued strong performance. The 2017 inspection programme is underway at time of writing this report. 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 link nurses meet twice a year to receive training and to share good practice. Recent focus has been on sharps safety and the launch of additional needle safety devices with further training which took place in 2016. 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.

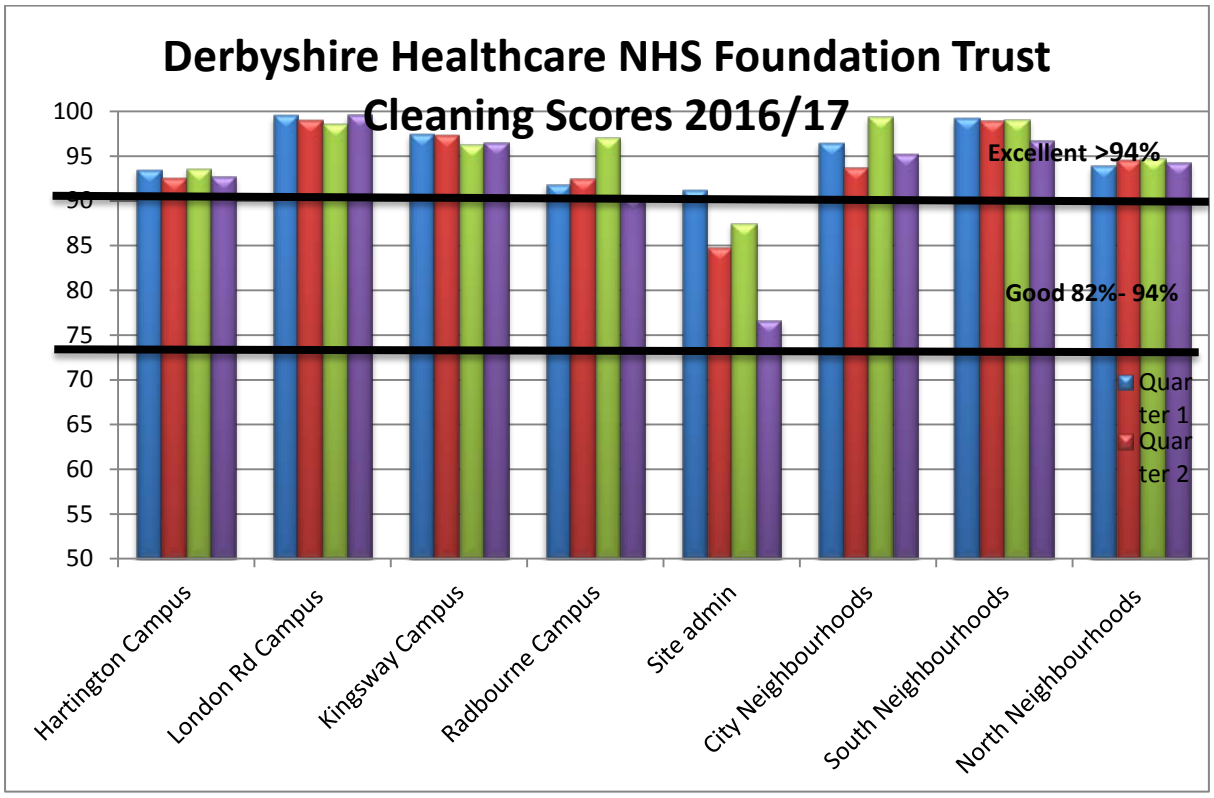
## 5.0 Assurances

5.1 The Facilities team continue to deliver high standards of cleanliness, and the graph below (Graph 1) demonstrates the performance from April 2016 until March 2017. 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 (MHU north, site admin).

The Quality Committee should note that currently Hotel Services are required to reconfigure some working arrangements in line with restrictions in use of Agency staff, and therefore this has had a small and hopefully temporary impact on standards, with clinical areas and wards being prioritised.

The Hotel Services and Estates teams also undertook a series of visits to the Community Mental Health units premises to ensure all environmental standards and being met and to check that all planned maintenance is in accordance with the proposed works schedule. The identified backlog maintenance and also some furniture replacement for areas such as Corbar View, Buxton and The Old Vicarage, Bolsover.

Graph 1: Performance against National Standards of Cleanliness



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.

Table 2: Surveillance of healthcare associated infection (HCAI)

| 2016/17 | APRIL | MAY | JUNE | JULY | AUG | SEPT | OCT | NOV | DEC | JAN | FEB | MARCH |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **MRSA bacteraemia (trajectory = 5)** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **Clostridium Difficile (trajectory = 10)** | **0** | **0** | **0** | **0** | **0** | **1** | **2** | **0** | **0** | **0** | **0** | **0** |
| **Outbreaks of infection (Norovirus type)** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |

5.4 During 2016/17, there have been 0 ward closures as a result of diarrhoeal illness (suspected Norovirus).

Root cause analysis of the 3 cases of Clostridium diffiicle identified no areas of cross contamination (all 3 on separate wards), all patients has previous use of antibiotics or protein pump inhibitors (PPI) or had dietary concerns. The antibiotic use was in line with formulary, all patients fully recovered with no adverse effects. The Infection Control Committee has reviewed the reports and fed back any lessons learned to ward teams concerned. Learning points will also be distributed via the Infection Control link nurses and via clinical training.

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 produces ease of recording and thematic review. The link nurses continue to undertake audits and have been involved in the revision of the tool.
- An audit of the Childrens Specialist services including the Special Schools and CAMHS has been undertaken and raised a number of concerns regarding some of the working and care environments. Toy care and cleaning was identified as not being of the required standard, with actions taken to address including a new policy and recording method.

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' 31/03/17 was 79.1%.

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 38.4% (was 22.7% 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 10 '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. This is against a backdrop of a CQUIN target of 70% (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 awarded 5star 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 27, with planned inspections of kitchen areas taking place as a preventative measure.

5.12 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.

5.13 Review of the DATIX Complaints system for 01/04/16 until 31/03/17 shows no complaints related to cleanliness / infection risk.

## 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.

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.

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.

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 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.

**Hayley Darn**
**Nurse Consultant (lead for Infection Prevention & Control)**
**5 April 2017**

**Derbyshire Healthcare NHS Foundation Trust**
Report to Board of Directors 24 May 2017

# Quality Position Statement

## Purpose of report

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

## Executive Summary

This position statement sets out:

1. Safety – Drug related deaths and learning from effective governance of clinical consortium arrangements
2. Safe care - National Guidance on Learning from Deaths published by the National Quality Board March 2017 and Schedule 28 benchmarking
3. Safe care - Physical Healthcare and the National alert on care of nasogastric tubes (NG)
4. Safety Safeguarding Children – Section 11 audit and changes to the Children and Social Work Act 2017
5. Quality Leadership – responding to staff feedback, professional systems leadership in Chief Nurse fellows
6. Responsive services- Improving access to Psychological therapy- quality performance and exploring management of clinical demand
7. Well led- changes to the NMC standards on revalidation
8. Well led - CQC additional service visits for Mental Health Act inspections

| **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 |

**Strategic considerations**

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

**(Board) Assurances**

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

**Consultation**

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

**Governance or Legal issues**

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

Children and Families Act 2014

**Equality Delivery System**

Any impact or potential impact on equality is considered as a key part of all our quality work.

**Recommendations**

The Board of Directors is requested to:

1) Receive this quality position statement
2) Gain assurance, be advised on quality leadership strategy and engagement and information on its content and seek clarity or challenge on any aspect of the report

**Report prepared by:** **John Sykes Medical Director and Carolyn Green Executive Director of Nursing & Patient Experience**

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

# QUALITY POSITION STATEMENT

## 1. SAFE SERVICES

### 1.1 Drug related deaths in Substance Misuse. National trends in mortality rates and local action

The National context:

There were 3,674 drug poisoning deaths involving both legal and illegal drugs registered in England and Wales in 2015, the highest since comparable records began in 1993. Of these, 2,479 (or 67%) were drug misuse deaths involving illegal drugs only.

The mortality rate from drug misuse was the highest ever recorded, at 43.8 deaths per million population. Males were almost 3 times more likely to die from drug misuse than females (65.5 and 22.4 deaths per million populations for males and females respectively).

Deaths involving heroin and/or morphine doubled in the last 3 years to 1,201 in 2015 and are now the highest on record. Deaths involving cocaine reached an all-time high in 2015 when there were 320 deaths – up from 247 in 2014.

People aged 30 to 39 had the highest mortality rate from drug misuse (98.4 deaths per million population), followed by people aged 40 to 49 (95.1 deaths per million).In 2015, the mortality rate from drug misuse was significantly lower in England than in Wales (42.9 compared with 58.3 deaths per million populations).

Within England, the North East had the highest mortality rate from drug misuse in 2015 for the third year running (68.2 deaths per million population), while the East Midlands had the lowest (29.8 deaths per million).

All figures presented in this bulletin are based on deaths registered in a particular calendar year. Out of the 2,479 drug-related deaths registered in 2015, half (1,132) occurred in years before 2015.

"Deaths involving heroin and morphine have more than doubled since 2012, partly driven by a rise in heroin purity and availability over the last 3 years. Age is also a factor in the record levels of drug deaths, as heroin users are getting older and they often have other conditions, such as lung disease and hepatitis that make them particularly vulnerable."

In our Trust our Quality structures and committee carefully monitors both our City and County Drug related death reporting continue to monitor performance in this area and physical health innovations to prevent death such as new ECG monitoring, targeted high risk interventions and a new development in Derby Gyms in Steroid injecting clinics and preventative monitoring and harm minimisation clinical advice.

Derby Drug and Alcohol service (DDAS) is a consortium drug treatment service between Derbyshire Healthcare NHS Foundation Trust, Phoenix Futures (third sector) and Aquarius (third sector). This successful consortium has overseen budget reductions, clinical innovation and improvements in clinical governance.

Our integrated service model has successfully managed a consortium arrangement in providing a public health contract which provides a high intensity support service including physical, addiction treatment and mental health support for both Drugs and Alcohol.

The service is based at St Andrews House and St Peters Churchyard in Derby. The service is for any adult (18 years +) who wishes to address any issues they have caused by the use of drugs or alcohol. This can include binge drinking, the use of 'legal highs' (or New Psychoactive Substances), as well as physical alcohol or drug dependence.

The Substance Misuse Service has actively used clinical team skill mix initiatives to provide a RMN Social work and Registered Nurse workforce, collaborated effectively with key partners in this consortium service which has presented nationally at the NHS Substance Misuse Provider Alliance

**Action:** The Quality Committee will continue to monitor the Substance Misuse integrated services and maintain a monitoring brief on this National trend and the local data. For the Director of Strategy and the Medical Director to consider this clinical consortium model and its effectiveness and whether this model has learning for other services and how it could be replicated for other Trust services?

### 1.2 Safe care – Physical healthcare governance

The recent safety alert regarding the care of nasogastric tubes (NG) has been fully considered by the Physical Care Committee. The alert pertains to issues identified in the care of the tube – the insertion of and also the on-going care to check placement of the tube highlighting safety concerns. We do not currently care for patients who require the insertion of a nasogastric tube and having considered the alert, the Committee have endorsed the position that we are not in a position to provide this care safely. This is reflected in the policy which has been developed around the safe care of percutaneous gastrostomy (PEG) feeding tube, which also includes a competency self- assessment for nursing staff, which outlines the way in which we can manage safely to care for a patient with a PEG tube. The policy details that other types of tube, such as jejunostomy and NG cannot be safely cared for in our inpatient wards.

The Committee has also recently developed and approves a venepuncture policy with an associated competence document to set out clinical standards and training needs for staff. The falls policy is now under review, and the Nutritional Risk screening policy was also updated and approved. The Committee is also overseeing the deployment of the emergency resuscitation equipment into community bases and the additional training required by staff.

**Action:** The Executive lead for Physical Healthcare is Dr John Sykes to monitor improvements in this area and oversee strategic developments and improvements in performance.

### 1.3 Safe care - National Guidance on Learning from Deaths published by the National Quality Board March 2017

This recently published guidance is complementary to the CQC's report Learning, Candour and accountability; a review of the way NHS trusts review and investigate the deaths of patients in England.

The Quality Committee has received an improvement and action plan in this area. As this is a matter of significant public concern and interest nationally. The following information has been placed in the public domain to identify the Trust's actions.

**Background**

The National Guidance on Learning from Deaths highlights the need for a comprehensive and systematic process for the review and learning from deaths that take place in health care services. The report recognises that people may experience excellent quality care but the outcome of their contact is death and deaths in health care may occur for a number of reasons.

However, where there is poor quality provision, the causes must be sought and understood and learning must take place to avoid the same issues recurring. It is imperative that as a Trust that provides mental health, learning disability and children's services, we follow the specific guidance under the Serious Incident Framework and the LeDeR (learning disability Review Programme).

The document highlights the following changes that require implementation:-

1. Identification of an executive board member to take responsibility for the Learning from Deaths agenda with an non-executive director to have oversight of the process

2. There should be a systematic approach to investigation of deaths that is underpinned by a recognised, structured process and that identified the need for review where 'red flag' alerts are identified in care.

3. Trusts should have clear rationale for the scope of the deaths that come under review and a proportionate approach is expected from Trusts who provide services for people mental health needs and learning disabilities.

4. The Trust should demonstrate a clear policy for the engagement of families which will be supported future guidance from NHSE.

5. Each Trust is expected to have published a new updated Serious Incident policy by September 2017 that reflects the requirements of the National Guidance.

6. Improved Data Collection – the type and way of reporting of data around deaths needs refinement including evidence of regular reporting of protected characteristics and inclusion of Mortality Data in the Trust Quality account being a requirement by June 2018.

7. There needs to be evidence of strengthening the learning that takes place from deaths.

8. In addition it is best practice to continually monitor and benchmark Schedule 28 rulings with other organisations. This table has been included as part of our death analysis to provide the Board with assurance on our current performance.

Number of Regulation reports received by MH Trusts in the category of Mental Health Related deaths (April 2016 – March 2017)

| **Organisation** | **Number of Reg 28 reports received** |
|---|---|
| Avon & Wiltshire Mental Health NHS Trust | 4 |
| Birmingham and Solihull Mental Health Trust | 2 |
| Cambridge & Peterborough NHs Trust | 1 |
| Tees Esk and Wear Valley NHS Trust | 1 |
| Hertfordshire Partnership University NHS FT | 1 |
| South West and St George's Mental Health Trust | 1 |
| Leicester Partnership NHS Trust | 1 |
| The Priory | 1 |
| Oxford Health NHS FT | 1 |
| Powys Teaching Health Board | 1 |
| South London and Maudsley NHS Trust | 1 |
| West London MH NHS Trust | 1 |
| South Staffordshire and Shropshire Healthcare | 2 |
| Manchester Mental Health and Social Care NHS Trust | 1 |
| Dudley & Walsall Mental Health NHS Trust | 1 |
| Greater Manchester West Mental Health NHS Trust | 1 |
| Aneurin Bevan University Hospital Board | 1 |
| **Derbyshire Healthcare NHS FT** | **1** |

**Action:** DHCFT will undertake the following actions to ensure its compliance with the guidance:-

- Confirm board level responsible officers – to be documented in the revised SI report for publication by September 2017.
- Benchmark current policies and procedures for Serious Incident investigation against the new guidance and action plan required changes. Actions to be completed and revised policy to be published by September 2017
- Confirm data collection supports requirements of new guidance. We will build the data set over the next 12 months and be able to report on 1 year indicator with

improved statistical validity. This would form a minimum standard to benchmark against by June 2018.

- SI report to include data on incidents relating to people with protected characteristics from June 2017.
- Include the refined mortality data in the Trust quality account by June 2018.
- Review and benchmark the Family Liaison services against the new guidance and action plan required changes. Actions to be implemented by September 2017. Additional changes may be required once the NHSE guidance is published

## 1.4 Safety Safeguarding Children – Section 11 audit and changes to the Children and Social Work Act 2017

Our Trust services s submitted a self-assessment and provided a mapping and data in May on our Safeguarding Children and Think Family work in the Trust. The Trust had an inspection visit form the Derbyshire and Derby Safeguarding Children Boards representatives and the Designated Nurse. This was a review of our compliance information and a letter stating the outcome of the review is expected in May/ June 2017. Overall the self-assessment was rated ‘green’ and informal feedback was positive, subject to written confirmation of the outcome and findings from the external inspection team.

