Derbyshire Healthcare NHS
NHS Foundation Trust

Meeting of the Board of Directors

27 September 2017

Trust Headquarters, Ashbourne Centre, Kingsway Site, Derby, DE22 3LZ
Tel: (01332) 623700
Acting Chief Executive: Ifti Majid Trust Chair: Caroline Maley

NOTICE OF PUBLIC BOARD MEETING –WEDNESDAY 27 SEPTEMBER 2017
TO COMMENCE AT 1.00 PM IN CONFERENCE ROOMS A&B
FIRST FLOOR, CENTRE FOR RESEARCH & DEVELOMENT, KINGSWAY HOSPITAL

	TIME	AGENDA	ENC	LED BY
1.	1:00	Chair's welcome, Chief Executive's opening remarks on Trust Chair appointment, apologies for absence and Declarations of Interest Register	**A**	Caroline Maley Ifti Majid
2.	1:05	Service Receiver Story	**-**	Carolyn Green
3.	1:30	Minutes of Board of Directors meeting held on 27 July 2017	**B**	Caroline Maley
4.	1:35	Matters arising – Actions Matrix	**C**	Caroline Maley
5.	1:40	Questions from governors or members of the public	**-**	Caroline Maley
6.	1:45	Chair's Update	**-**	Caroline Maley
7.	1:50	Acting Chief Executive's Update	**D**	Ifti Majid
OPERATIONAL PERFORMANCE, QUALITY AND STRATEGY				
8.	2:00	Integrated Performance and Activity Report	**E**	Mark Powell/Claire Wright/Amanda Rawlings/Carolyn Green
9.	2:30	Position Statement on Quality incorporating quarterly publication of specified information on death – Trust policy and approach'	**F**	Carolyn Green
10.	2:40	Board Committee Assurance Summaries and Escalations: Quality Committee held on 10 August, Mental Health Act Committee held on 24 August and People & Culture Committee held on 21 September 2017 *(minutes of these meetings are available upon request)*	**G**	Committee Chairs
3:00 B R E A K				
11.	3:15	Deep Dive – Psychology – *to be presented during the meeting*	**H**	Mark Powell
12.	3:45	Safeguarding Children and Adults at Risk Annual Report	**I**	Carolyn Green
13.	3:55	Equality Delivery System 2 (EDS2) 2017/18 Update and Workforce Race Equality Standard (WRES) Action Plan	**J**	Amanda Rawlings
14.	4:05	Pulse Check Findings	**K**	Amanda Rawlings
GOVERNANCE				
15.	4:15	Board Effectiveness Summary	**L**	Sam Harrison
CLOSING MATTERS				
16.	4:25	Any Other Business	**-**	Caroline Maley
17.	4:35	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	**-**	Caroline Maley
FOR INFORMATION				
Report from Extraordinary Council of Governors Meeting held 13 September 2017-			**M**	-
2017/18 Board Forward Plan			**N**	-

Questions that are applicable to the agenda, and at the Chair's discretion, can be sent by email to the Board Secretary up to 48 hours prior to the meeting for a response provided by the Board at the meeting. Email: sue.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 1 November 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 Chair's discretion

Declaration of Interests Register 2017-18

NAME	INTEREST DISCLOSED	TYPE
Margaret Gildea Non-Executive Director	Director, Organisation Change Solutions Limited Non-Executive Director, Derwent Living	(a, b)
Ifti Majid Acting Chief Executive	Board member, North East Midlands Leadership Academy Board Kate Majid (spouse) Assistant Chief Commissioning Officer, NHS North Derbyshire CCG	(a, d)
Caroline Maley Acting Trust Chair	Director – C D Maley Ltd Trustee – Vocaleyes Ltd.	(a) (a, d)
Barry Mellor Non-Executive Director	Non-Executive Director, Rotherham NHS Foundation Trust Trustee, Rotherham Hospital Charity Mrs Mellor is a befriender with Age UK	(a, d)
Amanda Rawlings Director of People and Organisational Effectiveness (DHcFT)	Director of People and Organisational Effectiveness, Derbyshire Community Healthcare Services (DCHS) Co-optee Cross Keys Homes, Peterborough	(a, d)
Dr Julia Tabreham Deputy Trust Chair and Non-Executive Director	Non-Executive Director, Parliamentary and Health Service Ombudsman Director of Research and Ambassador Carers Federation Leads the Parliamentary and Health Service Ombudsman's contribution to establishing NHS complaints advocacy support in Ireland	(a, d)
Lynn Wilmott-Shepherd Interim Director of Strategic Development	Substantive post – Director of Commissioning and Delivery, NHS Erewash CCG	(d)
Richard Wright Non-Executive Director	Director, Sheffield Chamber of Commerce Chair, The Sheffield College Multi Academy Trust Chair Sheffield University Technical College 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 Conference Rooms A&B
Research and Development Centre, Kingsway, Derby DE22 3LZ

Wednesday 27 July 2017

MEETING HELD IN PUBLIC	
Commenced: 1pm	Closed: 4.20pm

PRESENT:	Caroline Maley	Acting Trust Chair
	Dr Julia Tabreham	Deputy Trust Chair and Non-Executive Director
	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
	Carolyn Green	Director of Nursing & Patient Experience
	Samantha Harrison	Director of Corporate Affairs & Trust Secretary
	Mark Powell	Acting Chief Operating Officer
	Lynn Wilmott-Shepherd	Interim Director of Strategic Development
	Rachel Leyland	Deputy Finance Director - deputising for Claire Wright
	Dr Mark Broadhurst	Deputy Medical Director - deputising for Dr John Sykes
	Harinder Dhaliwal	Assistant Director for Engagement and Inclusion - deputising for Amanda Rawlings
IN ATTENDANCE:	Anna Shaw	Deputy Director of Communications & Involvement
	Sue Turner	Board Secretary (minutes)
For DHCFT 2017/115	Aileen Knowles	Moving & Handling Advisor/Falls Prevention Lead
For DHCFT 2017/115	Nicola Fletcher	Acting Assistant Director of Clinical Professional Practice
For DHCFT 2017/123	Fiona White	Area Service Manager
For DHCFT 2017/123	Sam Kelly	Consultant Nurse
For DHCFT 2017/123	Katie Evans	Service Manager
For DHCFT 2017/123	Cath Dunning	Senior Nurse
For DHCFT 2017/123	Dr Mathew Joseph	Consultant Psychiatrist
VISITORS:	John Morrissey	Lead Governor and Public Governor, Amber Valley South
	Carole Riley	Deputy Lead Governor and Public Governor, Derby City East
	Kevin Richards	Public Governor, South Derbyshire
APOLOGIES:	Claire Wright	Director of Finance & Deputy Chief Executive
	Dr John Sykes	Medical Director
	Amanda Rawlings	Director of People & Organisational Effectiveness

DHCFT 2017/114	**ACTING CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST** Acting Trust Chair, Caroline Maley, opened the meeting and welcomed everyone. No declarations of interests were received. Apologies for absence were received as noted above.

DHCFT 2017/115	**SERVICE RECEIVER STORY** Nicola Fletcher introduced Aileen Knowles, the Trust's Moving & Handling Advisor/Falls Prevention Lead who is also a carer for her elder sister. Aileen described how events in her sister's life had led to her experiencing high levels of anxiety. Her sister's children had grown older and did not need the same level of support which led to her being concerned about losing her identity as a mother. Her role at work had changed which made her anxious with regard to her financial security and also led to her developing a level of paranoia that made her believe everyone was looking at her and talking about her. As time went by Aileen's sister's level of paranoia increased. This was mainly caused by responsibilities involved in becoming a grandmother and the unexpected bereavement of their brother which was the catalyst for her increased paranoia. Aileen eventually managed to persuade her sister to let her take her to see her GP who referred her sister to the Crisis Team. Aileen described the level of treatment offered by the Crisis Team as disappointing. Her sister was diagnosed as suffering from anxiety and she went on to describe how during a psychiatrist appointment the psychiatrist did not have her sister's notes in his possession which meant Aileen had to retell her sister's symptom history which was very upsetting for them both. The Board also heard of the distress that resulted from cancelled outpatient appointments. Ifti Majid responded first by apologising to Aileen that the Trust had not supported her sister as well it could have done. He acknowledged that Aileen's story was connected with her employment by the Trust and that she is also a carer and he hoped this would help triangulate what works well within the system and what does not. Julia Tabreham, Chair of Quality Committee, informed Aileen that carer representatives attend meetings of the Quality Committee and have helped to improve the quality of the services the Trust is delivering. She was concerned that people have reached tipping point when they come into contact with the Crisis Team and that services are not resourced sufficiently to deal with every situation and carers are let down at the crucial point. As a Board member Julia Tabreham gave her commitment to ensuring that people have the support they need when they need it. Aileen was concerned that there are people who go through the same experience as her sister who do not have family resource to support them. From an employee point of view she feels very fortunate that her job gives her an insight into patient needs and that her mentor and business manager, Carolyn Green, Director of Patient Experience and Nursing, understands her situation and has allowed her the flexibility to care for her sister while carrying out her role. Carolyn Green informed the Board that improving the culture and values of family and carers is one of the Trust's quality priorities. The service will be improved and will drive family and carer involvement and will join up services so that carers and their family only have to tell their story once. She would also make sure that the service focusses on carers' needs and the value carers bring as they have a wealth of information that can make providing care more effective Caroline Maley concluded that the Board was committed to ensuring that the perspectives of carers and families will be more focussed upon during treatment. Today's review identified recommendations for engaging with carers regarding their needs and those who they care for. The Board was fully committed to ensuring that consultants are always in possession of patient notes so that patients do not have to repeat their medical history. **RESOLVED: The Board of Directors expressed thanks to Aileen for sharing her story which gave a clearer insight into the service the Trust had provided**
DHCFT	**MINUTES OF THE MEETING DATED 28 JUNE 2017**

2017/116	The minutes of the previous meeting, held on 28 June were agreed and accepted as an accurate record, subject to the first sentence of the ninth paragraph of the Integrated Performance Report, item DHCFT 2017/101 being corrected from *'Julia Tabreham was concerned about adherence to CPA (Care Programme Approach) and the overwhelming pressure this placed on staff'* to read '*Julia Tabreham was concerned, that due to overwhelming pressure on staff, there is a lack of adherence to the CPA (Care Programme Approach). The lack of completion of CPAs is a persistent feature in Serious Untoward Incident Reports'.*
DHCFT 2017/117	**<u>ACTIONS MATRIX AND MATTERS ARISING</u>** The Board agreed to close all completed actions. Updates were provided by members of the Board and were noted on the actions matrix. All completed 'green' actions were scrutinised to ensure that they were fully complete and actions that were not complete were challenged with Executive leads.
DHCFT 2017/0118	**<u>ACTING CHAIR'S VERBAL REPORT</u>** Caroline Maley reported that she had attended the Health and Wellbeing Board on 29 June with Ifti Majid the detail of which is covered his Acting Chief Executive report. The Board held an effective Board Development day on 12 July that focussed on the Trust's strategy. Caroline looked forward to attending further Board Development sessions that will focus on carrying on the good work developing the skills of Board. A meeting of the Council of Governors was held on 18 July and Caroline described the governors' role in challenging the Board to ensure that the Trust delivers its strategy. She also took the opportunity to welcome new members of the Council of Governors Amran Ashraf and Cllrs Robin Turner and Linda Grooby. Caroline described the interesting meeting she attended with Ifti Majid at Lincolnshire Partnership NHS Foundation Trust. They both enjoyed discussing how Lincolnshire took their CQC Improvement Notice from 'requires improvement' to 'good' which led to them considering holding joint meetings and working together. Caroline talked about the day she spent at a Chairs Networking meeting where good discussions were held about trying to reduce the use of agency staff. An inspiring presentation was made by Sherwood Forest Foundation Trust which showed how they are managing urgent care and she was interested to see the changes they are making to develop their services. Last week Ifti Majid and Caroline Maley attended the first STP Board meeting and Caroline also carried out a quality visit to Pharmacy. **RESOLVED: The Board of Directors noted the activities of the Acting Chair throughout the month of July.**
DHCFT 2017/119	**<u>ACTING CHIEF EXECUTIVE'S REPORT</u>** The Acting Chief Executive's report provided the Board of Directors with an update on developments occurring within the local Derbyshire health and social care community. The report also updated the Board on feedback from external stakeholders such commissioners and feedback from staff. The report was used to support strategic discussion on the delivery of the Trust strategy. Ifti Majid referred to the CQC's (Care Quality Commission) publication called *'Driving Improvement'*. He was pleased to see this report focused on cultural change and staff ownership of improvements and he urged Board members to familiarise themselves with

this report in preparation for the CQC's forthcoming visit to ensure resources are focussed on the right areas and that the Quality Committee and Trust Management Team optimise the outcomes in key areas.

Ifti Majid's report drew attention to the NHS Providers 'State of the Provider Sector'. He described how this key document detailed the current performance, challenges and opportunities this sector is facing which revealed that we are expecting to see significant increases in demand around core mental health services. Coupled with this is the pressure that many central services are under which Ifti Majid thought was a sad indictment of the austere environment the Trust is currently operating in. In response to Richard Wright's observation that that the STP recommends focussing on these priority areas, Ifti Majid replied that as there is not yet a clear plan for mental health and the STP this has exacerbated the need for us to have confidence in our plans to make efficiencies to ensure the STP plans are not to the detriment of mental health services and he undertook to continue to share this type of information with the Board.

Ifti Majid referred to the positive assurance received from the Fire and Rescue Services' response to the Grenfell Tower disaster and was pleased with the work undertaken with regard to in-patient health provision. It was noted that no Derbyshire properties contain the same cladding as Grenfell Tower. There are 28 buildings across Derbyshire with more than 6 floors and they have all been prioritised for assessment. In addition to this all schools, university buildings and adult education establishments are being assessed.

Ifti Majid's report made the Board aware of improvements made around CQC compliance and the confirmation that all breach requirements have been met. He was delighted to confirm that the Trust's rating has now returned to green which is the highest possible rating that can be achieved.

In July Ifti Majid had a meeting with the Trust's BME network to understand how to implement reverse mentoring and create the prototype cohort of people to be mentored. He was pleased to report that the timeline for implementing this for the Board would be some time in the Autumn and he looked forward to this initiative helping to influence our culture.

Finally, Ifti referred to the programme closure report from the transaction with DCHS (Derbyshire Community Health Services NHS Foundation Trust). This report summarised the Trust's decision to withdraw from the transaction and also outlined the position for each of the work streams and set out the next steps towards taking the pathway areas forward through back office collaboration and the STP work streams.

Barry Mellor appreciated the effort that had gone into the closure report and reiterated that only about 20% of the Trust's services would have been improved by the merger by acquisition process and was concerned that this fact was not included in the report. Julia Tabreham agreed with Barry Mellor. She would have preferred the rationale for not proceeding with the acquisition to have been captured in the report especially as there were many stakeholders involved in the work that supported joint working with Derbyshire Community Health Services (DCHS). Ifti Majid explained that as this was the combined programme report it did not give the detail behind the Trust's decision for not going ahead with the acquisition. He assured the Board that joint executive groups are being set up which will enable the Trust to strategically move forward with the clinical benefits and build relationships for the future.

Caroline Maley responded that she had requested that the next STP Board meeting discusses why the transaction did not go ahead. She hoped that this would allow the Trust to make a measured response that the STP should have been involved in this decision making process while recognising that at the time the STP was not in full operation. She emphasised that the Board's energy is now focussed on working towards an Accountable Care System (ACS).

RESOLVED: The Board of Directors noted the Acting Chief Executive's update

DHCFT 2017/120	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT (IPR)** The IPR provided the Trust Board with an integrated overview of performance as at the end of June 2017. The focus of the report is on workforce, finance, operational delivery and quality performance. The Trust continued to perform well against many of its key indicators during June even though staffing levels remain a constant challenge both in the community and ward areas. Although staffing levels against planned standards remain a concern, the Board was assured that safe and effective operational management is in place to mitigate all risks and was pleased to note that nursing and quality staff are being deployed to support campus services over the summer period to maintain safety and to support staff until new staff commence in post. The Board was also pleased to note that the number of outstanding actions following the CQC (Care Quality Commission) comprehensive review has reduced. Continued focused meetings are driving continual service improvement and will ensure learning is embedded. The number of outstanding actions following serious incident investigations has also reduced. A number of learning events have been scheduled over the summer period for children's, substance misuse and county wide services to address the improvement required in safeguarding training. Staff attendance remains a significant challenge to the Trust with an annual sickness absence rate of 5.53%. In June the sickness absence rate for the month was 5.49% which is lower than the annual rate and 0.79% lower than in the same period last year (June 2016). Work continues on the recruitment action plan and shows how we plan to tackle each vacancy. This includes a number of incentives campaigns and open days being held across the UK as well as overseas recruitment for hard to fill posts. From a financial perspective the Trust is slightly ahead of plan in surplus terms for the month by £5k and is ahead of plan by £22k year to date. The forecast is to achieve the control total at the end of the financial year but there are risks to achieving 4% CIP (Cost Improvement Programme) by the end of the year. Commissioner-driven QIPP (Quality, Innovation, Productivity and Prevention) disinvestment schemes that require £3.05m income and cost reduction are not yet agreed but are incorporated into the Mental Health STP (Sustainability Transformation Programme) work stream planning. After hearing today's service receiver story Anne Wright was concerned about cancelled outpatient clinics and the number of patients not attending appointments. This resulted in the Board discussing at length how inpatient clinics are operating. Mark Broadhurst explained that this was caused by the national problem with recruiting doctors and psychiatrists. Added to this is the difficulty in replacing locums and this has resulted in cancelled appointments. The Board heard that the outpatient clinics are trialling using non-medical pre-subscribers to support outpatient clinics although it was understood that this method will not see a short term solution. Despite these problems outpatient clinics are a very efficient way of providing effective care and it was noted that a number of positive comments are received from service users on the clinical approach being taken. The Board decided it would be wrong to change the traditional outpatient clinic model and committed the Quality Leadership Team, the Trust Management Team and Quality Committee to assess how to improve outpatient clinical practice to make sure the Trust operates the best quality outpatient clinics. Mark Powell undertook to improve the outpatient experience by the end of the September and pledged to bring a report to the Board on 1 November quantifying what the problems are as well as setting out the solutions. The Board also discussed outpatient appointment DNAs (Did not Attend). Barry Mellor

	informed the Board that the Finance & Performance Committee had discussed outpatient appointment DNAs as it noted that clinics had experienced 15% DNAs against a target of 7%. One of the main causes of DNA is the rescheduling of appointments. The Committee talked about the method of text message reminders that alert patients of appointments and it was discovered that more DNAs occurred when text message alerts were made. DNA is very high in children's services and work is taking place to drastically reduce DNAs by using resources more effectively. The Board discussed the format of the IPR as Julia Tabreham was concerned that the Executive Summary was becoming increasingly long and suggested that issues be reported on an exception only basis along with the resulting action. The Board considered this suggestion and agreed that the narrative descriptor plays an important part in linking the operational functions that gave an effective overall picture of performance. Julia Tabreham made a second point that she thought the STP contained many outliers such as the transfer of care relying on system partners and she asked if the STP would start to consider some of these worrying pathway issues. Ifti Majid advised that there would be a strong mental health voice in the work streams and as individual projects develop it will be easier to understand further work. Lynn Willmott-Shepherd also assured the Board that she anticipated a high level of engagement from local authorities and other governing bodies would be involved in the STP relaunch event which will be a good case for developing relationships and working opportunities. Margaret Gildea brought discussions back to today's service receiver carer story and asked the Board to consider how to improve the flow of information so that related information is always available to ensure consultants have accurate notes in front of them. Mark Powell assured her that clinicians and IT will work closely together to resolve the issues described today and will develop a set of patient measures that will be taken through the Quality Committee and the Finance &Performance Committee by John Sykes and Mark Broadhurst. The solutions to this review will be then reported to the Board on 1 November. Caroline Maley concluded discussions and was assured that the data contained in the IPR is regularly reviewed at various performance management meetings and by the Executive Leadership Team as well as the Board Committees. **ACTION: Quality Leadership Team, Trust Management Team and Quality Committee to assess how to change the practice of Outpatient Clinics to allow an Outpatient Model Report to be brought to the Board on 1 November setting out causes of cancellations and the solutions.** **ACTION: Report identifying patient measures through IT solutions developed with clinicians to be received by the Quality Committee and Finance & Performance Committee prior to a report setting out the solutions is submitted to the Board on 1 November.** **RESOLVED: The Board of Directors considered the Integrated Performance Report and obtained significant assurance on current performance across the areas presented with the exception of outpatient metrics which will be reported to the Board at the November meeting.**
DHCFT 2017/121	**<u>QUALITY POSITION STATEMENT</u>** 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. The Board noted the fire safety action that has been taken to ensure the safety of the

	Trust's premises following the Grenfell Tower fire and was pleased to hear that fire evacuations are being increased to build up confidence in staff so they know how to respond. Carolyn Green was pleased to report that work is continuing on closing down actions relating to the CQC action plans both from the major inspection and regular Mental Health Act visits. This work is closely monitored by the Quality Committee and there has been a significant improvement in the status of the 2016 comprehensive inspection actions. She assured the Board that she will continue to ensure that these recommendations and actions are fully delivered and embedded within the Trust's services. In response to Barry Mellor enquiring if a further CQC inspection is to be carried out, Carolyn Green responded that a site visit is planned for September. Preparation for the visit is being focussed through the Trust Management Team meetings where the CQC action plan and expectations is assessed against the Trust's performance. She also advised that the CQC will be observing the Trust's Board meetings and have made a request to meet governors. The report also provided an insight into the positive work of MASH (Multi Agency Safeguarding Hub) which operates co-location of health, Police and social care staff and enables sharing of safeguarding intelligence and planning which allows teams to have instant access to information instead of services taking weeks to share information. Reference was made to learning obtained from a service user story heard earlier this year from a gentleman who fed back to the Board that he was unclear on how to gain support from the Trust's advocacy service which was mainly due to a complexity of commissioning arrangements between Derby City and Derbyshire local authorities. The Board was pleased to hear that new advocacy posters have been redesigned to signpost service users and will be displayed throughout the Trust's services and that the Mental Health Alliance and expert by experience colleagues will review the information contained in the posters during ward visits and will report back their thoughts. As a result of discussions Caroline Maley concluded that the report provided the Board with significant assurance relating to patient safety but limited assurance was obtained around the completion of some of the CQC actions although it was understood that this work was still in progress. **RESOLVED: The Board of Directors:** **1) Received and noted the Quality Position Statement** **2) Gained significant assurance with regard to safety** **3) Gained limited assured with regard to some CQC actions**
DHCFT 2017/122	**BOARD ASSURANCE SUMMARIES & ESCALATIONS** Assurance summaries were received from the meetings of the Quality Committee held on 15 June, Audit & Risk Committee held on 11 July and the People & Culture Committee held on 20 July 2017. Committee Chairs summarised the escalations that had been raised and these were noted by the Board as follows: Julia Tabreham, Chair of the Quality Committee informed the Board that good discussions had been held at the June meeting on the CQC pipeline of actions. The Committee received limited assurance with regard to Mental Capacity Act (MCA) compliance. Compliance checks on key elements are now being monitored on a monthly basis and are showing demonstrable improvement with regard to completion and quality of documentation. An MCA clinical skills paper on the Radbourne Unit is being prepared which shows that this targeted work is starting to produce dividends and thanks were made to the Finance & Performance Committee for providing this investment in our staff.

	Ifti Majid referred to the Ligature Risk Reduction item and asked if work was taking place to reduce the safety risk. Carolyn Green assured him that she has every confidence that completion of the red rated risks will be completed now that budgets have been adjusted in the capital programme. Barry Mellor, Chair of the Audit & Risk Committee informed the Board that a deep dive took place at the July meeting on BAF risk 1a Clinical Quality Safety Standards. Whilst limited assurance was received by the Committee it is clear that significant work is taking place and will be further driven by the Quality Leadership Teams to raise standards. Barry Mellor was pleased to report that significant assurance was received on implementation of the Trust's Raising Concerns policy. Limited Assurance was obtained on the outcome of Clinical Audit. The Committee could see that good processes are in place but further work is required on the completion of clinical audit objectives. As a result it was agreed that the Quality Committee would receive a report quantifying the full benefits of Clinical Audit. Margaret Gildea reported that the People & Culture Committee held a very effective meeting in July. She proposed that this Committee could oversee the operational groups and intended to pursue this through the through the work of the Committee. **ACTION: Quality Committee to receive a report quantifying the full benefits of Clinical Audit** **RESOLVED: The Board of Directors received and noted the Board Committee Assurance Summaries and Escalations**
DHCFT 2017/123	**DEEP DIVE – CRISIS AND HOME TREATMENT SERVICE** The crisis in mental health provision is often in the news and reflects the great demands made on services. Today's service receiver story also covered the support delivered by the Crisis Team. Fiona White, Sam Kelly, Katie Evans, Cath Dunning, and Dr Mathew Joseph from the Crisis And Home Treatment Service joined the meeting and provided the Board with an insight into some of the key challenges and achievements experienced by the service team. Derbyshire's Crisis Resolution Home Treatment Teams are based around Derby, Chesterfield and High Peak. The service is for people aged 18 - 65 who experience a severe mental health illness who would otherwise be at risk of hospital admission. The team provides an assessment service, home treatment, least restrictive environment options and a comprehensive discharge process. There have been some serious incidents in the city and in the county and concern was expressed by the team due to the difficulties in dealing with large caseloads. Sam Kelly emphasised that the service's biggest achievement was successfully commissioning a review of Crisis Resolution Home Treatment Service, the recommendations of which have been commissioned by the Board to carry out this work. This review was undertaken by Sam Kelly based on patient and staff feedback and was benchmarked as having a good standard of practice for the team. This review identified that the teams were under a considerable amount of pressure working to recommended staffing models which resulted in a service that was compromising the health of patients. The Board noted that as a result of this review a full ownership approach has been taken and the team is fully engaged and working on a new clinical model and is engaging with carers to incorporate what they need from the crisis service. The team established that the majority of people's needs are being met through commissioning. However, there is a commissioning gap for people who are in acute distress who may feel they want to harm themselves and they have nowhere else to go. The Board heard how work going forward will be aligned with the STP to ensure there is a proper pathway.

	The team's other key achievements include continued work to improve links with GPs, campus services, social care and particularly the Police. The Crisis Team is also developing at a multi-disciplinary model and now includes occupational therapy and social work and a pharmacy link within the team. The team talked about their key challenges and emphasised how a lack of resource was having an impact on the service. The Board was aware that this has been raised with commissioners and NHS England and that the team has implemented and rolled out crisis review recommendations until staffing levels improve. The Board was told of the Crisis Team's plans for future improvements, particularly in delivering all recommendations from the recent review. Ongoing recruitment to improve staffing levels was at the forefront of their plan. Succession planning will continue due to the interim and acting posts being in place and work was taking place to ensure these posts are filled in the future. The team has also developed a patient and carer feedback system that will inform future developments within the service. The Board was extremely appreciative of the efforts the Crisis Team is taking. Ifti Majid referred to the problem with inpatient beds and capacity in neighbourhoods and wondered if the problem could be improved with people working in a more integrated way resulting in a broader flow of services. Sam Kelly replied that the team had implemented clinical assessments to assess those who need home care. The average case load has reduced considerably and is much more manageable but this had not had a great impact on availability of beds. The problem arises when the team become involved in a patient's care too late. It is important that the Crisis Team should not be seen as a panacea for keeping people out of hospital. Integration with community services would help this and the team is looking to see what they can learn nationally about this. Barry Mellor asked if the team was hopeful of filling all its staff vacancies. It is hoped that this can be achieved from the current recruitment drive. Lynn Wilmott-Shepherd added that the Trust has been commissioned for these staff. Commissioners are working well with the Trust and we are trying to receive funding from the Better Care Fund and are also looking at cases for next year's contracting round. Carolyn Green reiterated that recommendations from the crisis review were accepted by commissioners. There are actions underway to provide investment back into the Crisis Team and work is taking place with commissioners to understand how investment can be improved in order to implement the new modelling. Caroline Maley concluded that this was a very helpful deep dive into the Crisis and Home Treatment Service and whilst it was pleasing to hear about how morale is beginning to improve clearly there are pressures linked to capacity, flow and cohort that must be resolved to make a clinically led change. **RESOLVED: The Board of Directors considered and noted the presentation made by the Crisis And Home Treatment Service team**
DHCFT 2017/124	**<u>BUSINESS PLAN 2017-18 MONITORING</u>** Lynn Willmott-Shepherd's report provided the Board with an update on the performance management process of the Business Plan for 2017/18. The Board noted that for the first time in 2017/18 clinical divisions and corporate directorates have developed a plan on a page and was assured that the plan is being performance managed. The report also set out the process for next year along with the intention to submit the final plan to the Board in March ahead of the new financial year. Caroline Maley was pleased to see that the plan is focussed on a simple process that will measure performance and looked forward to receiving quarterly update reports in the

	future. **RESOLVED: The Board of Directors:** **1) Noted the content of the Business Plan 2017 – 18** **2) Agreed to the proposal that performance and progress will be reported quarterly to the Board**
DHCFT 2017/125	**BOARD ASSURANCE FRAMEWORK (BAF) 2017/18 SECOND ISSUE** This report presented by Sam Harrison detailed the second issue of the BAF for 2017/18. Attention was drawn to the movement of new risks that were incorporated in the 2017/18 first issue received by the Board in April and the proposal that three of the risks are to be closed due to the decision to not proceed to merger with DCHS (risks 2b and 4c) and the Trust being informed that it is now compliant with all licence undertakings (risk 3c). A new risk BAF Risk 3e has been included in the BAF at the request of the Remuneration & Appointments Committee in relation to any potential instability of the Board. Sam Harrison outlined the process for undertaking 'Deep Dives' for all risks. She informed the Board that it had been agreed that the Audit & Risk Committee will conduct Deep Dives carrying a current rating of extreme and also risks for which it is the Responsible Committee. All other Deep Dives will be undertaken by the identified Responsible Committee for each risk. Julia Tabreham raised an escalation from the Quality Committee with regard to BAF Risk 1c *Failure to fully comply with the statutory requirements of the Mental Health Act Code of Practice and the Mental Capacity Act* and asked for assurance from the Medical Director that this risk is included in the assurance model. In response, Ifti Majid proposed that this matter is addressed outside of the Board meeting with the Medical Director. The Board understood that the programme outlined in the report is based on the current risk rating at Q2 2017/18 and will be subject to change. The Board was assured by the Deep Dive programme of work to be undertaken by the Board Committees and agreed to the closure of three of the risks and to the addition of new risk BAF Risk 3e outlined above. **ACTION: Escalation from the Quality Committee relating to the to BAF Risk 1c *Failure to fully comply with the statutory requirements of the Mental Health Act Code of Practice and the Mental Capacity Act* to be raised with the Medical Director and considered in the re-assessment of this risk** **RESOLVED: The Board of Directors agreed and approved the second issue of the BAF for 2017/18, including the closure of three of the risks on the BAF and the addition of one.**
DHCFT 2017/126	**WORKFORCE RACE EQUALITY STANDARD (WRES) 2017/18 SUBMISSION** Harinder Dhaliwal presented her report which updated the Board on the Trust's annual Workforce Race Equality Standard submission and included the Board statement for consideration and sign off. The Board noted how WRES indicators will be monitored and the current progress against those indicators and how they will be used to track progress and the steps being taken to close the gaps. Harinder Dhaliwal referred to the data analysis on ethnicity and banding which indicated under-representation and a proportionately lower number of BME staff in the relevant bands. The Board was mindful that this was the baseline for this year and that future reports should show an improvement in the diversity of the Trust's workforce. It was

	proposed that positive action should be taken to empower the BME network through training to allow more opportunities to become available for BME staff. As a result of this discussion the Board requested that Amanda Rawlings works with HR colleagues to make comparisons and benchmark the Trust's performance against other organisations. Caroline Maley confirmed that the Board had considered the WRES 2017/18 submission template and approved the draft statement of commitment. The report also included targeted recommendations for where action is to be taken which was noted by the Board. **ACTION: Trust's performance on ethnicity and banding to be benchmarked against other trusts** **ACTION: Update on WRES 2017 action plan to be received by the Board at the next meeting in September** **RESOLVED: The Board of Directors:** **1) Approved the WRES 2017/18 submission/reporting template and findings, including the Board statement prior to submission to the NHS England national WRES team by 1 August, 2017 and sharing with Hardwick CCG and external website (in line with WRES technical guidance).** **2) Noted the link to the Board Equality Action Plan priority 2: Board developing engaging and inclusive leadership key performance indicators to drive culture change, address under-representation, potential barriers and continuous improvement in equality performance and benchmarking.** **3) Noted the equality impact, neighbourhood/service inclusion profiles and equality performance: Board to seek assurance that workforce reflects the local neighbourhood population, fair employment and that we are leveraging the talents/assets and community knowledge of our workforce.** **4) Noted that the WRES 2017 action plan demonstrates the Trust's intention in closing the differences between the treatment and experience of white and BME staff and will be refined in partnership with BME Staff Network. This will be tabled at the Equalities Forum and key committees as part of reporting schedule, including an update to the Board at the meeting to be held on 27 September.**
DHCFT 2017/127	**ANY OTHER BUSINESS** Ifti Majid informed the Board that two difficult questions had been put to him during the Annual Members Meeting around outpatient appointments. He was of the opinion that the work being undertaken by Mark Broadhurst and John Sykes will address this and will provide assurance that these were isolated incidents.
DHCFT 2017/128	**REPORT FROM THE CONFIDENTIAL COUNCIL OF GOVERNORS MEETING** This report was provided for information and was noted by the Board. **RESOLVED: The Board of Directors noted the report from the Confidential Council of Governors meeting held on 6 June 2017.**
DHCFT 2017/129	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK** A detailed review of the BAF took place during the BAF agenda item. It was agreed that no further changes are required to be updated or included in the BAF.
DHCFT 2017/130	**2017/18 BOARD FORWARD PLAN** The forward plan was noted by the Board.

DHCFT 2017/131	**MEETING EFFECTIVENESS** The Board agreed that a good mix of strategic discussions took place especially around the workings of the STP. Mark Powell's suggestion that the Board reverts to summarising the IPR so that key issues are discussed by individual directors on performance, finance, and people was agreed.

The next meeting of the Board held in Public Session will take place at 1pm on Wednesday, 27 September 2017.