**Action:** The Safeguarding Board Committee will review the findings of the Section 11 audit. In addition the Safeguarding Committee will review the implications of changes to the Children and Social Work Act 2017, specifically Chapter 16 which received Royal assent and the strategic and operational implications for the Trust will be overseen and changes to systems and process as required due to the following changes.

This will result in changes to: Looked after children, corporate parenting principles for English local authorities, care leavers in England, care orders: permanence provisions, placing children in secure accommodation elsewhere in Great Britain, which may impact upon Children and CAMHS services. The Child Safeguarding Practice Review panel, which will change the Safeguarding Children procedures and functions. The ability to combine child death review partner areas and delegating functions, in addition to Changes to the Child death overview panels. This includes the abolition of Local Safeguarding Children Boards.

## 1.5 Responsive and Effective services - Improving Access to Psychological therapies

Primary Care Psychological Therapy for people aged over 16+. This is a primary mental healthcare service which would connect into PLACE developments.

The Trust provides a Derbyshire wide and provides a tariff based Any Qualified Provider (AQP) model. This is a partnership model and the Trust is able to successfully partner with other agencies. This is a Stepped care model, providing steps 2, 3 and 3.5 which is set too clinical standards and an operating procedure set by National Improving Access to Psychological Therapies (IAPT), NHS and Local Trust requirements.

The IAPT service provides a mix of staff and therapeutic modalities, to increase primary care rapid and effective access to services.

- Guided Self Help
- Cognitive Behavioural Therapy
- Counselling for Depression
- Interpersonal Therapy
- Dynamic Interpersonal Therapy
- Behavioural Couples Counselling
- Brief Systemic Therapy
- Eye Movement Desensitization and Reprocessing
- LTC Group Therapy
- *Employment Support

Two new measures for Improving Access to Psychological Therapies (IAPT) have been implemented nationally and the Quality committee will be monitoring this information in its assurance reviews:

- IAPT access to treatment for older people (65+) in IAPT as a proportion of older people in the adult population
- IAPT recovery rate for black or minority ethnic (BME) groups.

The team has a number of challenges:

- Complexity of the service with the number of modalities
- Communication county wide, reducing isolation of workforce
- Nationally set recovery rate target of 50%
- Accommodation (Trust premises, GP surgeries, partner locations, community settings, privately rented)
- Financial viability balanced with service quality
- High demand, easily accessible point of contact
- Waiting times

The IAPT Service Manages:

- Referrals of 12,162 per year
- Self-referral accounts for 80%
- Other referrals sources; GPs, Secondary Care, Drug and Alcohol, Charity and Social Agencies
- % are triaged for suitability
- Inappropriate referrals due to misunderstandings, long waits for other services, gaps in service, ease of access
- Clinical outcomes. The Trust clinical service is consistently above the National recovery and outcome rate.

The service is key to rapid access to prevent suicide, GP and demand management from primary care

**Action:** Exploration of how the Trust and other providers of IAPT services can divert avoidable activity from Accident and Emergency services, into this primary care model. Further exploration of whether further co- location primary care IAPT services with GP settings or walk in centres may be beneficial in supporting consultation, self-referral and access to primary care mental health services.

## 2. WELL LED

### 2.1 Quality Leadership

**Responding to staff survey concerns in the Children's services**

The Children's services have raised in their staff survey that they sometimes feel overshadowed by the Mental Health and Learning Disability services and would value more contact from middle and senior managers. In addition some of the team have expressed some concerns about integration following on from a large service remodelling and the impact of more change on the service.

**Action:** The Nursing and Quality team have committed to spending more focused time with Children's Services in particular Health Visiting to listen to feedback and learn. Dates have been scheduled. Other teams would be welcomed and encouraged to join the team to listen and learn from the feedback given.

**Chief Nurse Fellows - Rotational scheme and developing future talent**

The Chief Nurses of Derbyshire have collaborated on a Health Education England Nursing Cabinet initiative to develop three Chief Nurse development schemes to develop future talent in the workforce. These posts are 12 month projects to develop a nursing and

workforce improvement project to benefit the provider organisations in Derbyshire as well as developing Nursing talent.

The DHCFT Chief Nurse led project is to develop an inter-organisational nurse secondments scheme across clinical pathways. The post holder has been appointed is a Royal Derby registered nurse who will work within DHCFT to develop the inter Trust internal rotation scheme.

## 2.2 Well led- Professional Leadership

The Nursing and Midwifery Council have issued revised guidance on Revalidation. As a Trust we have noted the new guidance and are meeting to refine the policy to comply with the new changes.

The NMC have recently launched new guidance to clarify some of the aspects of the revalidation process, in line with the planned review they undertook 12 months after the process was launched. Feedback from registrants has been used to clarify the requirements around practice hours, supervision sessions and the sign off of the reflective sessions which should be an 1:1 activity. There is also clarification on exceptional circumstances.

Our existing policy will be reviewed to ensure the new guidance is reflected in our standards, and also a number of further revalidation awareness sessions are being planned and advertised to ensure those staff who will be revalidating this year have access to support if they wish. We continue to monitor revalidation and professional registration with the support of the workforce information team.

## 2.3 Care Quality Commission Comprehensive and Mental Health Act Inspection – re-visits results

Our teams and colleagues in Substance Misuse Services continue to prepare for their expected visit, which would be expected in 2017. This may receive a 12 week notice period or an unannounced inspection visit.

The Trust has been notified of two further Mental Health specialist visits to the Trust.

- **In June to review Community Treatment orders practice; this is an additional visit which can be planned at two yearly intervals.** The MHA reviewer will be visiting Derbyshire Healthcare NHS Trust on 7 June 2017. The visit will be specifically to monitor the use of the Mental Health Act 1983 in relation to CTOs.

  This includes a full review of any / current CTO patients ( please only give an ID number) – one for the city and one for the county by community team and a review of the number of discharges, recalls and revocations from 1 April 2016 to the 31 March 2017

- **Notification of visit on 12 July 2017. Monitoring under Section 120 of the Mental Health Act 1983: Assessment and Application for Detention and Admission visit**

  *The Care Quality Commission is responsible for monitoring the use of the Mental Health Act. In addition to visiting detained patients in hospital, we also check arrangements for assessment and application for detention discharge from detention, aftercare and supervised community treatment. We carry out these checks in each two-year cycle of monitoring for each mental health NHS trust and, as appropriate, independent hospitals. We have selected your service to visit on the date above, so that we can monitor your arrangements for assessment and applications for detention.*

  *We recognise that the statutory responsibility for Approved Mental Health Professionals (AMHPs) sits with councils, and that a number of organisations are responsible for different aspects of assessment and admission. However, we expect hospital providers to facilitate organising the visit. This is partly because so many aspects of the process join up with hospitals as detaining authorities, making them a good conduit for us to access the range of local organisations. We have found that this arrangement results in more effective monitoring, and therefore safeguarding of people's rights, if we fit these checks within our on-going regulatory relationship with your organisation, rather than establishing separate relationships with each council, police force, etc who may be involved. I hope that you will be able to fulfil this role in facilitating the visit, and we are grateful for your help.*

  *The purpose of the visit will be to check compliance with the Mental Health Act and Code of Practice. This will include considering how well assessment is joined up with the various parts of the care pathway and how it contributes to outcomes of care for people who use services. We will follow up any issues that arise in relation to individuals' care, but this type of visit is primarily a review of the systems in place.*

| | |
|---|---|
| **Report prepared by:** | **Carolyn Green, Executive Director of Nursing and Patient Experience and John Sykes Medical Director** |
| **Report presented by:** | **Carolyn Green, Executive Director of Nursing and Patient Experience** |

Derbyshire Healthcare
NHS Foundation Trust

# Paediatric and CAMHS waiting times

Report to Trust Board – 24th May 2017



Better together

# Introduction

**1. Waiting Times for Community Paediatrician Service**

**2. Waiting Times for Child & Adolescent Mental Health Service (CAMHS)**



Better together

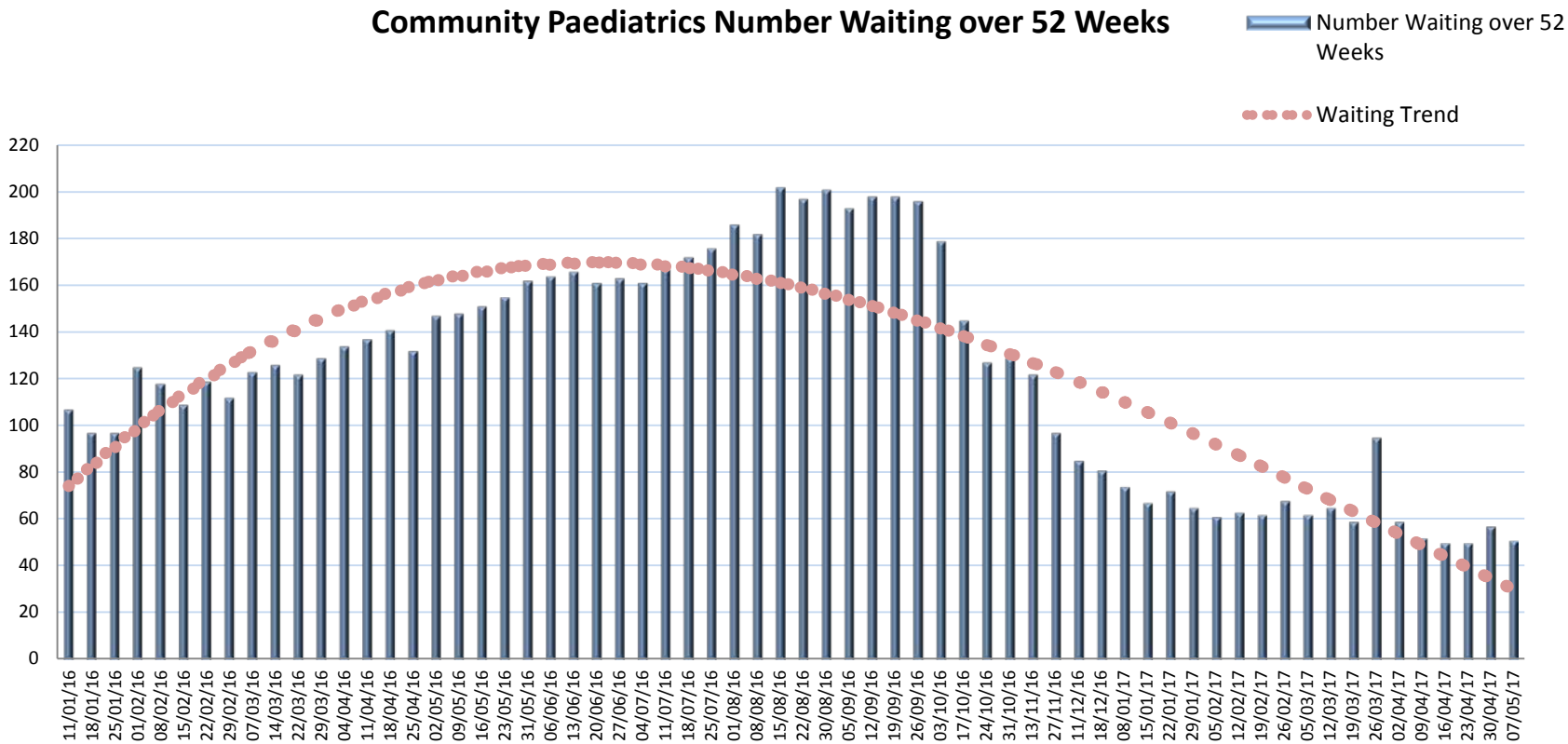
# Paediatricians Waiting Times Actions Taken

- Resource Allocation
- Job Plan (Safeguarding/SEND/LAC)
- Recruitment
- Locum Cover
- Neuro Development Team
- Multi Agency Neuro Development Pathway
- Psychologist
- Joint recruitment with Derby Teaching Hospital



Better together

# Paediatricians Number waiting Over 52 Weeks (08/05/17)



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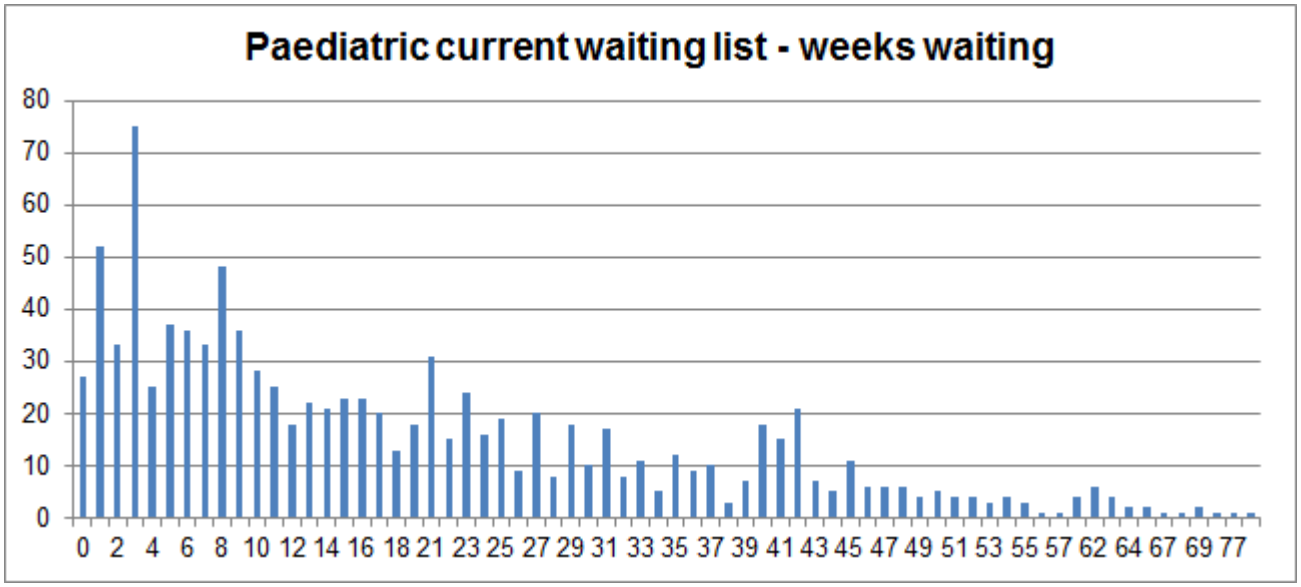
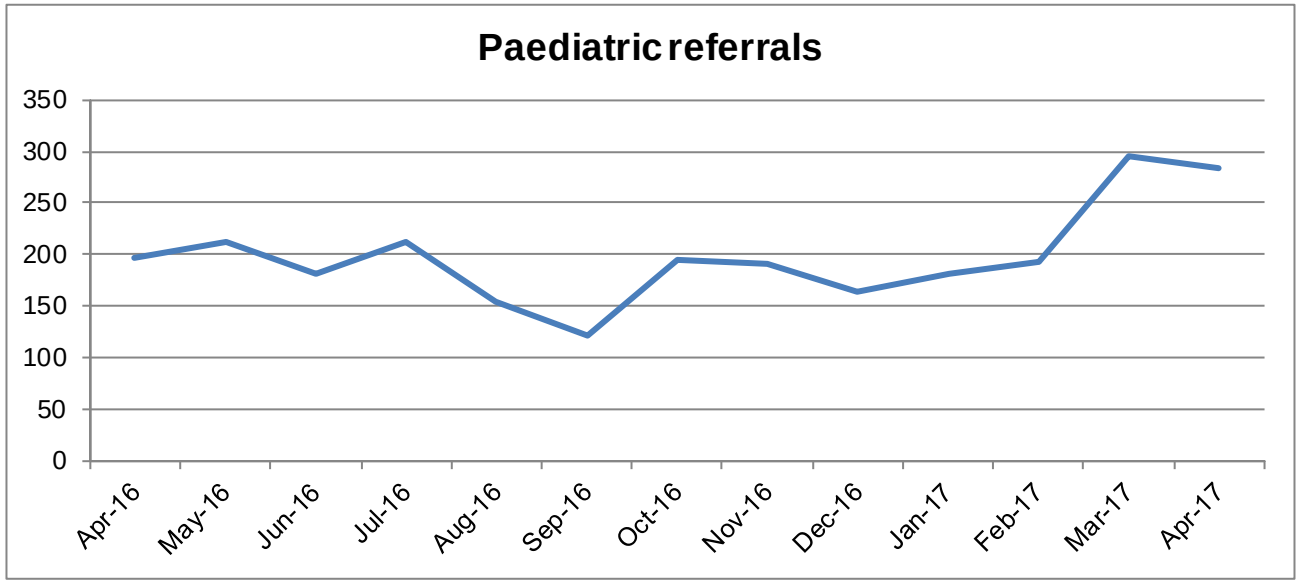
# Current waits






Better together

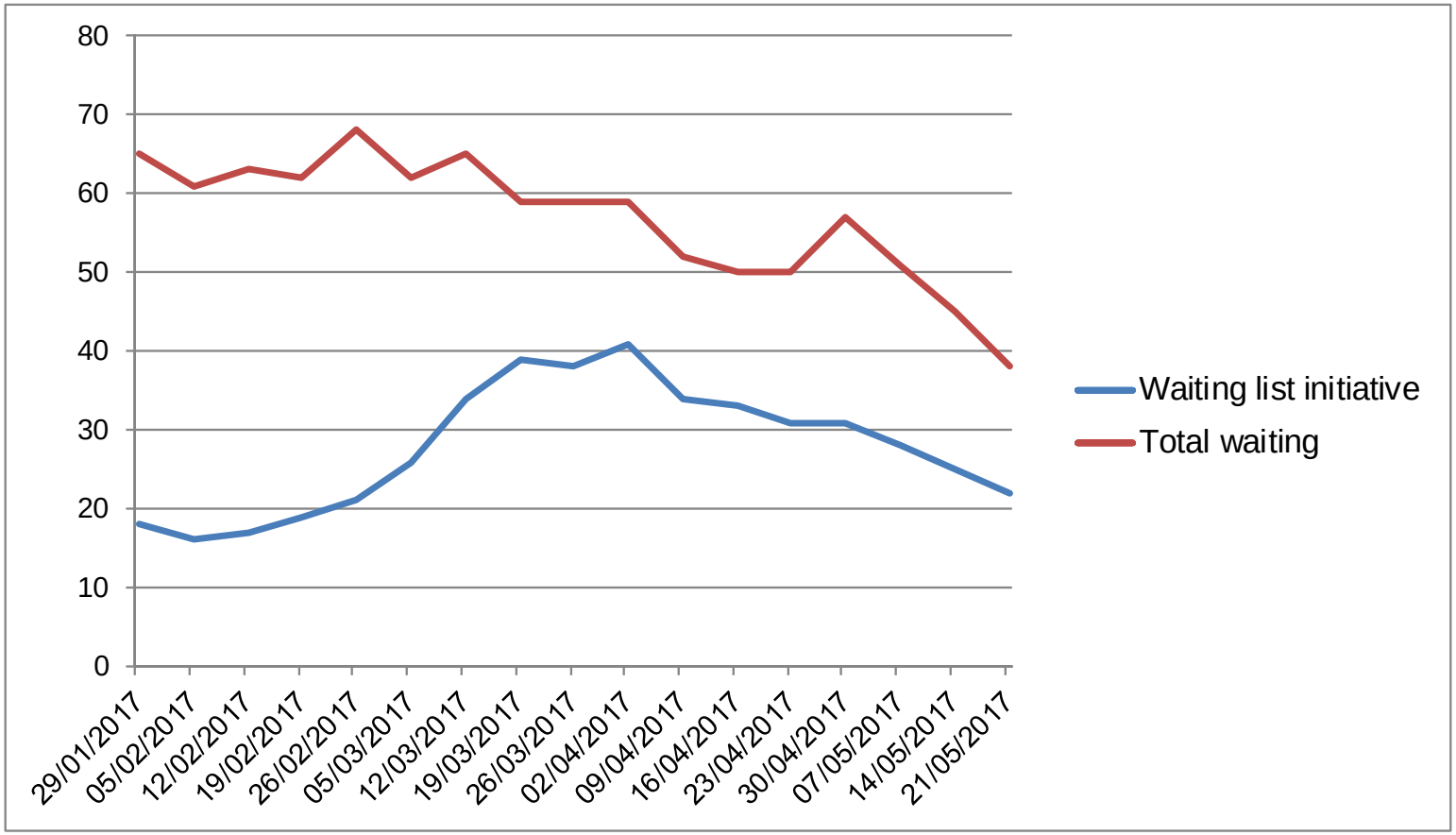
# Paediatricians 6 Longest NON WLI Waits (End Quarter 4)

| | Age | Wait weeks | DNA | Locality | Pathway | |
|---|---|---|---|---|---|---|
| Child #1 | 3 years of age | 82.29 | X1 | Amber valley | ASD | Appointment arranged for 17/05/17 with locum |
| Child #2 | 4 years of age | 53.14 | X1 | City North | ASD | Appointment arranged for 16/05/17 |
| Child #3 | 4 years of age | 65.14 | | City North | ASD | Appointment arranged for 16/05/17 with locum |
| Child #4 | 4 years of age | 61.14 | | City North | ASD | Appointment arranged for 16/05/17 with locum |
| Child#5 | 3 years of age | 54.14 | | City South | ASD | Appointment arranged for 22/05/17 with locum |
| Child #6 | 10 years of age | 53.14 | | City North | ASD | Appointment arranged for 23/05/17 with locum |



Better together

# Paediatricians Waiting List
# Waits over 52 weeks



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# Key Challenges

- DNA/Was Not Brought - Number of appointments lost each week equates to 3 whole time staff. Statement added to letters
- Waiting list Initiative is now accounting for majority of longest waits. Need to implement new patient pathway.
- Commissioning Gap - Community Paediatricians are commissioned to work with young people up to the age of 16 years unless in attendance at special schools or subject to Child Protection.



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# Plans for future improvement

- Speciality Doctor due to start June 2017
- Consultant Post to be recruited. Job Plan
- New pathway Implementation 1st Sept 17
- SEND Clinical Co-ordinator – recruitment
- Service Specification review



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# CAMHs Waiting Times

# Current waits - Assessment

## Child & Adolescent Mental Health Service

| Team | 0-14 Weeks | 14-18 Weeks | 18-26 Weeks | Total Number Waiting | Average Waiting | Maximum Waiting |
|---|---|---|---|---|---|---|
| CAMHS Eating Disorders | 3 | 0 | 0 | **3** | 3.90 | 10.57 |
| County South CAMHS | 127 | 8 | 3 | **138** | 7.18 | 23.14 |
| Derby City CAMHS | 86 | 16 | 1 | **103** | 9.00 | 19.14 |
| Derbys CAMHS Liaison | 15 | 0 | 0 | **15** | 2.65 | 10.14 |
| Derbyshire LD CAMHS | 18 | 0 | 3 | **21** | 10.30 | 22.14 |
| **Total** | **249** | **24** | **7** | **280** | **7.81** | **23.14** |
| **Percentages** | **88.9%** | **8.6%** | **2.5%** | | | |



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# CAMHS Waiting Times – 6 Longest Waits

- Patient 1 - Admin error- Date of birth entered as for referral date rather than actual date of referral
- Patient 2 – Young Person is open to City CBS Team. However for NHSE reporting purposes is open to PARIS.
- Patient 3 – DNA/Was Not Brought to one appointment. Further appointment offered on 19/6
- Patient 4 – DNA/Was Not Brought to one appointment. Further appointment offered on 08/06
- Patient 5 – Reluctant to engage with services. Has moved. Further appointment offered on 05/06
- Patient 6 - Appointment offered on 23/05



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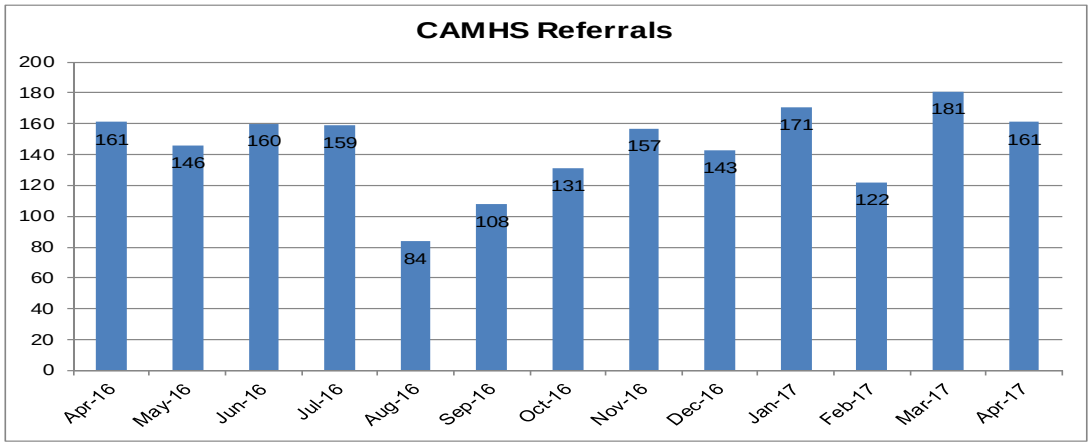
# Key Challenges



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# Key Challenges

- Difficulty to recruit evidenced based therapists
- Difficulty accessing treatment following assessment
- Sickness was previously frequently over 5.04%. However March and April 17 significantly under. April 2.36%
- Difficulty to recruit consultant psychiatrist posts
- Increasing Complexity & Consistent Demand



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# Plans for Future Improvement

- New Service Model – Pathway; Clinically Led; Assessment Function; Consultants
- CBT therapists will be able to deliver more CBT interventions
- Parenting therapy strategy being developed for a cascade model
- Development of the groups offer- both within service and as a cascade model
- Centralised duty- 6 duty systems to 1
- ADOS waiting list blitz to increase accessibility- TBC in June
- Assessment - ASIST have been developed and have decreased both the internal and external waits by 16%

# Questions

# Board Committee Summary Report to Trust Board
# Audit & Risk Committee - 27 April 2017

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other Committee) |
|---|---|---|---|---|---|
| **Welcome/Apologies Draft Minutes Audit & Risk Committee meeting held14 January 2017 Action Matrix and Matters Arising:** | Caroline Maley, Trust Chair, was welcomed to the meeting.<br>Actions matrix – updates were noted to the matrix. | Full assurance was provided that completed actions were fully actioned and that these could be archived.<br>Significant assurance was given that items scheduled for future meetings were on track for delivery. | None | Actions agreed as completed as noted. | None |
| **GOVERNANCE** | | | | | |
| **Going Concern Assessment 2016/17** | Claire Wright presented the report which outlined the reasons for the going concern decision with supporting assumptions/ qualifications. | Full assurance was outlined to support the statement that the financial statements have been prepared on a going concern basis. | None | Agreed appropriate that the 2016/17 accounts are prepared on a going concern basis. | None |
| **Review Draft Annual Accounts** | Claire Wright (CW) presented the draft accounts, with input from Rachel Leyland (RL) and Stacey Forbes. The financial statements were reviewed page by page with members' queries addressed and | Significant assurance was received on the draft accounts and actions agreed:<br>Proof read and grammar check to be undertaken: Action: CW and Anna Shaw | Challenging timeframes set by NHSI have been a risk that has been managed by effective working of the Finance Team. | The Committee agreed that they were content with the draft accounts, subject to further update and amendments as highlighted. | None |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other Committee) |
|---|---|---|---|---|---|
| | clarified. The accounts had been submitted to NHSI on 25 April as per the deadline and also to external auditors. | Additional planned updated content was outlined and further amendments were noted for the final accounts: Action : CW and RL<br><br>A paper outlining the detail relating to commissioner related de-designation to be covered in future F&P paper : Action CW. | | | |
| **Review Draft Annual Report** | Anna Shaw presented the draft annual report which was reviewed on a page by page basis.<br><br>Feedback received from members prior to the meeting was acknowledged. | Significant assurance was received on progress and that the report had been shared with external auditors. Grant Thornton gave full assurance that all required elements of the Annual Reporting Manual were covered in the report.<br><br>ELT are to review the report at their 15 May meeting prior to the final version of the report being presented to A&R on 25 May.<br><br>Assurance was provided that consent has been provided for all photos | None - subject to auditors comments. | Agreed subject to amendments noted and those previously submitted.<br><br>It was agreed that A&R members would be circulated an updated version of the report as soon as possible. | None |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other Committee) |
|---|---|---|---|---|---|
| | | used. The context of photos is to be reviewed, along with review of grammar and consistency. Action: Anna Shaw | | | |
| **Review Draft Quality Report** | Darryl Thompson presented the draft Quality Account which had been prepared in line with national guidance.<br>Positive stakeholder feedback has been received from Healthwatch Derby. Feedback from other stakeholders is awaited. | J Tabreham gave assurance that the Quality Committee had reviewed this draft in depth.<br>Amendments raised are to be incorporated and proof reading completed: Action: D Thompson<br>Significant assurance was received on progress. | None | The Committee agreed that they were content with the progress on the Quality Account.<br>Updated quality account to be circulated to A&R members as soon as possible | None |
| **Review Draft Annual Governance Statement (AGS)** | Rachel Kempster gave an overview of the updated AGS which has been drawn up following ARM guidance.<br>Recent updates had been added to reflect the lifting of the CQC Improvement Notice in full and external assurance received on governance improvement action plan | Significant assurance on progress was agreed. S Harrison and C Wright have input to the AGS.<br>Minor updates were noted and are to be incorporated into the final document. Action: R Kempster<br>Update to KPMG opinion to be reworded: Action: RK and S Harrison | None | The Committee agreed they were content with the progress made with the AGS | None |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other Committee) |
|---|---|---|---|---|---|
| | implementation. | | | | |
| **Exception reporting -** | Losses and Compensations (no exceptions to report)<br>Debtors and Creditors (no exceptions to report)<br>Hospitality and Sponsorship (no exceptions to report)<br>It was highlighted that there were no exceptions to report. | There were no items raised.<br>Losses and Comps, Debtors and Creditors to be removed from A&R workplan. Assurance was given that this was not a formal role of the Committee under the terms of reference and therefore review could be undertaken by Finance and Performance Committee. Action: S Harrison | None | It was agreed that debtors, creditor losses and compensations would be reported in future to the F&P Committee. Any escalations would be made to the Board via the Committee's assurance summary.<br>It was agreed that these items would be removed from the A&R Committee forward plan | None |
| **AUDIT COMMITTEE FUNCTIONS** | | | | | |
| **Draft Annual Report from the Audit & Risk Committee to the Board including updated terms of reference** | S Harrison presented the annual report from the Committee which outlined work undertaken aligned to the Committee's terms of reference<br>Proposed update to the terms of reference were outlined, noting that reference to equality and diversity role is to be added to all terms of | Amendments were proposed and will be captured in final version. Full assurance was received on the effectiveness of the Committee.<br>Priorities for 2017/18 are to be agreed for the May meeting. Action: B Mellor | None | Agreed that this report to be presented to the Board, subject to amendments, highlighting assurance regarding effectiveness of all other Board committees (see below).<br>The updated terms of reference were agreed. | None |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other Committee) |
|---|---|---|---|---|---|
| | reference. | | | | |
| **Receive Annual Reports from Board Committees** | Reports from the following Committees were presented along with updated terms of reference:<br><br>Remuneration and Appointments (SH), Finance& Performance (CW), Quality (Julia Tabreham), People & Culture (SH), Safeguarding (SH), Mental Health Act (SH).<br><br>Ongoing role in overseeing completion and embedding GIAP actions for all Committees was noted. Good practice arising from external observation of Committees by Deloitte is to be taken forwards during 2017/18. | Significant assurance was received on the effectiveness of Committees, with further assurance requested from the MHAC in 6 months. | Given the work to be undertaken by the MHA Committee it was agreed that a 6 monthly update report would be requested: Action : S Harrison to liaise with J Sykes<br><br>The risk to Committees who have had change in chair were highlighted, although good Executive Director support was noted. | Reports were agreed for all Committees and updated terms of reference agreed. These will be incorporated into the Trust's Corporate Governance Framework.<br><br>Following discussion it was agreed that MHAC and Safeguarding Committees would remain Board Committees | None |
| **EXTERNAL AUDIT** | | | | | |
| **Update on external audit progress** | Joan Barnett presented the annual report benchmarking report for | Significant assurance was received in that the Trust's 15/16 annual report had been 'done | None | The annual report Benchmarking report was noted and the Committee to review | None |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other Committee) |
|---|---|---|---|---|---|
| | information.<br>The annual accounts, report and quality account were currently being reviewed by Grant Thornton. | well'.<br>Deloitte external assurance report (April 2017) to be shared with auditors Action: Sam Harrison | | good practice at the July meeting. | |
| **INTERNAL AUDIT** | | | | | |
| **Annual report and Head of Internal Audit Report** | Sophie Jenkins outlined that KPMG were comfortable with the opinion given the work already undertaken.<br>Progress with implementing recommendations from previous auditors was noted. | Significant assurance with minor improvements had been received on the two reviews undertaken in year and overall opinion. | None | The Committee noted the report and welcomed the positive audit opinion. | None |
| **Internal audit plan 2017/18 (including Internal Audit Charter)** | The proposed 17/18 audit plan, which had been developed in liaison with the Executive Directors, was outlined and discussed.<br>Potential areas for contingency days included merger related work, cyber security and working with governors. | Significant assurance was received that the internal audit plan is in place for 17/18. This is subject to confirmation of detail and timings of reviews to ensure maximum organisational benefit/learning. Action: S Harrison to arrange further ELT discussion. | None | The 17/18 plan was agreed subject to final ELT recommendations.<br>The Committee agreed that it was comfortable that IG Toolkit review was not undertaken during the year. | None |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other Committee) |
|---|---|---|---|---|---|
| **CQC Internal Audit Report** | The internal audit review on progress with the CQC action plan was presented by KPMG. | Significant assurance with minor improvements was given for this review.<br>Actions have been agreed with the exception of one where further discussion between KPMG and Carolyn Green is scheduled to ensure the recommendation is agreed, and action and timescale confirmed. Confirmed timescale for completing agreed action 3 is also required. | None | Update to May Committee on agreement of recommendation 2 of the review. | None |
| **Counter fraud Annual report 2016/17** | Sophie Jenkins presented the report. Five referrals had been received since 1 December 2016. | Significant assurance was received from the self-review overall rating of green. | None | Agreed to note the report | None |
| **Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework** | No items raised. | S Harrison said that the programme for Deep Dives would be prepared for 2017/18 and the format of these would be reviewed. Action: S Harrison | None | None | None |
| **2017/18 Forward Plan** | The proposed forward plan was reviewed and | Significant assurance was received that all | None | Agreed to review the requirement for both a | None |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other Committee) |
|---|---|---|---|---|---|
| | agreed. | elements of the Committee's terms of reference were included. Amendments were noted. | | Dec 17 and Jan 18 meeting | |
| **Meeting effectiveness** | Barry Mellor invited comments on effectiveness of the meeting. | There was noted to be an extensive agenda which had been managed well. Agenda items were clearly summarised by the chair and level of assurance agreed. Early circulation of the annual report and quality accounts was welcomed. | None | None | None |
| **CONFIDENTIAL SESSION** | | | | | |
| **Draft Minutes of Confidential session held on 14 March 2017** | Minutes of the session were reviewed. | Final details of the external audit contract extension to be presented to the May A&R Committee. | None | Agreed as an accurate record. | None |