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

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - SEPTEMBER 2017			Enc C
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
24.5.17	DHCFT 2017/073	Service Receiver Story	Carolyn Green	**ACTION TRANSFERRED TO THE QUALITY COMMITTEE** Carolyn Green will work with the Nursing and Quality team specifically Allied Health professionals to develop a recovery and enablement strategy that will be submitted to the Quality Committee to focus upon employment and a positive approach to recovery	29.11.2017	The recovery and enablement strategy is currently in development and will be submitted to the October meetingt of the Quality Committee.	Yellow
26.6.17	DHCFT 2017/104	Equality, Diversity and Inclusion Update	Amanda Rawlings	Harinder Dhaliwal to develop the initiative of representatives from the BME network joining trust boards	27.7.2017	Work is progressing on this NHS Improvement initiative to improve BME representation on trust boards	Amber
27.7.17	DHCFT 2017/120	Integrated Performance Report	Mark Powell Carolyn Green	Quality Leadership Team, Trust Management Team and Quality Committee to assess how to change the practice of Outpatient Clinics to allow an Outpatient Model Report to be brought to the Board on 1 November setting out causes of cancellations and the solutions	1.11.2017	Agenda item for November Board	Yellow
27.7.17	DHCFT 2017/120	Integrated Performance Report	Mark Powell Carolyn Green	Report identifying patient measures through IT solutions developed with clinicians to be received by the Quality Committee and Finance & Performance Committee prior to a report setting out the solutions is submitted to the Board on 1 November	1.11.2017	Agenda item for November Board	Yellow
27.7.17	DHCFT 2017/122	Board Assurance Summaries & Escalations	John Sykes Carolyn Green	Quality Committee to receive a report quantifying the full benefits of Clinical Audit	12.10.2017	Report timeline to Quality Committee being agreed between Medical Director and Director of Nursing & Patient Experience	Amber
27.7.17	DHCFT 2017/126	WRES 2017/18 Submission	Amanda Rawlings	Trust's performance on ethnicity and banding to be benchmarked against other trusts	27.9.2017	Verbal update will be made at September meeting.	Yellow
27.7.17	DHCFT 2017/126	WRES 2017/18 Submission	Amanda Rawlings	Update on WRES 2017 action plan to be received by the Board at the next meeting in September	27.9.2017	Updated WRES 2017 submitted to September meeting	Green
27.7.17	DHCFT 2017/125	Board Assurance Framework (BAF) 2017/18 Second Issue	Sam Harrison	Escalation from the Quality Committee relating to the to BAF Risk 1c Failure to fully comply with the statutory requirements of the Mental Health Act Code of Practice and the Mental Capacity Act to be raised with the Medical Director and considered in the re-assessment of this risk	27.9.2017	Revised risk rating was considered at ELT on 18.9.17 and agreed that the risk rating should be maintained	Green

Resolved	**GREEN**	2	25%
Action Ongoing/Update Required	**AMBER**	2	25%
Action Overdue	**RED**	0	0%
Agenda item for future meeting	**YELLOW**	4	50%
		8	100%

Derbyshire Healthcare NHS Foundation Trust
Report to Public Board of Directors 27 September 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. Last month NHS Improvement and NHS England published their review of winter 2016/17. In summary whilst non elective admissions and ambulance calls each grew by just over 1%, overall A&E attendances fell by 1.7% and calls to 111 fell by a huge 4.2%. in fact all four types of activity grew by less than the 5 year average growth which does suggest a very marginal slowdown of activity during last winter

   That said:
   - In aggregate across England, acute providers had more acute hospital beds open in winter 16/17 than the previous winter.
   - Delayed transfer of care (DTOC) levels reached their highest recorded level in January, with DTOC levels over winter on average 22% higher than the year before, occupying on average about 6,400 beds every day.
   - Decline in A&E performance over the course of the past three years has largely arisen because the usual balance between demand and capacity has been altered which has further caused patient flow to slow. In the past three years increasing difficulties with discharging patients (DTOC) have led to a significant rise in emergency bed days (1.8m). This has in turn pushed up occupancy.

   Whilst this data relates to acute hospital care it resonates with the activity in the mental health sector and in our Trust where occupancy levels remain high driven an increasing difficulty to discharge often related to community capacity.

   The report makes three recommendations that in Derbyshire will be overseen by the Urgent Care Board:

   - Occupancy levels should be more actively monitored and actions taken to ensure that they remain below 92%, to allow patient flow to be maintained to deliver A&E performance.
   - To ensure delivery of safe, effective care this winter the NHS needs to free up 2,000-3,000 acute beds. This freeing up beds should come from a reduction in DTOCs.
   - Building on the forthcoming additional collection of data on primary care capacity, the NHS needs to routinely have a more complete picture of capacity available

across the system, particularly in community care.

2. The Royal Society for Public Health has published a report which looks at the positive and negative effects of social media on young people's mental health. The report finds that negative effects include: anxiety; depression; lack of sleep; poor body image. Positive effects include: learning about other people's experiences; self-expression; building relationships.

   Key recommendations include:
   - Provide users with a pop-up warning when they exceed a set level of usage.
   - Highlight when images of people have been digitally manipulated.
   - Teach safe social media use in schools.
   - Identify users at risk

Local Context

3. Our involvement continues in the Erewash Vanguard and the providers involved in delivering care as part of Wellbeing Erewash have now come together in the 'Erewash Alliance' The Vanguard Quarterly review took place on Wednesday 26th of July 2017 with NHS England and we received very positive feedback, particularly in the areas of Carers, Dementia and empowering people and communities. There was additional recognition for the robust plans evaluation that is now in place. Positive work around the community and personal resilience work streams is evident, particularly around the initiatives: TimeSwap and Brilliant Erewash. The key priority for the rest of this year will focus on further role out of the 'on day' joint primary care service offer as well as developing social prescribing.

   The New Care Models Team has confirmed Vanguard funding conditions for 2017/18. They have stated that a Vanguard's impact on non-elective admissions will determine Q3 and 4 release of funding. This is contrary to previous information stating that it is spend (not performance) that determines the quarterly release of funds. All Vanguards were RAG rated according to their impact on non-elective admissions and Wellbeing Erewash is *'almost at risk'*. Funding for Q3 is safe, and funding for Q4 is potentially at risk depending on performance and our ability to explain the reasons for any growth in activity.

4. NHS England has published the STP dashboard and it has confirmed Derbyshire as one of the areas rated *"advanced"* in the first STP Progress Dashboard. The Dashboard, driven by indicators in three broad areas; hospital performance, patient-focused changed and transformation. Senior colleagues, chief executives and chairs from all 11 organisations involved in Joined Up Care Derbyshire (our Sustainability and Transformation Partnership, or 'STP') have held the first board meeting and created a new governance structure to help transform health and care services in the county. The Board agreed to prioritise and speed up the implementation of the plans set out in Joined Up Care Derbyshire and focus their organisations on the main projects, or 'workstreams'. This will help all 11 organisations start working together as a whole system on an everyday basis, with patient care and services at the heart of their focus, and move away from functioning as separate entities

   Following the announcement by senior health leaders this week that the NHS is pumping £325 million into new projects in 15 areas across the country, it was

confirmed that Derbyshire would receive up to £30m for two local projects. The £325m has been awarded to Sustainability and Transformation Partnerships (STP) which are considered to be the strongest and most advanced in the country. Derby Teaching Hospitals Foundation NHS Trust will now be able to move forward plans for an Urgent Care Village' which will incorporate GP services, a frailty clinic and mental health services to make sure patients receive the right care in the right place, first time, and avoid going to A&E unnecessarily. The remaining investment will go towards supporting work that is considering new facilities that will bring community services, outpatient clinics, testing and diagnostics and specialist rehabilitation services together in one place in the county

5. The Better Care Closer to home plan was agreed following extensive public consultation at an extra ordinary public governing body meeting between North Derbyshire CCG and Hardwick CCG on 24 July 2017.A multi-agency implementation team will develop and deliver the implementation plan working with Place groups to develop local solutions this will be overseen by a program implementation board reporting to CCG Governing bodies with links to the Health and Wellbeing Board. A lay member reference group will act as a critical friend to constructively challenge the process. The first meeting of the Implementation Board was on 11 September 2017. Following the sign off of a consultation plan a critical issue, requiring rapid resolution, has already occurred. This issue related to the ability of the DCHS to safely staff Riverside ward at Newholme Hospital. The number of patients on Riverside ward has been falling for some time and for the previous six months the ward usually had between 4 to 6 patients. This recently dropped even below that and at the end of July there was only a single patient needing to remain on the ward. Adding to this occupancy issue providing qualified nurse cover to the ward was increasingly difficult. Derbyshire Community Health Services have taken the decision to temporarily close Riverside ward increasing their capacity in other wards to cover previous demand. The temporary closure of the ward frees up a small group of staff who in conjunction with our services are able to focus on the formation of a small dementia rapid response team to work with patients in the community to avoid admission.

Within our Trust

6. Staff from our Trust led two large scale World Suicide Prevention Day events one in Chesterfield where we had around 30 volunteers, the largest component from our own staff group and we engaged with as many of the 5164 fans as we could and had a number of conversations with service users and general public attending the match We were also able to make positive links with our partners in Derbyshire County Council, Public Health, Network Rail, Samaritans and Cruse. The trust also got good press from a PeakFM interview, Chesterfield Post article and website/social media posts from the football club.

Dr Allan Johnston (Consultant Psychiatrist) with the Chesterfield Football Club mascot

7. At Spotlight on Leaders event held of 13 September the Workforce and OD team provided a well-attended interactive learning development session focussed on Employee Relations (ER). Case studies and lessons learned meant that attendees left with a much deeper appreciation of the impact on individuals, teams and the wider Trust. It was a well-received opportunity to share experiences and key learning points to improve the experience of all involved. Key messages included addressing emerging ER problems early, following policy rigorously, concluding formal processes as quickly as possible and appropriately supporting all those involved. The imminent appointment of the new Freedom to Speak Up Guardian and the availability of a new jointly-developed ER management information system (developed together by WOD and ops) will complement the practical learning. Many thanks to Gary, Susan and Rose and their team for pulling the session together

8. On 6 September, James Mullins (Head of Hospital Inspections, Mental Health) from the CQC visited the Trust to meet staff and review the progress and improvements we have made since the comprehensive inspection. Whilst it was only an informal visit, James was pleased with what he saw and gave us positive feedback. Many local leaders and members of the operations and nursing/quality team worked very hard to prepare for the visit and I would like to thank them on behalf of the Board.

9. Since our last Board meeting I have met with/visited staff from our Crisis North Team in the High Peak, Teams at Dale Bank View, St Andrew's House, and our Estates leadership team. These meetings were either individually arranged or part of an opportunity before our Executive Leadership Team meetings that are now scheduled out in the Trust not just at HQ. Common themes that emerge from these meetings include:
    - We still need to be more responsive in supporting staff to have the 'tools' to do their job with staff citing delays in receiving some essential equipment or environmental improvements. Car parking was raised as an issue and frustration in several places.
    - The pressure of recruitment difficulties is telling on teams, staff working very hard to manage increased pressure due to demand with less capacity. It was also noticeable that in some instances staff were not aware of all the measures put in place to address our recruitment challenges

- Extended role requirements add further pressure, particularly for more senior leaders, for example involvement in investigations. The need for ongoing training for managers around conducting grievance and disciplinary investigations was clear.
- Some teams were looking for support in managing relationships with other Organisations that are key to their service for example Pennine Care, Stepping Hill in the High Peak.

I would ask the Board to note that the Executive Team are focussed on actions from this feedback and importantly will ensure feedback is given directly to teams.

10. At the end of August I met with Toby Perkins, MP for Chesterfield to update him on the progress the Trust has made around the governance and quality improvements as well as the decisions not to progress with the merger. I also had the opportunity to brief him on the current pressure facing providers such as ourselves and the risks this poses to residents of Derbyshire. Toby was responsive and agreed to raise these issues in the House particularly a reality check of the expectation of Trusts to deliver the mental health *'national must do's'* in an environment where finances talked about nationally are not finding their way down to the front line.

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

Assurances

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

Consultation

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

Governance or Legal Issues

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

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

Actions to Mitigate/Minimise Identified Risks

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

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

That said some of the reports both nationally and within the Derbyshire system have the potential to have an adverse impact on people with protected characteristics (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 carried out will determine a response to the three aims of the general equality duty:

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

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 development of a dementia rapid response team is an example of a new service that will have more flexibility to respond to the local needs of individual communities than a fixed in-patient provision.

The work we are leading in Erewash around 'timeswaps' and Brilliant Erewash are specific community focussed initiative responding to reported REGARDS needs.

Recommendations

The Board of Directors is requested to:

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 27 September 2017

Integrated Performance Report (IPR) Month 5

Purpose of Report

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

Executive Summary

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

There are a number of key issues that have been set out below for further discussion by the Board of Directors.

1. Staffing issues continue across the acute inpatient wards
2. Caseload activity within Community teams
3. No of falls on in-patient wards has increased
4. Consistent data regarding CTR compliance remains a challenge
5. Time taken to investigate complaints and the number of outstanding actions following complaints remains high
6. Out of Area patient placements
7. CIP delivery
8. Performance against a number of workforce metrics continues to be challenging

Despite the delivery of recruitment activities, staffing remains a substantial challenge for many Trust services in the ward areas. As requested by the Board of Directors, the Director of Nursing has reviewed the safer staffing report.

In the last report and over the summer we have continued to work on implementing the revised workforce plan and review of the in-patient skill mix. This was reviewed by the Quality committee and agreed with a new dashboard approach to assessing changes. Key areas of progress are the Campus skill mix is set at five staff on shift which is set at three registered professionals.

Acute areas have had very traditional skill mix models, over 2016/17, pilots of occupational therapists working day shifts at the Hartington unit have been undertaken and in design at the Radbourne unit. These posts were out to advert and this has been led by the teams and in particular Rachel Chambers our Lead Occupational Therapist (OT) / AHP (Allied Health Professional) for Campus and we have had significant success in recruiting shift based OTs, matching the number of RMN's (Mental Health Nurse) in some service areas. The quality of OT's at interview

has been very high. We now need to move to ensure we successfully onboard all new recruits and pay attention and provide substantial support to this new workforce as they join the acute service and put in place high levels of supervision and monitoring to retain this workforce.

The Director of Nursing has partial assurance on staffing levels, against planned standards, however, is assured that safe and effective operational management is in place to mitigate all risks, however the operational impact upon improving our clinical supervision, training standards our performance in appraisal is reducing as our focus on immediate safety filling ward staffing is fluctuating significantly.

Nursing and Quality staff, as well as other staff, have been deployed to support Campus services over the summer period to maintain safety and also to support our staff in this time of transition until our new staff commence. This may need to recommence in the Autumn to enable teams to maintain skill mix, safety and safely induct staff.

Additional quality improvement projects may need to be restricted and reviews of timescales to ensure this new workforce, is supported to flourish, this may hinder our progress significantly until the end of the calendar year.

Bed occupancy is lower at this time and this is creating a balancing situation of risk which is being monitored closely by the leadership team. If clinical activity and bed occupancy substantially change proactive action to reduce bed stock and maintain safety may be required and activated in this delicate period.

If operational vacancies and mitigating plans are not fully realised, the Director of Nursing's opinion is there is still a risk to patient experience and to the quality of the service which we provide. Further mitigation and deployment of our resources and additional resources from across the Trust including temporary redeployment will still required to maintain the quality of our services.

For Neighbourhood teams authorisation to over recruit community staff over budgeted establishment in key hotspot areas continues and this is in place at Derby City Neighbourhood. The long standing substantial gap between commissioned service and actual capacity and demand remains a significant risk to delivery, which the Trust is partially mitigating through use of our internal resources.

This issue is known and accepted by our commissioners, further benchmarking continues against care coordination levels of CQC (Care Quality Commission) good rated trusts e.g. care co-coordinator levels per 100,000 population and Trusts with substantially smaller commissioned service despite national directives continue. This so far is not evident in any new use of resources developments in CQC standards and inspections to date.

Our complex staffing issues are both in today's performance ad for future planning. Community violence and substantial levels of violence and crime continue to rise in Derby and the South. This is responding to known people who have been released from prison after serving long sentences for significant offences and their risks to our community and more vulnerable patient population and people with mixed and unspecified presentations who would be subject to public protection procedures. The Mutli Public Protection Arrangements (MAPPA) strategic board chaired by

Derbyshire Police have re-escalated a concern of the impact of no commissioned community forensic service and the impact of this on effective MAPPA arrangements and future arrangements. This is an escalated issue form May that has not made significant progress with commissioners to date. Safer staffing in the community is not operating in optimised conditions e.g. the lack of community forensic service is not optimising our clinical staff and their ability to manage risk. Although this is again accepted by our commissioners, since entry into the issues log in 2014/15, it remains a substantial commissioning gap. Progress on STP (Sustainable Transformation Plan) plans are in development stage on this pathway. The Director of Nursing and Chief Operating Officer have requested a more formal meeting with commissioners to discuss this this issue and request exploration of more immediate risks mitigations and a full programme management approach to this development. This should include the local authority and reviewed patterns in very serious incidents and community Domestic homicide reviews that do not necessarily involve individuals open to the Trust's services.

Any disinvestment in the future in community mental health services would have a substantial and significant impact on quality and it is of my current clinical professional opinion this would adversely impact upon patient safety.

Quality and Operational Performance

There is improvement in a number of areas since the last IPR was presented to Trust Board. These are set out below;

- No of incidents of moderate to catastrophic harm has fallen
- No of episodes of seclusion and incidents involving patients held in seclusion has fallen
- No of incidents of physical assault and incidents involving physical restraint has reduced in campus areas
- No of patients on a Safety Plan is improving
- HCR20 assessment compliance (Low Secure) is 100%
- No of compliments is increasing
- No of recorded capacity assessments is increasing
- No of outstanding actions following CQC 2016 review has reduced
- The combined indicator for Level 3 and Think Family training compliance is now shown, rather than the separate indicators

There remains a continued focus in a number of areas to improve performance in areas such as safety plans and VTE assessment.

This report also now provides a mortality dashboard, which has been a request that has been made nationally and is being overseen by the Trust's mortality group.

Operational performance remains relatively stable with the vast majority of KPI's being achieved.

There are a number of other areas where performance remains variable, with further detail provided in the main body of the report.

People Performance

Staff attendance remains a significant challenge to the Trust with an annual sickness absence rate of 5.39%, but there has been a month on month reduction since January 2017 when the annual sickness absence rate was running at 5.62%. In August the sickness absence rate for the month was 5.84% which is 0.57% higher than the previous month but 0.25% lower than in the same period last year (August 2016).

Compulsory training compliance remains high at 87.69% which is below our 90% target but above our main contract non CQUIN target of 85%. There has been a slight decrease in overall appraisal completion at 73.03% against a target of 90%. Medical staff appraisal completion has decreased by 1.39% to 78.22%.

The budgeted full time equivalent vacancy rate for August was 8.68%, a decrease of 0.05% compared to the previous month. During the period January 2017 to August 2017 157 employees left the Trust and 195 people have joined the Trust.

Work continues on the recruitment action plan which covers how we plan to tackle each vacancy and includes campaigns and open days across the UK, incentives where necessary and overseas recruitment for hard to fill posts.

Financial Performance

In surplus terms, the Trust is ahead of plan in the month and year to date by £1.1m. The forecast remains 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 year to date and is forecast to be a 2 at the end of the financial year. Current performance is strong in all measures. Forecast-wise four of the five metrics remain strong at 2, 1, 1 and 2, but there is deterioration in agency spend against ceiling, which is forecast at a 3 by year end. This is, however, still better than last year and would meet our objective of being less than 50% above the ceiling. Currently the forecast for agency medical expenditure is above the required reduction by £390k. However it is important to note that the forecast includes a contingency for unforeseen agency requirements of £175k.

Planning continues for additional cost improvement action required to achieve 17/18 control total financial plan and to seek to address the level of non-recurrent CIP in preparation for 18/19. The Commissioner-driven QIPP disinvestment schemes that require £3.05m income and cost reduction are not yet agreed. These are incorporated into the Mental Health STP workstream planning.

The numbers reported in the attached finance report are consistent with the numbers reported in the monthly finance return sent to NHS Improvement on 15 September 2017.

Board can be assured that the Executive will regularly review the integrated performance reporting, given recent new or updated Regulator guidance recently issued (Well led, Use of Resources and Single Oversight Framework) to ensure Board oversight on the most appropriate metrics continues to be maintained.

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

Assurances

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

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

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

Consultation

This paper has not been considered elsewhere however 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

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

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics of REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation) and Public Sector Equality Duty & Equality Impact Risk Analysis.

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
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.

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

Financial Perspective

Highlights
- Surplus ahead of plan year to date
- Forecast achievement of control total
- Cash better than plan
- All UoR ratings strong YTD
- Delivery of Cost Improvement Programme

Challenges
- Containment of agency expenditure within ceiling set by NHSI
- Receipt of full CQUIN income assumed in forecast
- Reduction in Out of Area costs
- High level of non-recurrent CIP
- Additional action required to achieve forecast control total

Operational Perspective

Highlights
- IAPT People Completing Treatment Who Move To Recovery underperformance has been addressed
- There has been no under 18 admitted onto our wards
- 7 day follow-up for all inpatients has improved

Challenges
- Data completeness - Priority Metrics
- Clustering continues to be a challenge
- Cancellations and DNAs in outpatients
- Delayed Transfers has breached the target
- Discharge Fax sent in 2 working days has been addressed.
- Inpatient 28 day readmissions has breached.

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.
- Appraisal compliance rates remain low.

Quality Perspective

Highlights
- Data from the Mortality Database has been included this month, in line with national reporting requirements and timescales.
- No of incidents of moderate to catastrophic harm has fallen
- No of episodes of seclusion and incidents involving patients held in seclusion has fallen
- No of incidents of physical assault and incidents involving physical restraint has reduced
- No of patients on a Safety Plan is improving
- The CTR indicator has been amended to % of CTR's completed and was 100% compliant this month
- HCR20 assessment compliance (Low Secure) is 100%
- No of compliments is increasing
- No of recorded capacity assessments is increasing
- No of outstanding actions following CQC 2016 review has reduced
- The combined indicator for Level 3 and Think Family training compliance is now shown, rather than the separate indicators

Challenges
- No of falls on in-patient wards has increased
- Complaint investigations are still taking too long to complete
- The no of outstanding actions following complaint investigations remains high

FINANCIAL OVERVIEW – August 2017

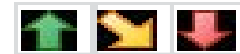
Category	Sub-set	Metric	Period	Plan	Actual	Rating	Trend	Key Points
Governance	Use of Resources (UoR) Metric	**Overall Use of Resources Metric**	YTD	1	1	Y		At the end of August the Use of Resources Rating is an overall '1'. Forecast is a rating of '2' which is slightly worse than the plan of '1'. This is mainly driven by the agency metric which is forecast at a '3' for the end of the financial year.
			Forecast	1	2	Y		
		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	Y		
			Forecast	1	2	Y		
		Agency variance to ceiling	YTD	1	2	Y		
			Forecast	1	3	A		
	Single Oversight Framework	NHS I Segment	YTD		2	n/a	n/a	
				Plan	**Actual**	**Variance**	**Trend**	
I&E and profitability	Income and Expenditure	Control Total position £'000	In-Month	209	205	R		At the end of August the surplus is ahead of plan by £1.1m. This is due to additional non-recurrent income related to an overage on a previous asset sale being received in a previous month. The forecast is to achieve the control total at the end of the financial year. The normalised forecast takes out the non-recurrent income and expenditure. Without the non-recurrent income mentioned we would have a gap to the control total. EBITDA is forecast £1.2m behind plan. This is offset by below the line items such as profit on disposal, small underspends on depreciation and Public Dividend Capital payments.
			YTD	1,360	2,440	G		
			Forecast	2,765	2,765	G		
		Control Total position ex STF £'000	In-Month	156	152	R		
			YTD	1,135	2,215	G		
			Forecast	1,971	1,971	G		
		Normalised Income and Expenditure position £'000	In-Month	156	168	G		
			YTD	1,135	1,242	G		
			Forecast	1,971	1,184	R		
	Profitability	Profitability - EBITDA £'000	In-Month	822	804	R		
			YTD	4,464	4,449	R		
			Forecast	10,159	8,951	R		
		Profitability - EBITDA %	In-Month	7.4%	7.0%	R		
			YTD	8.0%	7.7%	R		
			Forecast	7.6%	6.5%	R		
Liquidity	Cash	Cash £m	YTD	13.772	17.052	G		Cash is ahead of plan year to date due to the overage income and the additional STF income from 2016/17. The forecast cash is ahead of plan by £3.3m which is due to the current cash balance plus forecast cash receipts from asset disposals. Capital expenditure is behind plan year to date but is forecast to achieve full spend.
			Forecast	12.193	16.046	G		
	Net Current Assets	Net Current Assets £m	YTD	8.108	8.064	R		
			Forecast	8.345	7.161	R		
	Capex	Capital expenditure £m	YTD	1.029	0.564	R		
			Forecast	3.338	3.338	G		
Efficiency	CIP	CIP achievement £m	In-Month	0.321	0.260	R		CIP is ahead of plan YTD and the forecast assumes an overachievement of £1.1m by the end of the financial year. A significant amount of CIP is non-recurrent in nature.
			YTD	1.604	2.574	G		
			Forecast	3.850	4.912	G		
			Recurrent	3.850	1.770	R		

Key:

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

Achieving plan
Not achieving plan

Plan In-month or Year end Trust plan


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

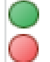
OPERATIONAL OVERVIEW – AUGUST 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	Key Points
Performance Dashboard	NHSI	CPA 7 Day Follow-up (M)	Month	95.00%	96.61%	G			All NHS metrics are all compliant except "Priority Metrics" which is a new indicator since April 2017. See detailed slide for actions in place to address the under performance. For each metric we have indicated if it is monitored by NHS Quarterly (Q) or Monthly (M).
			Quarter	95.00%	96.48%	G			
		Data completeness - Identifiers (M)	Month	95.00%	99.40%	G			
			Quarter	95.00%	99.49%	G			
		Data completeness - Priority Metrics (M)	Month	85.00%	71.40%	R			
			Quarter	85.00%	69.54%	R			
		Crisis Gatekeeping (Q)	Month	95.00%	98.57%	G			
			Quarter	95.00%	99.44%	G			
		IAPT RTT within 18 weeks (Q)	Month	95.00%	99.71%	G			
			Quarter	95.00%	99.88%	G			
		IAPT RTT within 6 weeks (Q)	Month	75.00%	92.43%	G			
			Quarter	75.00%	94.03%	G			
		Early Intervention in Psychosis RTT Within 14 Days - Complete (Q)	Month	50.00%	96.00%	G			
			Quarter	50.00%	91.23%	G			
		Early Intervention in Psychosis RTT Within 14 Days - Incomplete (Q)	Month	50.00%	100.00%	G			
			Quarter	50.00%	84.00%	G			
		Patients Open to Trust In Employment (M)	Month	N/A	9.19%				
			Quarter	N/A	8.93%				
		Patients Open to Trust In Settled Accommodation (M)	Month	N/A	59.40%				
			Quarter	N/A	57.11%				
		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%	52.27%	G			
			Quarter	50.00%	51.92%	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:

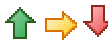
Period Month Current Month

Quarter Current Quarter



Achieving target

Not achieving target



Trend compared to previous month/quarter

OPERATIONAL OVERVIEW – AUGUST 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	Key Points
Performance Dashboard	Locally Agreed	CPA Settled Accommodation	Month	90.00%	94.94%	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%	95.01%	G			
		CPA Employment Status	Month	90.00%	95.97%	G			
			Quarter	90.00%	95.90%	G			
		Data completeness - Identifiers	Month	99.00%	99.40%	G			
			Quarter	99.00%	99.49%	G			
		Data completeness - Outcomes	Month	90.00%	92.85%	G			
			Quarter	90.00%	92.81%	G			
		Patients Clustered not Breaching Today	Month	80.00%	75.58%	R			
			Quarter	80.00%	75.99%	R			
		Patients Clustered regardless of review dates	Month	96.00%	93.85%	R			
			Quarter	96.00%	93.88%	R			
		7 Day Follow-up - all inpatients	Month	95.00%	97.71%	G			
			Quarter	95.00%	94.70%	R			
		Ethnicity coding	Month	90.00%	91.45%	G			
			Quarter	90.00%	91.23%	G			
		NHS Number	Month	99.00%	100.00%	G			
			Quarter	99.00%	100.00%	G			
		CPA Review in last 12 Months (on CPA > 12 Months)	Month	95.00%	95.66%	G			
			Quarter	95.00%	94.94%	R			
		Community Care Data - Activity Information Completeness	Month	50.00%	94.14%	G			
			Quarter	50.00%	94.15%	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%	73.93%	G			
			Quarter	50.00%	74.17%	G			
		Early Interventions New Caseloads	Month	95.00%	136.80%	G			
			Quarter	95.00%	136.80%	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 – AUGUST 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	Key Points
Performance Dashboard	Schedule 6	Consultant Outpatient Trust Cancellations	Month	5.00%	8.59%	R			The most common reason was "consultant absent from work". Alternative approaches to outpatient appointment booking are being piloted.
			Quarter	5.00%	8.15%	R			
		Consultant Outpatient DNAs	Month	15.00%	16.08%	R			
			Quarter	15.00%	16.46%	R			
		Under 18 admissions to Adult inpatients	Month	0	0	G			
			Quarter	0	1	G			
		Outpatient letters sent in 10 working days	Month	90.00%	91.75%	G			
			Quarter	90.00%	92.63%	G			
		Outpatient letters sent in 15 working days	Month	95.00%	97.88%	G			
			Quarter	95.00%	97.39%	G			
		Inpatient 28 day readmissions	Month	10.00%	10.67%	R			There were 18 patients re-admitted within 28 days of discharge.
			Quarter	10.00%	9.12%	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%	95.12%	R			4 discharge emails wer sent late due to staff illlness.
			Quarter	98.00%	97.92%	R			
		Delayed Transfers of Care	Month	0.80%	1.50%	R			currently only 1 DTOC on the wards awaiting accomodation.
			Quarter	0.80%	1.38%	R			
		18 Week RTT Less Than 18 Weeks - Incomplete	Month	92.00%	96.92%	G			
			Quarter	92.00%	96.20%	G			

OPERATIONAL OVERVIEW – AUGUST 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	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%	97.33%	G			
			Quarter	92.00%	96.21%	G			
		Mixed Sex accommodation breaches	Month	0	0	G			
			Quarter	0	0	G			
		Completion of IAPT Data Outcomes	Month	90.00%	96.80%	G			
			Quarter	90.00%	96.12%	G			
		Ethnicity coding	Month	90.00%	92.28%	G			
			Quarter	90.00%	91.64%	G			
		NHS Number	Month	99.00%	100.00%	G			
			Quarter	99.00%	100.00%	G			
Other Dashboards	Health Visiting	% 10-14 Day Breastfeeding coverage	Month	98.00%	99.24%	G			Compliant with Targets.
			Quarter	98.00%	99.45%	G			
		% 6-8 Week Breastfeeding coverage	Month	98.00%	98.05%	G			
			Quarter	98.00%	100.00%	G			
	IAPT	Recovery Rates	Month	50.00%	52.27%	G			Compliant with Targets.
			Quarter	50.00%	50.38%	G			
		Reliable Improvement Rates	Month	65.00%	67.98%	G			
			Quarter	65.00%	66.59%	G			
	Safer Staffing	Inpatient Safer Staffing Fill Rates	Month	100.00%	104.5%	R			Detailed ward level information shows specific variances
			Quarter	100.00%	104.5%	R			

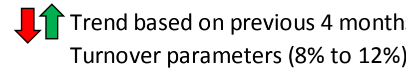
WORKFORCE OVERVIEW – August 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance		Trend	Key Points
Workforce Dashboard	NHSI Key Performance Indicator (KPI)	**Turnover** (annual)	**Aug-17**	10%	**10.64%**	↘	G	↑	Annual turnover remains within the Trust target parameters and is below the regional Mental Health & Learning Disability average of 12.38% (as at June 2017 latest available data). The monthly sickness absence rate is 0.57% higher than the previous month, however compared to the same period last year (August 2016) it is 0.25% lower. The annual sickness absence rate continues to reduce running at 5.39% (as at July 2017 latest available data). The regional average annual sickness absence rate for Mental Health & Learning Disability Trusts is 5.20% (as at May 2017 latest available data). Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 31.37% of all sickness absence, followed by surgery at 15.08% and other musculoskeletal problems at 12.68%. The Funded Fte vacancy rate has decreased by 0.05% to 8.68%. The number of employees who have received an appraisal within the last 12 months has decreased slightly by 0.12% to 73.03%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £610k. Compulsory training compliance has decreased slightly by 0.21% to 87.69% but remains above the 85% main contract non CQUIN.
			Jul-17		10.89%		G		
		Sickness Absence (monthly)	**Aug-17**	5.04%	**5.84%**	↗	R	↑	
			Jul-17		5.27%		R		
		Sickness Absence (annual)	**Jul-17**	5.04%	**5.39%**	↘	R	↓	
			Jun-17		5.46%		R		
		Vacancies (including funded fte flexibility / cover)	**Aug-17**		**8.68%**	↘		↑	
			Jul-17		8.73%				
		Appraisals (**all staff** - number of employees who have received an appraisal in the previous 12 months)	**Aug-17**	90%	**73.03%**	↘	R	↓	
			Jul-17		73.15%		R		
		Appraisals (**agenda for change staff only** - number of employees who have received an appraisal in the previous 12 months)	**Aug-17**	90%	**72.82%**	↘	R	↓	
			Jul-17		72.86%		R		
		Appraisals (**medical staff only** - number of employees who have received an appraisal in the previous 12 months)	**Aug-17**	90%	**78.22%**	↘	R	↓	
			Jul-17		79.61%		R		
		Agency Usage (£ year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Aug-17**	£0	**£0.610m**	↗	R	↑	
			Jul-17		£0.442m		R		
		Agency Usage (% year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Aug-17**	0%	**44.17%**	↗	R	↑	
			Jul-17		39.81%		R		
	Other KPI	**Compulsory Training** (staff in-date)	**Aug-17**	90%	**87.69%**	↘	A	↑	
			Jul-17		87.90%		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%)

QUALITY OVERVIEW – AUGUST 2017

Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Safe	No of incidents of moderate to catastrophic actual harm	Month	29	24			Plan: average last fin yr 2016/17 (month).
		Quarter	88	98			Plan: average last fin yr (Qtr) 2016/17. Actual: 2017/18 Q1 data
	No of deaths of patients who have died within 12 months of their last contact with DHcFT	No of deaths of	104	102			Note, data as at 07/08/2017
		Quarter	312	382			Plan: average last fin yr (Qtr).Actual: 2017/18 Q1 data
	No of serious incidents reported to the CCG	Month	5	7			Plan - average last fin yr (month)
		Quarter	16	22			Plan: average last fin yr (Qtr). Actual: 2017/18 Q1 data
	No of episodes of patients held in seclusion	Month	10	7			
		Quarter	30	33			Plan: average last fin yr (Qtr). Actual: 2017/18 Q1 data Note, 1 incident form did not have the patients details.
	No of incidents involving patients held in seclusion	Month	16	9			
		Quarter	47	50			Plan: average last fin yr (Qtr). Actual: 2017/18 Q1 data
	No of incidents involving physical restraint	Month	48	37			
		Quarter	143	126			Plan: average last fin yr (Qtr). Actual: 2017/18 Q1 data
	No of incidents involving prone restraint	Month	10	14			Month plan based on average from 1/7/16 when prone restraint collected on Datix as defined field
		Quarter	29	32			Qtr plan based on average for Q2/Q3/Q4. Actual 2017/18 Q1 data
	No of incidents of physical assault - patient on patient	Month	12	15			
		Quarter	37	37			Actual: 2017/18 Q1 data
	No of incidents of physical assault - patient on staff	Month	19	8			
		Quarter	56	61			Actual: 2017/18 Q1 data

QUALITY OVERVIEW – AUGUST 2017

No of falls on in-patient wards	Month	32	39			
	Quarter	96	83			Actual: 2017/18 Q1 data
No of incidents of absconsion	Month	33	34			
	Quarter	99	90			Actual: 2017/18 Q1 data
No of patients with a clinical risk plan (FACE or Safety Plan)	Month	100%	75.31%			
	Quarter	100%	75.39%			
Of above, no of patients with a Safety Plan	Month	90%	37.66%			Safety Plan replaced FACE from 1/4/2017
	Quarter	90%	27.64%			
% of staff compliant with combined Level 3 Safeguarding Children and Think Family training	Month	85%	94.58%			
	Quarter	85%	NA			Qtr comparison not available
% of staff compliant with Clinical Safety Planning eLearning	Month	95%	95.40%			
	Quarter	95%	NA			Qtr comparison not available
% of CTRs (Care & Treatment Reviews) completed	Month	100%	100%			
	Quarter	NA	NA			
% of compliance with inpatients VTE assessment	Month	95%	79.58%			
	Quarter	95%	NA			
HCR20 assessment completed (Low Secure)	Month	100%	100.0%			
	Quarter	100%	NA			

QUALITY OVERVIEW – AUGUST 2017

Caring	No of complaints opened for investigation	Month	12	14			
		Quarter	37	47			Actual: 2017/18 Q1 data
	No of concerns received	Month	35	33			
		Quarter	104	106			
	No of compliments received	Month	100	94			
		Quarter	300	266			
	No of investigations by the Parliamentary Ombudsman	2016/17	NA	6			Data is provided cumulatively from 1st April each year
		2017/18	NA	0			Data is provided cumulatively from 1st April each year
	% of complaints upheld (full or in part) by the Parliamentary Ombudsman	2016/17	2	0			1 ongoing and 5 no further action
		2017/18	0	0			1 ongoing
	% of responded to (orange) complaint investigations completed within 40 working days, opened after 01/04/2016	Year	100%	25%			As at 04/09/2017, 217 (orange) complaints. 124 not responded within 40 working days. 52 ongoing
		Year	100%	0%			As at 01/08/2017, 9 (red) complaints. 4 not responded within 60 working days. 5 ongoing.
	No of incidents requiring Duty of Candour	Month	1	0			These figures will fluctuate based on the outcome of investigations.
		Quarter	2	7			
Effective	% of in-patients with a recorded capacity assessment	Month	100%	95.03%			
		Quarter	100%	93.21%			
	% of patients who have had their care plan reviewed and have been on CPA > 12months	Month	90%	95.31%			
		Quarter	90%	95.30%			
	No of seclusion forms not received by MHA Office	Month	0	NA			Seclusion pathway moved to PARIS. Seclusion end date and time not yet automated to inform MHA office. Resolution being pursued during Sept 2017.
		Quarter	0	NA			
	% of CTO rights forms received by MHA Office	Month	100%	92.0%			As at 06/09/2017
		Quarter	NA	NA	NA	NA	
	% of in patient older adults rights forms received by MHA Office	Month	100%	NA			Current position not accurately available
		Quarter	NA	NA	NA	NA	

QUALITY OVERVIEW – AUGUST 2017

Responsive	% of staff uptake of Flu Jabs	Month	45%	NA			Data to end of 30/11/16
		Year	45%	38.40%			Relates to 2016 campaign. Final data as shown in 16/17 Quality Account
	% of policies in date	Month	95%	94.50%			As at 04/09/2017
		Quarter	NA	NA	NA	NA	
Well Led	% of staff who have received Clinical Supervision, within defined timescales	Month	100%	60.10%			
		Quarter	100%	NA	NA	NA	
	% of staff who have received Management Supervision, within defined timescales	Month	100%	70.60%			
		Quarter	100%	NA	NA	NA	
	No of outstanding actions following serious incident investigations	Month	0	21			Total overdue actions as at 25/08/2017
		Quarter	0	NA		NA	
	No of outstanding actions following complaint investigations	Month	0	50			Total overdue actions as at 04/09/2017
		Quarter	0	NA	NA	NA	
	No of outstanding actions following CQC comprehensive review report (2016)	Month	0	27			Figure as at 04/09/2017

Financial Section

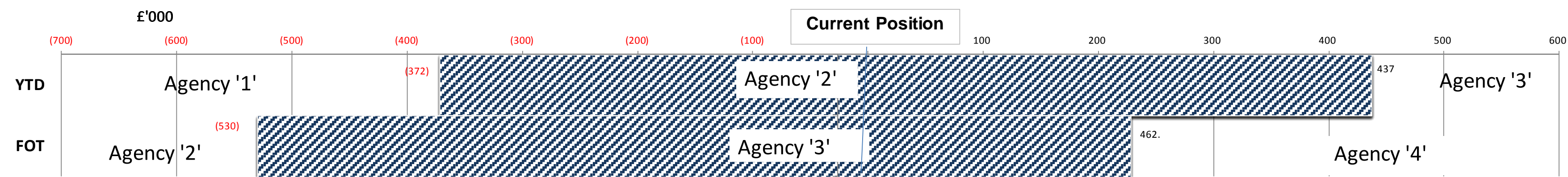
Governance – Use of Resources (UoR) Rating

The Use of Resources rating at the end of August is a ‘1’, with the capital service capacity rating and the agency metric at a ‘2’.
The ratings for each of the future quarters are forecast to be a ‘2’ which is mainly driven by the agency metric moving to a 3 by the end of quarter 2’.

	YTD @ Quarter 1		YTD August 17		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	2	1	1	1	1	1	1	1	2
Agency distance from Cap	1	2	1	2	1	3	1	3	1	3
UoR	1	2	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	2	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 in the forecast, 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’ by the end of March then we need to reduce agency expenditure by £530k. However if we spend an additional £228k 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 — August 2017

	Current Month			Year to Date			Forecast		
	Plan	Actual	Variance *Fav (+) / Adv (-)*	Plan	Actual	Variance *Fav (+) / Adv (-)*	Plan	Actual	Variance *Fav (+) / Adv (-)*
	£000	*0*	*£000*	*£000*	*£000*	*£000*	*£000*	*£000*	*£000*
Clinical Income	10,313	10,657	344	51,828	53,257	1,429	124,378	127,768	3,390
Non Clinical Income	805	853	47	3,986	4,314	328	9,822	9,530	(291)
Employee Expenses	(7,991)	(8,189)	(198)	(39,739)	(40,840)	(1,101)	(95,932)	(99,883)	(3,951)
Non Pay	(2,305)	(2,517)	(212)	(11,612)	(12,283)	(670)	(28,108)	(28,464)	(356)
EBITDA	**822**	**804**	**(18)**	**4,464**	**4,449**	**(15)**	**10,159**	**8,951**	**(1,209)**
Depreciation	(278)	(280)	(2)	(1,391)	(1,369)	22	(3,338)	(3,344)	(6)
Impairment	0	0	0	0	(685)	(685)	(300)	(685)	(385)
Profit (loss) on asset disposals	0	0	0	0	950	950	0	950	950
Interest/Financing	(176)	(179)	(3)	(917)	(892)	25	(2,146)	(2,119)	27
Dividend	(159)	(139)	20	(796)	(697)	99	(1,910)	(1,673)	237
Net Surplus / (Deficit)	**209**	**205**	**(4)**	**1,360**	**1,755**	**396**	**2,465**	**2,080**	**(385)**
Technical adjustment - Impairment	0	0	0	0	(685)	(685)	(300)	(685)	(385)
Control Total Surplus / (Deficit)	**209**	**205**	**(4)**	**1,360**	**2,440**	**1,081**	**2,765**	**2,765**	**0**
Technical adjustment - STF Allocation	53	53	0	225	225	0	794	794	0
Control Total Net Surplus / (Deficit) ex STF	**156**	**152**	**(4)**	**1,135**	**2,215**	**1,081**	**1,971**	**1,971**	**0**

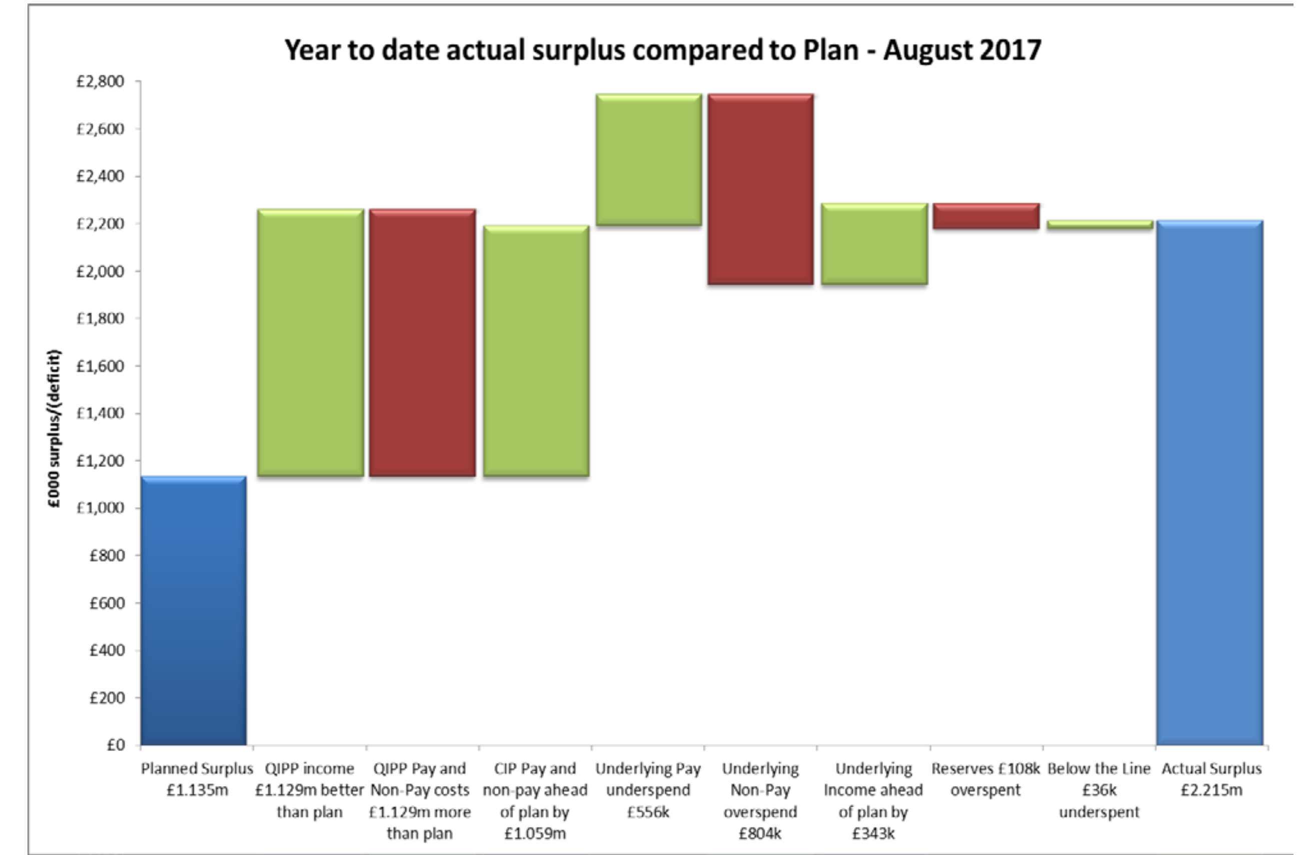
The Statement of Comprehensive Income shows the financial performance against both the control total surplus of £2.77m which includes the Sustainability Transformation Fund (STF) income and the surplus / (deficit) against the plan with the STF income excluded £1.97m.

Clinical Income is £1.429m more than plan year to date and at the end of the year is forecast to be £3.4m ahead of plan. This is mainly 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 year to date by £328k but is forecast to underachieve plan by £291k. This mainly relates to Pharmacy recharge income being lower than planned (with corresponding expenditure reductions).

Pay expenditure is £1.1m more than the plan at the end of July and forecast £4.0m more than plan. This relates to costs not yet being released relating to QIPP disinvestments (offsetting income) and CIP forecast to be delivered in a different way to the plan.

Non Pay is overspent year to date by £670k and is forecast to be £356k overspent by 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 pay and non-pay expenditure being more than plan. This is due to the disinvestment not yet being fully agreed with Commissioners.
- CIP is currently ahead of plan mainly due to the non recurrent allocation of income benefits in a previous month.
- Underlying pay underspends (exc. QIPP/CIP) due to various vacancies across the Trust, partially offset by bank and agency expenditure.
- Underlying non-pay overspend (exc. QIPP/CIP) mainly driven by out of area expenditure higher than plan.

Forecast Range

The main variables in the forecast range are: STF income loss, CIP forecast not fully realised, agency expenditure, CPC income, CQUIN income not received and other unexpected pay and non-pay costs.

Forecast Range

Best Case	Likely Case	Worst Case
£4.5m surplus	£2.8m surplus	£2.0m deficit

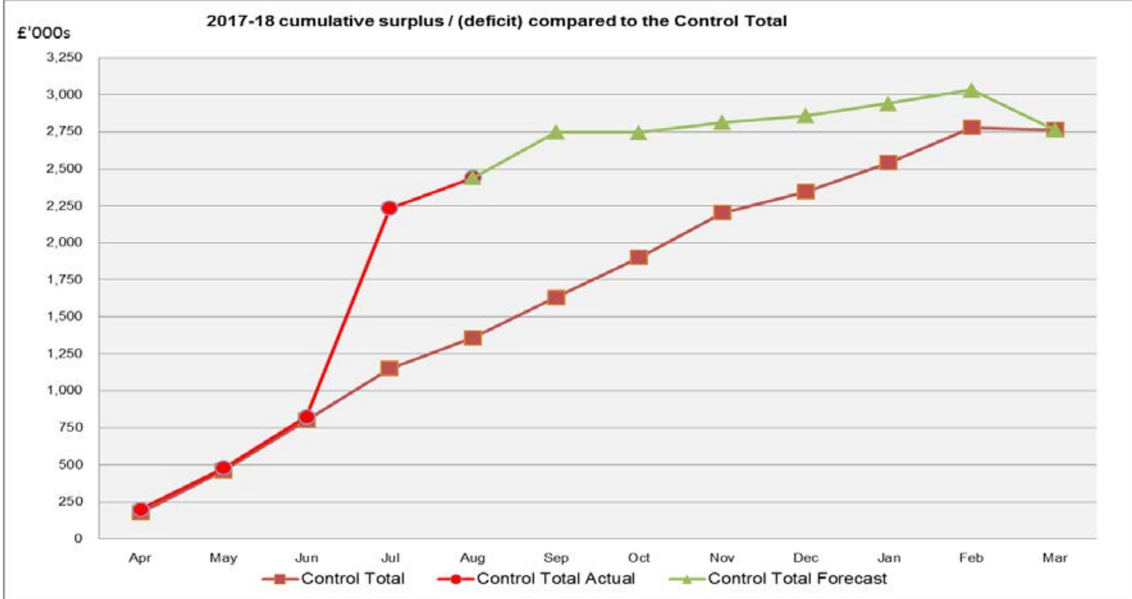
£'000s

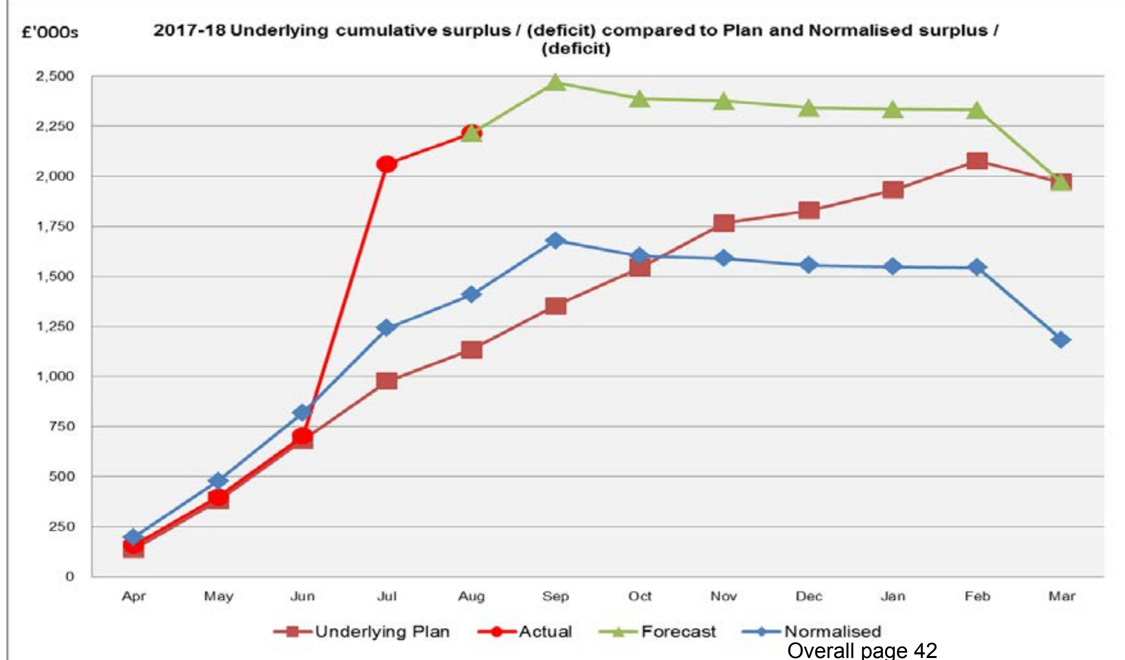
Forecast + surplus / - deficit

-£2,000 -£1,500 -£1,000 -£500 £0 £500 £1,000 £1,500 £2,000 £2,500 £3,000 £3,500 £4,000 £4,500

Worst Case **Best Case**

Normalised Income and Expenditure position





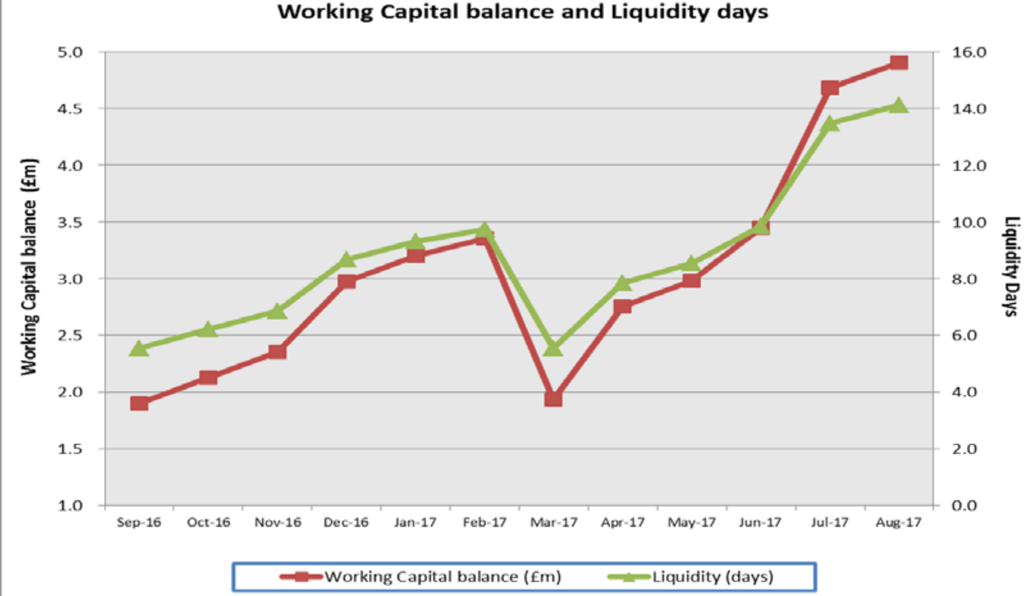
The first graph shows the actual cumulative surplus against the control total (including the Sustainability Transformation Fund (STF).

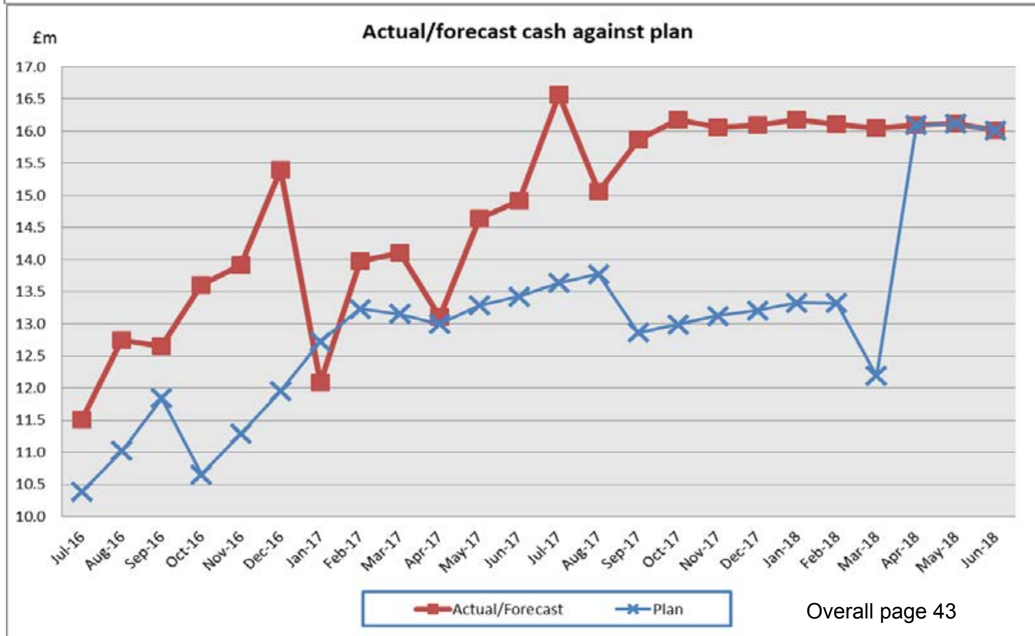
The peak in July (on both graphs) relates to overage income from a previous asset disposal.

This second graph 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 and non-recurrent transaction costs. There is also some non-recurrent income from the overage related to a previous asset disposal. In the normalised position these have been removed.
As shown in the graph if these non-recurrent items were not incurred then the forecast outturn would be below the plan and would require additional management action to achieve the control total.

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.

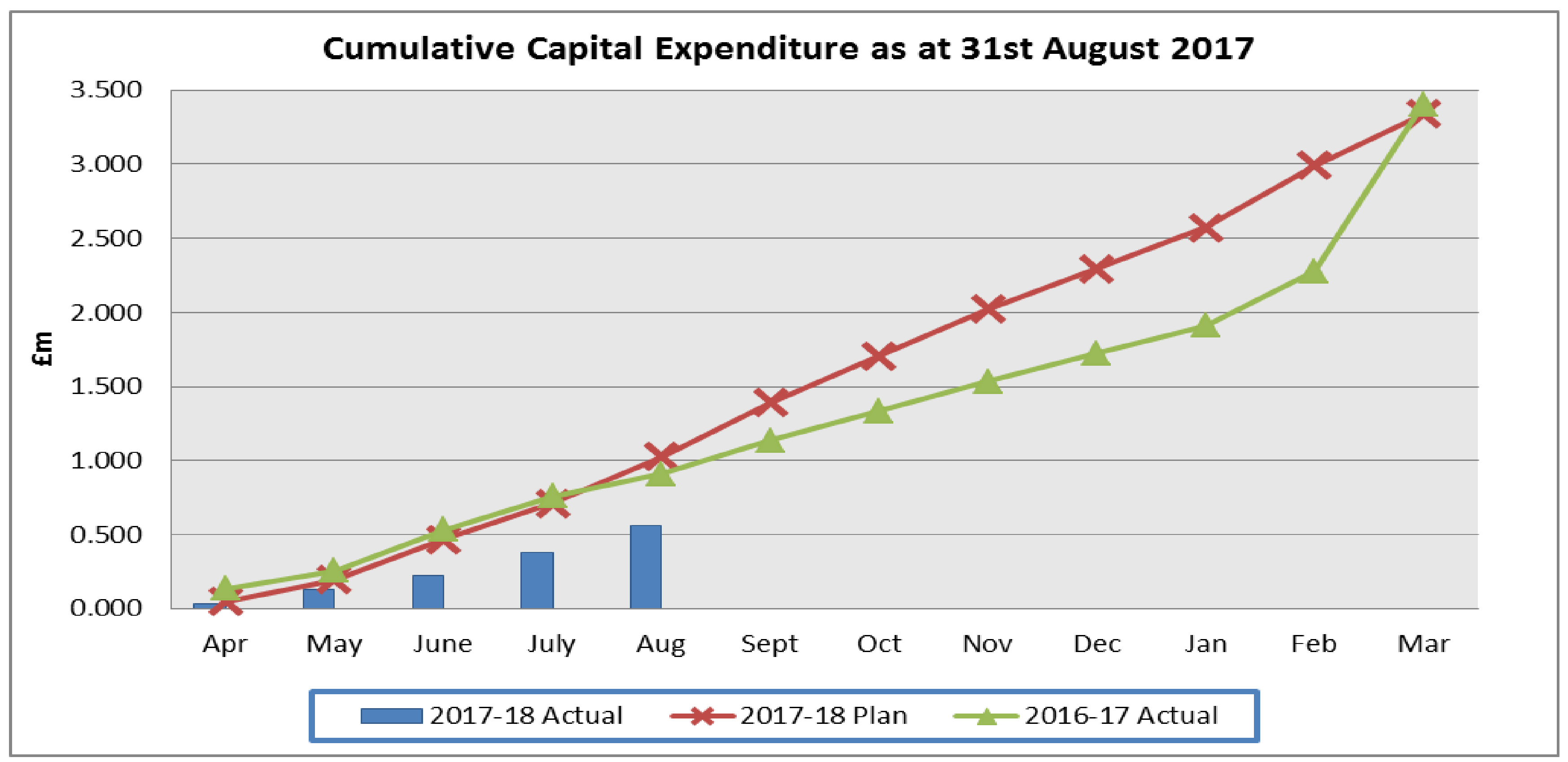
During the last 12 months working capital and liquidity continues to improve due to higher cash levels. The downturn in March 2017 is reflective of the increase in year end transactions such as provisions, along with an increase in payables mainly related to capital as works have concluded at the end of March.

The liquidity at the end of August is just over 14 days which 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 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 £17.1m which is £3.3m better than the plan at the end of August and is forecast to be above plan by £3.9m. This is mainly due to sale proceeds and additional STF income related to 2016/17.

Capital Expenditure

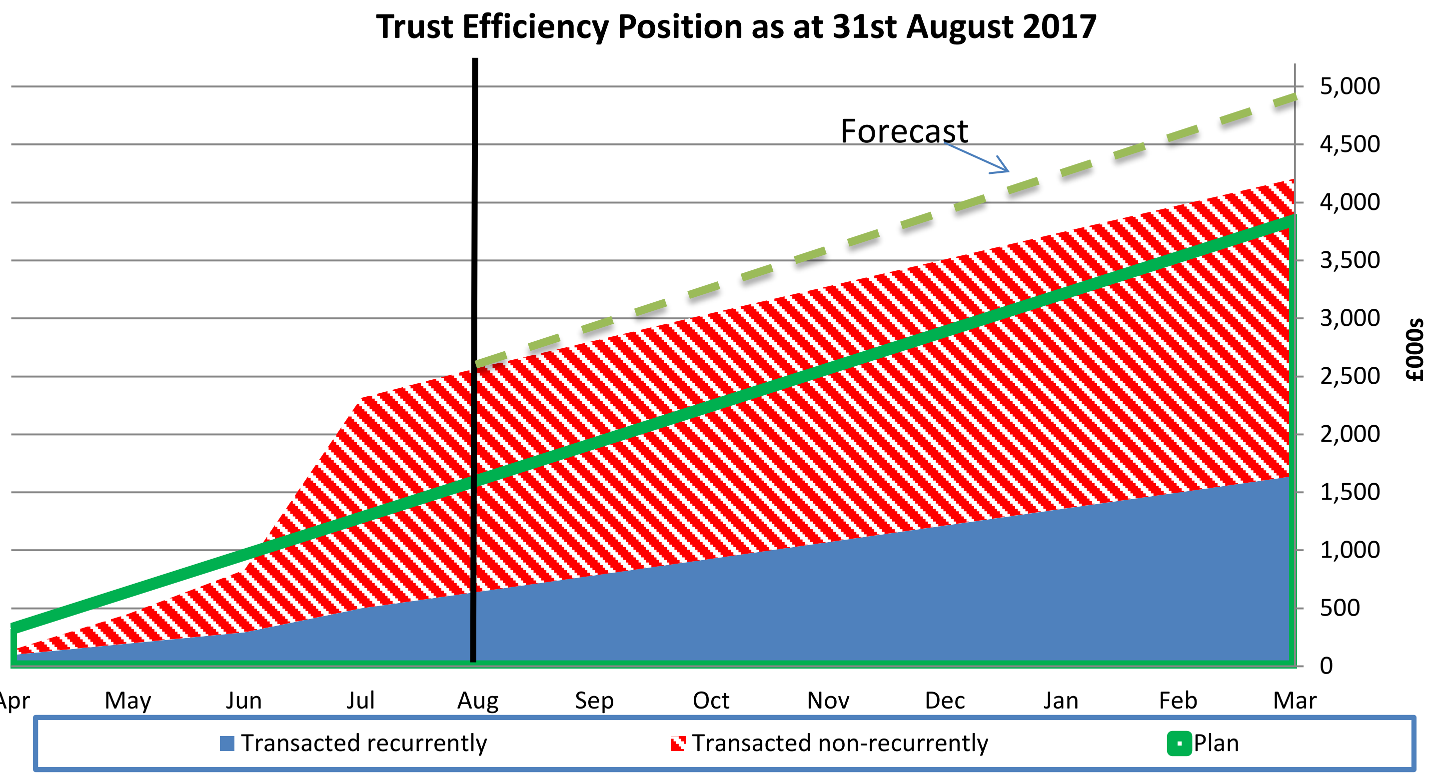


Capital Expenditure is behind plan by £465k at the end of August. There is a fully committed plan which may need to be re-prioritised in year to take into account any urgent bids that arise, which will be monitored by the Capital Action Team.

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 and to benefit staff well being. This is currently not included in the forecast.

Efficiency

Cost Improvement Programme (CIP)



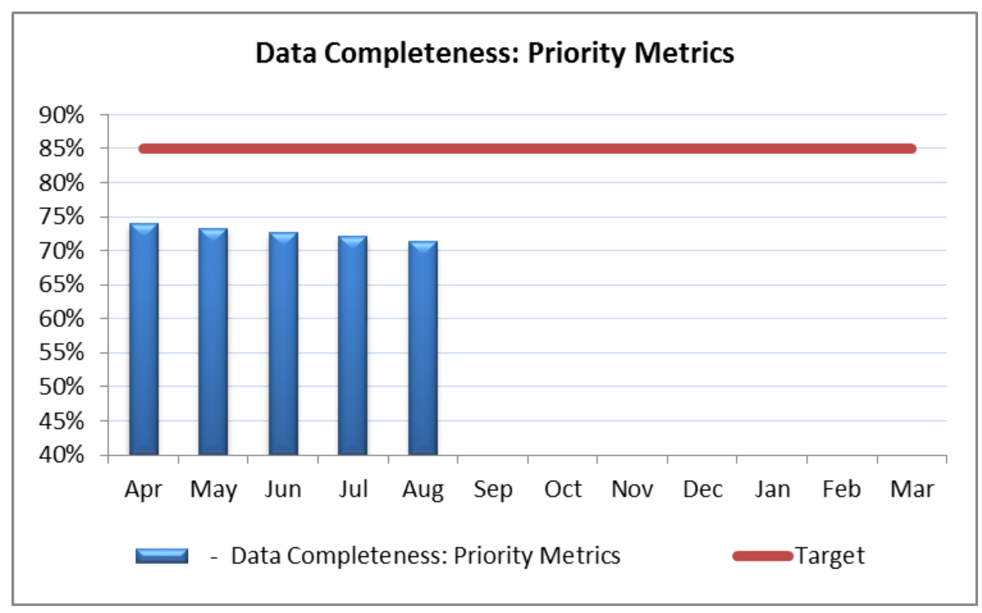
At the end of August there was £4.2m of assured CIP against a plan of £3.85m, making an overachievement of £357k. Of the £4.2m assured, £2.6m was assured non-recurrently.

The forecast assumes a further delivery of £0.7m of which £0.6m is non-recurrent. The total CIP forecast to be delivered is £4.9m which is an overachievement of £1.1m against the target of £3.8m. Of the forecast £4.9m, £3.1 m is non-recurrent in nature.

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

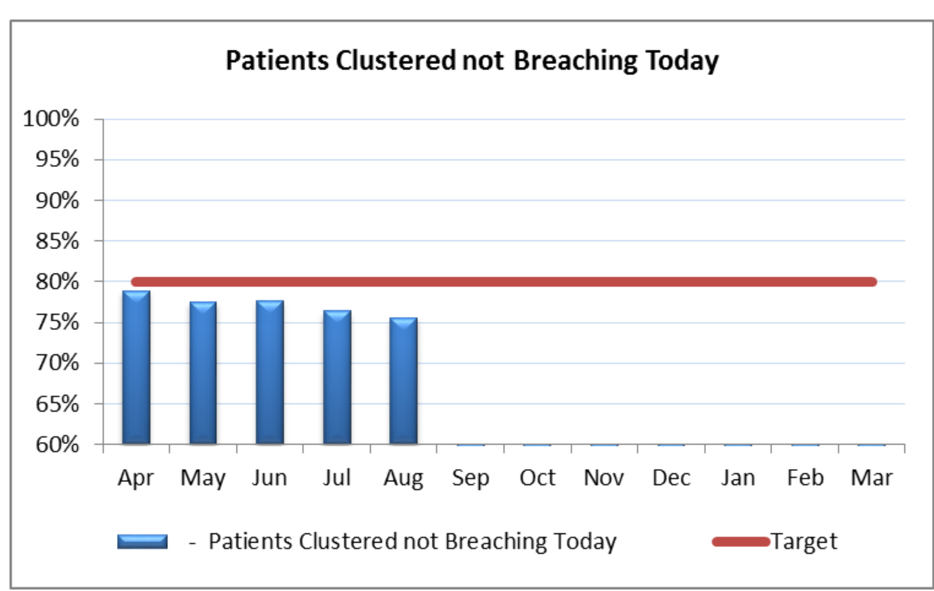


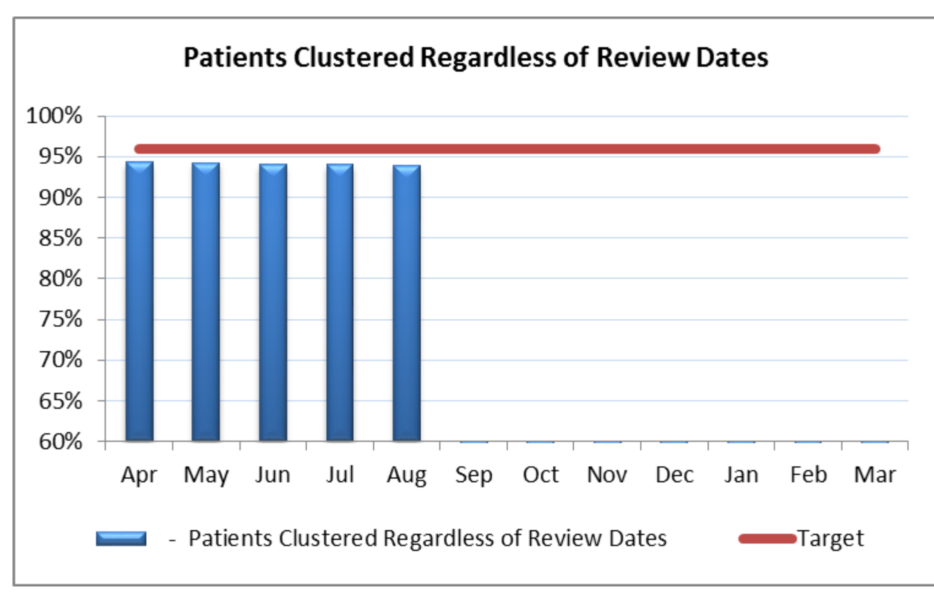
This is an NHS Improvement Single Oversight Framework (SOF) target which came into force from 1st October 2016. The national requirement is to achieve the priority metrics target of 85%. Achieving this target would be extremely challenging without additional resource. It is acknowledged there are capacity issues.