# Board Committee Summary Report to Trust Board
# Quality Committee - meeting held on May 2017

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other committee) |
|---|---|---|---|---|---|
| **Minutes and Actions matrix** | Agreed and ratified | Good assurance | See minutes for full actions<br>Risks with some overdue actions that need further information. John Sykes | | |
| **Carer feedback** | The risk and stability of the carer and service receiver feedback | Family and care experience | Disengagement and loss of vital carer engagement which risks are threefold<br>Risks to mental health carers and support networks<br>Risks to MH pts. due to reduced carers support<br>Risk to soft intelligence and carer involvement in the Trust | Executive and safeguarding lead support and feedback to commissioners<br>The ability to extend ward visits to carers not viable in the foreseeable future | |
| **Policy Governance** | Policy compliance is solid<br>Some further changes and amendments proposed | This improvement has been maintained and embedded into practice | Scrutiny of policy governance. | Policy review against TOR completed and actions recommended | |
| **CQC**<br>**Action Plan** | Significant improvement and good assurance on progress.<br>Reviewed with review and challenge. | Limited assurance partial assurance due to being a work in progress due to capacity pressures due to other significant competing priorities | MHAC and MCA quality improvements and the pace of improvement | Information governance meeting to lead following SIRI investigation and put in place risk mitigation plan | Escalation on capacity and competing priorities and impact on business as usual |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other committee) |
|---|---|---|---|---|---|
| **CQC MHAC report** | Review of detailed progress on MHA AND MCA.<br>Evidence of significant work, but evidence of full completion is not fully realised<br>Actions overdue and behind plan | Challenge on debate that this is tolerated, rather than signing in off in complete actions, sustained practice improvement, is the required outcome<br>Limited assurance | Pace of progress and definition of sustained improvements.<br>Deep dive in MHAC for June MHAC, to be led by Dr Ed Komocki and Dr Sykes. | Evidence presented and agreed. | |
| **Quality Dashboard** | Significant improvement<br>Detailed discussion on the information included and actions already in place, demonstrating progress.<br>Additional new quality metrics for 2017- VTE and HCR20<br>Additional deep dive on HCR20- risk assessments/ Restraint/ Seclusion Equalities indicators in restraint/ Gender issues | Good assurance on planning<br>Further work on a summary that distinguishes- quality committee and Board level information and discussion | Clinical and management of performance | Dashboard deep dives will continue on high risk indicators | None |
| **Service receiver/ feedback** | The risk and stability of the service receiver feedback<br>All bar two representatives have resigned from the service engagement model due to contractual changes | Service receiver feedback experience | Feedback on ward visits, feedback on responsiveness.<br>Risks to people, form loss of involvement<br>Risks to Trust soft intelligence, substantial value of ward visits. | Disengagement and loss of important service<br>Executive lead action | |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other committee) |
|---|---|---|---|---|---|
| | in provider | | | | |
| **Community mental health capacity** | The clinical risk capacity and stability of the neighbourhood services | Good assurance on understand and mitigation plan<br>Limited assurance on outcome and risks to fully mitigate | Risks and action plan.<br>Some potential opportunities but not a full mitigation plan.<br>Risk and audit to explore GP NICE guideline compliance and threshold<br>3 months for an up-date report | Close monitoring of incidents and waiting list<br>Proactive management action to explore | |
| **Serious incident report** | Performance on serious incidents<br>Low level of incidents, but bed occupancy is lower. Review incident levels and bed occupancy snapshot on falls<br>Limited assurance<br>NQB National guidance on learning from deaths | Plan in place<br>Plan in place | Action plan to improve<br>Implementation plan and mitigating actions | Concerns re resource implications. | |
| **Report on the reduction of prone** | Detailed report on restraint in line with positive and safe strategy | Significant assurance | Positive outcome, significant improvement and outlines | Review in data and quality dashboard and full report in 12 months | |
| **Care planning and plans** | Improvement plans in systems and process for a key quality priority area | Significant assurance | Significant assurance | Positive improvement and work | |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other committee) |
|---|---|---|---|---|---|
| **Quality assurance group** | Clinical issues<br>Triangulation of Trust risk issues and commissioner concerns log | Limited assurance, incomplete report, due to missing front sheet | Clear communication of risk<br>Governance of risk escalation to commissioners and response is in evidence. | Executive lead to include front sheet at the next meeting | |
| **Analysis of inquest activity** | Significant assurance<br>Benchmarking of national picture<br>Positive outcome and feedback from coroners on Trust's openness and involvement of families | Significant assurance | Analysis of risk issues<br>Training for staff on inquest and how to write statements | Significant pressure on staff in attendance | |
| **Clinical audit** | Presented the audit performance and assurance report<br>Significant improved performance<br>Quality committee required actions have been completed | Significant assurance | No current key risks to delivery | Agreed and thanks to the Audit manager for the improved performance in this area | |
| **EDS2 and equalities** | Assurance on progress and the work plan<br>Evidence of significant work, across all Trust areas in both quality and workforce areas | Significant assurance | Maintain performance and plans | Bi-monthly monitoring to ensuring | |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other committee) |
|---|---|---|---|---|---|
| **Childrens and Central services COAT** | Evidence of clinical leadership<br>Evidence of substantial clinical work, against TOR | Significant assurance | Evidence of operational QLT meetings<br>Improved performance<br>Evidence of demonstrable improvement in decision making and escalation | Review in evaluation in 6 months | |
| **Any other business** | Risk based escalation on Safeguarding committee issues with regard to Independent Prisoners | Limited assurance | Clinical capacity and competence to respond to a changing community patient profile | Executive lead recommended BAF briefing Scheduled for Quality next meeting | |
| **Effectiveness review** | Feedback on meeting<br>Good meeting<br>NED challenge<br>Equalities impact and improving.<br>Finished on time | Positive meeting | No issues | Good positive meeting, with significant levels of assurance led information | |
| **Confidential section** | None<br>Minutes from last meeting agreed and ratified | | | | |

# Board Committee Summary Report to Trust Board
# Safeguarding Committee - 5 May 2017

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other Committee) |
|---|---|---|---|---|---|
| **Minutes from Safeguarding Committee** | A detailed review of the minutes and actions was undertaken | Accuracy was confirmed | None | Ratified and agreed | None |
| **Action Matrix and Policy Matrix** | A detailed review of actions was undertaken<br>A review of the actions and matters arising and an additional any other business | Confirmed | None<br>One outstanding action on training needs analysis and training plan matter. | Ratified and agreed<br>Additional mitigating action was requested. | None<br>Actions allocated to People and Culture committee |
| **SAFEGUARDING CHILDREN** | | | | | |
| **Safeguarding Children Work Plan Update 2016/17** | A detailed review of the work plan<br>Review and challenge by NEDs on the style and the content of the report, to include summary and exception report only | Further improvement work required of the safeguarding lead on report summary only. Full action plan not to be included | None | Ratified and agreed<br>Head of safeguarding children to schedule revised work plan on the future agenda | None |
| **Safeguarding Children Training Update Safeguarding Children Training Needs Analysis Update** | A detailed review of the all associated paper and findings<br>Detailed review of current performance / exploration of risks | Limited assurance – medial workforce compliance and ESR data<br>Significant assurance on progress, further exploration of the future | Significant deficits in medical workforce compliance, accrediting prior learning and training plan for medical staff in the organisation for less than 6 months | Immediate action required to improve performance and ESR data | None |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other Committee) |
|---|---|---|---|---|---|
| | Medical workforce significant outlier and mitigation plan<br>Presentation of key issues and risks by Safeguarding Named Doctor | plan for 2017/18 at the next meeting | Culture of compliance with required standards with the medical workforce | | |
| **Markers of Good Practice** | Completed<br>New date for inspection confirmed as 4 May pm. | Significant assurance on progress, all actions completed with the trust control | NHS England independent investigation TOR for near miss homicide received in draft for comment | | None |
| **CQC Safeguarding Children Action Plans** | A detailed review of the paper and findings<br>Significant progress on all actions<br>Significant concern re one outstanding action, linked to key issues and community care coordinator capacity | Significant assurance on progress<br>Limited assurance on remaining actions resolution through contracting round<br>Exception report at next meeting rather than full report | Mitigation by Trust management however no full resolution in place to reduce structural deficit in care coordinators currently running at 60 wte deficit<br>This is a known and accepted risk by Lead commissioners | Escalation to line manager of individual by Head of Safeguarding on outstanding issues<br>Discussed at reviewed at QAG | Escalation to Board<br>Triangulation with BAF quality concerns with commissioning gaps |
| **CQC Comprehensive Specific to Safeguarding Children** | A summary report of actions and confirmation on progress and completed | Significant assurance on progress<br>Feedback and up-date report confirms progress is sustained | Continuation of embedding into practice | Maintenance of training standards | Escalation to ELT – Safeguarding Level 3 training capacity |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other Committee) |
|---|---|---|---|---|---|
| **Serious Case Reviews Update** | A summary report of current cases, and assessment of potential escalation into learning or SCR FD17 / GD17 | Significant assurance on progress | Identification of risks to be added into the audit work programme and improvement plan | Ratified and agreed<br>Scheduling of future up-dates, when SCR signed off | None |
| **SEND inspection in Derbyshire** | A summary report of findings<br>Discussion of the learning and impact on strategy and compliance | Action plan delayed but mitigating actions in Trust in progress<br>As systems joint action plan not available at this time | Delays in a shared joint action plan | Transferring learning from county to potential city inspection | None |
| **Cases of Child Sexual Abuse - Summary of Progress and Bradbury Report** | A summary report of findings to enable learning from other trusts and proactive management | Limited assurance on progress, further work to complete action plan | Developing effective early warning systems to spot abuse of this nature. | Further revision and development of work plan to consider, audit, policy or standards to mitigate this in the Trust | None |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other Committee) |
|---|---|---|---|---|---|
| **SAFEGUARDING ADULTS** | | | | | |
| **Safeguarding Adults Strategy Update Against Workplan and SMART Action Plan Safeguarding Adults Performance Dashboard** | A summary report detailing of findings<br>Discussion of the learning and impact on strategy and work plan<br>CQC improvements and actions up-dated<br>Including high level scrutiny on complex enquiries. Briefing on performance PREVENT and MAPPA | Significant assurance on progress | Capacity and preparation<br>MASH advisors renewed for 12 month period<br>MAPPA meeting in May to discuss MAPPA 3 and IPP. Indeterminate imprisonment for public protection (IPP Prisoners) who remain in prison. | Review of BAF risks<br>Exploration and escalation of this potential health and systems support needs of individuals. | None |
| **Safeguarding Adults Training Update and Progress Update** | A summary report of findings across areas | Limited assurance – medical workforce compliance | Maintaining and improving compliance in this professional areas and maintain Trust wide performance | Continued support by the education team on compliance reports and improvement trajectories | None |
| **AC Female Report (2013 incident)** | A summary report on learning event on draft report and developments | Awaiting full report to be agreed and publications | Delays in completion, awaiting publication to fully implement/ complete all actions on an agreed action plan | Leadership of the safeguarding leads to drive this action plan | None |
| **AC Male Report (2010 incident)** | Awaiting publication of report | Awaiting full report to be agreed and publications | Delays in completion, awaiting publication to implement/ complete all actions. | Leadership of the safeguarding leads to drive this action plan | None |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other Committee) |
|---|---|---|---|---|---|
| **Application of the Mental Capacity act** | A summary report of progress relating to Safeguarding scope of the committee | Limited assurance – some evidence of progress | Delays in completion, oversight to be maintained by the Mental Health committee | Oversight to be maintained by the Mental Health committee | None |
| **Safeguarding committee – year-end review** | A review of the meeting compared to the scope of the committee and full terms of reference<br>Attendance reviewed | Limited assurance – positive review but improvement areas noted. | Executive attendance<br>Current risks remain if Safeguarding committee subsumed into Quality Committee | Review of TOR and attendance by the Chair<br>Executive attendance with mitigation plan | None |
| **POLICY REVIEW** | | | | | |
| **Care of the acutely disturbed pregnant patient** | Ratified with minor governance checks to re-confirm Drug and therapeutics agreements and revisit final checks | Ratification, subject to final checks | None | Operational group to lead on full roll out | None |
| **Forward Plan** | Review and revised | | | | |
| **Meeting Effectiveness** | Team reflections – positive meeting with significant progress on work. Refinements to continually move from operational detail to strategy and assurance | Reviewed | Significant workload and agenda requirements from regulatory activity and high levels of systems issues | | None |

| Agenda Item | Summary of issue discussed | Assurance and actions required | Key risks identified | Decisions made | Escalations to Trust Board (or referral to other Committee) |
|---|---|---|---|---|---|
| **Confidential section** | Review of AC male issues and information not in public domain, awaiting publication<br>Review of detailed action plan.<br>Circulation to NEDs of action plan ad briefing | | | | |

**Derbyshire Healthcare NHS Foundation Trust**
Report to Board of Directors 24 May 2017

# Governance Improvement Action Plan (GIAP)

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

Therefore, the purpose of this paper is as follows:

1. To provide Board members with an update on progress on the delivery of the GIAP, including the identification of tasks and recommendations that are off track.
2. To receive assurances on delivery and risk mitigation from Board Committees and Lead Directors.
3. To enable Board members to constructively challenge each other to establish whether sufficient evidence has been provided for completed actions.
4. To decide whether tasks and recommendations can be closed and archived.

**Executive Summary**

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

The governance of each core area is as follows:

| Core | Committee | Lead Director |
|---|---|---|
| Core 1 - HR and associated Functions | People and Culture | Interim Director of People and Organisational Effectiveness |
| Core 2 - People and Culture | People and Culture | Interim Director of People and Organisational Effectiveness |
| Core 3 - Clinical Governance | Quality | Director of Nursing and Patient Experience |
| Core 4 - Corporate Governance | Audit & Risk | Director of Corporate Affairs |
| Core 5 - Council of Governors | Council of Governors | Director of Corporate Affairs |
| Core 6 - Roles and Responsibilities of Board Members | Remuneration and Appointments | Director of Corporate Affairs |
| Core 7 - HR and OD | People and Culture | Interim Director of People and Organisational Effectiveness |
| Core 8 - Raising concerns at work | People and Culture | Director of Corporate Affairs |
| Core 9 - Fit and Proper | Remuneration and Appointments | Director of Corporate Affairs |
| Core 10 - CQC | People and Culture | Interim Director of People and Organisational Effectiveness |
| Core 11 - NHS improvement undertakings | Board of Directors | Director of Corporate Affairs |

The summary table below provides Board members with an overview of performance against all 53 recommendations, set against each respective core area and from the perspective of the oversight Committees.

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

There are **two** blue forms to present to the Board – these are the final forms to be submitted as part of the GIAP.

**Strategic considerations**

Delivery of the GIAP links directly to NHS Improvement's enforcement action and associated licence undertakings

| | |
|---|---|
| 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 | |

**Board Assurances**

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

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

**Consultation**

Core areas have been discussed at respective Board Committees

**Governance or Legal Issues**

This paper links directly to NHSI enforcement action and associated licence undertakings

**Equality Delivery System**

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

**Recommendations**

The Board of Directors is asked to:

1) Note the completion of all actions addressing GIAP recommendations
2) Formally approve the **two** blue forms as presented and confirm that this is provides assurance of completion, namely:

    - **M1**
    - **M3**

3) Note the full completion of the Governance Improvement Action Plan.

| | |
|---|---|
| **Report presented by:** | **Kelly Sims (CQC and Governance Coordinator)** |
| **Report prepared by:** | **Samantha Harrison (Director of Corporate Affairs and Trust Secretary)** |

# Blue Completion Form

| Recommendation | Current BRAG Rating | Recommended BRAG Rating |
|---|---|---|
| **M1** - The Trust will deliver a Governance Improvement Action Plan (GIAP) to address the findings and recommendations from the Employment Tribunal Investigation, Deloitte report, and the CQC focused inspection<br><br>**DR13**: Further iterations of the governance action plan should include a greater depth of detail, including summary of progress and clearer insight into priority actions required<br><br>The action plan should include:<br><br>•Priority ratings for each action<br><br>•Key tasks required for each recommendation / action area<br><br>•Associated risks with non-implementation<br><br>•Outline of any key resources required<br><br>•Completion of KPIs and success measures<br><br>•Comments on progress comments<br><br>•Links to demonstrable outcomes | **Complete** | **Assurance Received** |

**Detail**

The GIAP and governance and delivery framework were agreed by the Board in March 2016. The GIAP included the findings and recommendations from the employment tribunal investigation, Deloitte report February 2016 and the CQC focused inspection February 2016.

The GIAP delivery framework was implemented from April 2016, with updates made to the plan accordingly. The GIAP has been in operation throughout 2016/17 with progress against key tasks monitored and overseen, progress RAG rated and associated risks to delivery of actions reviewed.

Deloitte carried out a review of the implementation of the GIAP, which took place between February 2017 and April 2017. (See M3).

On 10 April 2017 verbal feedback was provided, a draft report was received on (19 April) followed by the final report on (24 April). This provided assurance that the Trust now meets the benchmark Deloitte would associate with organisations rated

| |
|---|
| amber-green against NHS Improvement's well-led framework. |
| **Evidence** |
| 11.5 GIAP reports to Board monthly, e.g. October 2016<br>GIAP report to Board reporting completion of GIAP, May 2017 |
| **On-going Monitoring Arrangements**<br>Ongoing monitoring arrangements have been defined and agreed for all recommendations, as outlined in blue completion forms.<br><br>Work will continue to ensure embeddedness and effectiveness of these monitoring arrangements as part of our work towards an anticipated full well-led review during 2017/18. |

| | | | |
|---|---|---|---|
| **Executive Director Responsible** | Director of Corporate Affairs | **Responsible Assurance Committee** | Board of Directors |

# Blue Completion Form

| **Recommendation**<br>**M3** - The Trust will undertake to gain external assurance that the Governance improvement action plan has been implemented in full or that it can be implemented in full | **Current BRAG Rating**<br>**Complete** | **Recommended BRAG Rating**<br>**Assurance Received** |
|---|---|---|

**Detail**

A phase one external review was undertaken by Deloitte LLP in September 2016 to review progress and approach to implementation of the GIAP. This provided positive assurance of programme approach and informed further work on implementation and ensuring embeddedness and monitoring of actions undertaken.

Deloitte were commissioned to undertake a full review (phase two) of implementation of the GIAP between February and April 2017. During this period Board and Board Committees were observed, interviews took place with staff and Board members, focus groups were held with our governors, and information was submitted as part of their desk top review process.

On 10 April 2017 verbal feedback was provided, a draft report was received on (19 April) followed by the final report on (24 April). This gave positive assurance that significant improvement had been made across all three areas of the scope of the review, namely Board effectiveness, governance and HR associated functions, such that the Trust now meets the benchmark associated with organisations rated Amber/Green through similar well-led reviews. This Amber/Green rating reflects 'some areas of good practice, no major omissions and robust action plans to meet perceived gaps with proven track record of delivery'.

**Evidence**

11.6 Deloitte report phase one, September 2016
Deloitte report phase two, April 2017

**On-going Monitoring Arrangements**

Ongoing monitoring arrangements have been defined and agreed for all recommendations, as outlined in blue completion forms.

Work will continue to ensure embeddedness and effectiveness of these monitoring arrangements as part of our work towards an anticipated full well-led review during 2017/18.

| | | | |
|---|---|---|---|
| **Executive Director Responsible** | Director of Corporate Affairs | **Responsible Assurance Committee** | Board of Director |

**Derbyshire Healthcare NHS Foundation Trust**
Report to Board of Directors - 24 May 2017

# Information Governance – Quarter 4 Report

**Purpose of Report:** This report provides the performance update on our Trust Quarter 4 progress towards meeting the requirements of the 2016-17 Version 14 Information Governance Toolkit as well as the work of the Information Governance Committee and Information Governance breach monitoring.

## Executive Summary

- The IG Toolkit was submitted on 31 March 2016 with a self-assessed score of 98% and satisfactory. This keeps DHCFT at the forefront of our category as the draft highest scoring Mental Health and Community Trust. This is an improvement from the 97% score for the previous year.
- The IGC continues to progress the agreed work programme.
- There have been no new reportable incidents this quarter.

| **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. | |

## (Board) Assurances

- Full assurance on our IG Toolkit Version 14 submission;
- Full assurance that we continue to progress the IG agenda; and
- Full assurance that IG breaches are monitored and responded to appropriately including any actions required.

## Consultation

- Information Governance Committee

**Governance or Legal Issues**

Compliance with the IG Toolkit forms an important pillar of assurance around data protection (The Data Protection Act), Freedom of Information, confidentiality and information security.

| **Public Sector Equality Duty & Equality Impact Risk Analysis**<br>The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people). | |
|---|---|
| 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** | |
| None identified. A high level of compliance in the IG Toolkit supports improved practice around data collection that enables analysis of activity supporting improving outcomes for all REGARDS Groups | |

**Recommendations**

The Board of Directors is requested to:

1) Acknowledge the successful completion of the IG Toolkit;
2) Acknowledge the progress made with the IG work plan; and
3) Acknowledge the risk to the organisation of failing to meet the requirements of the IG Toolkit particularly with regards to the mandatory IG Training requirement.

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

**Report prepared by:** **Andy Preston**
**Information Standards Lead**

# Information Governance Q4 (Jan- March 2017) Report

## Introduction

This report provides information on our Version 14 Information Governance Toolkit submission demonstrating we have met all the requirements for 2016-17 at level 2 or above. We have surpassed our target of 94% and Satisfactory and the expectation is to remain top in our category.

## Background

The annual cycle of Information Governance (IG) implementation starts with the publication of the IG Toolkit which enables organisations to self- assess baseline compliance and develop plans to achieve improvements in-year, prior to the final annual return submitted at year end.
v14 of the toolkit requires the 3-stage reporting process requiring organisation's to carry out the following increments:

- Baseline assessment on 31 July 2016.
- Performance update on 31 October 2016. This was submitted showing 62% attainment and Not Satisfactory.
- Final submission on 29 March 2017. The Annual Return submitted on line as in previous years with our IG Statement of Compliance (IGSOC). We have achieved 98% and Satisfactory.

To be considered "satisfactory" a Trust must obtain level 2 for all IG criteria. We have obtained level 3 for 43/45 criteria. This includes the requirement for Trust Board involvement at the "highest level" in reviewing specified IG policies and the IG Management framework.

## Final Submission Status

| Assessment | Stage | Overall Score | Self-assessed Grade | Reviewed Grade | Reason for Change of Grade |
|---|---|---|---|---|---|
| **Version 14 (2016-2017)** | Baseline | 62% | Not Satisfactory | n/a | n/a |
| | Published | 98% | Satisfactory | n/a | n/a |

## Progress of the 2016-17 IG Work Programme

The following planned priorities were agreed for 2016-17:

- To continue to review and update policy in line with National Guidance.
- To continue to promote IG awareness;
- To complete the IG Toolkit so that all relevant (45) standards were achieved at a minimum level 2 or above producing a score of 98% compliance. This has produced an overall rating of "Satisfactory" allowing us to submit our annual IGSOC.

It should be noted that one Information Governance requirement is that all staff (95%) are trained in IG awareness. Our final achievement was **91.6%** compliance.

Due to the NHS IG online Training Tool being decommissioned on 31 December 2016, staff who completed the required IG training module for the v13 assessment period (01/04/2015-31/03/2016) did not need to receive further IG training until 2017/18. These staff can be considered as trained for the IGT version 14 assessment (2016/17). It follows that the Trust met the training requirement having reached 96.3% the previous year.

The requirement beyond this was for all new starters to receive IG Training – the Trust has reported 100% compliance for this latter requirement. We continue to address the issues we have capturing new starters, manual updating from face to face training and unavailable staff.

The IG Bulletin continues to be produced bi-monthly; the latest edition included example breaches throughout the NHS and our Trust, articles to raise IG awareness, and references to policy.

**Information Governance Committee**

The IGC has met three times this quarter. The IGC has reviewed and ratified a number of IG and IT policies to ensure that they incorporate any legal changes or guidance provided by the ICO. The focus remains to ensure that relevant policies support the shift from paper to an electronic Full Single Patient record. The IG policy dashboard for year-end shows us at 97% with 1 policy out of date (Service User Internet Kiosk Usage Policy and Procedures which is currently under review). The IGC has ratified a number of new applications and Information Sharing Agreements.

**Information Governance Breaches**

During this quarter we have had no new level 2 reportable SIRIS. The table below shows this quarter's incidents broken down by outcome with no major and no catastrophic breaches. We continue to get a number of incidents reported which have originated outside the Trust which the Information Standards Lead liaises on. We also continue to liaise with Patient Experience as required.

| Breach Type | Insignificant | Minor | Moderate | Total |
|---|---|---|---|---|
| Breach of Confidentiality - Verbal | 0 | 4 | 0 | 4 |
| Breach of Confidentiality - via Social Networking Sites | 0 | 0 | 1 | 1 |
| Electronic Record - Incorrect address or other personal details | 2 | 1 | 0 | 3 |
| Electronic Record - Other electronic breach | 1 | 6 | 3 | 10 |
| Electronic Record - Unauthorised access to clinical record (Actual or Potential) | 0 | 0 | 1 | 1 |
| Electronic Record - Unsafe e-mailing of confidential information | 1 | 2 | 2 | 5 |
| Paper Record - Breaches related to faxing | 0 | 2 | 0 | 2 |
| Paper Record - Incorrect address or other personal details | 0 | 3 | 0 | 3 |
| Paper Record - Misfiled document(s) | 0 | 2 | 0 | 2 |

| Breach Type | Insignificant | Minor | Moderate | Total |
|---|---|---|---|---|
| Paper Record - Missing/Lost document(s) | 0 | 1 | 0 | 1 |
| Paper Record - Missing/Lost record(s) | 3 | 3 | 0 | 6 |
| Paper Record - Other paper record breach | 3 | 7 | 2 | 12 |
| Paper Record - TNT unable to locate | 1 | 0 | 0 | 1 |
| Paper Record - Unavailable - not retrieved or sent on time | 0 | 1 | 1 | 2 |
| Paper Record - Unsafe disposal of confidential waste | 1 | 0 | 0 | 1 |
| **Total** | **12** | **32** | **10** | **54** |

The IG Team use IG incidents in mandatory IG training to help ensure organisational learning and promote best practice.

## Risks

The main risks:

- Failing to meet the requirements of the IG Statement of Compliance
- IG Breaches which are SIRI reportable to the ICO at Level 2

## Year End Benchmark Position

The Trust's attainment level of 98% and Satisfactory maintains our position as one of the highest achieving Trusts within the Mental Health, Community and Acute categories. At the time of writing the formal result publication of the v14 Toolkit across all organisations has not been published. This will confirm the final Trust ranking on release.

**Derbyshire Healthcare NHS Foundation Trust**
Report to Board of Directors 24 May 2017

# Fit and Proper Persons Test Policy and Chair's Declaration

## Purpose of Report

To present the Chair's declaration that all Trust Board Directors meet the fitness test and do not meet any of the 'unfit' criteria as per the Fit and Person's Test regulations (Health and Social Care Act 2008 Regulation 2014).

## Executive Summary

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 introduced a 'Fit and Proper Person Test' for NHS bodies. At its meeting on 30 March 2016 the Trust Board approved a Fit and Proper Persons Test policy which outlines how the Trust will meet the requirements placed on NHS providers.

Under the regulations, all provider organisations must ensure that Director level appointments meet the 'Fit and Proper Persons Test' and the regulations place a duty on NHS providers not to appoint a person or allow a person to continue to be an Executive Director or equivalent or Non-Executive Director under given circumstances. The regulations have been integrated into the Care Quality Commission's (CQC's) registration requirements, and falls within the remit of their regulatory inspection approach.

It is the responsibility of the Chair to discharge the requirement placed on the Trust to ensure that all Directors meet the fitness test and do not meet any of the 'unfit' criteria. The Trust has processes in place to ensure that the appropriate checks are made on appointment of Director level posts, that relevant checks and supporting information relating to existing post holders has been provided and there are proactive processes set in place to ensure the ongoing review and monitoring the filing system for all Directors. These have been carried out at appointment for all Director and Non-Executive Director appointments made during 2016/17. In addition, self-declarations have been made by all Directors as at 31 March 2017. Comprehensive files containing evidence to support the elements of the fitness test are retained and regularly reviewed to ensure contents are updated as required.

This declaration evidences the embeddedness of processes set in place as part of the Governance Improvement Action Plan (recommendations FF1 (4) and FF (5)) relating to compliance with the Fit and Proper Persons Test.

**DECLARATION:**

**I hereby declare that appropriate checks have been undertaken in reaching my judgment that I am satisfied that all Directors of the Trust, including Non-Executive Directors, and Executive Directors (including voting, non-voting and Acting) are deemed to be fit and that none meet any of the 'unfit' criteria. Specified information about Board Directors is available to regulators on request.**

**Strategic considerations**

- This declaration confirms that the Trust meets the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 'fit and proper person test' for NHS bodies.
- It is an element of NHS Improvement's Code of Conduct for NHS Trusts (Reference B.2.2) for which the Trust must 'comply or explain' within the Annual Report and Accounts

**Board Assurances**

- The Board can receive assurance that due process has been followed to ensure that all relevant post holders meet the fitness test and do not meet any of the 'unfit' criteria.
- That comprehensive files have been established for each relevant post, evidencing compliance and that proactive processes have been set in place to monitor the filing system.