A proposal to revise the SOF is currently out for consultation1. NHS Improvement are proposing to replace the "data completeness priorities metrics" and "data completeness identifiers metrics" indicators with a single "data quality maturity index – mental health services data set score" indicator. The proposed target is 95%. In the latest published national data2 the Trust scored 98.9% therefore if this change comes into effect we should be able to achieve the revised target.

https://improvement.nhs.uk/resources/updating-single-oversight-framework-share-your-views/
http://content.digital.nhs.uk/dq

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

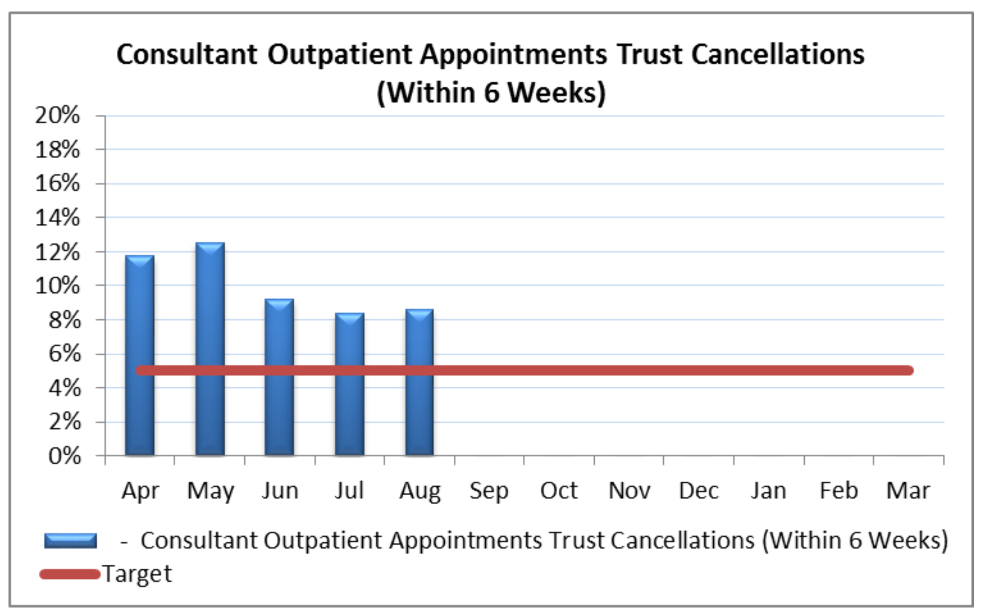




A paper was presented to the Finance and Performance Committee on 22nd May 2017. The Committee stated that it was important to achieve the identified performance standards and commissioned an action plan to address the requirements:

- The 2 performance targets should be complemented by the approved quality indicators not replaced by them
- Clusters to be used to help analyse caseloads and case flow.
- Audit to understand why there is a discrepancy with the red rule adherence.
- Multi-disciplinary reference group to be established.
- Target teams or individuals where clustering seems out of kilter with the performance and red rules

Consultant Outpatient Appointments Trust Cancellations (within 6 weeks)

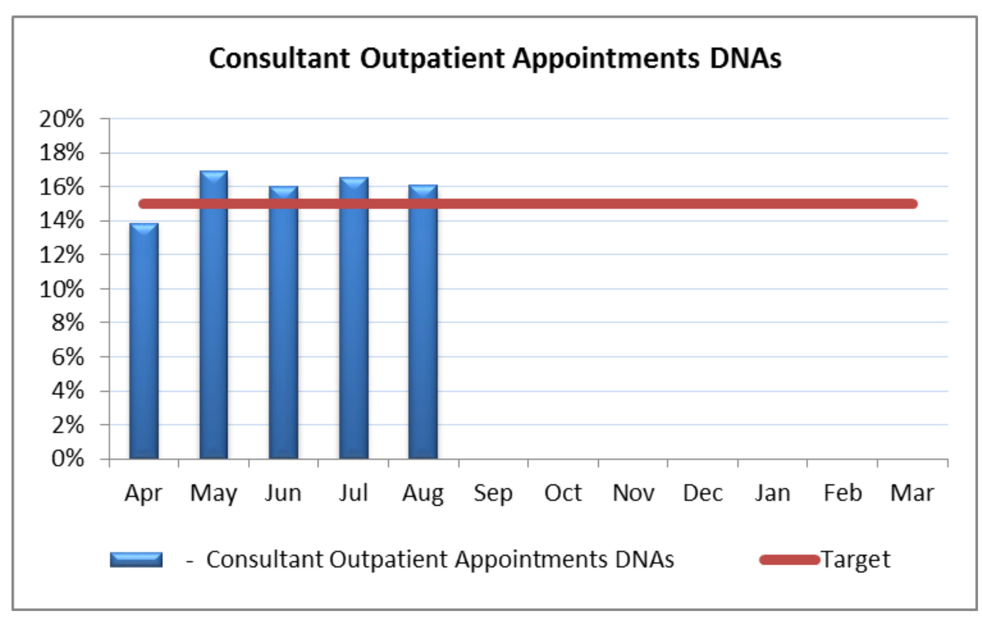


The majority of cancellations were owing to clinician absence, there being no consultant, or appointments needing to be moved to accommodate more urgent cases.

Recruitment to vacant consultant posts is progressing slowly. We have finally succeeded in recruiting to the South Derbyshire post which has been vacant since November 2016. This should start to have a positive impact on cancellations once the consultant starts work. Absence is being managed in line with trust policies.

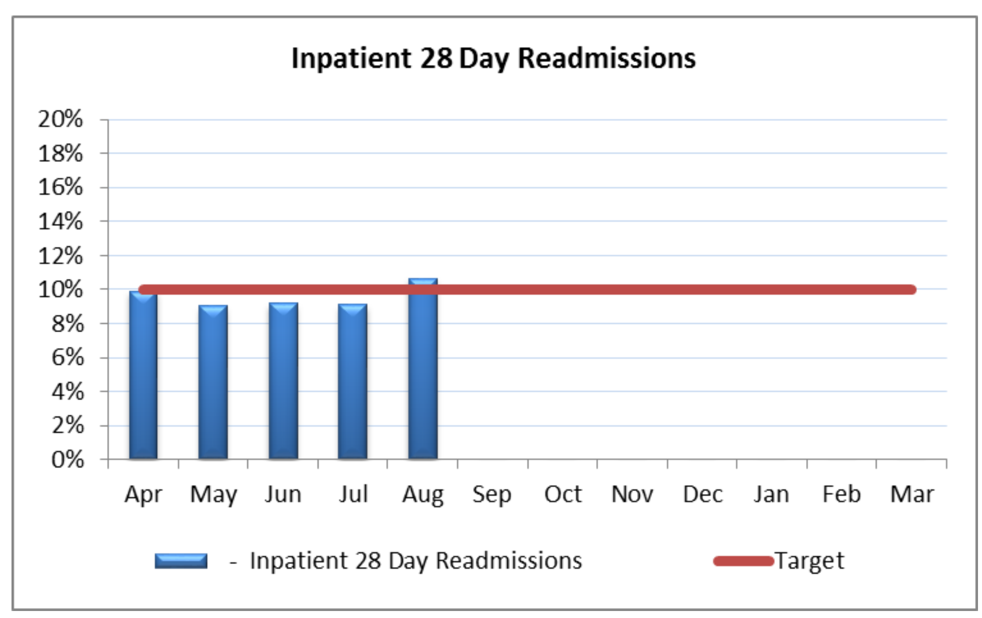
Reason Given	n	%
Clinician Absent From Work	106	30%
No Consultant	91	26%
Moved - Staff Issue	71	20%
Moved - Trust Rescheduled	48	14%
Clinic Booked In Error	12	3%
Moved - Clinic Cancelled	11	3%
Moved - Location Issue	4	1%
Clinic Cancelled	2	1%
Clinician On Annual Leave	2	1%
Clinician Must Attend Meeting	1	0%
Location Issue	1	0%
Grand Total	**349**	**100%**

Consultant Outpatient DNAs



Despite the trust sending text message appointment reminders, the number of patients who do not attend scheduled outpatient appointments remains persistently high. There were 465 DNAs in August which equates to a cost of roughly £25.6k in terms of consultant time wasted, time which could have been spent seeing other patients. An audit of appointment processes has been commissioned by the Deputy Director of Operations. In Derby City the booking of outpatient appointments has been centralised. It will be several months before we see the impact of that, but feedback to date has been positive.

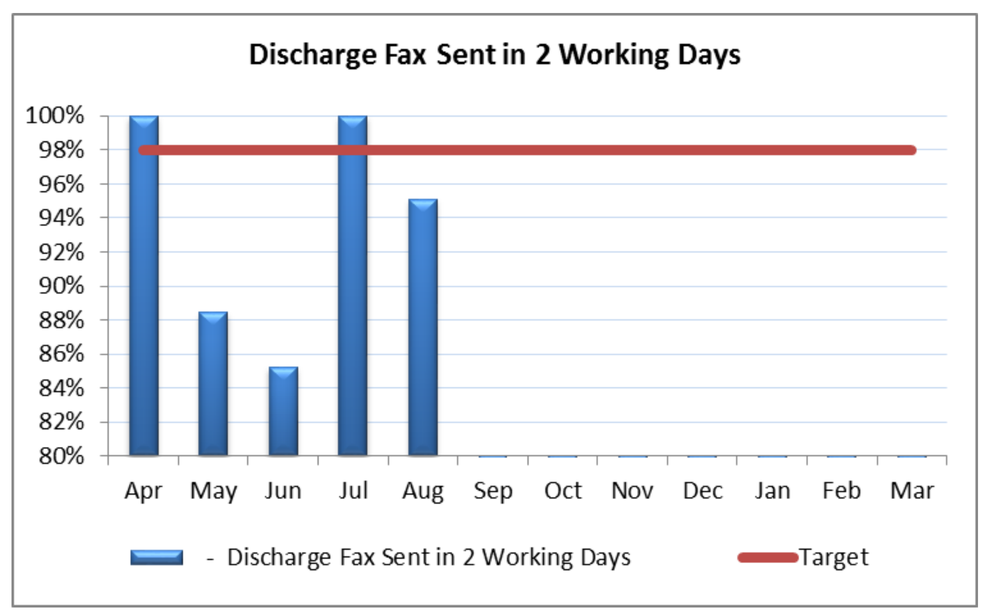
Inpatient 28 day readmissions



In August there were 18 patients readmitted within 28 days of discharge.

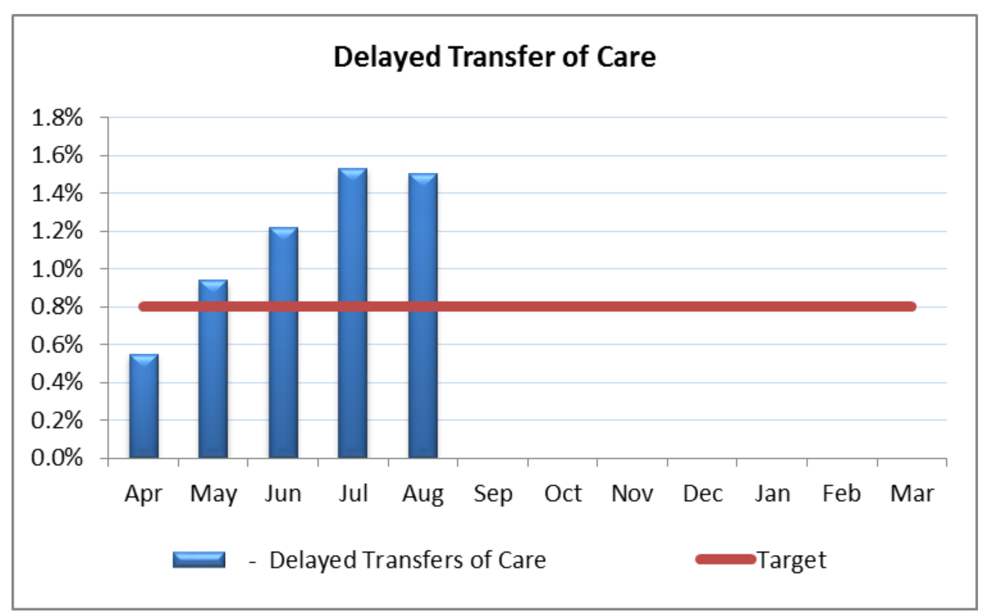
Action: A review of all 18 cases has been instigated to fully understand the reasons for re-admission.

Discharge Fax Sent in 2 Working Days



4 discharge emails to GPs were sent late this month. This was a result of ward admin sickness at the Hartington Unit. Admin cover was arranged and the emails were sent 2 days late.

Delayed Transfers of Care



There is currently 1 delayed discharge, on ward 1. Social Care are in the process of arranging accommodation.

Campus Division Performance Dashboard 2017/18 Month 5

Quality, Safety and Experience

Indicator	Period	Target	Actual	RoG
CPA 7 day follow-up	Monthly	95%	97%	G
Delayed transfers of care	Monthly	0.8%	1.53%	R
Never events	Monthly	0	0	G
Serious incidents reported to CCG via STEIS	Monthly	N/A	1	N/A
Crisis gatekeeping	Monthly	95%	99%	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	<=4	3	G
New concerns	Monthly	<=7	15	R
Complaints upheld/partially upheld	Monthly	<=2	2	G
Compliments	Monthly	>=39	50	G
Friends and Family Test % positive	Monthly	89%	90%	G

Performance

Indicator	Period	Target	Actual	RoG
Hartington Unit bed occupancy – including leave	Monthly	85%	97%	R
Hartington Unit bed occupancy – excluding leave	Monthly	85%	81%	G
Hartington Unit length of stay	Monthly	36	43	R
Radbourne Unit bed occupancy – including leave	Monthly	85%	104%	R
Radbourne Unit bed occupancy – excluding leave	Monthly	85%	87%	R
Radbourne Unit length of stay	Monthly	36	52	R
Kingsway bed occupancy – including leave	Monthly	85%	74%	G
Kingsway bed occupancy – excluding leave	Monthly	85%	69%	G
Activity against contract – inpatient rehab.	Monthly	95%	84%	G

People

Indicator	Period	Target	Actual	RoG
Vacancy rate	Monthly	10%	16.9%	R
Turnover	Monthly	10%	11.5%	G
Sickness – in month	Monthly	5%	7.9%	R
Annual appraisals	Monthly	90%	76%	R
Mandatory training	Monthly	85%	88%	G
Agency staff use	Monthly	1.9%	1.3%	G
Bank staff use	Monthly	5%	14.9%	R
Clinical supervision	Yearly	85%	42%	R
Managerial supervision	Yearly	85%	56%	R

Pulse Check

Indicator	Period	Target	Actual	RoG
Kingsway Staff recommending as a place for care and treatment	Quarterly	79%	55%	R
Kingsway Staff recommending as a place to work	Quarterly	64%	36%	R
Hartington Staff recommending as a place for care and treatment	Quarterly	79%	61%	R
Hartington Staff recommending as a place to work	Quarterly	64%	50%	R
Radbourne Staff recommending as a place for care and treatment	Quarterly	79%	70%	R
Radbourne Staff recommending as a place to work	Quarterly	64%	57%	R

Finance

Indicator	Period	Target	Actual	RoG
Performance against budget £'000s	In month	2,464	2,607	R
Performance against budget £'000s	Year to date	12,320	12,682	R
Forecast outturn £'00s	Forecast	29567	30786	R
Out of area placement expenditure £'000s	Year to date	202	813	R
Out of area placement expenditure forecast £'000s	Forecast	486	1,951	R

General Manager Feedback:

- Delayed transfers of care - there is currently 1 delayed discharge – Social Care are currently in the process of arranging accommodation
- New complaints, concerns and compliments - the concerns received was above average this month however compliments were well above average
- Adult acute inpatient occupancy and length of stay – a length of stay/out of area placements project continues to progress which is focusing on length of stay issues and will involve implementing a structured programme of improvement. • Inpatient rehabilitation
- Cherry Tree currently has 19 beds in use out of 23. The referral pathway has been reviewed and a more streamlined process is now in use.
- Sickness and vacancies - Recruitment and Retention group is focusing on these issues trust-wide. Within Campus, given the current staffing pressures the overarching sickness rate is lower than would be expected. We are aware of individual areas of pressure and sickness management processes are in place. Drop-in sessions are in place in support of stress in the workplace.
- Annual appraisals - The short-term emergency plan implemented last month of Band 7 staff working within numbers across Radbourne and Hartington Unit has had the negative effect on this trajectory that we anticipated.
- Supervision - owing to the way we report compliance on a rolling 12 months basis, any significant absence through maternity leave, long term sickness etc. makes the target unachievable. In Campus this is the case for 28 of our teams. Capacity to undertake supervision is also a factor: inpatient nurses are required to undertake in excess of 11 days a year of training plus 2 days a year of supervision, yet only 6 days a year per nurse are factored into the funded establishment. We are trying to develop options for group supervision and using practice development forums as an underlying strategy, but we anticipate the staffing difficulties impacting developments over the next 2 months.
- Finance - the main overspend this financial year continues to be a result of out of area placements and additional temporary staffing at the Radbourne Unit to cover vacancies and acuity.

Central Services Division Performance Dashboard 2017/18 Month 5

Quality, Safety and Experience

Indicator	Period	Target	Actual	RoG
Never events	Monthly	0	0	G
Serious incidents reported to CCG via STEIS	Monthly	N/A	2	N/A
New complaints opened for investigation	Monthly	<=2	0	G
New concerns	Monthly	<=4	5	R
Complaints upheld/partially upheld	Monthly	<=1	0	G
Compliments	Monthly	>=13	22	G
Friends and Family Test % positive	Monthly	89%	100%	G

Performance

Indicator	Period	Target	Actual	RoG
Activity against contract - ASD assessments (cumulative)	Monthly	100%	83%	R
Activity against contract - perinatal inpatient bed days	Monthly	100%	84%	R
Activity against contract - perinatal south community contacts	Monthly	169	88	R
Activity against contract - eating disorder service contacts	Monthly	204	131	R
Waiting list - ASD assessment: total and average wait (weeks)	Monthly	<=18	342 42	R
Waiting list - dietetics: total waiting and average wait (weeks)	Monthly	<=18	1 0.4	G
Waiting list - eating disorders: total waiting and average wait (weeks)	Monthly	<=18	8 2.1	G
Waits - LD speech & language therapy: total and average wait	Monthly	<=18	175 36	R
Waiting list - physiotherapy: total waiting and average wait (weeks)	Monthly	<=18	38 5.5	G
Waiting list - psychological therapies: total and average wait	Monthly	<=18	77 21	R
IAPT step 2 discharges	Monthly	67	103	G
IAPT step 3 discharges	Monthly	516	584	G
IAPT recovery rate	Monthly	50%	52%	G
IAPT reliable improvement & recovery rate	Monthly	65%	68%	G

Performance (continued)

Indicator	Period	Target	Actual	RoG
Substance Misuse City: TOPS compliance - start	Quarterly	80%	91%	G
Substance Misuse City: TOPS compliance - review	Quarterly	80%	97%	G
Substance Misuse City: TOPS compliance - exit	Quarterly	80%	94%	G
Substance Misuse City: Waiting time into treatment over 21 days	Quarterly	0%	0%	G
Substance Misuse County: TOPS compliance - start	Quarterly	80%	83%	G
Substance Misuse County: TOPS compliance - review	Quarterly	80%	95%	G
Substance Misuse County: TOPS compliance - exit	Quarterly	80%	98%	G
Substance Misuse County: Waiting time into treatment over 21 days	Quarterly	0%	0%	G

People

Indicator	Period	Target	Actual	RoG
Vacancy rate	Monthly	10%	9.5%	G
Turnover	Monthly	10%	8.9%	G
Sickness - in month	Monthly	5%	4.9%	G
Annual appraisals	Monthly	90%	76%	R
Mandatory training	Monthly	85%	88%	G
Agency staff use	Monthly	2%	1.1%	G
Bank staff use	Monthly	5%	2.9%	G
Clinical supervision	Yearly	85%	73%	R
Managerial supervision	Yearly	85%	77%	R

Pulse Check

Indicator	Period	Target	Actual	RoG
Central Services staff recommending as a place for care and treatment	Quarterly	79%	74%	R
Central Services staff recommending as a place to work	Quarterly	64%	63%	R

Central Services Division Performance Dashboard 2017/18 Month 5

Pulse Check (continued)					
Indicator	Period	Target	Actual	RoG	
Substance misuse staff recommending care and treatment	Quarterly	79%	100%	G	
Substance misuse staff recommending as a place to work	Quarterly	64%	100%	G	
Psych. therapy staff recommending as a place for care and treatment	Quarterly	79%	73%	R	
Psych. therapy staff recommending as a place to work	Quarterly	64%	48%	R	
IAPT staff recommending as a place for care and treatment	Quarterly	79%	88%	G	
IAPT staff recommending as a place to work	Quarterly	64%	62%	R	
Learning Disability staff recommending care and treatment	Quarterly	79%	65%	R	
Learning Disability staff recommending as a place to work	Quarterly	64%	34%	R	

Finance					
Indicator	Period	Target	Actual	RoG	
Performance against budget £'000s	In month	1777	1816	R	
Performance against budget £'000s	Year to date	8901	8855	G	
Forecast outturn £'000s	Forecast	21341	21236	G	

General Manager Feedback:

- Perinatal bid is being prepared; Consultant cost pressure remains until November. We are currently seeking new accommodation in the north.
- In IAPT we have seen the traditional decrease in activity through the Summer months. We are expecting a higher volume of referrals for September to November.
- Psychological Therapies are working with commissioners on an options paper and confirming temporary arrangements in CBT.
- LD are working with commissioners to revise new specifications. Impact on morale related to uncertainly and unsettling time of change. Rolling out of awareness training with mental health to improve working relationships.
- Eating Disorders have staffing pressures owing to staff changes (team manager retiring/sickness absence/mat leave) and impact on caseload management. Return imminent - expected to return to usual activity levels.
- Dietetics/Physio employing dietitian within service to further enhance service.
- Sub Misuse implementation of new County model is underway with some issues around bottlenecks in the new referral pathway. City service is due new tender specification in early October starting competitive tender process once more.
- Admin/Med Sec new structure is working well.

Children's Services Division Performance Dashboard 2017/18 Month 5

Quality, Safety and Experience

Indicator	Period	Target	Actual	RoG	
Never events	Monthly	0	0	G	
Serious incidents reported to CCG via STEIS	Monthly	N/A	0	N/A	
New complaints opened for investigation	Monthly	<=3	3	G	
New concerns	Monthly	<=6	5	G	
Complaints upheld/partially upheld	Monthly	<=3	4	R	
Compliments	Monthly	>=13	2	R	
Friends and Family Test % positive	Monthly	89%	100%	G	

Performance

Indicator	Period	Target	Actual	RoG	
Paediatric current waits < 18 weeks	Monthly	92%	54%	R	
Paediatric waiting list: number waiting and average wait (weeks)	Monthly	<=18	888 19	R	
Paediatric new referrals (A) and attended 1st appointments (B)	Monthly	B>A	A 289 B 266	R	
CAMHS current waits < 18 weeks	Monthly	92%	91%	R	
CAMHS waiting list: number waiting and average wait (weeks)	Monthly	<=18	299 10	G	
CAMHS activity – attended contacts	Monthly	2056	1842	R	
CAMHS caseload	Monthly	1980	1736	G	
CAMHS RISE – referrals from A&E seen same day	Monthly	61%	80%	G	
CAMHS RISE – discharges with completed ESQ	Monthly	38%	35%	R	
CAMHS RISE – discharges with completed SFQ	Monthly	46%	39%	R	
CAMHS RISE – A&E referral rate (as a percentage of total referrals)	Monthly	72%	63%	G	

Performance (continued)

Indicator	Period	Target	Actual	RoG	
Children in care health assessments – children under 5	Monthly	75%	90%	G	
Children in care health assessments – children 5 plus	Monthly	75%	79%	G	
10-14 day breastfeeding coverage	Monthly	98%	95%	R	
6-8 week breastfeeding coverage	Monthly	98%	98%	G	
6-8 week breastfeeding prevalence	Monthly	43%	39%	R	
SEND process – letter 1 responses within 15 days	Monthly	83%	100%	G	
SEND process – letter 2 responses within 42 days	Monthly	51%	61%	G	

People

Indicator	Period	Target	Actual	RoG	
Vacancy rate	Monthly	10%	8%	G	
Turnover	Monthly	10%	11%	G	
Sickness – in month	Monthly	5%	4.7%	G	
Annual appraisals	Monthly	90%	82%	R	
Mandatory training	Monthly	85%	86%	G	
Agency staff use	Monthly	2%	1.5%	G	
Bank staff use	Monthly	5%	1.3%	G	
Clinical supervision	Yearly	85%	86%	G	
Managerial supervision	Yearly	85%	81%	R	

Pulse Check

Indicator	Period	Target	Actual	RoG	
Child Therapy & Complex Needs staff recommending care and treatment	Quarterly	79%	71%	R	
Child Therapy & Complex Needs staff recommending as a place to work	Quarterly	64%	50%	R	

Children's Services Division Performance Dashboard 2017/18 Month 5

Pulse Check (continued)					
Indicator	Period	Target	Actual	RoG	
Universal Children's Services staff recommending care and treatment	Quarterly	79%	72%	R	
Universal Children's Services staff recommending as a place to work	Quarterly	64%	56%	R	
CAMHS staff recommending as a place for care and treatment	Quarterly	79%	72%	R	
CAMHS staff recommending as a place to work	Quarterly	64%	72%	G	
Finance					
Indicator	Period	Target	Actual	RoG	
Performance against budget £'000s	In month	1220	1112	G	
Performance against budget £'000s	Year to date	6101	5826	G	
Forecast outturn £'000s	Forecast	14641	14174	G	

General Manager Feedback:

- We have a number of vacancies across community paediatrics, CAMHS psychiatry and health visiting. Recruitment is ongoing. Recruitment of Health Visitors went well, but the long lead-in time means this can remain vulnerable until actually in post.
- Waiting times – these continue to challenge in Community Paediatricians, but significant progress has been made and data cleansing is underway. (Work done to consider further actions needed)
- Therapy (OT & Physiotherapy) - waiting times beginning to rise with increased referrals to service
- Vulnerability in special school contracts & S75 agreement is considerable
- CAMHS transformation – underway into pathway model,
- Changes to leadership – new General Manager in post, plus there is soon to be a new Area Service Manager for CAMHS .

- Staff morale & wellbeing issues – impact of reduced Learning Beyond Registration, for example.
- 0-19 contract – possible issue of re-tender (3+1+1 model), with problems in engaging with schools to meet targets
- Commissioning gap re 16-18 years in Community Paediatrics remains, but work to inform commissioners has been undertaken.
- Work to implement the neurodevelopmental pathway across the health community has stalled (work in-house continues).
- SEND action plan has been developed and implementation commenced, following County inspection. Challenges are significant regarding sending out letter 2 within timescale.
- There has been significant progress with CQC actions from June 16 and January 17, with improvements sustained.
- Supervision levels are high within the Division.
- Access to safeguarding level 3 training is currently an issue.
- The financial position is healthy, but mainly due to the number of vacancies.

Neighbourhood Services Division Performance Dashboard 2017/18 Month 5

Quality, Safety and Experience

Indicator	Period	Target	Actual	RoG
Never events	Monthly	0	0	G
Serious incidents reported to CCG via STEIS	Monthly	N/A	4	N/A
New complaints opened for investigation	Monthly	<=6	8	R
New concerns	Monthly	<=18	21	R
Complaints upheld/partially upheld	Monthly	<=5	6	R
Compliments	Monthly	>=27	23	R
Friends and Family Test % positive	Monthly	89%	67%	R

Performance

Indicator	Period	Target	Actual	RoG
North Derbyshire				
Caseload per funded wte care coordinator (exc.waiting list)	6 - Monthly	<=35	67.3	R
Community waiting list: number waiting and average wait (weeks)	Monthly	<=18	2140 12	G
Community referrals (A) and discharges (B)	Monthly	B>A	A 921 B 962	G
Community activity	Monthly	>=5473	5293	R
Outpatient memory assessment service caseload	Monthly	<=1116	941	G
Outpatient caseload (exc. MAS)	Monthly	<=5117	5089	G
Outpatient waiting list < 18 weeks	Monthly	92%	99%	G
Outpatient caseload % seen within the last 6 months	Monthly	75%	85%	G
Outpatient caseload % seen within the last 12 months	Monthly	99%	97%	R
South Derbyshire				
Caseload per funded wte care coordinator (exc. waiting list)	6 - Monthly	<=35	41	R

Performance (continued)

Indicator	Period	Target	Actual	RoG
Community waiting list: number waiting and average wait (weeks)	Monthly	<=18	1662 18	G
Community referrals (A) and discharges (B)	Monthly	B>A	A 696 B 668	R
Community activity	Monthly	>=4356	4468	G
Outpatient memory assessment service caseload	Monthly	<=561	551	G
Outpatient caseload (exc. MAS)	Monthly	<=3419	3377	G
Outpatient waiting list < 18 weeks	Monthly	92%	97.9%	G
Outpatient caseload % seen within the last 6 months	Monthly	75%	84%	G
Outpatient caseload % seen within the last 12 months	Monthly	99%	95%	R
Derby City				
Caseload per funded wte care coordinator (exc. waiting list)	6 - Monthly	<=35	45	R
Community waiting list: number waiting and average wait (weeks)	Monthly	<=18	1253 14	G
Community referrals (A) and discharges (B)	Monthly	B>A	A 648 B 670	G
Community activity	Monthly	4492	5350	G
Outpatient caseload	Monthly	3351	3328	G
Outpatient waiting list < 18 weeks	Monthly	92%	96%	G
Outpatient caseload % seen within the last 6 months	Monthly	75%	76%	G
Outpatient caseload % seen within the last 12 months	Monthly	99%	91%	R
Early Intervention County North				
Referral to treatment within 14 days – currently waiting	Monthly	50%	100%	G
Referral to treatment within 14 days – completed	Monthly	50%	100%	G
EI County North caseload	Monthly	148	181	G

Neighbourhood Services Division Performance Dashboard 2017/18 Month 5

Performance (continued)

Indicator	Period	Target	Actual	RoG	
Early Intervention County South & City					
Referral to treatment within 14 days – currently waiting	Monthly	50%	100%	G	
Referral to treatment within 14 days – completed	Monthly	50%	75%	G	
EI County South & City caseload	Monthly	215	229	G	

People

Indicator	Period	Target	Actual	RoG	
Vacancy rate	Monthly	10%	10.6%	R	
Turnover	Monthly	10%	10%	G	
Sickness – in month	Monthly	5%	6%	R	
Annual appraisals	Monthly	90%	67%	R	
Mandatory training	Monthly	85%	87%	G	
Agency staff use	Monthly	2%	7.8%	R	
Bank staff use	Monthly	5%	1.4%	G	
Clinical supervision	Yearly	85%	63%	R	
Managerial supervision	Yearly	85%	69%	R	

Pulse Check

Indicator	Period	Target	Actual	RoG	
Derby City staff recommending as a place for care and treatment	Quarterly	79%	78%	R	
Derby City staff recommending as a place to work	Quarterly	64%	54%	R	
County North staff recommending as a place for care and treatment	Quarterly	79%	90%	G	
County North staff recommending as a place to work	Quarterly	64%	78%	G	
County South staff recommending as a place for care and treatment	Quarterly	79%	78%	R	
County South staff recommending as a place to work	Quarterly	64%	50%	R	

Finance

Indicator	Period	Target	Actual	RoG	
Performance against budget £'000s	In month	1965	1884	G	
Performance against budget £'000s	Year to date	9643	9492	G	
Forecast outturn £'000s	Forecast	23363	23540	R	

General Manager feedback:

- There have been more complaints and concerns this month than target. With the teams stretched beyond capacity, unfortunately this is to be expected. The teams are carrying large caseloads, receiving more referrals than discharges, meaning that waiting lists are increasing in all areas and patients are being seen less frequently in outpatients.
- These high levels of clinical activity are impacting on sickness, appraisal and supervision levels. The most common reason for sickness is stress. The pulse check feedback demonstrates that staff still believe they are providing quality care despite the pressures, but would not recommend it as a place to work for the same reason.
- A review of the neighbourhood model has recently been undertaken by eliciting anonymous feedback from the staff in the neighbourhoods. The data is currently being analysed and will be used to inform service model and capacity and demand solutions.
- The use of agency staff necessitated to cover vacancies impacts on patient experience, workforce experience and has financial implications.
- In the City a physical health monitoring clinic has been established, providing support to people who have been prescribed antipsychotic medication. This will be reviewed to establish effectiveness and potentially rolled out to other areas.

WARD STAFFING

Ward name	Occupancy % Rate	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
		Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
AUDREY HOUSE RESIDENTIAL REHABILITATION	94.19%	159.1%	70.7%	90.0%	0.0%	Yes	
CHILD BEARING INPATIENT	83.87%	70.6%	90.4%	103.3%	140.0%	Yes	The ward has broken current fill rate tolerances for August for registered nurses on days due to backfill for staff career break. For care staff day and night to cover x 2 long term sickness absences and high observations from the 20th – 31st August
CTC RESIDENTIAL REHABILITATION	78.82%	113.1%	93.8%	120.0%	90.0%	No	
KEDLESTON LOW SECURE UNIT	40.00%	77.4%	139.8%	60.0%	200.0%	Yes	We have low bed numbers at present due to refurb works and have therefore reduced staffing levels. Where only one RN is indicated, 2nd RN was bleep holder and will not show up on the same rota. We are also working on one less staff at night which means that care staff percentage is reduced. We currently also have 3 clinical staff off long term sick and 4 RN vacancies, 2NA vacancies
KINGSWAY CUBLEY COURT - FEMALE	66.67%	100.2%	135.3%	55.0%	256.7%	Yes	Yes this is accurate. The shortfall in planned R/N is the result of being 5 R/N down – 2 vacancies, 1 – career leave, 1 – maternity, 1 – sickness. We hope to have all 5 R/N back to work Sept/Oct.
KINGSWAY CUBLEY COURT - MALE	67.74%	93.6%	93.7%	51.7%	196.7%	Yes	There were 53 shifts of Short /long term sickness which affected the planned versus actual and 1 Maternity leave Vacancies have been filled and awaiting start date Staffing has been increased to cover increased levels of observation and maintain patient safety The staffing is occasionally below planned to cover other areas with sort term emergencies and when the temporary staffing service is unable to meet demand
LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP	105.91%	84.6%	107.4%	58.3%	196.7%	Yes	Registered staffing levels for ward 1 in August were effected by vacancies and sickness. One band 5 has started this week and another will be starting later in the month. There has also been the added pressure of ECT escort x 2 per week for an out of area patient

WARD STAFFING

Ward name	Occupancy % Rate	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
		Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
HARTINGTON UNIT - MORTON WARD ADULT	96.10%	84.5%	64.8%	100.0%	99.2%	Yes	In response to the unavailability of registered staff on the Radbourne and Hartington Units during July, August and September the following mitigation has been put in place: • Recruitment of registered nurse agency staff where possible • Recruitment of bank registered nurse where possible • Safe offers of additional hours at appropriate rates to both inpatient and community based registered staff • Request for corporate staff who have a registered nursing qualification to be redeployed for 1 day a week to the units • Utilisation of additional nursing assistants to cover gaps in registered nurse availability [within agreed safe parameters] • Review of all secondments • Inpatient Band 7 Registered Nurses to be included in the numbers • Cease training unless essential for safety of the unit • Pilots developing regarding Pharmacy technicians within the skill mix • Pilots developing regarding OTs within the skill mix The situation remains fragile despite the mitigation in place and the units remain vulnerable in terms of the ability to cover for any further unanticipated absence. The situation is being closely monitored and ASMs and Divisional Nurses will escalate situations of heightened risk on a day to day basis.
HARTINGTON UNIT - PLEASLEY WARD ADULT	95.81%	114.6%	108.9%	58.4%	183.3%	Yes	
HARTINGTON UNIT - TANSLEY WARD ADULT	98.12%	74.9%	107.8%	75.0%	157.8%	Yes	
ENHANCED CARE WARD	97.10%	89.3%	110.5%	100.0%	170.0%	Yes	
RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT	104.19%	82.6%	160.6%	65.0%	240.0%	Yes	
RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT	105.32%	90.4%	131.9%	85.0%	193.3%	Yes	
RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT	106.61%	84.4%	133.8%	56.7%	121.7%	Yes	
RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT	103.23%	93.1%	124.7%	50.0%	243.3%	Yes	

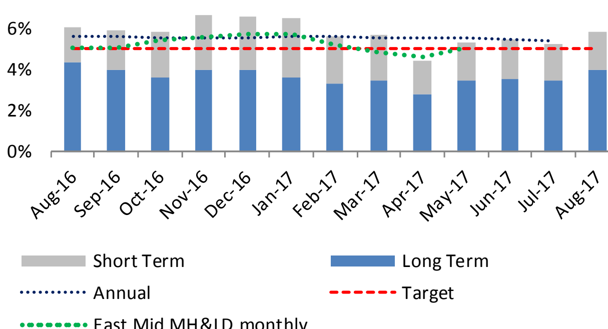
Workforce Section

WORKFORCE DASHBOARD

Sickness Absence

	Jun-17	Jul-17	**Aug-17**
(Monthly)	5.49%	5.27%	**5.84%** ↗
(Annual)	5.46%	5.39%	**tbc** ↘

Target 5.04%

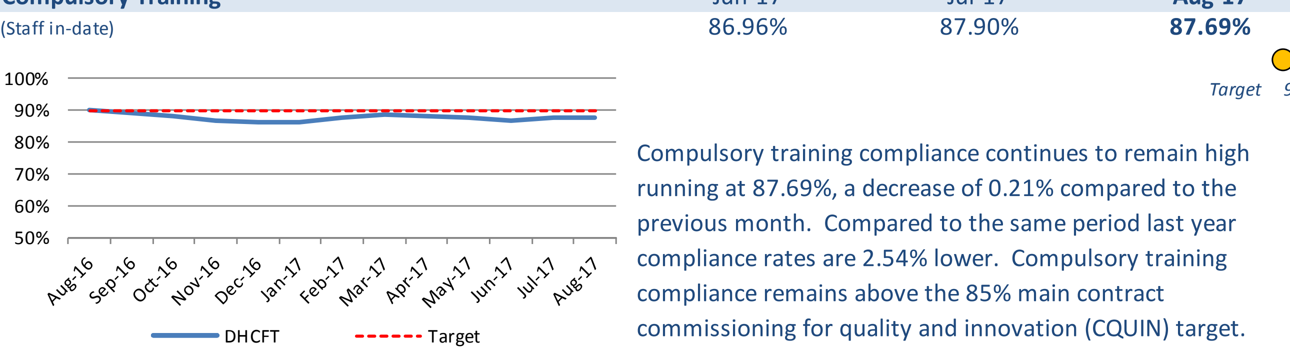


The monthly sickness absence rate is 0.57% higher than the previous month, however compared to the same period last year (August 2016) it is 0.25% lower. The Trust annual sickness absence rate continues to reduce and is running at 5.39% (as at July 2017 latest available data). Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 31.37% of all sickness absence, followed by surgery at 15.08% and other musculoskeletal problems at 12.68%. Compared to the previous month short term sickness absence has increased by 0.08% and long term sickness absence has increased by 0.49%.

Compulsory Training

	Jun-17	Jul-17	**Aug-17**
(Staff in-date)	86.96%	87.90%	**87.69%** ↘

Target 90%

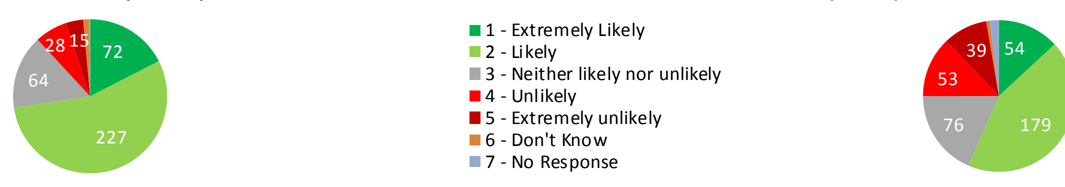


Compulsory training compliance continues to remain high running at 87.69%, a decrease of 0.21% compared to the previous month. Compared to the same period last year compliance rates are 2.54% lower. Compulsory training compliance remains above the 85% main contract commissioning for quality and innovation (CQUIN) target.

Staff FFT Q1 2017/18 (412 responses, 18.4% 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.



54
179
76
53
39

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

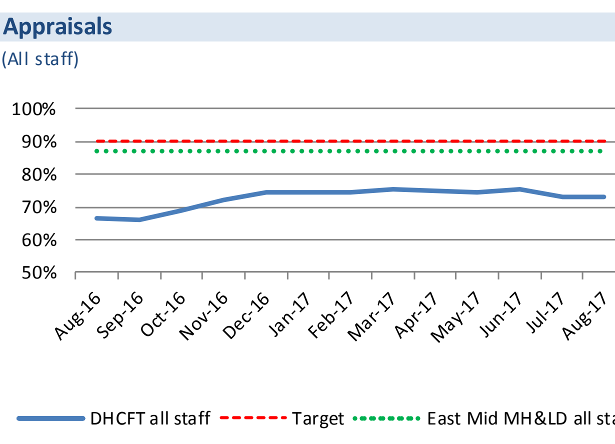
WORKFORCE DASHBOARD

Appraisals

(All staff)

	Jun-17	Jul-17	Aug-17
	75.22%	73.15%	**73.03%**

Target 90%



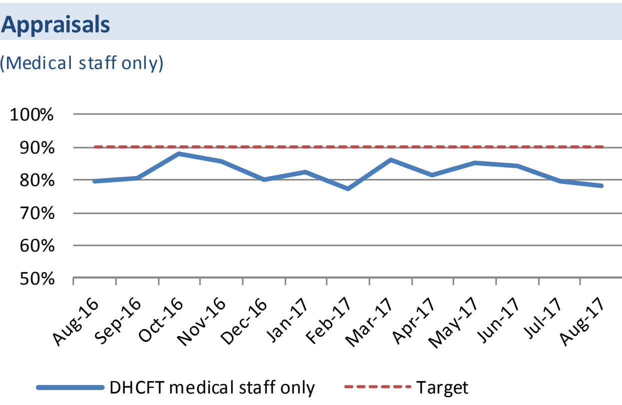
The number of employees who have received an appraisal within the last 12 months has decreased by 0.12% during August 2017 to 73.03%. Compared to the same period last year, compliance rates are 6.74% higher. According to the 2016 staff survey results, the national average for Mental Health & Learning Disability Trusts is 88.79%. Local benchmarking data for a range of Trusts in the East Midlands shows an average completion rate of 83.57%.

Appraisals

(Medical staff only)

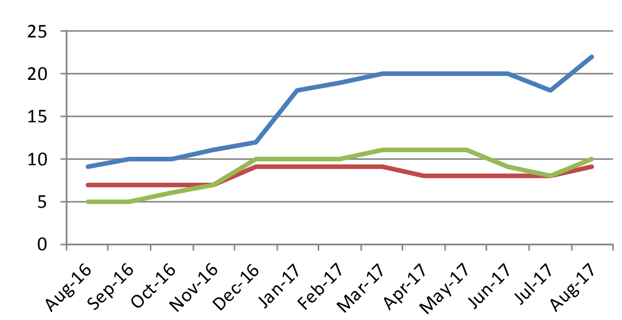
	Jun-17	Jul-17	Aug-17
	84.16%	79.61%	**78.22%**

Target 90%

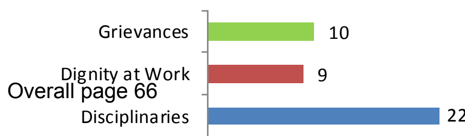


The number of Medical staff who have received an appraisal within the last 12 months has decreased by 1.39% to 78.22%. Compared to the same period last year, compliance rates are 1.24% lower. Junior Doctors on rotational training are excluded from the figures.

Grievances/Dignity at Work/Disciplinaries as at 31/08/2017



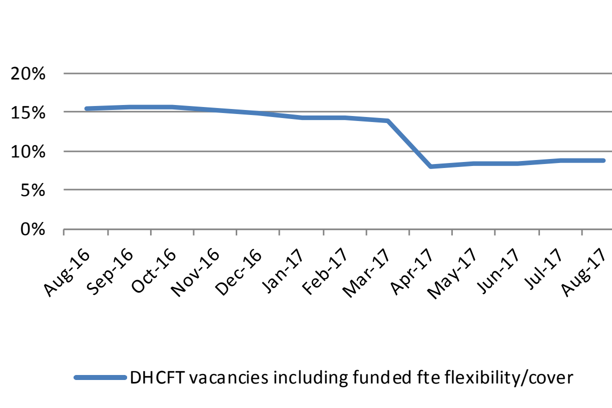
There are 10 grievance cases lodged at the formal stage, 1 new grievance lodged in July and two cases have been resolved. There are 9 Dignity at Work cases, 3 new cases in July and August and 2 resolved. There are 22 Disciplinary cases, 9 new cases in July and August and 7 cases have been resolved.



WORKFORCE DASHBOARD

Vacancy

Vacancy	Jun-17	Jul-17	**Aug-17**
(Funded full time equivalent) Including funded fte flexibility/cover	8.32%	8.73%	**8.68%** ↘

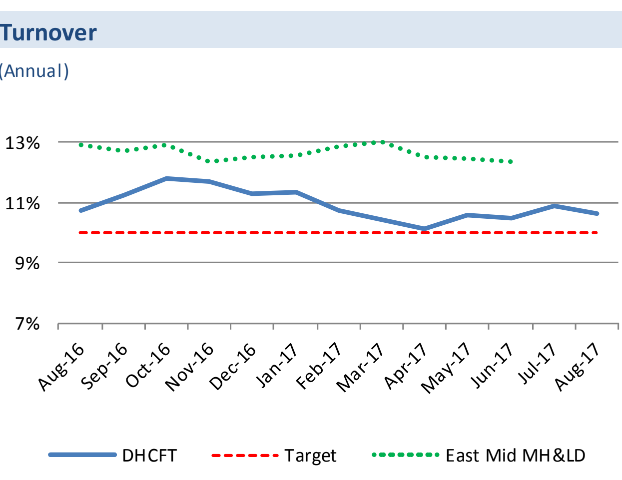


The Trust vacancy rate includes funded Fte surplus for flexibility including sickness and annual leave cover. Funded vacancy rates have decreased to 8.68% in August 2017. 2017/18 budget changes included a large reduction in Fte from 2016/17 investment not materialising and Cost Improvement Programmes. During the period January 2017 to August 2017, 157 employees have left the Trust and 195 employees have joined the Trust.

Turnover

Turnover	Jun-17	Jul-17	**Aug-17**
(Annual)	10.49%	10.89%	**10.64%** ↘

Target 10%



Annual turnover remains within Trust target parameters at 10.64% 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 0.59 to 21.08. During August 2017 15 employees left the Trust, a decrease of 7 compared to the same period last year (August 2016). August 2017 leavers included 5 retirements.

Agency Usage

Agency Usage	Jun-17	Jul-17	**Aug-17**
(Spend)	5.09%	5.32%	**5.34%** ↗

8%
6%
4%
2%
0%
Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17 Apr-17 May-17 Jun-17 Jul-17 Aug-17
DHCFT

Total agency spend in August was 5.34% (5.86% including medical locums). Of total agency and locum spend for all staff groups, Qualified Nursing represented 1.2%, Medical 3.7% and other agency usage 0.4%. Agency Qualified Nursing spend against total Qualified Nursing spend in August was 3.3%. Agency Medical spend against total Medical spend in August was 19.9%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £610k.

Quality Section

Learning from Deaths

- In line with the CQC's recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a new national framework for NHS Trusts - *'National Guidance on Learning from Deaths'.*
- The purpose of the new framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and improved embedded learning
- From 2017/18 Q3 onwards, Trusts are required to publish data and learning points as a result of learning from their review of deaths. A ‘Mortality Dashboard’ has been designed to collate this information and the initial data, to date, is provided as part of this report

Mortality Dashboard

The NHSI suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care. This 'sample' dashboard has been adopted for use by the Trust.

Developments:
Following scrutiny of deaths by the Mortality Review Group, work is underway to categorise the outcome the outcome of the death as either:

Expected / unavoidable (end of life care) - the focus in this category is getting end of life care right and providing patients and their families and carers with a good experience.

Unexpected / unavoidable

Unexpected / avoidable – the focus within this category is to maximise learning from deaths that may be the result of problems in care.

Summary of total number of deaths and total number of cases reviewed

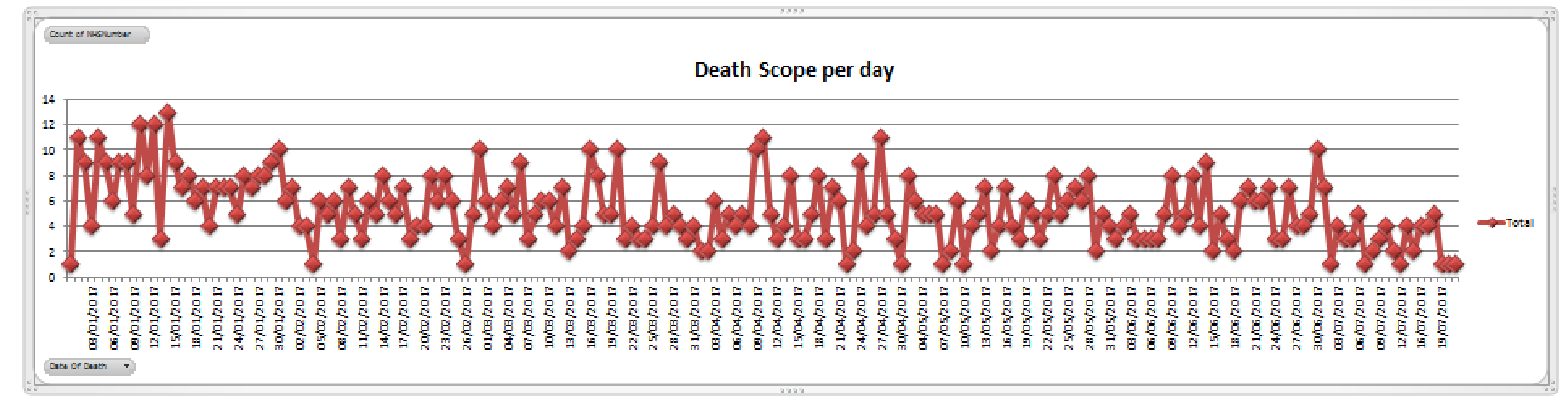
Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

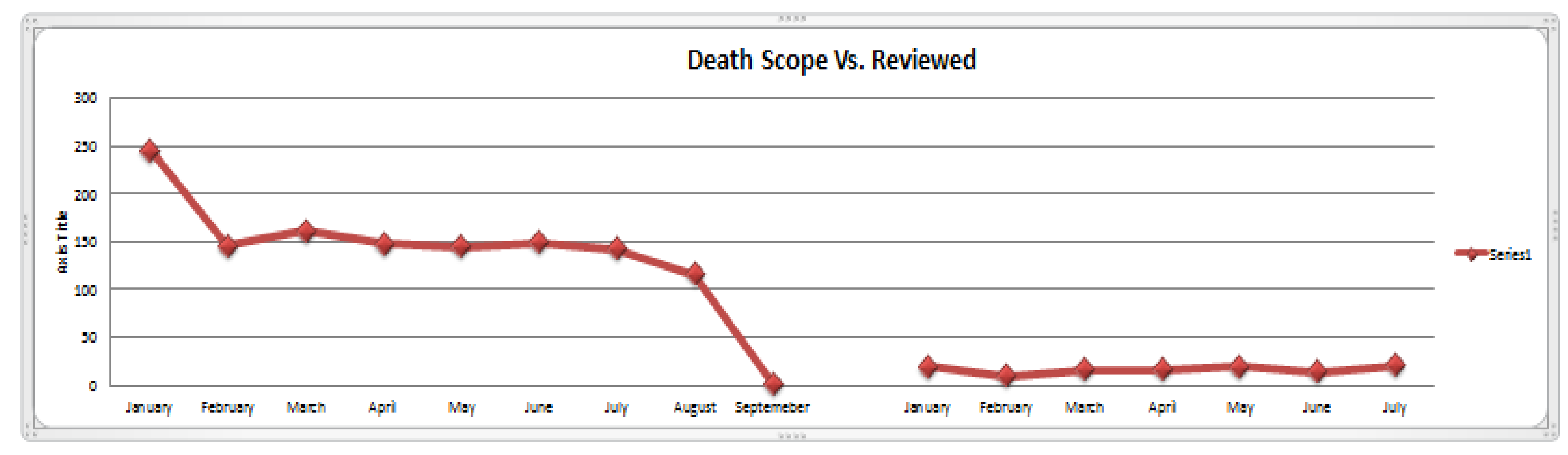
Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable	
Month	**Total**	**Month**	**Total**	**Month**	**Total**
January	245	January	20	January	0
February	146	February	10	February	0
March	161	March	16	March	0
April	148	April	16	April	0
May	145	May	20	May	0
June	149	June	14	June	0
July	142	July	21	July	0
August	116	August	15	August	0
September	2	September	2	September	0
October		October	0	October	0
November		November	0	November	0
Decemeber		December	0	December	0

Summary of total number deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
2	116	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1254	0	0	0	0	0


Count of NHSNumber
Death Scope per day
14
12
10
8
6
4
2
0
Total
Date Of Death


Death Scope Vs. Reviewed
300
250
200
150
100
50
0
Axis Title
January
February
March
April
May
June
July
August
Septemeber
January
February
March
April
May
June
July
Series1

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 27 September 2017

Quality Position Statement

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

Executive Summary

This position statement sets out:

1. Safety – Fire safety and Smoke free, Learning from Deaths and our Family first model in Childrens services (Quality priority)
2. Safety and Responsiveness - Learning From Very Serious Incidents
3. Effectiveness - Psychological Ill Health of Wordlessness
4. Responsive - Learning From Our Experts by Experience
5. Well led – Quality visits
6. Well led - Our CQC Action Plan Performance, to assure the public of our commitment and the timeline for completion.

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
- The Care Act 2014
- There are legal issues under the Regulatory Reform (Fire) Safety Order 2005, the Health & Safety at Work etc. Act 1974 and the Health & Social Care Act 2010 contained within this Report
- Care Quality Commission Regulations this report provides assurance to:-
  - Outcome 4 (Regulation 9) Care and Welfare of people who use services
  - Outcome 10 (Regulation 15) Safety and suitability of premises
  - Outcome 11 (Regulation 16) Safety, availability and suitability of equipment
  - Outcome 12 Regulation 210) Requirements relating to workers
  - Outcome 14 (Regulation 23) Supporting staff
  - Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
  - Compliance with the Health & Safety at Work etc Act 1974 (HSWA)
  - Compliance with the Regulatory Reform (Fire Safety) Order 2005

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 of REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation) and Public Sector Equality Duty & Equality Impact Risk Analysis.

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

Any impact or potential impact on equality is considered as a key part of all our quality work. Some of the examples are improving the equalities position for individuals and their families are fully in line with our duties and responsibly and due regard.

Individuals without capacity are equally affected by the risks associated with fire and safety improvement work will be applied to all groups but with some groups requiring adaptation of leaflets or information to meet their needs. This preventative work would not adversely affect specific groups.

Specifically the duty to protect children and support families with safeguarding requirements are highlighted in this report and this preventative work should be a positive outcome for this group.

Individuals with mental health and learning disabilities are often adversely affected by economic disadvantage due to the significant impact on life due to the period of illness. This model to reduce worklesness would be positive in equalising the disadvantages that surround the population that we are supporting in the Trust.

Recommendations

The Board of Directors is requested to:

1) Receive this quality position statement.
2) Gain assurance, be advised on safety.
3) Review its content and seek clarity or challenge on any aspect of the report

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

Report prepared by: **Carolyn Green**
Executive Director of Nursing & Patient Experience

Quality Position Statement

1.1 Safety – Our work towards Sign up to safety

Fire safety is a key component of our safety agenda.

In the reflections from the Grenfell Tower, we are testing and checking our own fire procedures, re-visiting our fire doors to check for wear and tear and practice and our own Trust Board also had a live Board evacuation to test our procedures.

We will continue to work closely with Derbyshire Fire Rescue in a number of safety initiatives, which include safety and smoke detector briefings. Advisory information in fire risks associated with paraffin based creams for treatment of eczema and dry skin conditions to protect our patients and carers particularly with individuals who may not fully understand or retain the risks associated with some commonly used skin preparations.

Smoke free

Out Trust is reducing the impact of smoking on reducing access to nicotine in our in-patient services. It is evident that this work requires a refresh of the strategic direction and how we measure the impact.

Although we have many success stories of individuals making progress, we have some service areas who have much to do to improve and succeed. The approach to support individuals to reduce their mortality rates requires a review and a more invigorate approach. This coupled with significant use of new and novel psychoactive substances and dual diagnosis in our services.

As one step toward this goal, the Trust is engaging in webinars to learn from other Trusts where they have succeeded and what areas we need to improve.

In addition, we will hosting the national conference on achieving and then maintaining a smoke free environment. The NHS continues to be a challenge up and down the country. Many of the successful stories come from Mental Health trusts and we felt it was timely to hold our third forum sponsored conference to share best practice, learn from each other and from national leaders in the field. Confirmed speakers for this conference are National and Mental health Trust leaders in this field.

We have completely redesigned over serious incident policy, we have developed our Mortality and learning form Deaths policy which has been ratified by the Quality Committee earlier in this month. We have redesigned how we learn from deaths to focus on patterns and clusters and we have established a system of red flags, this model was discussed at a regional event and we are working with the Royal College of Psychiatrists to learn from this model and consider its application with other Trusts. This model was recently commended; this work has been led by Dr John Sykes, Rachel Williams and Dr Paul Rowlands with the wider patient safety team. This substantial level of work ensures our compliance with the National Quality board and required changes have been delivered ahead of target. Our integrated dashboard this month includes our emerging work, which we will continue to develop and revise to enable the Trust to learn effectively.

Action

1. Our Trust will support our Safeguarding and Public Health in key safety campaigns.

2. It is foreseeable that fire safety will be subject to additional assurance checks and changes to legislation. In preparation for these changes, our executive team are proactively investing in a Band 5 Fire Safety Officer to increase our own capacity to respond effectively to a fire incident for our patients and staff. This is also in preparation for the potential for significant changes and additional assurance in these areas. This post is in the recruitment phase.

3. We continue to implement Mortality reviews and new models of analysis. The Learning from Deaths policy has been uploaded to our Trust website and we will provide data and assurance in our Quality committee and Board papers.

a. Effectiveness

The Trust has undertaken a 6 month evaluation of the Family First Model

Family First Model

Partnership working within 0-19 service

In response to the new service specification, it had been identified that there was a gap within Derby City for vulnerable families who did not meet the criteria for Family Nurse Partnership restricted criteria. Thus the development of a new parenting model was created in response to this need.

Have a Healthy Pregnancy - providing babies with the best start in life and become knowledgeable, sensitive and responsive parent (s). Overall our collective aim is to develop positive health, social and economic outcomes for families and their children

Impact of Partnership working- reflections

- It's the sharing of skills, workforce development and expertise between Family Nurse Partnership and the 0-19 service.
- It's a strengthening of relationships.
- Promoting innovative practice.
- Enhancing practice and client's experience.

- Promotes a more equitable service for families within the city.
- It is a consistent approach within the workforce.

There was a lot of concern re the roll out of the new Model of Practice. This featured in the June 2016 comprehensive visit.

The voice of our staff, now:

- Change in delivery style for universal contacts.
- Increased morale and job satisfaction.
- Professional development.
- New group work initiated within the Children's Centre for Antenatal contact which has improved partnership working.
- Better understanding of and relationships with specialised services within 0-19 partnerships.
- Supervision - By using the new tools (vulnerability matrix and the 7 P's) has enhanced supervision sessions and directly impacted on the positive outcomes for families.
- Child protection contacts have more focus with the use of PIPE tools.
- The tools have enabled the Trust to start an Antenatal group at a local Children's Centre. This has benefited the clients by increasing their knowledge base before the baby is born. It has also promoted partnership working with the Children's Centre and increased the access antenatal clients have to their centres.

Impact on the Family First Model for parent(s)

- These tools have been used within the Family First Model and also some universal contacts.

- The families report that they really like this delivery style as they are able to participate in the games and let the practitioner know what they have learnt. It is easier for them to say if they do not understand an aspect of the visit.
- Information is elicited from the client to check their understanding of topics.
- New information is being delivered in a fun way.

Impact on workforce - Mobilisation of knowledge

- Staff members have been curious to explore the different ways of working - enhanced team morale.
- Enhanced the quality of visits they offer for both Practitioner and clients.
- Job satisfaction increased.
- Team dynamics improved.
- Enabled a new way of working - further developments of model to explore a second tier relating to the healthy child programme contents, enabling the family first style to reach more families within the 0-19 service.

Additional information

This service is having positive outcomes following substantial re-modelling and a significant period of instability and change for our teams. This feedback is starting to show stability and positivity.

This is through the achievement of solid and effective leadership of David Tucker, Sue Earnshaw and colleagues who have been a credit to our Trust. This includes the whole service re-locating from Cardinal Square to St Pauls and the reality that our Health visitors are seeing and supporting a hundred more families on a child protection plan this year then the same date 12 months ago. This is in reality of substantial service disinvestment and a number of competing priorities.

External feedback

Derby has been recognised as taking a lead on integration and partnership working by Professor Derek Ward, Family Nurse Partnership National Unit and National research Clinical psychologist Dr Crispin Day.

A new Consultant level Social worker and Lead for Childrens and CAMHS has been appointed, namely Scott Lunn and we wish him well in supporting the team going forward.

Action

To feedback to the Childrens team, our Board thanks on their commitment to Childrens services and wish David Tucker well in his future endeavours in Neighbourhood services.

1.3 Safety and Responsiveness - Learning From Very Serious Incidents

Mental Health homicides are our most serious incidents. In 2013, our Trust and our community experienced one of these incidents. An independent investigation has been undertaken and there are recommendations for learning. Our Safeguarding Adults team and Patient Safety team have met with staff to explore learning. We can never reflect enough on these very serious incidents. The Trust is dedicating a ‘Spotlight leadership’

event in 2017, to learning from this case and asking our most senior leaders to reflect upon what commitments they will make to reduce the likelihood of this happening again and learning from what we got right and areas where we significantly need to improve.

Our thoughts and condolences are with the family and on behalf of the Board, we are deeply sorry for your loss and the impact upon your family.

We continue to learn from very serious incidents and continually develop our family liaison services.

Effectiveness in our Neighbourhood and Campus services

We have shared with the Trust Board, the feedback from teams that our Neighbourhood clinical staff often feel under significant pressure of people who require our services.
As well as looking at our capacity, the ability of our staff to support individuals to recovery and our services to help individuals to reduce the pressure and impact of their psychological ill health of worklessness. The Lead Occupational Therapists are working on a Trust Recovery, activity and enablement strategy. One of the pillars of this strategy will include a new model of practice that the Director of Nursing is the Executive lead.

The Royal College of Occupational Therapists (RCOT) and Public Health England (PHE) supported by the Council for Work and Health are carrying out a project in which 25 Occupational Therapists and others across England have become Health and Work Champions. They are using peer to peer education training sessions to encourage their NHS colleagues to routinely ask working age adults about their employment aspirations. We are now ready to train an additional 50 Health and Work Champions and would welcome applicants from a broad range of professional backgrounds.
Our Trust is a member of this trial only 17 staff nationally were supported to undertake this prestigious work. Our congratulations to our team.

Action

1. Executive Lead, John Sykes is leading the session and report on the learning and the experience will be reviewed at the Safeguarding Committee. We offer our full Board commitment to implementing the action plans and supporting our staff through this period.

2. Executive Lead, Carolyn Green is the Childrens service Breast Champion lead and the Executive lead for Safeguarding, which includes our safeguarding families approach to care.

3. Executive Lead, Carolyn Green is the lead for Clinical Effectiveness and Professional Executive lead for Occupational Therapy and the joint Executive lead for Quality and is coaching the Occupational Therapy leads in designing a new strategic direction for the Trust.

1.4 Responsiveness - Learning From Our Experts by Experience

This year saw a significant level of feedback on our Trust use of service users and carers as equal partners in our strategy, innovations and learning. We would like to endorse this continued model of practice and we will have a service user and carer representatives on the appointment of our Trust Chair and Trust Chief Executive. We will continue to support our service user led ward visits to learn directly from this that use our services for expert by experience peers who support our trust in continually improving and working to provide the best service that we can.

Action

1. Our CEO and Chair panels will include assessment by experts by experience.

2. We will be asking our Mental Health Alliance colleagues on ward visits to review the information and posters and tell us what they think. Derbyshire Mental Health Alliance and Healthwatch Derbyshire have agreed to a three month extension in ward visits and we will ask our expert by experience colleagues to tell us their view.

1.5 Well Led – Leadership - Quality visits are continuing

Quality visits continue to be an important part of our make up in our organisation. Our more revised rating criteria has lifted the bar this year. It is shining a light both upon the outstanding range of innovations that our services are able to showcase. Family inclusive practice and Think Family benchmarking were particularly evident in the quality visit this month to the Learning Disability Assessment and treatment service in addition their revised approach to the Life Star - a life goal approach of a similar model to the Recovery Star outcome measure which was impressive to see. This was even more rewarding, as this team are under significant pressure in demand management and going through a significant period of change with an extensive change to their service specification. We endeavour to work with this team, and our commissioning partners to listen to our staff, their concerns about pressure of a small team managing an out of hours service.

1. Focusing on our staff, to re-define our clinical care pathways to work effectively and safely is a key outcome for our staff and our teams. Quality visits are one of our key ways of supplementing our engagement events to talk to listen to teams about their very real pressures and their progress and solutions in resolving some of them.

Action

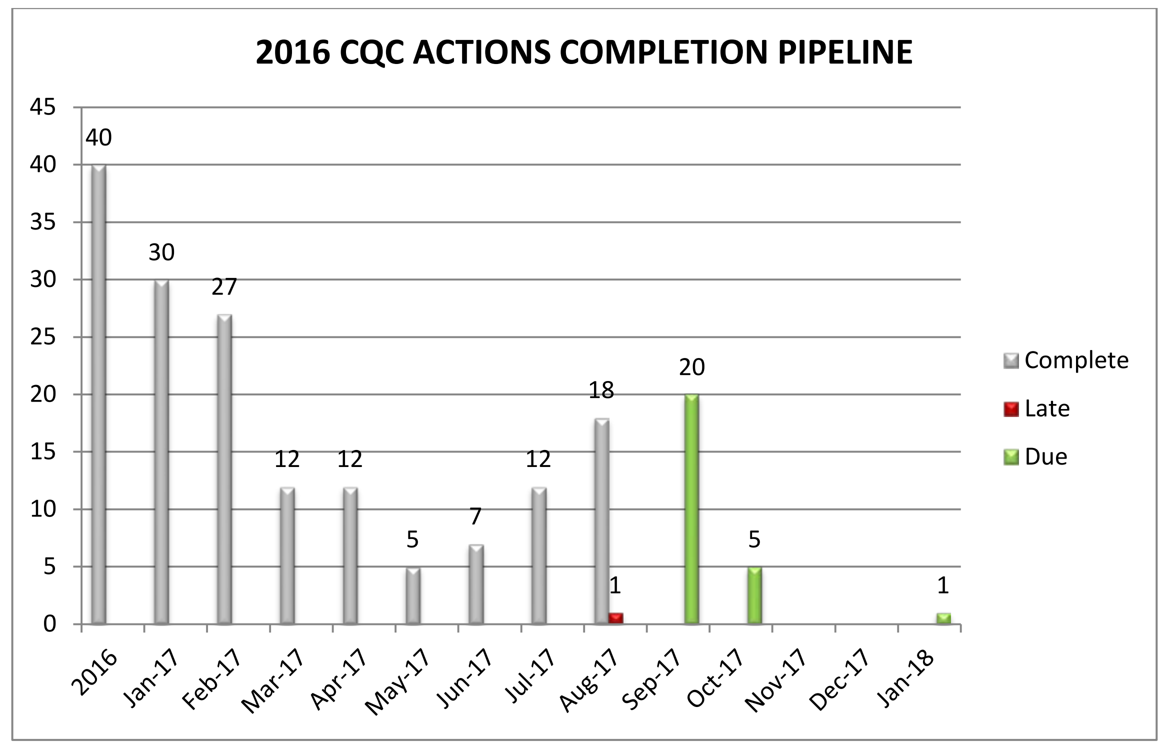
1. The Nursing and Operational leads will ensure that they respond to quality visit feedback and support teams to overcome their service struggles, using a coaching methodology and enlisting other support teams and departments to enable them to succeed.

1.6 Well led – Care Quality Commission Comprehensive – completing our action plan

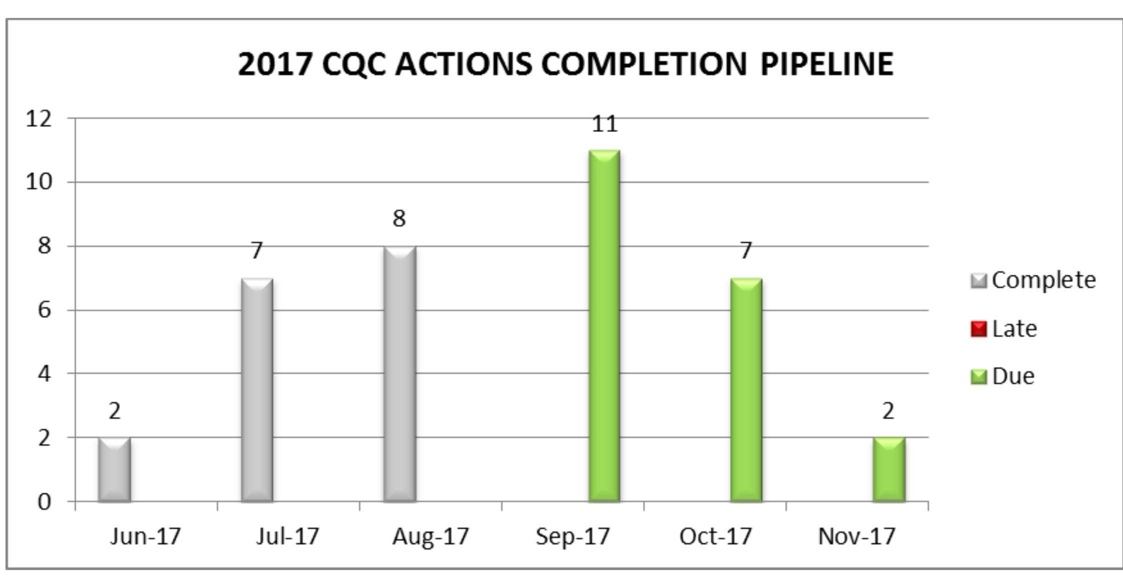
The learning from the Care Quality Commission Comprehensive visit continues and this is closely monitored by the Quality Committee.

There has been overall improvement in the status of the **2016** comprehesive inspections actions in this report:

	Current 2016 Action Status			
Portal Review	**At Risk of Not Delivering**	**Concerns**	**In Progress and on Target**	**Completed**
October 2016	0	34	136	20
December 2016	0	22	128	40
January 2017	0	24	96	70
February 2017	0	12	81	97
March 2017	0	5	76	109
April 2017	0	4	65	121
May 2017	0	4	60	126
June 2017	0	1	56	133
July 2017	0	0	45	145
August 2017	0	0	27	163
Comparison To Previous Month (% of all actions)	**The Same**	**0.5% Decrease**	**9.5% Decrease**	**9.5% Increase**



	Current 2017 Action Status			
Portal Review	**At Risk of Not Delivering**	**Concerns**	**In Progress and on Target**	**Completed**
May 2017	0	0	37	0
June 2017	0	0	35	2
July 2017	0	0	28	9
August 2017	0	0	20	17
Comparison To Previous Month (% of all actions)	**The Same**	**The Same**	**22% Decrease**	**22% Increase**



Action

We continue to make progress on our CQC action and improvement plan and we will continue to ensure that these recommendations and actions are fully delivered.

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

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

Enc F

Learning from Deaths Procedure

See also:	Located in the following policy folder on the Trust Intranet
Untoward Incident Reporting and Investigation Policy and Procedure	Corporate and Risk Policies and Procedures
Handling Patient Feedback: Comments, Concerns, Complaints and Compliments Policy and Procedure	Corporate and Risk Policies and Procedures
Policy and Procedure for 'Duty of Candour and Being Open' Communicating openly with patients and their carers.	Corporate and Risk Policies and Procedures

Service area	Issue date	Issue no.	Review date	
Trust wide	Sept 2017	01	Sept 2020	
Ratified by	**Ratification date**	**Responsibility for review:**		
Quality Committee	Sept 2017	Medical Director		

Document published on the Trust Intranet under: Clinical Policies and Procedures

Did you print this document?

Please be advised that the Trust discourages retention of hard copies of policies and can only guarantee that the Policy on the Trust Intranet site is the most up-to date version

ACCESSIBLE INFORMATION STANDARD

The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of service users.

Ensure you have considered an agreed process for: sending out correspondence in alternative formats and appointments for patients / service users with communication needs, where this is applicable.

Learning from Deaths Procedure

Summary (Plain English) Summarise the main points of the policy below in a style that is clear and easy to understand. Ensure the whole policy is written in plain English, using simple language where possible and avoiding convoluted sentences and obscure words. The resulting policy should be easy to read, understand and use,
This procedure outlines how the Trust will respond to and learn from deaths of patients who die under its management and care.