**Consultation**

This report has not been considered by other groups/committees.

**Governance or Legal Issues**

- It is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that NHS bodies undertake a 'fit and proper person test'.
- The regulations have been integrated into the CQC's registration requirements, and falls within the remit of their regulatory inspection approach.

**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).

| | |
|---|---|
| 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**

No risks have been identified at this stage.

**Recommendations**

The Board of Directors is requested to:

1) Receive full assurance from the Chair's declaration that that all Directors meet the fitness test and do not meet any of the 'unfit' criteria

**Report presented by:** **Caroline Maley, Acting Chair**

**Report prepared by:** **Samantha Harrison, Director of Corporate Affairs**

**Derbyshire Healthcare NHS Foundation Trust**
Report to Trust Board – 24 May 2017

# 2016/17 Year-end Report of the Audit & Risk Committee

## Purpose of Report

The report summarises how the Committee has discharged its remit during 2016/17 and is in addition to the assurance summary reports which have been presented to Board meetings throughout the year. The report also provides assurance on the effectiveness of all other Board Committees.

## Executive Summary

This paper provides a report to the Board on the activity and effectiveness of the Audit and Risk Committee for 2016/17, comparing the work of the Committee to its Terms of Reference.

The report was considered by the Audit and Risk Committee at its meeting on 26 April 2017. The Committee received significant assurance on the effectiveness of the Committee.

The review contained in this paper takes into account the Committee's meetings held from April 2016 to March 2017.

28 April 2016 – full meeting
24 May 2016 – full meeting
19 July 2016 – full meeting
19 July 2016 – private meeting of members with the Director of Finance
11 October 2016 – full meeting
11 October 2016 – private meeting of members with the Directors of Finance and Corporate Affairs
13 December 2016 – full meeting
17 January 2017 – full meeting
14 March 2017- full meeting
14 March 2017 – private meeting of members with the Directors of Finance and Corporate Affairs

For 2016/17 the Committee had set as its objectives:

- To promote good governance by ensuring greater clarity and cohesion between Board Committees
- To ensure that the Committee has a formal process for the interaction with Governors
- To apply clarity to the oversight of risk within the Board Committee structure
- To consider the implications of non-audit work carried out by the auditors
- To ensure robust governance processes are in place to enable the Audit & Risk Committee to seek the appropriate assurance over systems, controls and processes

- To ensure that the Board and Council of Governors are provided with the appropriate training to ensure knowledge of Audit and the role of the Audit & Risk Committee.

The Audit and Risk Committee in its governance oversight role also considered Reports from the following Committees along with updated terms of reference:

- Remuneration and Appointments Committee
- Finance& Performance Committee
- Quality Committee
- People & Culture Committee
- Safeguarding Committee
- Mental Health Act Committee.

The Audit and Risk Committee received significant assurance on the effectiveness of these Committees. An interim update on progress is to be provided by the Mental Health Act Committee given on the ongoing development of the Committee that was underway.

Terms of reference of all Committees were agreed and will be presented to the Trust Board as part of the annual review of the Corporate Governance Framework in July.

**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 purpose of the Audit & Risk Committee is to establish and maintain an effective system of integrated governance, risk management and internal control across the organisation, in a way that supports the organisation's objectives.

**Consultation**

This paper has not been considered by any other group.

**Governance or Legal Issues**

Satisfactory governance performance underpins many aspects of statutory, regulatory and legal compliance for Foundation Trusts. The Audit & Risk Committee forms part of the Trust's Corporate Governance Framework as a Committee of the Board.

**Equality Delivery System**

The operation of the Committee does not directly affect any REGARDS groups.

**Recommendations**

The Trust Board is requested to:

1. Receive full assurance on the effectiveness of the Audit and Risk Committee during 2016/17
2. Receive significant assurance regarding the discharge of the remit of all other Board committees, as considered by the Audit and Risk committee.

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

**On behalf of:** **Barry Mellor**
**Chair Audit & Risk Committee**

# AUDIT & RISK COMMITTEE

# ANNUAL REPORT 2016/17

## 1. Purpose

The Audit & Risk Committee is responsible for establishing and maintaining an effective system of integrated governance, risk management and internal control across the organisation, in a way that supports the organisation's objectives. It achieves this by:

- Ensuring there is an effective internal audit function that provides appropriate independent assurance to the Committee, the Chief Executive and the Board of Directors
- Reviewing the work and findings of the Trust's external auditor
- Reviewing the findings of other significant assurance functions, both internally and externally
- Reviewing the work of other committees within the organisation
- Requesting and reviewing reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control
- Reviewing the annual report and financial statements before they are submitted to the Board
- Ensuring that the systems for financial reporting to the Board, including those around budgetary control, are subject to review in order to be sure that they are complete and accurate.

Throughout the year, the Audit & Risk Committee considers external audit reports, internal audit reports, and counter-fraud progress reports. All audit outcomes are overseen by monitoring the delivery of internal and external audit report recommendations.

The Committee considers the Board Assurance Framework, Annual Report, Quality Report, Annual Governance Statement and progress with internal and external audit plans. It also receives updates on losses and compensation payments, exit payments, hospitality and sponsorship, tenders and waivers, debtors and clinical audit. The Committee also considers governance and compliance documents.

The Committee assesses the effectiveness of the external audit process by undertaking a self-assessment each year and by meeting with auditors in private. Auditors attend every meeting of the Audit & Risk Committee, and the Trust's compliance with the audit plan approved by the Committee is monitored.

## 2. Authority

As a Committee of the Board, the Audit and Risk Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's Strategic objectives which fall within the Committee's remit.

The Committee had a role during the 2016/17 financial year to oversee progress and provide assurance to the Board on the implementation of key tasks as outlined in the Trust's Governance Improvement Action Plan. The Committee is assigned as responsible committee for a range of tasks and is required to provide assurance to the Board on the progress towards completion of tasks and evidence of demonstrable outcomes in working towards ensuring that effective governance processes are embedded within the Trust.

The Committee had specific oversight of Core 4 of the GIAP which comprised 13 recommendations relating to corporate governance.

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the trust with relevant experience and expertise

## 3. Membership of Audit & Risk Committee

The Audit & Risk Committee comprises three independent Non-Executive Directors.

Non-Executive Directors' membership and attendance at the Audit & Risk Committee during the year 2016/17 is listed below:

| Name | Title | Membership Period |
|---|---|---|
| Barry Mellor | Committee Chair from 7 January 2017 | Member from December 2016, Chair from January 2017 |
| Caroline Maley | Committee Chair | April to December 2016* |
| Julia Tabreham | Non-Executive Director | From October 2016 |
| Margaret Gildea | Non-Executive Director | From October 2016 to November 2016. Following review of Committee membership, reinstated as A&R member from January 2017. |
| Phil Harris | Non-Executive Director | April to August 2016** |

*Caroline Maley was appointed to the role of Acting Trust Chair from 1 January 2017
**Phil Harris ceased to be a Non-Executive Director on 31 August 2016.

## 4. Attendance

The attendance log reflects attendance by members of the Committee, as well as the Directors of Finance and Corporate Affairs who are required to attend routine meetings of the Committee to support the Chair and Committee members. Other Executive Directors have attended by invitation to consider areas of risk or operation that are their responsibility.

The Acting Chief Executive, as accountable officer, attended the May 2016 meeting of the Committee at which the Annual Report and Accounts including the Annual Governance Statement was considered, as well as the opinion of the Head of Internal Audit which supports the conclusion within the Annual Governance Statement. The Interim Chair also attended this meeting to consider and approve the Annual Report and Accounts.

The External Auditor was represented at all meetings. The Internal Auditor attended all but one routine meeting of the Committee (May 2016). A representative of the Counter Fraud Service attended three meetings of the Committee, in line with the requirements of the

Terms of Reference. The Lead Governor attended the May meeting to observe the final approval of the Annual Report and Accounts for 2015/16. The Director of Corporate Affairs acted as secretary to the Committee throughout the year and provided appropriate support and advice to the Chair and the Committee members.

Both the Internal and External Auditors had the opportunity to meet with the Audit & Risk Committee in private (without Executives present) prior to all Committee meetings to discuss any concerns relating to performance.

## 5. Access

The Head of Internal Audit, representatives of External Audit and Counter Fraud Specialist have a right of direct access to the Chair of the Committee and are aware of the channels through which this can be achieved. In practice, this has been undertaken through the auditor meetings held prior to each Committee.

## 6. Frequency of Meetings

The Committee has met on seven occasions, discharging its responsibilities as set out in the Terms of Reference. In addition, there were three private meetings with members and the Directors of Finance and Corporate Affairs only (19 July 2016, 11 October 2016 and 14 March 2017) to discuss commercial matters relating to the contracts for internal and external auditor and counter fraud services.

## 7. Required frequency of attendance by members

According to the Committee's terms of reference, members should attend at least 75% of all meetings each financial year, but should aim to attend all scheduled meetings. In 2016/17, with the exception of one member, as evidenced through the attendance log (below), all have achieved in excess of 75% attendance at the meetings of the Committee in the financial year. The member who has not achieved the 75% attendance was not able to attend one meeting due to short notice of the meeting date following appointment as an Audit and Risk Committee member. All meetings have been quorate.

| **Audit & Risk Committee 2016/17** | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Attendance Record | 28-Apr-16 | 24-May-16 | 19-Jul-16 | 11-Oct-16 | 13-Dec-16 | 17-Jan-17 | 14-Mar-17 | Number of meetings attended in 2016/17 | Number of meetings eligible to attend | % |
| **MEMBERS** | | | | | | | | | | |
| Barry Mellor | | | | | 1 | 1 | 1 | 3 | 3 | 100% |
| Julia Tabreham | | | | 1 | 1 | 1 | 1 | 4 | 4 | 100% |
| Margaret Gildea | | | | 1 | | 0 | 1 | 2 | 3 | 67% |
| Caroline Maley | 1 | 1 | 1 | 1 | 1 | | | 5 | 5 | 100% |
| Phil Harris | 1 | 1 | 1 | | | | | 3 | 3 | 100% |
| **REQUIRED ATTENDEES** | | | | | | | | | | |
| Claire Wright | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 6 | 7 | 86% |
| Sam Harrison | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 7 | 7 | 100% |

## 8. Duties and Responsibilities

The following subheadings, shown in italics, are copied from the Duties & Responsibilities section of the Terms of Reference of the Audit & Risk Committee (Appendix 1). The commentary underneath each subheading is drawn from a review of the minutes of all meetings and other relevant information.

***The Committee's duties and responsibilities can be categorised as follows:***

***Integrated governance, risk management and internal control***

***8.1 To review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities, clinical and non-clinical, that supports the achievement of the Trust's objectives.***

The management of risk underpins the achievement of the Trust's Strategy and related objectives. The Trust's approach to Risk Management has been articulated within a 'risk management approach' section in the Quality Framework supported by a Risk Management Procedure. In 2016/17 it was agreed to underpin the risk management approach with a Risk Management Strategy, which was developed in year, overseen by the Audit & Risk Committee and ratified in December 2016.

The Audit & Risk Committee has oversight of 13 recommendations in the Governance Improvement Action Plan (GIAP). It regularly reviewed evidence of progress against each of the recommendations and closed 12 of these during the year.

***8.2 In particular to review the adequacy and effectiveness of:***

- ***all risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances.***

  The Annual Governance Statement was subject to scrutiny and challenge by the Audit & Risk Committee to ensure it met the requirements as set out for the report. The Committee was assured that the report was balanced and fair.

- ***the underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements***

- ***arrangements for the effective management of clinical and corporate risk to underpin the delivery of the Trust's principal objectives***

  The Committee continued the process to receive 'Deep Dive' reviews of high or extreme BAF risks, which proved invaluable in providing assurance over controls and gaps in assurance with a focus on action plans to manage risks. This approach informed and supported the overall review of the BAF prior to regular submission to the Trust Board. Significant clinical and corporate risks are identified and linked to the BAF risks as part of routine reporting.

- ***arrangements in place for preventing and countering fraud, bribery and corruption and managing security in compliance with the related NHS Protect Standards.***

  The Trust's Counter Fraud Service is provided by an external organisation, which changed in year. From 1 April to 30 November 2016, services were provided via

360 Assurance. Effective 1 December, KPMG were appointed to the role. However, each organisation had conducted its work in line with an annual plan which was agreed by the Audit & Risk Committee. The plan is designed to provide counter-fraud, bribery and corruption work across generic areas of activity in compliance with NHS Protect guidance and Provider Standards.

During 2016/17 the Trust used 44 days of counter fraud activity with 360 Assurance and 12.5 days with KPMG, across the following areas:

- Inform and involve (fraud awareness training, publicity, liaison) – 18 days
- Prevent and deter (issue alerts, reviews policies and system weaknesses, provide guidance) – 17 days
- Hold to account (investigations) – 9 days
- Strategic governance (assessment and reporting) – 13.5 days
- Total – 56.5 days.

In submitting its report at the conclusion of its contract, 360 Assurance was assured that the Trust's counter fraud, bribery and corruption arrangements are embedded, that there is a strong anti-fraud, bribery and corruption culture within the Trust and that Counter Fraud service delivered by 360 Assurance (as positively commented upon by NHS Protect in their inspections) has been and is efficient and effective.

Each organisation is required to submit a self-review tool annually, summarising anti-fraud, bribery and corruption work conducted over the previous 12 months in accordance with the standards set by NHS Protect. The overall level of the Trust was found to be Green (Organisation Meets Standard).

- ***The Committee shall maintain an oversight of the Trust's general material control and risk management systems, including processes and responsibilities, the production and issue of any risk and control-related disclosure statements. The key record to guide the Committee's work will be the Board Assurance Framework (BAF).***

The BAF is a 'live' document and as such is regularly reviewed and updated. The Audit & Risk Committee is responsible for reviewing the BAF to assure itself that the BAF appropriately addresses objectives and risks and also to ensure that newly arising risks are identified. The Board Assurance Framework (BAF) was reviewed by the Committee four times in year (July, October, January and March). The Audit & Risk Committee has confirmed that it is satisfied that the BAF shows a clear mapping across all risks identified by the Board of Directors and that good engagement has taken place with the Executive Directors in managing the overarching Risk Register.

During the year the Audit & Risk Committee invited Executive Leads to give presentations and discuss the issues involved in high level risks:

| BAF Risk | Risk | Deep Dive Received |
|---|---|---|
| 4b | **Transformation** | July 2016 |
| 4a | **Financial Plan** | October 2016 |
| 1a | **Clinical Quality** | December 2016 |
| 3a | **Regulatory Compliance** | January 2017 |
| 3b | **Loss of Confidence in Leadership** | January 2017 |
| 1c | **Clinical Workforce** | March 2017 |
| 1d | **Compliance with Mental Health Act/Mental Capacity Act** | March 2017 |
| 2a | **System Change** | March 2017 |

KPMG reviewed the Trust's BAF and Risk Management arrangements during January – February 2017. Their findings were presented to the March Audit & Risk Committee, giving significant assurance with improvement opportunities.

***8.4 As part of its integrated approach, the Committee will ensure appropriate information flows, to the Committee from executive management and from and between other Board Committees, in relation to the Trust's overall internal control and risk management position.***

The Audit & Risk Committee secures its oversight on assurance of effectiveness of other committees via each committee's year-end report. The Finance & Performance Committee year-end report to provide assurance on effectiveness was presented to the Audit & Risk Committee in April 2016. Annual reports for Quality Committee, Mental Health Act Committee, Safeguarding Committee and the Remuneration and Appointments Committee were received in July 2016. Assurance Summary Reports were received from April-October from the Quality Committee, Mental Health Act Committee and the People & Culture Committee. At the October meeting of the Audit & Risk Committee it was agreed that to avoid duplication and to ensure timely review, ongoing oversight could be secured from the Committee assurance summaries presented monthly to the Trust Board, and they would no longer be also presented to the Audit and Risk Committee.

***8.5 To monitor corporate governance (e.g. compliance with terms of the licence, constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests).***

A full corporate governance review was undertaken as part of GIAP in July 2016. This reiterated robust procedures for monitoring key governance areas on an ongoing basis. This review included the annual review of the standing orders and standing financial instructions.

***8.6 To develop and use an effective assurance framework to guide the Committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as fulfil its functions in connection with these terms of reference.***

Sections 8.1-8.5 above detail the range of assurance mechanisms used by the Committee in fulfilling its terms of reference.

**Internal audit**

***8.7 To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.***

The Trust takes a risk based approach to developing the internal audit programme and this was agreed by both the Executive Leadership Team and the Audit and Risk Committee in April 2016.

***8.8 To oversee on an on-going basis the effective operation of internal audit in respect of:***

- ***Adequate resourcing***
- ***Co-ordination with external audit***
- ***Meeting the Public Sector Internal Audit standards***
- ***Providing adequate independent assurances***
- ***Having appropriate standing within the Trust; and***
- ***Reviewing and approving the internal audit plan ensuring that this meets the internal audit needs of the organisation.***

The Committee has a standing item on its agenda

***8.9 To consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.***

Much of the work of the Committee is supported by the programme of work for internal audit services which has been provided in 2016/17 by both PricewaterhouseCoopers (PwC) and KPMG. Services with both providers have been within an agreed workplan, prepared in consultation with the Executive Leadership Team and approved by the Committee, which seeks to ensure that reviews focus on areas of risk identified by the Trust.

Internal Audit services in 2016/17 were provided by PricewaterhouseCoopers from 1 April to 30 November 2016. Having reached the end of their maximum appointment period, a tender process was followed for replacement internal auditors. KPMG were appointed as Internal Auditors with effect from 1 December 2016 for two years with an option to extend the contract by a further two years. Handover meetings were held between PwC and KPMG to understand the work carried out to date.

Each review report by the Internal Auditors, together with management responses are presented to the Committee. During the year the Committee has considered seven internal audit reports by PwC and one by KPMG resulting in the identification of four high, 16 medium and 26 low risk findings to improve weaknesses in the design of controls and/or operating effectiveness. The four high risk finds are outlined as below

and are being actively addressed and managed as part of ongoing monitoring processes:

**Section 132 (patient rights)**
*All patients who are put onto a community treatment order (CTO) should have a rights form completed which evidences how rights have been communicated. This rights form is required to be stored on the Trust's patient record system PARIS and needs to be signed by the responsible clinician. We tested 23 CTOs which started in the period. The Trust was unable to provide us with rights forms for seven individuals. 7 Out of the 12 patients for whom we received a rights form with the date recorded, nine of these patients had their rights communicated to them more than one week after the date they entered the CTO. The Average time delay for these nine patients was 130 days.*

**Consultant Job Planning**
*For 18 consultant job plans sample tested the following issues were identified:*

- *There was no evidence to support that job plans had been consistently signed off and Agreed. Five jobs plans were not signed by the Consultant, 8 by the relevant line manager and six by the Associate Clinical Director.*

- *Nine jobs plans were dated over one year ago. BMA guidance states that job plans should be set on an annual basis. Our sample included job plans which were set in 2013 and 2014. One further job plan had no date present in order to confirm when this was set.*

- *Job plans should be reviewed and reset annually. The BMA Pro-forma template used requires a date for review to be populated. There was only a specified review date for five out of the 18 job plans in our sample. One of the five completed had a review date in the previous years (April 2014).*

- *Two job plans received only included the Consultants timetable and did not include other elements required in a job plan as per BMA guidance. This includes objectives, additional programme activities and supporting resources required. Our discussions with Associate Clinical Directors identified that job plans are reviewed annually prior to the creation of the following year's job plan. No separate documentation is recorded as part of this process, alternatively any issues or changes required are recorded into the new job plan.*

**Agency Controls**
*In July 2016 NHSI brought in a new reportable requirement of maximum wage rates. This introduces a ceiling on the amount agencies pay their staff. As part of this trusts should seek confirmation from agencies that workers are not paid more than the maximum wage rates and report this to NHSI. The Trust had no formal agreement with any agency to ensure that this requirement is met when agency staff are hired. For the nursing staff, there had been conversations held between Procurement and some agencies. However nothing has been formalised in an email or an agreement. For all other staff, there was nothing in place to ensure.*

**Mental Capacity Act – Review of patient notes**
*The Trust implemented its new capacity assessment form which should be completed on PARIS (electronic patient record system). Of the 45 forms selected for our sample, only 23 could be located on the PARIS system. The Trust was unable to provide us*

*with any evidence of copies of the capacity form in 2. 6 were in a different format (e.g. paper copy) for the remaining 22 forms.*

PwC's Head of Internal Audit opinion at their conclusion of their contract was as follows:

*There are significant weaknesses and non-compliance in the framework of governance, risk management and control which put the achievement of organisational objectives at risk. Major improvements are required to improve the adequacy and effectiveness of governance, risk management and control.*

***8.10 To consider the provision of the internal audit service, the cost of the audit.***

The contract for internal audit and counter fraud services was put out to tender in July 2016. The tender was run as a mini-competition against the NHS SBS Internal/External Audit, Counter Fraud & Well Led Governance Review Framework in order to provide the best assurance of obtaining value for money and to simplify the procurement process. The contract was awarded to KPMG.

***8.11 To monitor the effectiveness of internal audit and to conduct an annual review of the internal audit function.***

Grant Thornton conducted a high level review of the Trust's internal audit's overall arrangements which form part of their standing report to the March 2017 Committee meeting. They concluded that the work of both the previous and current internal audit service provided a satisfactory service to the Trust. No weaknesses were identified. Feedback from Committee members on internal audit provision was also positive for both the 2016 and 2017 surveys undertaken.

**External audit**

***8.12 To make a recommendation to the Council of Governors in respect of the appointment, re-appointment and removal of an external auditor and related fees as applicable. To the extent that the recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.***

In March 2017 the Audit & Risk Committee proposed a recommendation to the Council of Governors to consider a one year extension to the appointment of Grant Thornton as the Trust's external auditors under procurement framework arrangements. This was supported by the Council of Governors and a one year extension was duly enacted (from 1 November to 31 October 2018).

***8.13 To discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy.***

Regular reporting to the Committee by the external auditor as a standing agenda item encompasses updates on the nature and scope of the annual audit to be undertaken.

***8.14 To assess the External Auditor's work and fees each year and based on this assessment, to make the recommendation above to the Council of Governors with respect to the re-appointment or removal of the Auditor. This assessment should include the review and monitoring of the External Auditor's***

***independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.***

Discussion on the ongoing provision of external audit services beyond the Grant Thornton contract end date of October 2017 was initiated during the year and discussed with the Council of Governors. The costs of services were benchmarked to review value for money against services provided to other Trusts (see also 8.12).

***8.15 To oversee the conduct of a market testing exercise for the appointment of an auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the Auditor.***

Refer to comments above at 8.12 and 8.14.

***8.16 To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.***

Implementation of recommendations has been overseen as part of regular reporting to the Committee on internal and external audit review recommendations. Frequency of this reporting has increased from quarterly to bi-monthly during the year.

***8.17 To develop and implement a policy on the engagement of the External Auditor to supply non-audit services.***

This policy is in place with the external auditors.

***8.18 To consider the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal of the auditors.***

See sections 8.12, 8.14 and 8.15.

**Annual accounts review**

***8.19 To approve the Annual Report and Accounts including the Quality Report and Annual Governance Statement on behalf of the Trust Board. In doing so the Committee will determine their completeness, objectivity, integrity and accuracy.***

*The Committee approved the documents for 2015/16 in May 2016.*

***8.20 To review all accounting and reporting systems for reporting to the Board of Directors, including in respect of budgetary control.***

Accounting policies were reviewed in year and remain largely unchanged.

**Raising Concerns (Whistleblowing)**

***8.21 To review the adequacy of the Trust's arrangements by which Trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.***

The Audit & Risk Committee received reports in May and December 2016 which mapped out the arrangements in place to address concerns within the Trust and

advised key routes and roles where concerns are raised. The reports enabled the Committee to review the robustness of policy and procedures in place.

**Standing orders, standing financial instructions and standards of business conduct**

***8.22 To review on behalf of the Board of Directors the operation of, and proposed changes to, the standing orders and standing financial instructions, the constitution, codes of conduct and standards of business conduct; including maintenance of registers.***

The Corporate Governance Framework was reviewed and approved by the Committee in July 2016.

***8.23 To examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension.***

No significant issues were reported during the 2016/17 year. Reports of waiving of the Standing Financial Instructions are routinely reported to the Committee.

***8.24 To review the scheme of delegation.***

This forms part of the Corporate Governance Framework of the Trust and was reviewed and approved by the Committee and subsequently the Board in July 2016.

**Other**

***8.25 To review performance indicators relevant to the remit of the Committee.***

Through reporting from the External Auditors, the Audit & Risk Committee remained appraised of the Trust's performance in each of 15 key financial indicators identified by Grant Thornton benchmarked against other mental health foundation trusts (February 2017).

***8.26 To examine any other matter referred to the Committee by the Board of Directors and to initiate investigation as determined by the Committee.***

No actions have been referred to the Committee by the Board of Directors during the year (as confirmed by cross-Committee actions matrix that has been in operation throughout the year).

***8.27 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health sector and professional bodies with responsibilities that relate to staff performance and functions.***

The Committee has overseen a wide range of actions relating to the Governance Improvement Action Plan (GIAP). Oversight of the full GIAP programme and response to the CQC inspection (June 2016) has been retained by the Trust Board. The Committee has overseen 13 recommendations in Core 4 and this involved ensuring development and implementation of a wide range of corporate governance structures, practices and policies.

***8.28 To review the work of all other Trust committees in connection with the Committee's assurance function.***

The Committee received and reviewed the year-end report for the Finance & Performance Committee in April 2016. Year-end reports for Quality, Mental Health Act, Safeguarding and Remuneration and Appointments Committees were reviewed at the July 2016 meeting. Regular assurance reports were received from all Board Committees from April to October 2016 (see section 8.4). 2016/17 year-end reports for Board Committees are scheduled to be reviewed at the April 2017 meeting of Audit & Risk Committee.

***8.29 The Committee may also request specific reports from individual functions within the Trust (for example, clinical audit).***

Reports have been requested during the year on a range of areas including clinical audit, policy governance and Raising Concerns (Whistleblowing) activity.

***8.30 The Committee may refer specific issues to the Board, Finance and Performance Committee and other Committees and make recommendations as appropriate.***

At the conclusion of every meeting the Committee has discussed and agreed any necessary referrals to other Committees. These are noted on the assurance summary of the meeting presented to the Public Board meeting. Referrals are noted on the Committee's actions matrix and archived once evidence and assurance has been received that these are complete.

**9. Minutes and Reporting**

***9.1 The minutes of all meetings of the Committee shall be formally recorded and submitted, together with recommendations where appropriate, to the Board of Directors. The submission to the Board of Directors shall include details of any matters to be escalated in respect of which actions or improvements are needed.***

Each meeting is formally recorded. An assurance summary is reported to the Public Board after each meeting, which summarises discussions, details assurance and actions required, as well as decisions made and identification of any key risks. Items for escalation to the Board or for referral to other Board Committees are also contained within the assurance summary.

***9.2 The Committee will report annually to the Board of Directors and the Council of Governors in respect of its work in support of the annual governance statement.***

The Committee presented its Annual Report for 2015/16 to the Trust Board in May 2016 and shared the same report with the Council of Governors in June 2016. The Trust's Annual Report & Accounts for 2015/16 were presented to the Council of Governors by Grant Thornton, the Trust's External Auditors, in July 2016. This is scheduled to be repeated in July 2017.

***9.3 The Committee's annual report should also describe how the Committee has fulfilled its Terms of Reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed. The Trust's annual report shall include a section describing the work of the Committee in discharging its responsibilities.***

The report above outlines how the Committee has addressed all elements of its terms of reference during the year. The work of the Committee is included within the Annual Report. The Board can have significant assurance regarding the contents of the Annual Report, Financial Statements, and Quality Report for the year ended 31 March 2017.

***9.4 The Committee will review its effectiveness at the end of each meeting***

The Committee reflected upon its effectiveness at the end of each meeting, the appropriateness of papers and received suggestions for improvement. Overall, members have been satisfied with the way the Committee operates and have commented on good level of debate, challenge and participation of members and attendees and chairing effectiveness. Areas to note for improvement include avoiding duplication with the work of other committees and the quality of papers presented. A peer observation took place at the December 2016 meeting and feedback will be taken forward in the work of the Committee during 2017/18 to further improve effectiveness of the Committee. In addition as part of the Deloitte review of the implementation of the GIAP, undertaken in February-April 2017, there has been specific feedback about the Committee and this will be considered by the Committee Chair going forwards into 2017/18. The external assurance review confirmed that this gave positive assurance that significant improvement had been made across all three areas of the scope of the review, namely Board effectiveness, governance and HR associated functions, such that the Trust now meets the benchmark associated with organisations rated Amber/Green through similar well-led reviews.

PWC carried out the HFMA Audit Committee survey during March 2016 which informed the Committee's 2015/16 year-end report. KPMG repeated this survey in March 2017 noting that the Committee continues to have a positive view of Committee processes. In terms of Committee effectiveness there is a mixed picture, with some areas of improvement, some no change and some of deterioration. This may be in part because the membership of the Committee has changed year on year. The Chair's survey (undertaken by the Committee chair from April-December 2016) portrays a stable picture of the Committee, with two areas of improvement noted (risk management and quality of reporting to Committee) and one area worsening since last year, which is opportunities for learning and development for Committee members. The Committee is to consider further findings of this survey in setting its priorities for 2017/18 and in improving effectiveness of the Committee.

***10. Administrative Support***

The Director of Corporate Affairs and Trust Secretary discharged her duties in support of the Audit & Risk Committee throughout the year.

***11. Review of terms of reference***

The terms of reference were reviewed in May 2016 as part of the Corporate Governance Framework review. They were updated to ensure that they reflected the Committee's role to oversee progress and provide assurance to the Board on the

implementation of key tasks as outlined in the Trust's Governance Improvement Action Plan. The terminology regarding Raising Concerns (Whistleblowing) was also amended.

**Derbyshire Healthcare NHS Foundation Trust**
Report to Board of Directors – 24 May 2017

## Report from Council of Governors
## 6 April 2017 & 2 May 2017

The Council of Governors has met twice since previously reported to the Public Board. Bi-monthly confidential meetings have been arranged, at the request of governors, to specifically discuss the merger by acquisition. The first confidential meeting was held on Thursday 6 April. It was chaired by Caroline Maley, Acting Trust Chair. Ten governors attended the confidential meeting. A public meeting was held on 2 May 2017 at Belper Football Club, also chaired by Caroline Maley. Twelve governors attended the public meeting on 2 May 2017.

**Thursday 6 April 2017 – Confidential Meeting (as reported to CoG on 2 May)**
Governors received a copy of the summary report of the first Joint Integration Programme Committee held on 9 March 2017. The report provided governors with a summary of the key discussions.

Governors also received a paper entitled 'Defining Positive Benefit Associated with the DCHS/DHcFT Transaction', a document previously discussed at the Confidential Trust Board on 29 March. The document outlined the merger expectations of the Trust including proposing the evidence/measurement that may be required to demonstrate these have been met. Prior to the meeting governors had been asked to consider their own expectations and these were also discussed during the meeting.

Governors welcomed the opportunity to have open and confidential conversations with the Non-Executive Directors and representatives from the Trust Executive. It was felt the private sessions offer much needed opportunity to focus on this very important subject. The first Joint Governor Working Group with DCHS governors to discuss the Trust Constitution for the acquiring organisation was also noted; with progress reported on the debate relating to the various Council of Governor constituencies in both constitutions.

**Tuesday 2 May 2017 – Public Meeting**

**Acting Chief Executive's Report**
The report updated governors on changes within the national health and social care sector as well as providing local updates within the health and social care community. The report supports the Council in its duty of holding the Board to account by way of informing members on internal and external developments.