Name / Title of policy/procedure	Learning From Deaths Procedure	
Aim of Policy	To outline the procedure that the Trust will respond to and learns from deaths of patients who die under its management and care	
Sponsor (Director lead)	Medical Director	
Author(s)	Lead Professional for Patient Safety and Experience/Mortality Technician	
Name of policy being replaced	New procedure	**Version No of previous policy:**

Reason for document production:	To meet requirements outlined in the *National Guidance on Learning from Deaths – A framework for NHS Trusts and NHS Foundation Trusts on identifying, Reporting, Investigating and Learning from Deaths in Care*
Commissioning individual or group:	Quality Committee

Individuals or groups who have been consulted:	**Date:**	**Response**
Executive Director of Nursing, Medical Director, Deputy Director of Nursing	Aug 2017	Agreed
Mortality Group	31/08/2017	Agreed subject to final amendments
Quality Committee	Sept 2017	Approved

Version control (for minor amendments)

Date	Author	Comment

Learning from Deaths Procedure

Table of contents

1. Introduction....4

2. New requirements....4

3. Scope....6

4. Purpose....6

5. Roles and responsibilities....6

6. Definitions....8

7. The process for recording deaths in care....10

8. Mortality Dashboard....11

9. Selecting Deaths for Case Record Review....11

10. Mortality Review Group....12

11. 'Red flags' for deaths to be reviewed by the Mortality Review Group....12

12 .Process for the review of deaths by the Mortality Review Group....13

13. Scrutiny of mortality data....13

14. Selecting deaths for investigation....14

15. Reporting....14

16. Staff Training....15

17. Involving families/carers....15

18. Learning....15

19. Supporting and involving staff....16

Appendix A: Process 17

Appendix B: TERMS OF REFERENCE FOR THE MORTALITY GROUP 18

REGARDS EIRA: Assessing Equality Relevance (Stage 1) 20

Learning from Deaths Procedure

1. Introduction

In line with the CQC's recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a new national framework for NHS Trusts *National Guidance on Learning from Deaths*[1] following the review undertaken by the CQC in response to the low numbers of investigation or reviews of deaths at Southern Health NHS Foundation Trust[2]. The purpose of the new framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and improved embedded learning.

The focus of the framework, and this subsequent procedure, is on improving governance processes around patient deaths. It includes: the Boards role in providing visible and effective leadership to ensure the Trust addresses any significant issues identified as a result of reviews and investigations; a new system of 'case record reviews'; quarterly reporting of specific information about deaths in care; and clarity as to how patients, families and others can raise questions or concerns in relation to the care provided through the *Handling Patient Feedback: Comments, Concerns, Complaints and Compliments Policy and Procedure.* This procedure, together with the linked *Untoward Incident Reporting and Investigation Policy and Procedure* and *Being Open/Duty of Candour Policy and Procedures* ensure the families/carers of patients who have died in care are properly involved at every stage.

For many people under the care of the NHS, death is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However some patients experience poor quality provision resulting from multiple contributory factors, which often include poor leadership and system wide failures. The purpose of reviews and investigations of deaths is addressed in this procedure, which outlines the steps the Trust will take to identify issues that might have contributed to a death or opportunities to learn, in order to minimise the risk of recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

This procedure has been reviewed against the 'Template Learning from Deaths Policy'[3] and is compliant with all aspects of the template that are required to be included.

2. New requirements

Under the *National Guidance on Learning from Deaths*, Trusts are required to:

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

[2] Learning, candour and accountability. A review of the way NHS trusts review and investigate the deaths of patient in England. Care Quality Commission. Dec 2016

[3] Template Learning from Deaths policy. NHS Improvement. Sept 2017

Publish an updated policy by September 2017 on how their organisation responds to and learns from deaths of patients who die under their management and care, including:

- how their processes respond to the death of an individual with a learning disability, severe mental illness, an infant or child death, a stillbirth or a maternal death
- their evidence-based approach to undertaking case record reviews
- the categories and selection of deaths in scope for case record review (and how the organisation will determine whether a full investigation is needed)
- how the trust engages with bereaved families and carers, including how the trust supports them and involves them in investigations
- how staff affected by the deaths of patients will be supported by the trust.

Collect specific information every quarter on:

- the total number of inpatient deaths in an organisation's care[4]
- the number of deaths the trust has subjected to case record review (desktop review of case notes using a structured method)
- the number of deaths investigated under the NHS's Serious Incident Framework (and declared as Serious Incidents)
- of those deaths subject to case record review or investigated, estimates of how many deaths were more likely than not to be due to problems in care
- the themes and issues identified from review and investigation, including examples of good practice
- how the findings from reviews and investigations have been used to inform and support quality improvement activity and any other actions taken, and progress in implementation.

Publish this information on a quarterly basis from December 2017 by taking a paper to public board meetings.

This policy sets out Derbyshire Healthcare Foundation Trust approach to meeting these requirements

3. Scope

This policy applies to all staff whether they are employed by the trust permanently, temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on the Trust's behalf.

4. Purpose

Derbyshire Healthcare NHS Foundation Trust will implement the requirements outlined in the Learning from Deaths framework[5] as part of the organisation's existing procedures to learn and continually improve the quality of care provided to all patients.

This procedure sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of Derbyshire Healthcare NHS Foundation Trust

It describes how the Trust will support people who have been bereaved by a death at the Trust, and also how those people should expect to be informed about and involved in any further action taken to review and/or investigate the death. It also describes how the trust supports staff who may be affected by the death of someone in the trust's care.

It sets out how the trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.

This policy should be read in conjunction with policies and procedures outlined on the front page of this document.

5. Roles and responsibilities

This section describes the specific responsibilities of key individuals and of relevant committees under this policy.

Role	Responsibilities
Chief Executive	Overall responsibility for the implementation of the policy
Medical Director (Board level lead	Responsible for acting as patient safety

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

with responsibility for leading the learning from deaths agenda)	director to take responsibility for the learning from deaths agenda.
Non-Executive Directors	Responsible for ensuring they: • understand the review process: ensuring the processes for reviewing and learning from deaths are robust and can withstand external scrutiny • championing quality improvement that leads to actions that improve patient safety • assure published information: that it fairly and accurately reflects the organisation's approach, achievements and challenges.
Executive Director of Nursing and Patient Experience	Responsible for ensuring that there are processes and procedures are in place to ensure that timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death. Work with commissioners to review and improve their respective local approaches
Learning disability lead	Responsible for ensuring that the Learning from Deaths Procedure is adhered to in the event of a death
Head of Safeguarding Children	Will ensure that child deaths will be reviewed under CDOP and reported as untoward incidents
All staff	To read, understand and take any action to meet the requirements of the learning

Committee	**Responsibilities**
Trust Board	Responsible for for ensuring: an identified board level leader and non- executive director are in place to provide oversight of progress; the learning from deaths paying particular attention to the care of patients with a learning disability or mental health needs. Ensuring that the Trust has:

	• A systematic approach to identifying those deaths requiring review • Adopts a robust and effective methodology for case record reviews • Ensures case record reviews and investigations are carried out to a high quality • Ensures that mortality reporting in relation to deaths, reviews , investigations and learning is regularly reported to the Board • Ensures learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care and reported in annual Quality Accounts Shares relevant learning and ensures that there are sufficient nominated staff have appropriate skills to review and investigate deaths.
Mortality Review Group	See Section 10 and Appendix A: Terms of Reference
Quality Committee	Board Committee with responsibility for assuring the Board that their responsibilities are being met with respect to the learning from deaths agenda and that it is being progressed

6. Definitions

The following definitions apply for the purpose of this policy:

The *National Guidance on Learning from Deaths* includes a number of terms. These are defined below.

Death certification

The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner.

Case record review

A structured desktop review of a case record/note, carried out by clinicians, to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families or staff raise concerns about care.

Mortality review

A systematic exercise to review a series of individual case records using a structured or semi-structured methodology to identify any problems in care and to draw learning or conclusions to inform any further action that is needed to improve care within a setting or for a particular group of patients.

Serious Incident

Serious Incidents in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm – abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services, and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services. See the Serious Incident framework for further information.[6]

Investigation

A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided. Investigations draw on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of similar events in the future. Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first.

[6] https://improvement.nhs.uk/resources/serious-incident-framework/

Death due to a problem in care
A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as cause of death'). The term 'avoidable mortality' should not be used, as this has a specific meaning in public health that is distinct from 'death due to problems in care'.

Quality improvement
A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.

Patient safety incident
A patient safety incident is any unintended or unexpected incident which could have led or did lead to harm for one or more patients receiving NHS care.

7. The process for recording deaths in care

The process relies on the NHS Spine system as its main source of information as well as Trust systems such as Paris and SystmOne.

The Trust employs a Mortality Technician who is responsible for extracting the data from the NHS Spine on a daily basis (Monday to Friday), regarding deaths of patients who are currently open to services, or have been open to services within the last 12 months. From this, a Trust mortality database is populated. Each case is assessed by the Mortality Technician using the 'red flags' for incident reporting and mortality review, to determine if the death should be reported as an untoward incident or should be subject to scrutiny by the Mortality Review Group. If the death meets the criteria for reporting as an untoward incident, the Mortality Technician will cross check with Datix to ensure the incident form has been submitted. For deaths which need to be reported as an incident (see Section 9), an incident form must be completed within 24 hours of the death, or of staff becoming aware of the death (See section 5.2 of the *Untoward Incident Reporting and Investigation Policy and Procedure*). If not submitted the technician will escalate to the Lead Professional for Patient Safety and Patient Experience to determine further action and escalation. Each death is also cross checked against complaint data to identify if there has been a complaint raised by the patient or family member/carer within 6 months prior to their death. If so, the clinical team will be asked to report as an untoward incident and the *Untoward Incident Reporting and Investigation Policy and Procedure* will be followed.

The Mortality Database provides the basis for enabling the Trust to identify trends and learning going forward. The Trust is currently using Excel as the central database for the Mortality Work but will explore further packages as the work expands over time.

8. Mortality Dashboard

The National reporting dashboard template has been adapted for local use. This suggested dashboard is a tool to aid the systematic recording of deaths and learning from the care provided by NHS Trusts. The dashboard will be used to record relevant incidents of mortality, deaths reviewed and lessons learnt to encourage future learning and the improvement of care.

9. Selecting Deaths for Case Record Review

The Mortality Review Group have identified a list of 'red flags' to determine which deaths should be reported as an untoward incident (through Datix) and which should be considered for review by the Mortality Review Group.

'Red flags' for deaths to be reported as untoward incidents (Datix)

An incident form (Datix) must be completed if the death meets any of the following criteria listed below. In these cases the process outlined in the *Untoward Incident Reporting and Investigation Policy and Procedure* must be followed:

Any patient open to services within the last 12 months who has died and meets the following:

- Homicide – perpetrator or victim. (This criteria only relates to patients open to services within the last 6 months)
- Domestic homicide - perpetrator or victim (This criteria relates to patients open to services within the last 12 months)
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatients who died within 30 days of discharge from a DHCFT hospital
- Death following an inpatient transfer to acute hospital
- Death of patient on a Section of the Mental Health Act or DoLs authorisation
- Death of patient following absconsion from an inpatient unit
- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family/ carer/ombudsman, or staff have raised a significant concern about the quality of care provision
- Death of a child (and will likely be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death

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

10. Mortality Review Group

(See Appendix B for Terms of Reference)

To meet the requirements set out in guidance , the Trust has implemented a Mortality Review Group (MRG). The aim of this Group is to:

- Receive an overview of deaths recorded of patients within our care on a monthly basis
- To then determine through the application of a rolling review programme of categories of 'mortality flags' those deaths which require further scrutiny, either through review of death certification; case record review; or investigation in line with *Untoward Incident Reporting and Investigation Procedure*.
- To identify themes and actions resulting from these reviews. There will also be a focus on systems and processes used by our services with cross reference to the recommendations and learning from the Serious Incident Group
- To share overall learning across the Trust

In undertaking this process, the Group will provide estimates of how many of the deaths subject to review were judged more likely than not to have been negatively influenced by aspects of our care.

11. 'Red flags' for deaths to be reviewed by the Mortality Review Group

If a death does not meet the criteria for reporting under the *Untoward Incident Reporting and Investigation Policy and Procedure* (is detailed above*)*, the scrutiny of the death will be undertaken in line with this Procedure.

'Red flags' for mortality review are as follows:

- Referral made, but patient not seen prior to death
- Patient referred to services, then assessed and, discharged without referral onto other mental health services (including liaison team)
- Patient diagnosed with a severe mental illness
- Death of patient on Clozapine
- Death of patient on Olanzapine
- Anti-psychotic medication
- Substance misuse death
- Patient only seen as an Outpatient

- Patient with a long term physical condition
- Patient in chronic pain
- Deaths up to 6 month post-discharge
- Patient on end of life pathway, subject to palliative care
- Patient who have died and were on an out of area transfers
- Patients whose care plan was not reviewed in the 6 months prior to their death
- Patient whose risk plan and or safety plan was not in place or updated as per policy, prior to death
- Death listed for review at inquest
- Death of a patient with an Eating Disorder

12 .Process for the review of deaths by the Mortality Review Group

See Appendix A for flowchart of process

13. Scrutiny of mortality data

The Mortality Review Group will choose four mortality ‘red flags’ to review in each six month period, as part of a rolling programme of review and scrutiny. These will be determined by the Mortality Review Group based on a literature review and knowledge of areas of concern.

The Trust has three levels of scrutiny that may be undertaken following the notification of a death that meets the ‘Red flags’ for deaths to be reviewed by the Mortality Review Group.

- **Review of Death certification** – undertaken through scrutiny of all available data provided by the Coroner’s Office or other sources such as GP, to determine cause of death and if further case record review or investigation is required
- **Case Record Review** – to identify learning through case record review or if investigation is required in line with the *Untoward Incident Reporting and Investigation Policy and Procedure.*
- **Investigation** – through *Untoward Incident Reporting and Investigation Policy and Procedure* as previously outlined

To ensure objectivity, case record reviews and investigations should be conducted wherever possible by clinicians other than those directly involved in the care of the deceased. If the specific clinical expertise required only resides with those who were involved in the care of the deceased the review process should still involve clinicians who were not involved in order to provide challenge and objectivity. The Trust will pilot both the Structured Judgement Review (SJR) methodology and also the PRISM review form to determine whether there were any problems in the care provided to a patient within a particular service.

- Following scrutiny, if further information is provided by other sources such as the Safeguarding Team or the Coroner's Office, the death will be re-opened to scrutiny and appropriate process followed. The Mortality Group will liaise with the coroner if there are concerns identified due to problems in care following the review of care.

Following scrutiny of the deaths by the Mortality Review Group, the Trust will categorise the outcome as either;

- **Expected / unavoidable** (end of life care) - the focus in this category is getting end of life care right and providing patients and their families and carers with a good experience.
- **Unexpected / unavoidable**
- **Unexpected / avoidable** – the focus within this category is to maximise learning from deaths that may be the result of problems in care.

14. Selecting deaths for investigation

Where a review carried out by the trust under the process above identifies patient safety incident(s) that require further investigation, this will be managed in line with the Trust's *Untoward Incident Reporting and Investigation Policy and Procedure*.

15. Reporting

The Mortality Review Group will provide on a quarterly basis, a report to the public session of the **Board of Directors** a report that includes the following data:

- Number of inpatient deaths
- Number of deaths subject to case record review
- Of the deaths subject to review, an estimate of how many deaths were judged more likely than not to have been due to problems in care

This report will be considered by the Quality Committee on a quarterly basis as part of the Serious Incident Report, prior to submission to Board.

This data will be summarised in the Trusts Quality Account from 2018, including evidence of learning and action as a result of this information and an assessment of the impact of actions that the Trust has taken.

The Mortality Technician will provide a monthly report to the Mortality Review Group on the numbers of deaths in the reporting month, broken down by Directorate and Division where required. The report will also contain information on;

- Numbers of deaths reported through Datix
- Numbers of deaths reported through the Spine

- Numbers of causes of death requested that month
- Numbers of causes of death received that month
- Trends in causes of death
- How many Serious Incidents are identified through cause of death information
  (Although this data will be presented monthly it will contain data spanning the duration of the project which means we could receive cause of death for someone from previous months, but we will record the month of death in the data)

16. Staff Training

The Trust will provide for the members of the Mortality Review Group to participate in the training provided nationally following the publication of the *National Guidance on Learning from Deaths*.

17. Involving families/carers

The Trust has a duty to engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to and investigating a death in line with the 'Being Open/Duty of Candour' Policy and Procedures.

Guidance on informing, supporting and involving families is also detailed in the *Untoward Incident Reporting and Investigation Policy and Procedure* (Section 5.4)

18. Learning

The Trust will derive learning from the reviews and investigations and will act on this learning within the Trust, and across the wider health community.

<u>Across our services:</u> Incident investigations and case record reviews will generate action plans which are discharged through the operational arm of the Trust and will be monitored to ensure completion of these actions, by the Mortality Review Group.

In addition to individual and team learning, organisational high level lessons will be identified to inform the development of our systems and processes including education and training. There will be reciprocal learning between the Research and Development Department and the Mortality Review Group, particularly around the prevention of self-harm and suicide.

The following internal learning and sharing mechanisms have been identified:

- Feedback intelligence Group (FIG)
- Serious Investigation Group (SIG)
- Mortality Review Group (MRG)
- Quality Committee (QC)
- 'Blue Light Information'
- Practice Matters

<u>Regionally:</u> The Trust will continue to attend Regional Mortality Meetings to share learning.

Nationally: The Trust will continue to share learning in the national virtual workspace known as SLACK. Where a patient safety incident is identified this is reported to the National Reporting System (NRLS) which periodically distributes lessons to be learnt.

The Trust contributes data to the National Enquiry Into Suicide and Homicide and is also part of the enquiries national benchmarking system, the status of which is regularly reported through the Quality Committee.

Coroners: Regulation 28 reports where lessons can be leant to avoid future deaths, will be considered by the Mortality Review Group and will also be integral to the Trusts system to support learning within and across the organisations and local partners

The Trust will seek to compare performance across specialities and divisions but also across health economies regionally and nationally and provide assurance to the Trust Board that the organisation has a robust culture of clinical excellence and processes in place to deliver and act on learning from the review of patient deaths in our care.

Where a case record review identifies a problem in care that meets the definition of a patient safety incident then this should be reported via the National Reporting and Learning systems (NRLS)

The following external reporting mechanisms have been identified:

- Care Quality Commission
- National Reporting and Learning System

19. Supporting and involving staff

As a caring organisation we would want to protect our staff from distress and trauma arising from risks associated with the nature of their work. The Trust values its staff and appreciates that it needs to ensure staff have appropriate support following any traumatic or stressful incident.

Please refer to the *Untoward Incident Reporting and Investigation Policy and Procedure* Appendix K: Guidance for supporting staff following traumatic or stressful incidents, for further information

Appendix A: Process

NHS Spine updated

GP notified of death

Death notification

Paris

Team notified of death

Open to core services

(Service user within last 12 months)

Each death checked against criteria (red flags) Datix & Mortality

Does not meet datix / Mortality red flag criteria

No further action

Datix Red flag criteria met

Datix Red flag criteria met

Mortality Red flag criteria met

Statistical analysis

No Concerns identified

initiate Datix form

Quarterly board report

Table top review

Concerns identified

SI process

Appendix B: TERMS OF REFERENCE FOR THE MORTALITY GROUP

Introduction:

In line with the CQC's recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a new national framework for NHS Trusts *National Guidance on Learning from Deaths*[7]. The purpose of the new framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and improved embedded learning.

To meet these requirements, the Trust has implemented a Mortality Review Group (MRG).

Purpose:

The aim of the Mortality Review Group is to:

- Receive an overview of deaths recorded of patients within our care on a monthly basis
- To then determine through the application of a rolling review programme of categories of 'mortality flags' those deaths which require further scrutiny, either through review of death certification; case record review; or investigation in line with *Untoward Incident Reporting and Investigation Procedure*.
- To identify themes and actions resulting from these reviews. There will also be a focus on systems and processes used by our services with cross reference to the recommendations and learning from the Serious Incident Group
- To share overall learning across the Trust

In undertaking this process, the Group will provide estimates of how many of the deaths subject to review were judged more likely than not to have been negatively influenced by aspects of our care.

The Executive Director lead for mortality review is Dr John Sykes, Medical Director. The Non-Executive Director is Dr Anne Wright.

Terms of Reference:-

1. Provide overview and scrutiny of mortality data including analysis with reference to geographical location/team/individual practitioners, diagnosis and cause of death

2. Establish a level of scrutiny for each death based on identified mortality 'red flags' .

3. Ensure reports completed in line with all relevant national guidance on reporting of deaths

4. Members of the Group to be trained in the use of the structured judgement review as a method to scrutinise case records and cascade training as required

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

5. Determine themes including organisational high level actions and learning

6. Implement appropriate methods for dissemination of learning for the Trust (including training and education), and services across the wider health economy such as independent health care and social care services.

7. Monitor Regulation 28 reports and actions, and any learning from inquests or claims to support learning within and across the Trust and local system partners

8. Review of nationally available data to benchmark against local information.

9. Scrutiny of Public Health data against other regional information in comparator trusts.

Frequency of Meetings

Monthly

Membership

Core Members

Chair: John Sykes
Dept. Chair: Dr Paul Rowlands
Consultant: Dr Arthita Das
Mortality Tech: Aneesa Akhtar
Audit Lead: Rubina Reza
Nurse Consultant: Sam Kelly
Patient Safety: Rachel Williams
Deputy Director of Nursing and Quality Governance: Darryl Thompson
CCG Representation: Phil Sugdan
Investigator Facilitator: Bhavnita Bunawah/ Debbie Scott

Other individuals may be invited to attend the group ad hoc when specialist opinion is required.

REGARDS EIRA: Assessing Equality Relevance (Stage 1)

1. Name of the service / policy / project or proposal (give a brief description):

Learning From deaths Procedure- this procedure outlines the action the Trust will take in response to learning from deaths of patients within their care

2. Answer the questions in the table below to determine equality relevance:

	Yes	No	Insufficient data / info to determine
Does the project / proposal affect service users, employees or the wider community, and potentially have a significant effect in terms of equality?		x	
Is it a major project / proposal, significantly affecting how functions are delivered in terms of equality?		x	
Will the project / proposal have a significant effect on how other organisations operate in terms of equality?		x	
Does the decision/ proposal relate to functions that previous engagement has identified as being important to particular protected groups?		x	
Does or could the decision / proposal affect different protected groups differently?		x	
Does it relate to an area with known inequalities?		x	
Does it relate to an area where equality objectives have been set by our organisation?		x	

3. On a scale of high, medium or low assess the policy in terms of equality relevance.

	Tick below:	Notes:
High		If ticked all 'Yes' or 'Insufficient data'
Medium		If ticked some 'Yes' and / or 'Insufficient data' and some 'No'
Low	x	If ticked all 'No'

EIRA completed by: Rachel Williams
Date: 30/08/2017

Board Committee Summary Report to Trust Board
People & Culture Committee - 21 September 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 of People & Culture Committee held 20 2017 **Actions Matrix and Matters Arising**	Leadership development strategy FAQ's that went to HR/Workforce staff about the restructure	Strategy deferred until the new structure and resources are in place FAQ's had been developed and shared across the directorate	HR/Workforce structure business case approval is key	To continue to develop the strategy, but require the focus and resources that will arise from the new service structure	N/A
Staff Story	New Dr to join DHCT. Dr moved from Egypt to Derbyshire	Explored the experience the individual had with the transfer. Identify new ways to support staff who join the trust from across the country discussed and identified	Need to develop a personal transition support plan	New approach to be developed	N/A
People & Culture BAF Risks	Has been refreshed and will now be at Audit and Risk committee	To be reviewed the A&R committee	N/A	N/A	N/A
Strategic Workforce Report	Sickness remains high linked to staffing issues in certain spots Retire and return process to be shared with all staff Policy for staff who leave and return with a 3	Committee was assured of the progress over the last twelve months. Staff attendance/welfare and filling the trusts vacancies was identified as trust critical priorities Develop the process and share across the trust To reengage staff who leave and would like to return	Ongoing recruitment process is driving the situation To create a process that encourages staff to retire and return	To continue to focus on filling our gaps/explore alternative models and solutions	N/A

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	month period				
People Plan – Quarterly Update	To add extra column Change format Progress noted	Progress on all action was noted	Actions that are in the plan are reflective the key people priorities and inevitable have risks identified	The plan focuses the key people priorities	None at this stage
Governance Improvement Action Plan (GIAP)	October commentary was reviewed and the ambers were discussed	Assurance was taken on the progress made	N/A	Comments were made to enhance the progress made	None at this stage
Pulse Check Results and 2017 Staff Survey Plan	Ongoing improvement To send out week before staff survey 'You said we did'	Committee noted the last two pulse checks show progress, albeit on a small sample of staff.	To achieve the maximum participation of staff	To have a robust communication plan	None at this stage
Draft Equality, Diversity Inclusion Strategy overview and WRES action plan	Equalities framework supported WRES action plan to develop aspirations not targets To set completion dates	Assurance taken from the paper and progress, committee support the framework	None	None	None
Skill Mix Review Inpatient Mental Health Settings and Neighbourhoods	Acknowledged and noted	N/A	N/A	N/A	N/A
People Performance Report	Appraisal chasing process in place to remind individuals of their appraisal completion requirements				
Temporary staffing	Discussed the future	It was noted the work	It was noted the work	N/A	N/A

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
update	service model for bank	programme required to move the service	programme to achieve the transition		
Recruitment Progress Update	Workforce supply and markets available Structure of roles and teams	It was noted the significant challenge this is for the trust and the ongoing focus	Key hot spots across the trust	Ongoing support to the teams	Board are fully aware of the risks
Training Compliance	Reviewed the training compliance report. The committee challenged if there are opportunities to refine the list and prioritise	Education training group to review the list of training and prioritise	We have many reds across a number of training programmes	To look at all alternatives	Included in this month's performance report to board
Any Other Business	N/A	N/A	N/A	N/A	N/A
Forward Plan	Noted				
Items escalated to the Board or other Committees	Training compliance which is included in the performance report				
Identified risks arising from the meeting for inclusion or updating in the BAF	BAF to be reviewed at the Audit and Risk				
Meeting effectiveness	Good discussion was assisted by helpful papers across all items				

Board Committee Summary Report to Trust Board
Mental Health Act Committee (MHAC) - 24 August 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 and Apologies **Minutes from Mental Health Act Committee held 9 June** **Matters Arising – Actions Matrix**	Minutes of meeting on 9 June agreed.	Nil	Nil	Nil	n/a
	A joint Derby City/County Report has not been received	To be proposed for MHAC Operational Group.	Nil	To be referred to MHAC Operational Group.	n/a
	Learning Disabilities bed management/finding service.	Still not resolved. Commissioners have agreed a service specification but no additional funding available.	At times of bed shortage highly vulnerable (and occasionally dangerous) patients may not get a safe service response.	Unresolved risk.	To escalate to Executive Leadership Team (ELT)
	136 Suite is un-staffed and attendance of bleep holder is sometimes required for lengthy periods.	To be considered in STP process but no prospect of timely resolution.	The function of the bleep holder can be compromised.	To quantify risk through monitoring of Datix reports.	n/a
Mental Health Act Manager's Quarterly Report	More narrative content is required to answer the 'so what' questions. Specific issues detailed below:	Future reports to be considered in the MHAC Operational Group and action plans developed.	Executive summary needs to be developed to give necessary level of assurance.	Report to be prioritised by MHAC Operational Group.	n/a
	Seclusion Pathway now documented on PARIS but technical problems persist in notifications to Mental Health Act (MHA) Office.	FSR Board to consider work priorities for IT/PARIS team.	PARIS development might not proceed at pace necessary to enable crucial assurance to be obtained.	Refer to FSR Board and compensate with 'manual' reporting where possible	FSR Board

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	Second Opinion Appointed Doctor (SOAD) requests are not being notified by responsible clinicians to MHA Office	PARIS System in place but update by RCs is patchy	Unable to ascertain in all cases why breaches in second opinions are occurring	To escalate to Medical Director to resolve through medical management	n/a
	It was noted that nurses do not record use of the Mental Capacity Act (MCA) in Datix reports when rapid tranquilisation is used for patients not detained under the MHA.	Medical Director to raise issue with Chief Nurse and distribute guidance	Use of MCA may be documented elsewhere in record but assurance is lacking	Medical Director to liaise with Chief Nurse and Mental Capacity Lead	n/a
Mental Health Act Manager's Annual Report	Annual Report was requested by previous MHAC chair, it is not a governance requirement. If continued the report could be developed to give assurance to the public on the 'state of play' and discharge our duty of candour. Objectives for the coming year could be mapped out.	To consider whether annual report should continue and if so how it is developed	The capacity to provide this report is already saturated with day to day clinical governance work.	To defer to ELT	ELT
Ward 36 Report	The CQC routinely visit our wars/units/teams and produce provider action statements which form the basis of action plans – this is one of several	In future the oversight of these action plans will be by the MHAC Operational Group with exception reporting to the Committee. High	The individual local action plan needs to be owned and delivered by the relevant team leaders /managers / consultants. Best	To refer to MHAC Operational Group	n/a

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	received in 2017.	level action plans will be developed as necessary to address universal themes. All action plans will have completion dates.	practice advice needs to be shared. A 'get it right first time' culture needs to develop around person centred / Think Family care		
Overview of 2016/2017 CQC Actions	The good progress against 2016 action plan was noted with PARIS development the only issue identified which could jeopardise completion in three cases	The 2016 action plan was a comprehensive behemoth with many areas of duplication and overlap. Whilst providing a high level of assurance it risked becoming overwhelming. A more synthesised approach will be required for the next comprehensive inspection. An overview of individual site visits will be developed in the MHAC Operational Group as explained in the previous item.	A high degree of tension developed around the best way to tackle the 2016 actions. This will be addressed by the Executive	To proceed with the approach to assurance outlined	n/a
Seclusion Review	The automation of seclusion exception reports has anomalies due to human and system errors which are being worked through compensated by manual reporting currently	Assurance is required regarding the timely development of reporting systems linked to PARIS	Face:Face seclusion reviews after normal working hours are often completed by trainee doctors with telephone access to Approved Clinicians. Senior psychiatrists on call and do not work shifts and so limited their availability to ensure safe working	To defer PARIS development issues to the FSR Board	FSR Board

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
			hours.		
Rapid Tranquillisation Improvement Action Plan	A series of previous audit reports have highlighted policy compliance with NICE guidance	The action plan details show how improved compliance will be achieved	The previous issued noted nurse compliance with MCA in patients not detained was recorded	To add compliance with MCA for patients not detained to action plan. Re-audit suggested in six months with a report to MHAC in nine month	n/a
Training compliance report	Slow progress towards three-yearly compliance was noted. Issues include difficulty releasing staff at a time of shortage, poor e-learning functionality, bourgeoning training passport, and extended MCA training requirement.	E-learning functionality is due to improve with a new ‘front end’. The medical training passport will be cropped and a more focussed approach taken. The MCA training will be revised and shortened. Face to face training continues.	Overall three types of assurance are required for MHA/MCA issues: 1) Compliance checks. These are developing but depend on PARIS functionality. 2) Quality Improvement Audits, showing improvement. These are tending to ‘flat line’. Clinical Audit approach is being provided. 3) The conversation ‘on the ground’. Anecdotally we are probably in a much better place than in 2016.	For the MHAC Operational Group to troubleshoot the training plan. For ELT to consider the challenge to training compliance overall.	ELT for training compliance overall
S17 Audit	A case in point from the preceding item – not much has improved	Action plans need ‘leader evidence’ of completion	That quality improvement ‘bobbles’ but fails to advance	To accept the action plan but to audit with specific actions	n/a

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Operational Mental Health Act Group Terms of Reference (notes from meeting held 24 July 2017 for information)	To further develop the Terms of Reference to include: • Ensuring timely delivery of CQC action plans • To escalate exceptions to MHAC	Revision of Terms of Reference	None	To revise Terms of Reference	n/a
Revised Mental Health Act Committee Terms of Reference	To add Operational Manager to attendees. To revise Terms of Reference to make them less passive.	To revise Terms of Reference	None	To revise Terms of Reference	n/a
Verbal Update from Associate Hospital Manager Representative	No problems identified	To arrange meeting with Non-Executive Directors	Nil	Hospital Mangers will set date for meeting	n/a
Combined Local Authority AMHP report	Derby City Council report was received County Report was tabled	Current form of reporting does not give assurance or pose questions	Deprivation of Liberty Safeguards (DOLS) authorisation backlog results in regular breaches. The proposed changes to legislation may not materialise if parliamentary time is squeezed by 'BREXIT'. If passed al DOLS patients currently in psychiatric wards will be detained under the MCA massively increased the workload of all	To consider combining the local authority reports with the DOLS section of the MHA Manager's reports whilst highlighting operational issues	n/a

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
			concerned.		
MHAC Board Assurance Framework (BAF) risks – review of discussions that could affect the risk rating of the Committee's risks	Due for Deep Dive at MHAC. What has been the impact of action taken? Community Treatment Order (CTO) and Section 37/41 have been added as a gap in assurance.	CTO audit is due in December 2017 and compliance reports included in MHA Manager's report. Section 37/41 Register being completed. Beth Masterson will inform peer review of recent homicide.	Main risk is regulatory failure. Initial screening of recent homicide did not suggest compliance with MHA to be a contributory factor.	To timetable Deep Dive of MHA.	Nil
2017/18 Forward Plan	To revise in light of MHAC Operational Group	Add Deep Dive to MHAC timetable	Nil	Revise forward plan	n/a
Issues escalated to Board, Audit & Risk Committee or other Board Committees	Overall problems of achieving training targets.	For consideration and feedback from ELT.	Governance gap. Training passport may be over inclusive.	For ELT discussion. MHAC Operational Group to troubleshoot MHA/MCA/DOLS training.	ELT
	Does Mental Health Act Manager's annual report add anything useful? A revision could give public reassurance but it is a further call on already stretched resources.	For consideration and feedback from ELT.	Annual report MHAC Is not part of regulatory requirements.	To refer to ELT.	ELT
	PARIS development is a rate limiting step in achieving and reporting compliance.	For the FSR Board to consider. Overall capacity and is outstripping prioritisation	Demand for PARIS development	To refer to FSR Board.	FSR Board.

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
		of supply			
Meeting effectiveness	This was a transition meeting pending the MHAC Operational Group getting up to speed. The timing of meetings this year may compromise effectiveness and will be revised for next year.	Terms of reference of MHAC Operational Group have been agreed.	Already covered in B.	To proceed.	n/a

Board Committee Summary Report to Trust Board
Quality Committee - meeting held 10 August 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 on model	See Minutes for full actions Risks with some overdue actions that need further information updated	One minor amendment made to Minutes	
Attendance Log	Reviewed log and improved attendance	Improved assurance	Stability in leadership	Agreed	
Policy governance log	Reviewed QC policies	Full assurance	All policies in date	Report confirmed	
Matters Arising	Reducing meetings	To consider reduction to bi-monthly or quarterly	To be planned	CG to discuss with Dr Anne Wright	
Carer Representative Feedback	Relationships with Healthwatch and meeting attendance Service receiver work	3 - 6 month mitigation plan has been developed	Instability in representation Loss of representation remains unresolved	The briefing on the current position based on escalated risk. Carolyn Green to meet with Hardwick CCG	To be escalated again to the Quality Committee end of year 2017
CQC Action Plan and Performance	Report presented on clinical standards, regulations and improvements in standards following 2016 and 2017 inspections	Significant assurance model Limited assurance provided due to key performance areas	2016 progress on actions noted and trajectory acknowledged. 2017 progress on actions noted and trajectory acknowledged. Risks and concerns included in the paper Key that the sustained improvement is evident. There are additional risks of	Progress noted on the 2017 actions, approach accepted to improve the action status, the monthly full CQC action portal reviews, the capacity focus group reviews and the General Managers meeting reviews	.