The report was delivered by Claire Wright on behalf of Ifti Majid. Claire Wright highlighted the next steps on the five year forward view, which defines the four key priorities for the coming year and how the Trust will enable the requirements. The Board has committed to support local delivery of core components of a recently published report by the Royal College of Psychiatrists into morale and training of junior doctors in psychiatry. Claire Wright reported that the Trust had met the requirements of the CQC's Warning Notice, issued in relation to the June 2016 inspection and as a result was pleased to announce that the Warning Notice had been lifted. Governors thanked the Board and staff for their hard work in achieving this.

**Update on DCHS and DCHcFT Collaborative Working**
Governors received the summary report from the Joint Integration Programme Committee (JIPC), which provided a summary of key discussions and highlighted issues to be aware of as the potential transaction discussion progress. Both organisations are collaborating on the production of the Outline Business Case, which will seek to establish the evidence on the potential benefits of the coming together of both organisations. Work on the Sustainability & Transformation Plan continues alongside, as Trusts look at ways to help ensure that services are built around the needs of local populations.

**Non-Executive Director Update – Quality Committee Deep Dive**
Dr Julia Tabreham gave an update on the work of the Quality Committee, highlighting the responsibilities of the Committee and its strategic focus. Governors had had an opportunity to submit queries to Dr Tabreham prior to the meeting in regard to her deep dive, and answers to these were provided in the meeting.

**Integrated Performance Report**
Claire Wright highlighted key areas contained in the report which gave governors an overview of performance as at the end of March 2016 with regards to workforce, finance, operational delivery and quality performance. Results of the Staff Friends & Family Test (Q2, 2016/17) and the Staff Survey (2016) were highlighted and governors were assured that the People & Culture Committee and the Staff Engagement Group continue to focus on workforce solutions to improve responses.

**Governance Improvement Action Plan Update**
Samantha Harrison presented an update on the delivery of the Governance Improvement Action Plan (GIAP). The Board at it April meeting formally signed off 14 'blue forms' to confirm that the recommendation within each had been completed. Two actions remain for completion, which involve external assurance. The focus will now shift to embedding and monitoring the work undertaken.

**Report from Governors Nominations & Remuneration Committee**
The Committee received confirmation that Dr Anne Wright had satisfied the Fit and Proper Persons Tests as per the Trust's Fit and Proper Persons Test Policy. Maura Teager's appraisal was reported and feedback given following her exit interview. A draft year-end effectiveness report was reviewed and will be received by the Council of Governors in July. The Committee debated its Terms of Reference and membership. Council of Governors will receive the revised Terms of Reference for approval in July.

**Protocol for Governor Attendance at Board Meetings**
The Council of Governors approved a protocol for governors to attend Board meetings as observers; providing governors with an additional opportunity to observe Non-Executive Directors holding the Executives to account. The protocol will be reviewed in six months' time.

**RECOMMENDATION**

The Board is asked to note the summary report from the Council of Governors.

**Report prepared by:** **Donna Cameron, Assistant Trust Secretary**

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

**Derbyshire Healthcare NHS Foundation Trust**
Report to the Trust Board – 24 May 2017

# NHS Improvement Year-End Self-Certification

## Purpose of Report

The aim of self-certification is for the Trust to assure itself it is in compliance with NHS Provider conditions. To present the proposed relevant declarations to the Trust Board.

## Executive Summary

NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements. This follows on from similar requirements in previous years to submit self-declarations to NHSI on these areas.

The Trust must publish the declarations within one month of the declaration by the Trust Board. Boards must sign off by 31 May for GS 6/7 and FT4 by 30 June 2017.

| **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 Trust is in compliance with the conditions set by NHS Improvement, as outlined in the report.

## Consultation

This report has not been received elsewhere.

| **Governance or Legal Issues** |
|---|
| The Trust has met the requirements of the self-certification. |

| **Public Sector Equality Duty & Equality Impact Risk Analysis**<br>The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people). | |
|---|---|
| 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** | |
| N/A | |

**Recommendations**

The Board of Directors is requested to:

1. Confirm agreement with the proposed declarations for signature by the Chair and Chief Executive.
2. To agree to publication of the self-declaration.

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

## NHS Improvement Year-end Self-Certification

NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements. This follows on from similar requirements in previous years to submit self-declarations to NHSI on these areas.

Providers need to self-certify the following after the financial year end:

### NHS provider licence conditions

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3))
- The provider has complied with required governance arrangements (Condition FT4(8))
- If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service (Condition CoS7(3)

The aim of self-certification is for providers to carry out assurance that they are in compliance with the conditions and providers may carry out this process as they see fit. DHCFT proposes to present the proposed relevant declarations to the Trust Board.

### 1. General Condition G6

Condition G6(2) requires NHS foundation trusts to have processes and systems that:

- identify risks to compliance
- take reasonable mitigating actions to prevent those risks and a failure to comply from occurring

Providers must annually review whether these processes and systems are effective must publish their G6 self-certification within one month following the deadline for sign-off (as set out in Condition G6(4)).

**Proposed declaration:**

**The Board declares that the Licensee continues to meet the criteria for holding a licence (condition G6)**

### 2. Continuation of Services Condition 7

Commissioner requested services are services commissioners consider should continue to be provided locally even if a provider is at risk of failing financially and which will be subject to regulation by NHS Improvement. Providers can be designated as providing CRS because:

- there is no alternative provider close enough
- removing the services would increase health inequalities
- removing the services would make other related services unviable.

**Proposed Declaration:**

**The Board declares that the licensee has a reasonable expectation that the licensee will have the required resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.**

## 3. Condition FT4 Declaration

NHS foundation trusts must self-certify under Condition FT4(8) whether the governance systems achieve the objectives set out in the licence condition.

*The Trust has during the year undertaken significant work to review and improve governance areas. This involves ensuring effective Board and committee structures, reporting lines and performance and risk management systems. See attached NHSI template for further information against each item.*

**Proposed declaration:**

**The Board confirms that it complies with all elements of the Corporate Governance Statement (condition FT4)**

## 4. Certification on Training of governors

Providers must review whether their governors have received enough training and guidance to carry out their roles.

*Governor training has been carried out on a regular basis throughout the year and includes sessions led by Trust Directors, senior staff, external parties and structured training programmes. This has been monitored, evaluated and reviewed by the Council of Governors and been evidenced as part of GIAP actions. Governors have confirmed that they are satisfied with the training provided, through their governor effectiveness survey, approval of the completed GIAP recommendation form on this topic, and through their input to the on-going training and development programme via the governor Governance Committee.*

**Proposed declaration:**

**The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.**

## Declaration process

The Trust must publish the declarations within one month of the declaration by the Trust Board. Boards must sign off by the 31 May for GS 6/7 and FT4.

From July 2017, NHS Improvement will contact a select number of NHS trusts and foundation trusts to ask for evidence that they have self-certified. This can either be through providing the templates if they have used them, or by providing relevant Board minutes and papers recording sign-off.

**Worksheet "FT4 declaration"**

## Corporate Governance Statement (FTs and NHS trusts)

*The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one*

| 1 | Corporate Governance Statement | Response | Risks and Mitigating actions | |
|---|---|---|---|---|
| 1 | The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. | Confirmed | As at 31 March 2017 the Trust is under enforcement action as per section 106 of the Health and Social Care Act. Enforcement undertakings agreed by the Trust and Monitor in February 2016 include the development of a Governance Improvement Action Plan (GIAP) which has been implemented in full and external assurance received. | Please complete Risks and Mitigating actions |
| 2 | The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time | Confirmed | The Trust has implemented a comprehensive GIAP during 2016/17 which has focussed on implementation of good governance practice | Please complete Risks and Mitigating actions |
| 3 | The Board is satisfied that the Licensee has established and implements:<br>(a) Effective board and committee structures;<br>(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and<br>(c) Clear reporting lines and accountabilities throughout its organisation. | Confirmed | The Trust's Corporate Governance Framework has been reviewed in year and implemented successfully. There is a process for year end review of all Committees to reflect on effectiveness. An accountability framework has been developed and implemented. | Please complete Risks and Mitigating actions |
| 4 | The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:<br><br>(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;<br>(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;<br>(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;<br>(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);<br>(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;<br>(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;<br>(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and<br>(h) To ensure compliance with all applicable legal requirements. | Confirmed | The Board, via its Committees where relevant, oversees the Trust duties as listed. Items are escalated to the Trust Board from Committees to ensure key risks are addressed. | Please complete Risks and Mitigating actions |
| 5 | The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:<br><br>(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;<br>(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;<br>(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;<br>(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;<br>(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and<br>(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate. | Confirmed | Quality leadership is overseen by the Board and assurance on quality of care is provided through the Quality Committee. Issues and risks are escalated to the Board as required. We have implemented an action plan following a comprehensive inspection in June 2016. | Please complete Risks and Mitigating actions |
| 6 | The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence. | Confirmed | The Remuneration and Appointments Committee consider the composition of the Board to ensure that this is appropriate in terms of skill mix and qualifications. Fit and Proper Persons Test policy has been fully implemented and embedded. Wider workforce issues are considered by the People and Culture Committee with risks and | Please complete Risks and Mitigating actions |

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

**Signature** _____ **Signature** _____

**Name** Ifti Majid **Name** Caroline Maley

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

| | | |
|---|---|---|
| A | | Please Respond |

## Worksheet "G6 & CoS7"

# Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

*The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.*

**1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)**

| | | | |
|---|---|---|---|
| 1 | Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution. | Confirmed | OK |

**3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)**

**EITHER:**

| | | | |
|---|---|---|---|
| 3a | After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. | Confirmed | Please fill details in cell E22 |

**OR**

| | | | |
|---|---|---|---|
| 3b | After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services. | | Please Respond |

**OR**

| | | | |
|---|---|---|---|
| 3c | In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate. | | Please Respond |

**Statement of main factors taken into account in making the above declaration**

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

Successful delivery of CIP and QIPP schemes - ongoing contract management processes and project management office arrangements, overseen by Finance and Performance Committee. This is described in full along with mitigating actions in the17/18 Board Assurance Framework 4a (Failure to deliver financial plans).

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

| | | | |
|---|---|---|---|
| **Signature** | | **Signature** | |
| **Name** | Ifti Majid | **Name** | Caroline Maley |
| **Capacity** | Acting Chief Executive | **Capacity** | Acting Chairman |
| **Date** | 24 May 2017 | **Date** | 24 May 2017 |

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

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## Worksheet "Training of governors"

# Certification on training of governors (FTs only)

*The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.*

### 2 Training of Governors

1 The Board is satisfied that during the financial year most recently ended the Licensee has provided the **Confirmed** OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

| | | | |
|---|---|---|---|
| **Signature** | _____ | **Signature** | _____ |
| **Name** | Ifti Majid | **Name** | Caroline Maley |
| **Capacity** | Acting Chief Executive | **Capacity** | Acting Trust Chair |
| **Date** | 24 May 2017 | **Date** | 24 May 2017 |

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

| Exec Lead | Item | Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives | 26 Apr 17 | 24 May 17 | 28 Jun 17 | 26 Jul 17 | 27 Sep 17 | 1 Nov 17 | 29 Nov 17 | 27 Jan 18 | 28 Feb 18 | 28 Mar 18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | **Deadline for papers** | **18 Apr** | **15 May** | **19 Jun** | **17 Jul** | **18 Sep** | **23 Oct** | **20 Nov** | **22 Jan** | **19 Feb** | **19 Mar** |
| CM | Apologies given | | X | X | X | X | X | X | X | X | X | X |
| SH | Declaration of Interests | FT Constitution | X | X | X | X | X | X | X | X | X | X |
| CM | Minutes/Matters arising/Action Matrix | FT Constitution | X | X | X | X | X | X | X | X | X | X |
| CG | Actions and learnings from patient stories. | | X | X | X | X | X | X | X | X | X | X |
| CM | Board Forward Plan | Licence Condition FT4 | X | X | X | X | X | X | X | X | X | X |
| CM | Board review of effectiveness of the meeting | Statutory Outcome 3 | X | X | X | X | X | X | X | X | X | X |
| **STRATEGIC PLANNING AND CORPORATE GOVERNANCE** | | | | | | | | | | | | |
| CM | Chair's report | Licence Condition FT4 | X | X | X | X | X | X | X | X | X | X |
| IM | Chief Executive's report | Licence Condition FT4 | X | X | X | X | X | X | X | X | X | X |
| MP/ CW | NHSI Annual Plan<br>*TBC awaiting NHSI guidance* | FT Constitution/NHSI Risk Assurance Framework (RAF) | | | | | | | | | | |
| CW | NHSI Compliance Return (Public) (subject to change (incorporated into Integrated Performance Report) | NHSI Single Operating Framework | | X | X | | | | X | X | | X |
| JS | Information Governance - annual report April interim report November | Strategic Outcome 1<br>Strategic Outcome 3<br>Information Gov toolkit | AR | | | | | IR | | | | |
| AR | Staff Survey Results and Action Plan | Strategic Outcome 3 and 4 | X | | | | | | | | | |
| AR | Equality Delivery System2 (EDS2) | Strategic Outcome 3 and 4 | AR | | | | | | | | | |
| AR | Approval of Equality Delivery System2 (EDS2) 2017/18 | Strategic Outcome 3 and 4 | | | | | X | | | | | |
| SH | Review SOs, SFIs, SoD | FT Constitution<br>Standing Orders | | | | X | | | | | | |
| SH | Trust Sealings | FT Constitution<br>Standing Orders | AR | | | | | | | | | |
| SH | Annual Review of Register of Interests | FT Constitution<br>Annual Reporting Manual | AR | | | | | | | | | |
| SH | Board Assurance Framework Update | Licence Condition FT4 | X | | | | X | | X | | X | |
| SH | Raising Concerns (whistleblowing) | Strategic Outcome 1<br>Public Interest Disclosure Act | | | X | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SH | Committee Assurance Summaries (following every meeting) | Strategic Outcome 3 | X | X | X | X | X | X | X | X | X | X |
| SH | Governance Improvement Action Plan | Licence Condition FT4 | X | X | X | X | X | X | X | X | X | X |
| SH | Fit and Proper Person Declaration | Licence Condition FT4 | | X | | | | | | | | X |
| MP | Emergency Planning Report (EPPR) | | | | | | | | X | | | |
| SH | Board Effectiveness Survey | | | X | | | | | | | | |
| SH | Report from Council of Governors Meeting | | X | X | | X | | X | | X | X | X |
| SH | Review of Policy for Engagement between the Board & COG | | | | | | | | AR | | | |
| SH | Board Development Programme | | | | | | | | | | X | |
| LWS | Business Plan 2017-18 | | X | | | | | | | | | |
| LWS | Measuring the Trust Strategy | | X | | | X | | | X | | | |
| **OPERATIONAL PERFORMANCE** | | | | | | | | | | | | |
| CG, CW, AR, MP | Integrated performance and activity report to include Finance, Workforce, performance and Quality Dashboard | Licence Condition FT 4<br>Strategic outcome 1<br>Strategic Outcome 3 | X | X | X | X | X | X | X | X | X | X |
| **QUALITY GOVERNANCE** | | | | | | | | | | | | |
| CG | Position Statement on Quality (Incorporates Strategy and assurance aspects of Quality management) Includes Annual Review of Recovery Outcomes in October and Annual Looked After Children Report in December | Strategic Outcome 1<br>CQC and Monitor | X | X | X | X | X | X | X | X | X | X |
| CG/JS | Safeguarding Children Annual Report | Children Act<br>Mental Health Standard Contract | | | | | | | AR | | | |
| CG/JS | Safeguarding Adults Annual Report | CQC<br>Mental Health Standard Contract | | | | | | | | AR | | |
| CG | Control of Infection Report | Health Act<br>Hygiene Code | | AR | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CG/JS | Integrated Clinical Governance Annual Report including MHA/Governance/Complaints and Compliments/SIRIs/Patient Safety/NHS Protect (LSMS) and Emergency Preparedness/H&S (including H&S and Fire Compliance and Associated Training) | CQC and H&S Act | | | | | | | AR | | | |
| CG | Annual Community Patient Survey | Clinical Practice<br>CQC | | | | | | | AR | | | |
| JS | Re-validation of Doctors | Strategic Outcome 3 | | | AR | | | | | | | |
| CG | Annual Review of Recovery Outcomes * | | | | | | | AR | | | | |
| CG | Annual Looked After Children Report * | | | | | | | | | AR | | |

* Incorporated in Quality Position Statement