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
			an improvement notice and or fine is possible		
Quality dashboard	A re view of risk Services are very active	Limited assurance due to service pressure	Key risks and issues associates with clinical service pressure. Mitigating actions in place at operational issues	Agreed	
Serious untoward incident	Reviewed model and findings	Limited assurance due to performance notice	We will continue to involve families We have made a risk based decision that we do not have the capacity to work with NHS E in more than an arm's length model	Agreed, Monitoring of improvement plan	To note a contractual improvement notice, to develop an action plan
Safer skill mix	6 monthly review Reviewed and submitted. Author was thanked for this work	Significant assurance and actions agreed Limited assurance on systemic pressures	Older Adult psychologist gap Positive assurance against the workforce plan	Agreed, to share with people and culture committee.	
Health And Safety Annual report	Reviewed and agreed Very good work	Significant assurance	Some improvement areas with mitigating actions in place with training and actions	Agreed	
Transition work for CQUIN	Progress up-date	Current performance is solid	Impact of transition of flow and pathways CQUIN achievement has a cost impact to the Trust	Agreed, future up-dates.	
Crisis team External review and quality issues	Assurance of our internal findings Review and external	Limited assurance and agreed plans	Gaps in crisis management and issues To review and the issues	Agreed and to be monitored quarterly	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	issues,		and modelling of the ECIP presented model compared to the Trust model. Family and carers and issues to be considered in the work		
Quality Assurance summary	Received briefing on the issues	Disconnect between meeting where the trust was given positive feedback on improvements in SIRI management and complaints and a subsequent Improvement notice issue	Communication from commissioners does not match behaviours.	QAG summary to submitted at the next meeting	
Responsible clinician	Assurance of our internal findings. Communication to teams and roles on this development	Significant assurance	No known risks Risk mitigation for workforce strategy and implementation	Agreed	
Complaints and patient experience	Agreed and ratified	Limited assurance Significantly improved action plan	Performance notice- limited assurance on action plan as above	Agreed	
Medicines management and Pharmacy strategy up-dates	Gaps in commissioning in specialist and neighbourhood services National ranges of pharmacy services Medicines reconciliation MOT now in post, direct support	Significant assurance on model and report Limited assurance on completion of some training such as RT, 60% has now increased to 88% following a mitigating action	Teams under pressure Time to attend training Sustained compliance with medicines standards, improved performance ., with mitigating actions to over 84% Substantial increase in nurse audits, sine time of	Agreed	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
			report writing Medicines management in neighbourhoods- needs improvement Exploration of STP solutions to changing workforce issues	Further improvement plan by Neighbourhood lead professional and operations teams, to be reviewed at TMT PMR	
Any other business	Absence of reporting from Teams	Receipt of assurance/escalation summaries from Teams at future meetings	-	Agreed	
Items for escalation to board	Contract improvement notice to supply an action plan				
Summary of BAF Risks and Consideration of any items affecting the BAF	There were no risks identified in the meeting for addition to or affecting the BAF	None required	None identified.	None in addition Agreed	
Meeting effectiveness	Solid papers Good meeting Positive improvements A number of papers have limited assurance due to pressure in services	None required			

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 27 September 2017

Safeguarding Children's and Adults Integrated Annual Report

Trust's Strategic Aims in line with Derby City and Derbyshire Safeguarding Boards and Trust Requirements

Purpose of Report

This Annual report summarises the year 2016 to 2017 and this includes Safeguarding Children's and Adults Board Strategic Plans and the Trust's position in providing assurance to the Board on our performance.

Executive Summary

The purpose of this report is to:

- Provide the Trust Board with an overview of the current issues and themes within Safeguarding and to provide assurance on the quality of the services.
- Safeguarding is a critical piece of governance and a key element of our safe clinical practice and operating standards in our provision of Children and Adult services.
- Provide details of the safeguarding service requirements in line with our community population needs. The report details the community needs for our Children and families and the significant increase in the needs of Children and Adults in our services in the Safeguarding arena
- Provide information to assure the Board on training compliance, which is improved performance with the need for continued scrutiny and prioritisation of training.
- Provide details of the Safeguarding Unit's reporting structure and changes
- Inform the Board of the high profile that child abuse has had over the past year, especially regarding neglect, modern slavery, radicalisation, sexual exploitation, female genital mutilation (FGM) and non-recent sexual abuse. In addition to overarching statutory guidance the Government is introducing new requirements for health agencies regarding specific concerns. Our responses to those issues are detailed in this report.
- Report on our own performance and how we are linking our commitments and system approaches with our Safeguarding Boards.
- Give an overview of the Safeguarding Boards and the Trust's priorities and audit against the work that has been happening in the multi-agency arenas.
- Highlight some of the multi-agency audit activity and single agency audit work, encompassing recommendations and actions resulting from the audit activity to provide assurance to the Board on the Trusts connectivity to the Safeguarding systems.

- Demonstrate effective systems and process's to implement the learning from Serious Case Reviews, Homicide and Learning Reviews covered over the report timeframe and show how the Trust has implemented this learning.
- Demonstrate how our preventative approach to Safeguarding families is being delivered through 'Think Family' and Family Inclusive practice / Triangle of Care has been driven throughout the last few years within the organisation, with the CQIN completed in 2016 and the current Quality priorities Outlines the Safeguarding committees and safeguarding units work plan for 2017-18, this is supplemented with a SMART action plan, with key deliverables which is monitored by the operational group
- Overall the safeguarding committee confirmed significant assurance of the systems and process's in place to effectively manage safeguarding and this took into account, areas of risk that have now been mitigated.
- The safeguarding services have maintained quality standards, developed new innovations and models of practice.
- This team supports the Trust structures to discharge substantial levels of safeguarding practice throughout the Trust, as the Trusts clinical services remain under sustained pressure. The reality is stark there are one hundred more children on the safeguarding children plan today than there were a year ago. There are substantial increases in Safeguarding adults and in public protection matters with over 300% increases in some areas. This has meant that safeguarding teams and structures continue to work in a climate that is significant and our communities are exposed to increasing risks.

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

Assurances

- A clinical audit programme will be re-developed and delivered based on the work plan and re-adjusted built upon the Safeguarding Operational Management Groups and their existing work plans and new intentions.
- A defined work plan and mechanisms to meet new legislative changes are being undertaken and being adapted based upon emerging evidence and being re

defined.

- Compulsory training standards and compliance with systems and processes are checked and assured through this process.
- Gap in assurance in 2016 in June with regard to some key essential standards for Safeguarding training level 3 compliance , Supervision practices for nursery nurses not being a cascade model and in particular for one service area with regard to allegation of theft / actual losses and, not upheld as theft at independent- Section 42 enquiry and training which were rectified.
- CQC standards are now complaint at the end of the year and the Children service up-graded too Good for Safety which included the Safeguarding service actions
- Section 11 and Safeguarding Adults Assurance Framework have been adhered to with continued scrutiny and meeting standards effectively. This is external submission and scrutiny of data
- Provide assurance that the trusts contribution to the Derby City Safeguarding Children Board has resulted in the City being rated as Outstanding, as the main provider for Children's Universal, Safeguarding unit and Disability services this is based upon our significant contribution.
- Provide assurance on feedback form partners on the Trusts systems and process and the direct feedback of working with the Trust on new service models implements in 2016/17.

Consultation

- This report has been reviewed by members of both the Safeguarding Children and Adult Teams.
- Various members of the wider Safeguarding Team have contributed to the report
- This report has been reviewed and scrutinised by the Safeguarding committee with external partners.
- Improvements were made by the safeguarding committee and their view included in this paper to the Board.

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people) (Public Sector Equality Duty & Equality Impact Risk Analysis)

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

There are no adverse effects on people with protected characteristics (REGARDS).	
There are potential adverse effect(s) on people with protected characteristics	

(REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	

Actions to Mitigate/Minimise Identified Risks

Specific details of our community population and adaptations that we need to take into account in economic disadvantage and social deprivation are included and how this impacts upon life expectancy.

Children who are looked after children or who experience adverse childhood events are at significant risk and this evidence and research is considered.

The report details the potential needs of the new and emerging community in Derby city and the specific community adjustments that may be required to meet our Roma communities needs effectively and provide an inclusive and adapted service within the safeguarding procedures of the city and county.

Children are identified in the report as under significant pressure with regard to their needs to be protected from abuse

Women and Children are identified at being at risk of Female genital mutilation and the services are adapted to identify and meet the needs of women and girls.

Community violence is increasing substantially, significant and substantial risks of Domestic violence both nationally and in community remain a concern with improvement work with partners planned for 2018/19.

Religious aspects and extremism are noted in the report for specific groups this is both for children and adults the protection of the community and the rights to religious observance are delicately explored in working in partnership with other safeguarding organisations and groups in channel process, in line with the statutory obligations of the PREVENT duty

Recommendations

The Board of Directors is requested to:

1) Note the performance and complexity of this report and the findings of the annual report, model and recommendations.
2) To receive assurance on the Trust position and interconnectivity with the Safeguarding Children's and Adults Board for the City and County
3) To receive assurance on the breadth and depth of Safeguarding activity to both prevent and respond to the needs of our community and being assured of an effective work plan for the Trust.
4) To give feedback on this Annual assurance report provides scrutiny and endorses and accepts its recommendations.
5) The Executive lead provides this report, with the knowledge that there is limited benchmarking information to confirm safeguarding data at a national level in the public domain. The lead does recommend significant assurance on current performance this is taking into account limited assurance within year and subsequent improvement within year.
6) However the Trust does provide external assurance on external scrutiny and external assessment that a key safeguarding board was externally reviewed in 2017 and achieved a rating of outstanding systems.

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

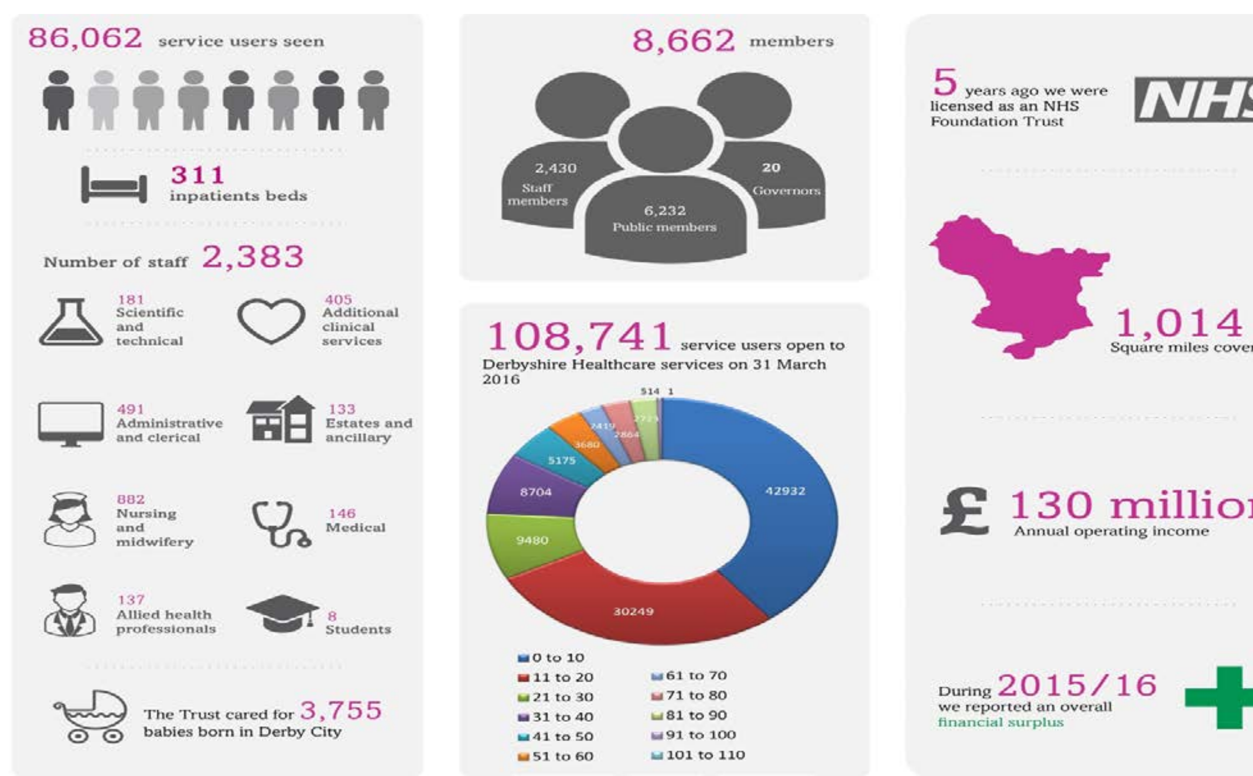
Report prepared by:
Tina Ndili - Safeguarding Children Lead
Karen Billyeald - Safeguarding Adults Lead
Jo Kennedy - Safeguarding Children Named Doctor/Consultant Psychiatrist
Kelly Sims - CQC & Governance Co-ordinator
Ruth Thomason - Safeguarding Children Unit Co-ordinator
Jane Elliot - Named Nurse, Safeguarding Children
Tracy Shaw - Training Manager
Liz Holmes - Safeguarding Children Nurse Advisor
Louise Haywood - MASH Health Advisor
Carolyn Green - Executive Director of Nursing and Patient Experience

Safeguarding Children and Adults at Risk Annual Report 2016/17

A. INTRODUCTION

The safeguarding of all our patients, both adults and children remains a high priority for DHCFT Trust. Safeguarding and 'Think Family' is a fundamental component of the care provided. The purpose of the report is to provide an update of Safeguarding activity across the Trust. This report sets out the work of DHCFT in relation to safeguarding and the necessary safeguarding frameworks in place to continue to develop the service. The Trust continues to work in partnership with statutory and voluntary partners across Derbyshire and bordering localities to discharge its responsibilities in relation to safeguarding children. The last 12 months have again been very busy and the complexity and breadth of responsibilities and assurances required continue to increase but we have been successful in many areas of development and implementation.

The following captures the demographics of the Trust.



The population that we serve in the context of Safeguarding Adults at Risk and Children (2016/2017).

Derby is a small, culturally diverse city with a population of 251,423 representing 182 nationalities, speaking 71 languages and 83 distinct dialects.

Approximately 25% of Derby's population are from BME communities, with its largest ethnic group comprised of the Asian/Asian British community. Derby's ethnic diversity is mirrored by its great variations in levels of deprivation.

Overall, the city is within the 20% most deprived areas in the country, about 25% (12,900) of children live in low income families. Pockets of deprivation are mainly concentrated

within Arboretum, Normanton, Sinfin and Alvaston, all within the top 10% most deprived areas in England. These wards are characterised by high rates of unemployment and households with a lower than average annual income.

Conversely, Allestree and Mickleover are amongst the least deprived 10% of wards in the country.

This translates into vast health inequalities between Derby's wards. For example, a child born in Allestree could expect to live up to 12 years longer than a child born in Arboretum. Overall the demand for social care services within Derby City has been increasing over recent years with:

- Early help cases – 48% increase
- Social Care referrals – 34% increase
- Children in need – 35% increase
- Children with a child protection plan – 25% increase
- Looked after children – 6% increase

Derbyshire has a small (approximately 4%) ethnic minority population which is mainly concentrated in the districts of Chesterfield, Erewash and South Derbyshire. The largest ethnic groups are 1.2% 'Other White' (that is not 'White British', Irish or Gypsy or Irish Traveller) followed by 0.6% Asian British. Derbyshire has an increasing elderly population, with pensioners currently making up 19% of the total (English average 16%). The health of people in Derbyshire is varied compared with England's average. About 17% (22,200) of children live in low income families. Life expectancy for both men and women is lower than England's average. In contrast with the City the number of referrals to Derbyshire Children's Services has decreased echoing a national reduction. Child in Need referrals and Children on a Child Protection plan have increased, but not to the same extent as in Derby City.

B. LEGAL CONTEXT

All Health Organisations including CCG's and NHS England are under a statutory duty to make arrangements to ensure that, in discharging their functions, they have regard to the need to safeguard and promote the welfare of children under Section 11 of the Children Act (2004). These arrangements need to comply with The Children Act 1989 and 2004 as set out in Working Together to Safeguard Children (2015) and Intercollegiate Document (2014). Arrangements should take into account the National Service Framework (2013) and Safeguarding Vulnerable People in the NHS-Accountability and Assurance Framework (2015).

There is also a duty to co-operate (Section 10) with Local Authority arrangements and the Local Safeguarding Children Board (Section 13).

Derbyshire Healthcare Foundation Trust Safeguarding Children Service will take into account all relevant legislation including:

- United Nations Convention on Rights of the Child. Ratified by the UK Government in 1991
- European Convention of Human Rights, in particular article 6 and 8

- The Children Act 1989
- The Children Act 2004
- The National Service Framework for Children Young People and Maternity Services (2004) – Core standard 5
- Working Together to Safeguard Children (2015)
- Information: To share or not to Share – Government Response to the Caldecott Review (2013)
- Safeguarding Children and Young People: Roles and Competences for Healthcare staff - Intercollegiate Document, March 2014
- Derby City and Derbyshire Safeguarding Children Board Procedures, which includes the Threshold Document and Escalation policy
- NICE Guidance – Child maltreatment: When to suspect maltreatment in under 18s (2009)
- CQC Safeguarding Children – A review of arrangements in the NHS for Safeguarding Children (2009)
- What to do if you're worried a child is being abused: Advice for Practitioners (March 2015)
- Information sharing: Advice for Practitioners Providing Safeguarding Services (2015)
- Revised Prevent Duty Guidance for England and Wales (HM Government, 2015)

In essence, Derbyshire NHS Foundation Trust are committed to:

- Keeping patients safe from harm, transparent in reporting and tackling abuse where issues are raised
- Compliance and support for legislative changes set at a national level
- Supporting families and carers to develop family resilience to keep people safe as part of our preventative Safeguarding Family practices
- Ensuring care in delivered in accordance with the principles and requirements of the Mental Capacity Act (2005), Mental Health Act (1983), Code of Practice 2015, Deprivation of Liberty Safeguards
- Recognising the impact of trauma and its links with safeguarding both Children and Adults, including both present and historical abuse
- Supporting our workforce to enable them to make safe assessments and decisions
- Reducing restrictive practice and supporting the wider agenda of Positive & Proactive Care (2015)
- We have a statutory responsibility to demonstrate adherence with 'The Care Act' (2014) and the national PREVENT duty (2015) to support our communities and preventing individuals being radicalised wherever we can
- We will consider learning from Kerr Haslam and we will consider specifically clinical professionals registered and non-registered and how we spot early warning signs for staff abuse on patients or families
- Amendments to the 'Serious Crime Act' (2015) adds a new offence of coercive and controlling behaviour to existing legislation on Domestic violence coupled with Nice Guidance Q5116 Domestic violence and abuse: Multi-agency working, strengthens

the requirement for the organisation to make these issues a priority within Safeguarding Adults agenda in the Trust

- The Department of Health's Female Genital Mutilation (FGM) Prevention Programme states that in a patient's healthcare record, we must now record FGM and fulfil our statutory reporting procedures. The law in relation to FGM has been strengthened in the Serious Crime Act (2015) needs to be embedded into our practitioners thinking and into routine clinical practice
- The role we play in Public Protection, MAPPA and our role in Domestic Homicide Reviews, Safeguarding (Adults) Review and Serious Case Reviews needs to be continually refined and embedded into clinical practice

The Care Act sets a direction of travel for making safeguarding personal and family orientated practice, laying down for the first time this requirement in statute. We need to embrace this development and refine our clinical standards to adopt this into practice.

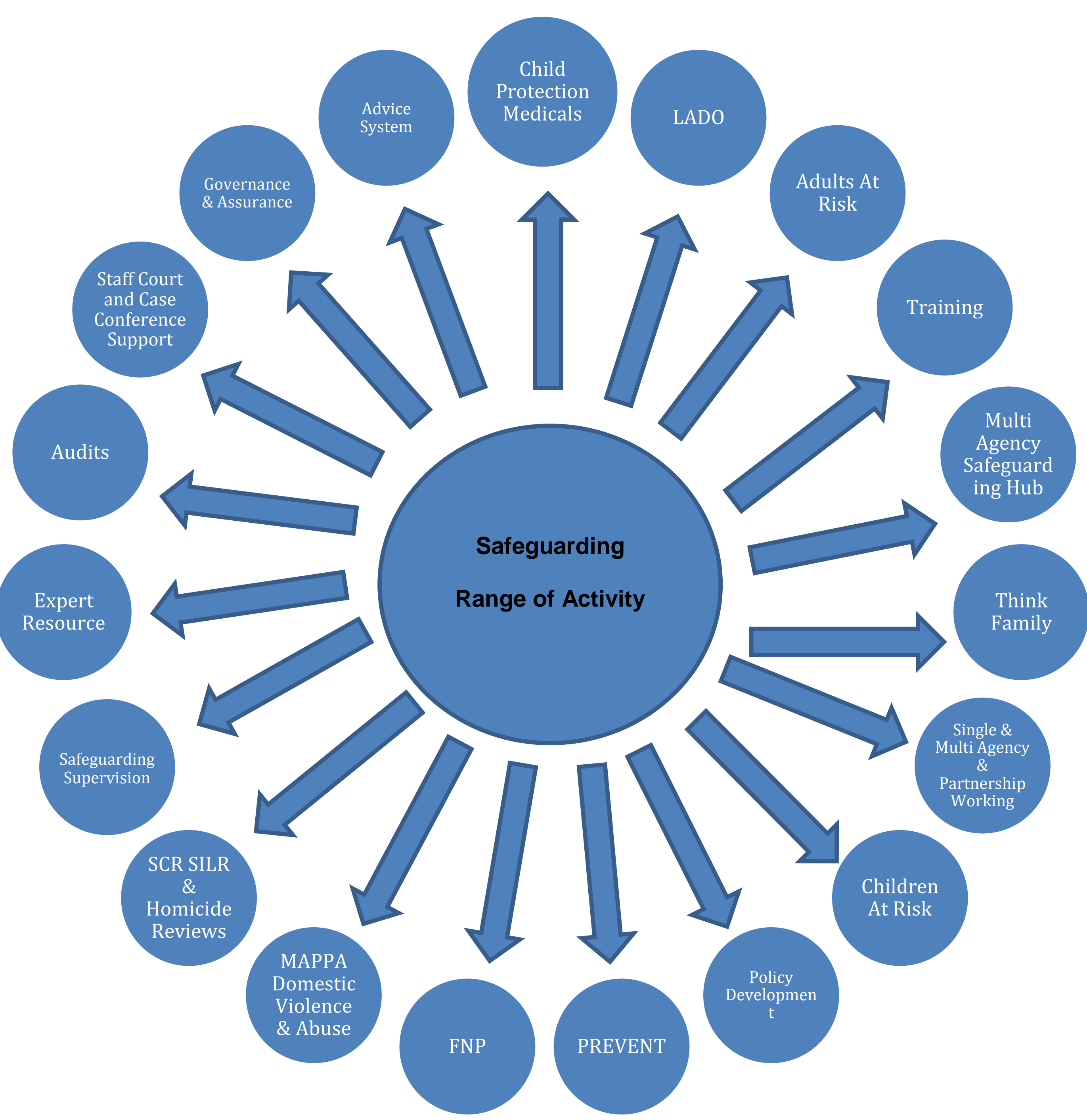
The strengthening of the Prevent agenda and the inclusion of the Prevent duty for the NHS sets the wider context of safeguarding in the local community.

C. ADULT LEGISLATION

- The Care Act (2014) outlines the statutory requirements and responsibilities which places Safeguarding Adults with equity to the long standing responsibilities around Children as defined in the 'Children's and Families Act' (2014). It recognises the importance of the individual in making decisions about their life and care, placing a co-ordinating responsibility on the Local Authority to ensure appropriate enquiry and support is offered. The statutory responsibility and approach is monitored via the two Safeguarding Adults Board within Derby City and Derbyshire County, of which we are contributing members.
- The national PREVENT strategy requires us to ensure staff are trained to recognise and respond to possible radicalisation, support a multi-agency approach, and identify Board level accountability for its delivery.
- The Mental Capacity Act (2005) provides the legal frame work for assessing people who may lack capacity to consent and ensuring that their rights to autonomy are protected and where capacity is compromised then care is delivered within the person's best interest and this is clearly documented.
- The Deprivation of Liberty (DoLs) Safeguards are defined to prevent harm from occurring from depriving a person of their liberty. Clear process and responsibilities ensure a person's rights are upheld and best interests served. This includes the use of least restrictive practices, options in providing care and best practice around such approaches is now supported by national guidance.
- The role of carers is acknowledged in the Care Act (2014). Their potential vulnerability and their need for involvement should be central to the development of approaches and care services.
- Positive and Proactive Care lays down a challenge to work ambitiously at reducing restrictive interventions and blanket rules in the care we provide.

- Local Safeguarding Boards offer a 'Dignity Challenge' – which acknowledges many existing approaches such as single sex sleeping accommodation, chaperoning and working with REGARDS.
- The Duty of Candour (2015) requires us to inform people when harm may have occurred in our care, and this may extend to safeguarding.

D. WHEEL OF ACTIVITY: SAFEGUARDING



KEY: SILR Serious Incident Learning Review MAPPA Multi-Agency Public Protection Arrangements FNP Family Nurse Partnership SCR Serious Case Review
LADO Local Authority Designated Officer

E.1 SAFEGUARDING UNIT REPORTING STRUCTURE

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

E.2 SAFEGUARDING UNIT STRUCTURE

A successful workforce capacity review was submitted and as a result the Head of Safeguarding Children was able to appoint a full time permanent Safeguarding Children Nurse Advisor to the safeguarding team. Due to the extensive work involved with the Aston Hall response, one of the Named Nurses for Safeguarding Children was seconded over to the Aston Hall Team for a 12 month secondment. This was due to the Named Nurse having the skills and competencies required to fill the post. The secondment will continue until October 2017. In response to this, a 12 month secondment was offered out to backfill this role and a Safeguarding Children Nurse Adviser will continue to backfill throughout this period. The full time Safeguarding Children Nurse advisor role complements the existing team bringing valuable skills, competencies and experience in CAMHS. This role has been invaluable and relationships and support for these teams have improved greatly .The Safeguarding Children Nurse Advisor has also successfully engaged with the Adult and Substance Misuse services to provide expert Safeguarding Children advise, support and supervision by attending multi-disciplinary meetings enabling a Safeguarding and a Think Family approach. The Safeguarding Children team continues to provide a solid service throughout the organisation and the team objective is to increase its presence through this in-reach model.

E.3 CURRENT COMPOSITION OF SERVICE – SAFEGUARDING UNIT

The DHCFT - NHS Trust Safeguarding Children Service comprises of:

- Assistant Director for Safeguarding Children – 1 WTE
- Assistant Director for Safeguarding Adults – 1 WTE
- Named Doctor Safeguarding Children – 12 hours per week
- Named Nurse Safeguarding Children – 1 WTE
- Named Nurse Safeguarding Children– 1 WTE
- Named Nurse Safeguarding Children – 1 WTE
- Safeguarding Children Nurse Advisor – 1 WTE

The Nursing Team is supported by an admin team which consists of:

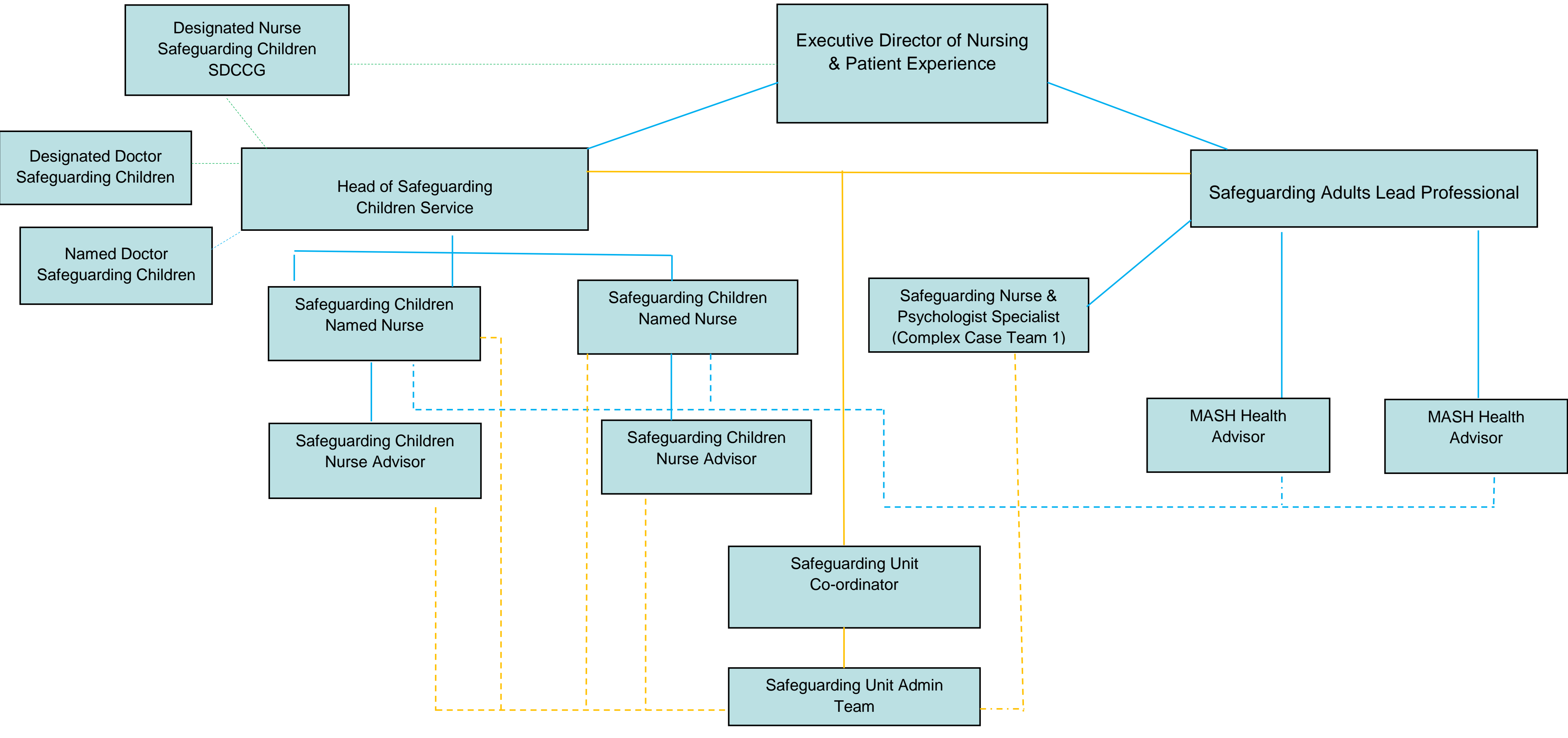
- Safeguarding Unit Co-ordinator - 1 WTE
- Child Protection Medical Co-ordinator – 0.8 WTE
- CDOP Co-ordinator – 0.6 WTE
- Safeguarding Administrator – 1.0 WTE
- Safeguarding Administrator – 0.48 WTE

The DHCFT - NHS Trust Safeguarding Adults service comprises of:

- Assistant Director for Safeguarding Adult
- Complex Case Team 1 Pscyhologist / Ad Nurse Practitioner
- MASH team → MASH Health Advisor x 1.96 WTE

An options paper for extra resource will be completed and submitted for consideration for extra resource within the adult team.

E.4 SAFEGUARDING UNIT STRUCTURE 2016-2017 - DIAGRAM



F. SAFEGUARDING CHILDREN AND YOUNG PEOPLE: ROLES AND COMPETENCIES FOR HEALTHCARE STAFF 2014

All health staff must have the competences to recognise child maltreatment and to take effective action as appropriate for their role. They must also clearly understand their responsibilities and should be fully supported by the organisation to fulfil their duties. Each individual member of staff within the organisation has been identified as to what level of Safeguarding Children training they need to undertake and their individual training passports have been amended in line with the Safeguarding Children and Young People: Roles and competencies for Health Care staff.

Training passports are closely monitored and activity reported into both Adult and Children operational meetings and the Safeguarding Adults at Risk and Quality Committees. All staff continue to have access internal and external Safeguarding Children Training in line with the training framework which continues to focus upon maximising flexible learning opportunities to acquire and maintain knowledge and skills, drawing upon lessons from research, case studies and serious case reviews.

We continue to work to the National Competence Framework for Safeguarding Adults developed by Bournemouth University and Learn to Care whilst we await finalisation of the Adult Safeguarding Levels and Competencies for Healthcare Professionals.

G.1 TRAINING - ADULTS AND CHILDREN

Healthcare workers can be in an important position in helping to recognise child maltreatment. Therefore they need to be alert to signs and symptoms of maltreatment or neglect. They have a vital role in ensuring effective recording, communication and sharing of information to help improve identification and ensure appropriate support for children and young people in need or at risk of harm. Healthcare organisations need to ensure that all staff that might be in contact with children or their carers have a clear awareness and understanding of safeguarding issues.

G.2 DHCFT TRAINING FRAMEWORK

Topic	Courses	Duration / method	Frequency	Target Group
Safeguarding Children **	An Introduction to Safeguarding Children Level 1	45 mins Taught programme OR E-learning programme	3 yearly non clinical staff This will be moving to an annual requirement from 2018 Once for clinical staff as part of incremental training	All staff at induction Non clinical staff including admin staff in adult services, pharmacy dispensary staff, finance, IT Clinical staff and non-clinical staff requiring higher level of training once only before completing level 2 training

	Safeguarding Children: Level 2 Recognising and Responding to Abuse / Everybody's Business	Half a day taught internal (DHCFT) programme	3 yearly depending on staff role	3 yearly requirement: • Admin staff (non -clinical) in : Universal children's services, CAMHS, Perinatal, Safeguarding Team • Support clinical staff in adult mental health teams, learning disability teams: community and Inpatient i.e. healthcare workers, OT assistants • Junior Doctors as part of rotation placement • Pharmacy ward based staff
	Safeguarding Children: Level 2 Recognising and Responding to Abuse / Everybody's Business	Half a day taught internal (DHCFT) programme	Once as part of an incremental training programme (Clinical staff in children, CAMHS and perinatal services, registered staff in adult clinical teams)	**Once as part of an incremental training programme for clinical staff needing to complete level 3 or 4** Need to have completed level 1 training prior to attendance of level To be completed in the first 3 months of employment All clinical staff (including clinical support staff) in: children services, CAMHS, perinatal services, Paediatricians, registered staff in: adult clinical teams, Learning Disability teams
	Safeguarding Children Level 3 Training pathway identifies relevant courses for completion	Level 3 course External training via safeguarding boards DSCB City and Count / conferences / seminars as per the identified training pathway. OR Internal training needs led	Annual	Need to have completed level 1 and 2 prior to attending level 3 training All clinical staff - qualified and unqualified in: • CAMHS • Children's Universal Services- health Visitors, School Nurses, Nursery Nurses, Children's Specialist Services • Perinatal Services • Safeguarding Team Clinicians • Paediatricians

	Safeguarding Children Level 3 Training pathway identifies relevant courses for completion	Level 3 course Internal training needs led OR External training via safeguarding boards DSCB City and Count / conferences / seminars as per the identified training pathway	3 yearly	Need to have completed level 1 and 2 prior to completing level 3 training Clinical registered staff in adult Mental Health teams, Learning Disability teams, Community and Inpatient. IAPT / CBT / Liaison / Therapy Teams / Psychology / Psychological wellbeing
	Safeguarding children Level 4	External training level 4 via safeguarding boards DSCB City and County. Conferences, seminars, workshops	Annual Named Safeguarding Lead to validate level of training at level 4 and maintain evidence for audit trail	Role specific for those with management or supervisory responsibility for Safeguarding Children, i.e. named Nurses and Safeguarding Children trainers Need to have completed level 1, 2 and 3 prior to level 4 training Annual level 3 training requirement in addition External Training

G.3 DHCFT SAFEGUARDING CHILDREN TRAINING PROVISION

During 2016-2017 a fixed term Safeguarding Children Trainer continued to be employed past the fixed term contract, for two days until the end of December 2016 and then one day until March 2017. Additional training has been augmented by the safeguarding children's team for level 2 training due to the lack of capacity of the trainer's time to deliver sufficient training.

Level 1 safeguarding training is required for all staff, clinical and non-clinical. For clinical staff this is a once only requirement.

- Safeguarding children's **level 1** training is delivered to <u>all</u> staff on the corporate induction by the Safeguarding Children team.
- Safeguarding Children's **level 1** is undertaken via e-learning for non-Clinical staff.
- Safeguarding Children's **level 1** training is delivered to Facilities and Estates staff every three years as a taught session due to the limitations in accessing e-learning. This did not occur during 2016-2017.

Level 2 - There are various requirements for this. Unregistered support staff in Adult Services and Admin staff in Children and CAMHS areas are required to do this every three years. For all other Clinical staff this is a once only requirement as part of a progression to level 3 and helps to provide the underpinning knowledge ready for level 3.

- Level 2 training is provided on the induction block every two months for new starters

- Additional sessions were available

Level 3 Safeguarding training was developed internally for staff requiring to annual training at this level (i.e. universal Children Services, CAMHS) due to the limitations of accessing external training with the Safeguarding Board in a timely manner. This was identified in a CQC action plan. This was delivered from Autumn 2016 for the remainder of the year. This significantly helped in increasing compliance to its highest level of over 85% in the late autumn 2016.

Think Family training at level 2 and level 3 was commissioned in January 2015 and is a requirement for all clinical staff and was recorded as a different training competency (but still updated staff needing to undertake either level 2 or level 3 training). This was designed and delivered by the Safeguarding Children Trainer.

Safeguarding Children Board provides a range of multi-agency courses which DHCFT staff access. This is particularly promoted for staff working in Children services. A pathway has been developed in conjunction with the Board to identify relevant training for staff roles and avoid courses that may not be applicable.

Level 4 training is for Safeguarding Leads to undertake via the Safeguarding Board or other external resources such as conferences in addition to their level 3 training.

DHCFT Training Position as at 31 March 2017:

Training Name	Target Group	Compliant	Non Compliant	Compliance %
Safeguarding Children Level 1 3 yearly	544	500	44	91.91%
Safeguarding Children Level 1 once only	1809	1751	58	96.79%
Safeguarding - Children Level 2 3 yearly	400	356	44	89.00%
Safeguarding - Children Level 2 once only	1527	1453	74	95.15%
Safeguarding - Children Level 3 3 yearly	1316	1037	279	78.80%
Safeguarding - Children Level 3 annual	343	290	53	84.55%
Safeguarding - Children Level 4 annual	11	6	5	54.55%
Safeguarding - Think Family once only	1742	1409	333	80.88%

All training compliance target is 85%

There were some adjustments made in the year to training passports as advised by the Head of Safeguarding in line with the intercollegiate document:

- Admin staff in Children's areas were increased from level 1 to level 2
- Registered staff in Adult services were increased from level 2 to level 3. However, in practice, any staff undertaking 'Think Family' training were recorded as also completing level 3 training

The Think Family training continues to increase to support improvement.

Level 4 training continues to remain low. A mitigation plan is underway to improve performance.

Level 3 annual training started to decrease by the end of the financial year due to the reductions in training places available; this was because the Trainer was working one day a week from January to March 2017.

Number of Courses Delivered 2016-2017

Course	Information	Number of courses
Level 1 Safeguarding Children	Trust induction	11
Level 2 Safeguarding Children	3 hour	20 6 (new starters)
Level 3 Safeguarding Children	1 day	8 1 (Sexual Trauma)
Think Family Safeguarding L3	1 day	49

Challenges

The short term contract of a part time Trainer (reducing hours in 2016-2017 from two days per week to one day due to budgets) reduced the number of available internal courses provided and development for the Trainer. The contract was extended three times. The Training Manager had identified and raised concerns about a lack of a medium term plan for training resources. This was documented in reports to the Safeguarding Committee and the Safeguarding Operational meeting.

The Safeguarding Children team had to pick up level 2 training to augment the training programme with limited resources or development in training delivery. This has a plan to mitigate the risks in 2017 led by Education.

E-learning issues were a factor in autumn 2016 / the early part of 2017. These are now resolved. However, e-learning generally has been raised as a potential barrier for compliance, i.e. complexity of undertaking e-learning, limited time in areas, work areas not being conducive to e-learning, staff do not always enjoy e-learning, time consumed addressing e-learning problems.

Staff have not attended training due to the clinical pressures. DNA (did not attend) rates can be as high as 40%.

On-Going Actions over the next months

- Safeguarding Children level 1 training is included at the corporate induction.
- Safeguarding Children level 2 training is part of the clinical staff induction block.
- Raising the concerns and risks of limited or no Safeguarding Children Trainer for the organisation.
- On-going work with the Safeguarding Board for training to promote attendance.
- On-going attendance and work with relevant meetings to ensure best outcomes and effective delivery.

H. CURRENT POSITION AGAINST 'DHCFT SAFEGUARDING CHILDREN AND ADULT STRATEGIC PLANS'

Our overall aim through the implementation of safeguarding strategies is to continue to provide outstanding safeguarding services in Derby and Derbyshire for adults at risk, children, young people and their families. To safeguard, protect and promote the welfare of adults at risk, children and young people whilst supporting families to flourish and to achieve optimum wellbeing, health and development with the best possible outcomes.

This Safeguarding Children Strategy is an enacting and empowering strategy which describes the priorities for continual improvement of the key priority areas, performance management and quality assurance within our Trust to achieve the strategic impact priorities that have been set by ourselves within the work plan, alongside the Derby City and Derbyshire Safeguarding Boards.

Within Safeguarding Children our aim has been to continue to achieve this through the accomplishment of the following key goals:

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

Our Vision Continues to Remains the Same

"To work together with adults at risk, children, young people and their families in order to keep them safe, achieve their full potential and continuously improve their outcomes."

We will respect and encourage the participation of adults at risk in service development and delivery, continue to value and respect the staff working with families and to learn from our mistakes when things go wrong. 'Think Family' – Remains the 'golden thread'

throughout the Trust's work and recognised as integral to the Trust's strategy and not merely an element of safeguarding. The Trust's aim has been to promote a culture of respectful challenge, curiosity and transparency and ensures that our workforce is highly trained, competent, motivated, effectively supported and supervised to safeguard and promote resilience.

Five key themes assist in making this strategy achievable. These remain:

- Culture
- Workforce
- Leadership
- Quality of Practice
- Performance management and quality assurance

Culture
There has been a definite change in the culture of the organisation which has been critical to achieve our aims. It is evident that there is now a clear understanding within the organisation that safeguarding is everyone's responsibility and that this function is not something separate from their everyday practice. Key to this is the 'Think Family Principles'. A closer stronger working relationship has been achieved internally across Adult and Children's Services and externally with partner agencies with openness to sharing information, joint assessments and care plans to achieve better outcomes for adults at risk, children and families. Effective implementation of early intervention and prevention strategies and joint identification of risk through sharing of information, assessment person centred care planning and listening to the voice have continue to be high on the safeguarding agenda and change has been tangible and can be highlighted through case example and audit outcomes and staff feedback. Systems and process are in place to ensure that supervision, advice and training supports the cultural change / transformational change process needed with frontline staff and services. We have had some excellent case examples which have been showcased on CONNECT (the Trust intranet) to motivate staff and further raise awareness.

Inclusivity of our Culture
We value very highly the good relationships that have been forged over many years with carers who support the work of our Trust. We have continued to pursue the commitments made in our 'Carers Strategy and Policy.' We try to ensure that these are 'live' documents developed and sustained through our work with the Carers forums in the North and South of the county, the Trust Service User and Carers Inclusion group and the Carers 4Es sub group. The latter has continued to meet whilst the 4Es parent group has been under review. The last six months of the year 2016/2017 was a challenging one in the arena of service user and carer support commissioning as the local authorities handed over functions that had previously been held centrally and awarded new contracts to local organisations for the first time, i.e. Derbyshire Carers Association and Healthwatch. Whilst some landscape changes were heavily influenced by the national driver of Sustainability and Transformation Planning (STP), the sense for local carers was one of a great deal of change in a very short space of time which has been reported by some to have had a de-stabilising effect. Going forward, we will seek to engage more with carers from less well represented services, e.g. substance misuse. We will continue to work with our carers against a backdrop of continuous change to establish what the new arrangements will mean for future involvement in the business of the Trust as they, alongside people who

use our services, are our most valued barometer of how we are doing and where we need to invest more effort and resources.

In the year ahead we aim to develop our work on Triangle of Care by working towards achievement of a second star in the Carer's Trust accreditation scheme. We currently have one star for the work that has been achieved so far including the self-assessments and action plans that have been developed in our inpatient services. The next phase focuses on our community teams and there is a significant scheme of work in place overseen by the newly established Triangle of Care steering group that the Carer's 4Es group provides oversight of.

Workforce
We continue to ensure our workforce is competent and that staff understand safeguarding pathways, policies and procedures and their role in implementing them, to develop our workforce by ensuring the delivery and attendance of both internal and multi-agency wide training and development programmes and from the findings and actions of local and National Serious Case Reviews, Homicide Reviews, Learning Reviews and internal Serious Untoward Incidents in order to improve practice and achieve best outcomes for children and their families. We have diligence in recruiting safe staff who do not pose a risk to children and adults at risk and effective, prompt management to ensure minimisation of risk if a member of the workforce or volunteer at any level of the organisation appears to pose a risk to others. Throughout 2016/2017, we have had two internal discussions around staff who pose a risk that went to LADO processes. The capacity of the workforce continues to be monitored and analysis of risk/impact in line with issues of resources is undertaken to ensure safe and effective practice. There have been a number of risks relating to the capacity of staff, these remain on the organisational risk register and mitigation plans are in place internally and capacity reports submitted to the Safeguarding Boards as these potentially impact on services and practice. The Safeguarding teams have worked well together to provide support and resilience for staff throughout the organisation.

Leadership
The leadership teams across the organisation have:

- Been visible and available to support and advise staff and to facilitate a culture of mentoring and support to be adopted and embedded in delivering better safeguarding outcomes for families, the teams are engaging staff via team meetings, MDMs, supervision and training.
- Ensured effective working arrangements between the Safeguarding Boards, the Trust and key partners as identified within the safeguarding work plans by ensuring these systems and structures are in place.
- Ensured a clear and effective governance structure and quality assurance framework that confirms evidence of leadership of Safeguarding via the Safeguarding Operational Groups and the Safeguarding Adults at Risk and Children Committee.
- Developed and embedded a clear system for communicating with Practitioners at all levels within the Trust and with partners that is open, honest and reliable – This should empower staff and ensures a no blame culture.
- Developed with teams an effective framework to ensure the voices and views of the child, young people and their families are listened to and acted on. Similarly, leaders are required to listen to and value the workforce.

- Engaged with any transformational projects to ensure that safeguarding is a fundamental part of delivery and planning of services.
- Discharged responsibilities within Section 11 of the Children Act, SAAF, CQC and Ofsted and ensure effective scrutiny and respectful challenge of safeguarding practice within the organisation.
- Interpret and ensure operationalization of Local and National Policy Guidance and Legislation.
- Ensured and provided evidence of their own professional development in order to be compliant with the 'Roles & Competences for Healthcare Staff, Intercollegiate Document, 2014' whilst identifying and developing talent in order to identify future Safeguarding professionals and leaders.

Professional development within teams has been somewhat stifled by the resource and capacity issues over the last year which is affecting the development of our next leaders in safeguarding. Development plans, additional training and shadowing and secondments need to be encouraged to develop staff who are interested in safeguarding roles to ensure there is no 'knowledge gap' in key strategic roles for the future. There continues to be concerns from Line Managers in two series, to not release staff to support due to sustained clinical pressures.

Quality of Practice, Performance Management and Quality Assurance
Over the year, the Safeguarding Team has ensured consistent interpretation and implementation of lessons learnt, recommendations, guidance, policies and procedures across the Trust, to improve the quality of safeguarding practice by all staff. Audits provide evidence of and evaluate continued improvement of clinical practice; a comprehensive yearly audit plan is on-going. The learning and recommendations from audits will inform the training needs analysis and deliver of the Trust training programme. To improve the quality of practice the Trust has also captured user feedback and involvement in order to capture and embed the voice of children, young people and their families and carers. The evidence of what is captured and collated will be used and embedded into services. NICE guidance informs practice in order to ensure quality and safe practice – The guidance is adhered to at all times.

Performance management relates to the reporting systems and data by which the Trust can ensure the quality and effectiveness of safeguarding within the organisation. Quality assurance has been consistently provided to the Trust, the Safeguarding Boards, Commissioners and regulatory bodies to ensure that our services are delivered to the highest possible standard for children, young people and their families. Data is collated and evidence provided to assure the above of the quality of our services. The collation of DHCFT 'adults who are parents data' for DSCBs has remained a challenge and no data has been reported in this period, however, the team have been working closely with IM&T and a solution is being developed. Assurance internally within the Trust has been provided through the Safeguarding Operational Groups via evidence on the delivery of the various action plans from Serious Case Reviews, CQC, section 11, Think Family and the Safeguarding Children Work Plan. Analysis of the themes and issues arising from the advice system and safeguarding referrals will serve to inform training, policy, guidance and professional development. Decision making processes, thresholds and the need for escalation of cases has been monitored via the above channels to ensure that the organisation is part of the multi-agency quality framework and feeds into the 'Health Quality Assurance Group' and the Safeguarding Boards' quality assurance processes,

providing assurance that performance indicator in relation to Safeguarding Children have been met.

The 'Children's Clinical Reference Group' meetings have taken place monthly. After a slow start of re-launching the group there has been representation of a wide range of professionals from children's and CAMHS services. The purpose of the meeting is to:

- Systematically review and improve services and thus the experiences of people who use them and their carers by improving the effectiveness, quality and safety of the care they receive.
- Triangulate and co-ordinate the development of care plans across all Children's and Young Peoples Services (internally and externally).
- Translate, implement and disseminate the Trust's core objectives and vision.
- Translate, implement and disseminate local and national policy, guidelines and strategies.
- Embed evidence-based practice.
- Monitor, review and evaluate clinical priorities and local service provision.
- Share examples of good practice and innovation across the division and the Trust and to promote a culture of mutual learning.
- Provide guidance and make recommendations to the division on matters of clinical practice and professional issues.
- Embed the quality governance framework in our services.
- Promote a multi-professional and multi-agency approach to practice.
- Ratify clinical policies for Children and Young People's Services.
- Ensure all Children and Young People's Services are compliant with CQC Regulations.
- Support Think Family, Safeguarding and You're Welcome principles

The group have successfully reviewed and updated NICE, procedures, policies, processes, complex case work and various projects.

The Safeguarding Adults work plan focusses on the following key principles:

We make it personal and professional:

Principle 1 – Empowerment – I am asked what I want from the safeguarding process and this directly informs what happens to me and my family.

Principle 2 – Protection – I get help to ensure that I am safe and, should this be compromised, I get support to report abuse and neglect. Those who support me have skills, know-how and are confident with safeguarding.

Principle 3 – Prevention – I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help. Those who support me know about safeguarding and help me to be safe.

Principle 4 – Proportionality – I am sure that those who support me will work in my interests and will only get as involved as much as is needed so I can keep my independence.

Principle 5 – Partnerships – I know that those who support me will treat information about me with care and will work together to get good results for me.

Principle 6 – Accountability – I understand what everyone who supports me does and they are open and honest with me and they know their roles.

We are meeting our statutory obligations and legal duties with regard to:

Mental Health Act (1983), Mental Capacity Act (2005), The Care Act (2014), Children and Families Act (2014), Human Rights Act (1998), Domestic Violence, Crime and Victims Act (2004), Modern Slavery Act (2015), Civil Contingencies Act (2004) and our internal systems, structures and processes are joined up and effective.

We meet the required standards for our regulators and our professional regulatory bodies' codes of practice, i.e. Safe, Caring, Effective, Responsive and Well-led, and safeguarding is one of the gold threads that runs throughout. We apply national guidelines and evidence based best practice e.g. NICE, DoH, National Statistics.

We contribute as equal partners in multi-agency forums**,** e.g. MAPPA, MARAC, Channel, Child and Adult Safeguarding Boards and sub groups and take part in peer assessment, benchmarking and self-assessment and assurance.

We invest in our staff across multiple agencies and services to ensure high levels of competence and confidence and achieve consistently good practice that is constantly updated and refreshed within a culture of learning from both successful and adverse situations.

I.1. SECTION 11 AUDIT

'The Markers of Good Practice' that has been undertaken over previous years has shown DHCFT's continued commitment to safeguarding children and adults and how the organisation has provided assurance to meet the seven areas of compliance successfully. Our assurance document 2015/2016 and previous years, has been presented to the 'Adults at Risk and Children's Safeguarding Committee' and the Trust Board and the results of the frontline audit the 'Traffic Light Summary' completed by the CCG. There were no challenges as a result of the last Quality Visit; an action plan has been developed with all recommendations complete. We have previously also submitted the strategic and organisational self-assessment section 11 audit tool to the safeguarding Children Boards alongside this.

This year the Health Assessment Tool 'Markers of Good Practice' has been withdrawn and a comprehensive Section 11 audit, along with a Quality Visit has been completed.

Members of both City and County Boards and Designated Professionals were part of the assessment as auditors.

Why do we carry out Section 11 Audits?

Local Safeguarding Children Boards (LSCB's) have a Statutory Duty to assess whether agencies in their area are fulfilling their statutory obligation to safeguard and promote the welfare of children as described in 'Section 11 of the Children Act 2004.'

The Section 11 Audit undertaken allows agencies to submit all their evidence, create action plans and to challenge findings. The Section 11 Audit ensures DHCFT also make arrangements to ensure that their functions are discharged having regard for the need to safeguard and promote the welfare of children and that the services they contract out (commission) to others are provided having regard to that need.

What is the Section 11 Audit?
Derby City and County Safeguarding Children Boards assess the effectiveness of local safeguarding arrangements against the following key features:

- Senior management commitment to the importance of safeguarding and promoting children's welfare.
- A clear statement of the agency's responsibilities towards children is available for all Staff.
- A clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children.
- Service development takes account of the need to safeguard and promote welfare and is informed, where appropriate, by the views of children and families.
- Staff training on safeguarding and promoting the welfare of children for all staff working with or, depending on the agency's primary functions, in contact with children and families.
- Safer recruitment.
- Effective inter-agency working to safeguard and promote the welfare of children.
- Information sharing.

I.2 SECTION 11 - POSITION STATEMENT 2016/17

RAG Rating	
(Red)	Recommendation Not Started
(Amber)	Recommendation Started
(Green)	Recommendation In Process

Standards Required		Rating
1	There is a clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children.	(Green)
1.2	There is a senior Board Level Lead to take leadership responsibility for the organisation's safeguarding arrangements.	(Green)
1.3	There is a designated professional lead (**or, for health provider organisations, named professionals)** for safeguarding. Their role is to support other professionals in their agencies to recognise the needs of children, including rescue from possible abuse or neglect. **(Please note the term designated Professional Lead includes named professionals in health. There may a number designated professional leads in an organisation).**	(Green)
1.4	Designated professional roles should always be explicitly defined in job descriptions. Professionals should be given sufficient time, funding, supervision and support to fulfil their child welfare and	(Green)

	Standards Required	Rating
	safeguarding responsibilities effectively **(Please note the term designated Professional Lead includes named professionals in health).**	
2	There is a culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development and improvement of services.	
2.1	There are clear whistleblowing procedures, which reflect the principles in Sir Robert Francis's Freedom to Speak Up review and are suitably referenced in staff training and codes of conduct, and a culture that enables issues about safeguarding and promoting the welfare of children to be addressed.	
3	The organisation has arrangements which set out clearly the processes for sharing information, with other professionals and with the Local Safeguarding Children Board (LSCB).	
4	The organisation has safe recruitment practices for individuals whom the organisation will permit to work regularly with children, including policies on when to obtain a criminal record check (disclosure and baring check)	
4.1	The organisation has clear policies in line with those from the LSCB for dealing with allegations against people who work with children. Such policies should make a clear distinction between an allegation, a concern about the quality of care or practice or a complaint. An allegation may relate to a person who works with children who has: o behaved in a way that has harmed a child, or may have harmed a child; o possibly committed a criminal offence against or related to a child; or behaved towards a child or children in a way that indicates they may pose a risk of harm to children.	
5	The organisation has appropriate supervision and support for staff, including undertaking safeguarding training: o Employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role All professionals should have regular reviews/ appraisals of their own practice to ensure they improve over time.	

I.3 SECTION 11 2016/17 – FORMAL FEEDBACK FROM DSCB

The Chair of Derby City Safeguarding Board, Mark Sobey, responding formally to the Section 11 Audit visit and commended the Safeguarding Children Unit for their full engagement with the process. Within the response were the following actions for consideration:

- The DSCB would welcome the submission of the Children Services Audit Plan to the Quality Assurance Group to assist with the triangulation of activity between the DSCB and work being carried out across the Trust.

- DHCFT have identified that they are working with an increasing number of adults with very complex needs which include 'hoarding'. DSCB would welcome that any future guidance document or policy development about 'hoarding' which takes into account the impact on children and young people is shared with the Policies and Procedures subgroup in order to improve multi-agency practice.

- DHCFT to continue to obtain 'the voice of the child' from the wide range of services that DHCFT provide to Children and Young People.

- The Safeguarding Board Managers both agreed to discuss with the Police concerns raised; on occasions the Police are reluctant to share information in regard to Section 3 assessments and look for ways to improve information sharing.

- The Safeguarding Board Managers agreed to endeavor to ascertain the number of allegations made against staff reported to Social Care per organisation rather than categorising all referrals made under 'Health'. This is so DHCFT can cross reference that they are fully aware of the cases being referred in regard to their members of staff.

J. SAFEGUARDING ADULTS ASSURANCE FRAMEWORK (SAAF)

A SAAF Visit took place on 17 August 2016 in order to audit the effectiveness and position of DHCFT around safeguarding adult processes.

Below outlines the formal feedback received from the Commissioners auditing the service against the Safeguarding Adult Assurance Framework.

	Derbyshire Healthcare NHS Foundation Trust	
	Self-Assessment Rating	Clinical Commissioner's Rating
Partnership and Collaborative Working		
Safeguarding Adults at Risk		
Training and Staff Development		
Patient Safety Initiatives		
Implementation of MCA		
Making Safeguarding Personal		
Associated Work Streams		

"The Trust provided an informative overview of how it endeavours to balance the implementation of safeguarding against other competing demands.

The DHCFT Adult Safeguarding Lead completed and submitted a well written and comprehensive SAAF return and has also provided a wealth of supporting evidence, including work undertaken in response to historic abuse disclosures at Aston Hall, that has had a significant impact and that has delayed the SAAF submission.

It was explained the operational, referral procedure, and how this ensures that safeguarding activity is sited. This also allows an opportunity to have an involvement and overview of more complex cases. The referral process loop is closed by giving staff feedback on referrals when outcomes are forthcoming from the local authorities.

The Adult Safeguarding Annual Report described how the Trust's work plan will provide structure to the demands of adult safeguarding work, incorporating the use of audit. This should therefore provide ongoing assurance to your Board and Safeguarding Committee that the Trust is meeting its statutory obligations to prevent abuse and neglect and to report where there are found to be concerns.

The Safeguarding Adults policy, submitted as part of this process, was noted to be the Derbyshire & Derby City Joint Safeguarding Adult Board Policy; as such this reflected statutory requirements detailed within Section 8 of the Care Act 2014 including the 'making safeguarding personal' mandates. All other relevant policies were also noted to be updated in accordance with local and national drivers.

It was clear from our visit that the Trust has recently spent time and effort re-evaluating how effective you are in being able to assure your Board that safeguarding is embedded across the organisation. This was reflected in the number of sections within your latest return SAAF for 2015/2016 that have been reduced from 'effective' to 'working towards' compared with the previous return by the Trust in 2014/2015. It was also noted the candour and open, honest approach in outlining the challenges that the Trust faces and the Commissioner was happy to consider the request for additional resource from the CCG's to meet the growing Safeguarding and Public Safety agenda.

It was noted with interest the content of your training programme and high levels of activity demonstrating that the content of the programme had been reviewed and revised to ensure Care Act (2014) compliance.

The Trust described to the work being undertaken in delivering the MCA and DoLS staff training which is currently completed via an e-learning package and although this is mandatory it has been identified that this method of training is not currently meeting the learning needs of the staff.

It was acknowledged the commitment and contribution of DHCFT to the LSABs inter-agency training Learning and Development sub group by supporting and developing the Section 42 multi-agency enquiries training.

As members of your internal Safeguarding Committee the CCG are assured of robust governance arrangements across your Trust. This was supplemented by strong levels of engagement from the senior team.

The hard work of the organisation was acknowledged, particularly with PREVENT and at MAPPA 3 and were pleased to hear that a Safeguarding Adult Doctor has been recruited.

A discussion on the impact upon resource of Prevent, MAPPA, and Channel on the Trust was held. The Trust submits quarterly activity returns as required by NHS England and the Home Office, and you now have five WRAP accredited Trainers.

It was acknowledged at the visit that the Trust has some way to go in embedding the MCA across clinical areas. There has been an on-going piece of work to educate staff in the correlation and synergy between the Mental Capacity Act and the Mental Health Act. As part of the Trust strategy a decision has been made to move from e-learning to face to face MCA training which should help to improve staff awareness and knowledge. We will be interested in the outcome of future audits and evaluations in monitoring the impact of this work. It was noted the intention to monitor the DoLS authorisation requests more closely to minimise the likelihood of the Trust being challenged over unauthorised or lapsed DoLS.

The challenges of the making safeguarding personal responsibilities following the introduction of the Care Act (2014) was highlighted and how this has also been included within the safeguarding training staff receive and is also being monitored by reviewing the completion of the safeguarding adult referral forms. We look forward to seeing how the MSP agenda is increasingly evidenced in future SAAF visits.

Noted was the significant contribution the Trust makes to partnership and collaborative working in particular in relation to attendance at Safeguarding Adult Boards, Quality Assurance Committees and Case File Audit meetings. The Adult Safeguarding agenda has expanded since the publishing of No Secrets in 2000. Your Trust works hard to support related patient and public safety work-streams including MARAC, MAPPA and Channel. Without the contribution of the Trust to these meetings they would struggle to be meaningful and effective.

Following the assessment of the evidence and as a result of our visit there are no immediate concerns about how the Trust safeguards those in its care."

K.1 2016 CQC COMPREHENSIVE INSPECTION FINDINGS AND CURRENT POSITION

K.2 2016 SAFEGUARDING CQC ACTIONS

There were 11 actions logged from the June 2016 CQC inspection reports that directly related to Safeguarding

The breakdown of actions per service area was:

Acute Older Adults	1
Children and Young People	2
Forensics	4
Trust Wide	4

Safeguarding Actions Summary

The 11 actions logged from the June 2016 CQC inspection reports covered the following themes:

Training	6
Supervision	3
Loss and theft	1
Referral completion	1

K.3 SAFEGUARDING TRAINING ACTIONS

RAG Rating	
(grey)	Complete
(green)	In Progress

Action	Service Area	Progress/Completion Summary	Status
The registered provider must ensure that clinical staff who have direct contact with children and young people have completed level three safeguarding training as identified through the Safeguarding Children and Young people: roles and competences for health care staff intercollegiate document (March 2014, v3)	Children and YP	Service level action plan undertaken. Action signed off once sustained compliance in place (85% of staff trained). This is monitored through the Safeguarding Committee going forward	**Complete**
Staff have not received the required safeguarding training for their role	Trust Wide	Training statistics analysed and submitted. Trust wide monitoring is now in place	**Complete**
Clinical staff who have direct contact with children have not completed level three safeguarding training	Trust Wide	Level 3 safeguarding training compliance levels were at 46% at the time of inspection. An internal and targeted drive to improve compliance was undertaken. Sustained improvement and full compliance with mandatory requirement (85%) was achieved in January 2017 – This has now been delivered	**Complete**
Staff training figures such as for safeguarding and 'control and restraint' were too low	Forensics	Forensics managers confirmed compliance levels as of June 2016 inspection - Submitted to the CQC on 25.08.16. Re-inspected	**Complete**

Action	Service Area	Progress/Completion Summary	Status
		January 2017. Upgraded and sustained improvement	
Staff compliance with Safeguarding training was 0%	Forensics	The 0% position stated for Safeguarding was incorrect - It was actually 0% for non-compliance. Forensics managers confirmed compliance levels as of June 2016 inspection - Submitted to the CQC on 25.08.16	**Complete**
Staff training figures for key training such as safeguarding, basic life support, intermediate life support, clinical risk and 'control and restraint' was extremely low. No medical staff had attended training in the drug management of violence and aggression	Forensics	Management of violence / PSTS compliance at 91%, ILS and safeguarding improved. No medical staff figures available at present. Safeguarding training is still below target for this service area and medical staff training figures are required The Adult Safeguarding Lead is taking oversight of this action and is liaising with the ward managers to embed the forward plan	**In Progress** **CQC are monitoring**

One of the training related actions was challenged in the factual accuracy checks and this was upheld. Four of the five remaining actions have been completed and signed off.

Safeguarding Adults – Training Compliance

Safeguarding training data is included in previous sections of the report.

The Safeguarding Adults Level 3 training compliance rate does not show improvement since June 2016. However, the parameters have changed to 'Safeguarding Adults: Making Enquiries under s.42 of the Care Act (2014).'

This is a multi-agency co-production. Dates for 2017 have been released. All identified staff have been emailed to promote the uptake. As this is external training, staff need to forward copies of their attendance compliance to the Learning and Development team so that 'training passports' can be updated.

Safeguarding Children – To Sustain Improvement

- Training is currently provided by the Named Nurse for taught courses of Level 1 induction and Level 2 clinical induction

- To ensure the sustainability of Safeguarding Children training, including the induction and maintenance of Level 2, but particularly at Level 3, a Safeguarding Children Trainer appointment is in progress
- The DNA (Did Not Attend) protocol has been developed and DNA data is sent from the Learning and Development team on a monthly basis for General Managers to action

Safeguarding Training Outstanding Action

- Plans to Complete the Outstanding Action
- The General Manager for Campus and the Adult Safeguarding Lead are taking oversight of this action and liaising with the Ward Managers to embed the forward plan
- The Consultant Child and Adolescent Psychiatrist (Dr Jo Kennedy) is working with the Medics on the forward plan
- The action will be complete once sustained improved compliance is seen. The target date for completion is 30 September 2017

K.4 SAFEGUARDING SUPERVISION ACTIONS

Action	Service Area	Progress/Completion Summary	Status
Staff who have contact with children must receive safeguarding supervision	Children and YP	Action plan undertaken and additional training dates for Safeguarding Supervisors established. Evidence of supervision (1-1 and group) provided previously. Now sustained	**Complete**
Staff who have contact with children did not receive safeguarding supervision	Trust Wide	Safeguarding audit report summary uploaded. Supervision sessions are taking place and names of individuals are available from ESR/Team Managers if required by the CQC. Supervision programme is on-going and Childrens Service Managers continue to ensure staff who have contact with children are engaged with safeguarding supervision as BAU. Evidence available	**Complete**
Safeguarding supervision is not always performed in line with the Trust's safeguarding policy	Trust Wide	There are significant levels of improvement in Safeguarding supervision content and uptake. Audit summary report uploaded	**Complete**

Action	Service Area	Progress/Completion Summary	Status
		showing number of staff receiving supervision. Supervision policy and procedures also uploaded which include clear direction on Safeguarding supervision. Reviewed Supervision Policy in place and being used. Improvements in safeguarding supervision are now embedded and are BAU. Substance improvement performance now 90%	

All supervision related actions have been completed and signed-off Safeguarding Adults. Hotspots have been identified and action plans for improved compliance are in place

Safeguarding Children Supervision

	June 16	January 17	July 17
Compliance	37.3%	83.3%	91.3%

Table as at 27.07.17

The Safeguarding Children Unit also provides daily advice sessions. Advice given is a continuance of the professional's supervision. Advice call figures for 01 April 2016 – 31 March 2017 show 379 calls received by the Unit. This is a significant level of activity and evidences that vigorous Safeguarding is occurring in the Trust.

K.5 SAFEGUARDING LOSS & THEFT ACTION

Action	Service Area	Progress/Completion Summary	Status
The Trust had failed to investigate the links between alleged thefts and losses on wards 1 and 2 under its disciplinary procedure. The provider did not ensure that learning from incidents; alerts were captured in a way that allowed for Managers to identify themes and trends in order to keep people who use the service safe. Managers did not ensure that potential themes and hot spots that relate to patient safety were captured on the trust risk register in order for the executive team to be fully aware	Acute - Older Adults	Completion of security action plan and reporting now in place to the H&S Committee, with escalation to Senior Managers and Directors. Disciplinary investigation first draft completed and will be submitted to Tracey Holtom, General Manager next week. Should a pattern of potential schemes or hotspots be identified, these will be escalated through External Section 42 and investigation. No evidence of theft – Closed	Complete

The loss and theft related action has been completed and signed-off. All loss and theft incidents are recorded on Datix (the Trust's electronic incident recording system). Since June 2016 monthly Datix loss and theft review meetings have been established, in which every loss and theft incident is reviewed by:

- Safeguarding Adults Lead
- Named Doctor for Safeguarding Adults
- Safety Management Service Advisor

Further actions are identified in the review meetings and the team liaise with the service areas to ensure that all actions are completed.

K.6 SAFEGUARDING REFERRAL COMPLETION ACTION

Action	Service Area	Progress/Completion Summary	Status
We found an incident recorded on 07 May 2016 where a patient had been injured as a consequence of bank staff not intervening during a violent incident. We could find no record of a Safeguarding referral having been made in relation to the patient who was injured	Forensics	There was a Safeguarding referral that was completed on 10 May 2016. This outlined the assault on 07 May 2016 and a previous incident. This was sent to City Social Care. Safeguarding compliance has been raised with individual Clinicians in supervision	Complete

The action relating to referral completion was challenged in the factual accuracy checks and this was upheld. Monthly reports are received by the Safeguarding Adults Lead. These detail all Datix incidents and indicate where an Adult Safeguarding referral was made. The Safeguarding Adults Lead reviews all incidents to ensure that referrals are made appropriately. The oversight of all actions allows the Lead to establish any trends. Monitoring of MASH (Multi-Agency Safeguarding Hub) activity is undertaken and monthly performance reports are produced. These also feed into the Operational Group and the Safeguarding Committee.

“This coalition Government is determined to tackle child abuse in whatever form it takes, and Multi Agency Safeguarding Hubs have a clear role to play in this.”

K.7 SAFEGUARDING POLICIES & PROCEDURES

Safeguarding Adults
Trust staff are directed to the ‘Safer Derbyshire’ website for all current Safeguarding Adults policies, procedures and professional guidance. For specific areas, the Trust develops its own policies and procedures, for example, PREVENT.

Safeguarding Children
Multi-agency, Derby City and Derbyshire, Safeguarding Children procedures are available on the Trust intranet (Connect) and also on the Safeguarding Children Boards websites.

All policies and procedures go through the DSCB Policy and Procedures sub-group for review and ratification and all policies are also updated by the national system (TRI-X).

K.8 LESSONS LEARNED SINCE JUNE 2016

Safeguarding Adults
There has a significant amount of audit activity over the past year that informed the development of the overarching Mental Capacity Act policy, briefings to staff, podcasts, and the development of staff manuals.

Learning from Safeguarding Adult Reviews and Domestic Homicide Reviews
Action plans demonstrate our achievement of outcomes and are subject to review by the Trust Safeguarding Committee. The Trust is represented at each DSAB SAR meeting where cases are presented and reviewed and the learning brought back to each partner organisation. Key learning is shared through operational and clinical lines of communication by the Trust Safeguarding Adults Operational Group. Significant safeguarding changes to practice or policy are incorporated into training programmes that are delivered by the Trust.

Complex Case Team 1
Development of a model of approach using acquired knowledge and skills has been established. The model includes information gathering and sharing, release of health records, partnership working across agencies and psychological support for non-recent trauma and abuse.

Safeguarding Children - Training and Supervision
The accuracy of recording training attendance and supervision uptake by staff has been improved since June 2016. The creativity of the delivery of training and supervision has been improved. Safeguarding Children Supervisors have been trained up to Level 4 within the cascade model, which leads to improved confidence in staff. Staff are urged to book onto Derby Safeguarding Children Board training at the earliest opportunity as the sessions are in high demand. Frequent exceptions reports are sent to Team Managers, which highlight any gaps in training and supervision.

K.9 IMPROVEMENTS MADE SINCE JUNE 2016

Safeguarding Adults

- Safeguarding performance dashboard
- MASH Health Advisors impact on Safeguarding Adults Strategy meetings
- Safeguarding Adults Accessible Safeguarding Initial Screening Tool
- Monthly reporting for safeguarding related incidents
- PREVENT data collection and Unify2
- Partnership working is constantly developing
- Complex Case Team 1 – Dedicated psychological therapy and complex case management

Safeguarding Children

- Training reports are routinely provided at the Safeguarding Children Operational Group for members to action in service areas
- Internal training is advertised via Connect (the intranet) training directory site with dates and times
- Training compliance is raised at performance meetings and there is evidence of improvement
- Periodically emails are sent to individuals to promote uptake of internal courses where appropriate
- DSCB courses are advertised on the Connect Safeguarding Children page
- An agreement has been made that a taught Safeguarding Level 2 training will be delivered to junior doctors' induction
- The Head of Safeguarding / Safeguarding Team provide relevant material annually to ensure a fresh approach each year for the e-learning programme
- MASH Health Advisors impact on Child Protection Strategy meetings

K.10 AREAS OF CONCERN/CHALLENGE

Safeguarding Adults

- Capacity within the Safeguarding Adults department / sustained increases in Adult referrals
- We achieved 100% attendance of Health (DHCFT) at strategy meetings

Safeguarding Children

- Additional 100 children on a Safeguarding Children's Plan in 2017 than in 2016 and activity

K.11 INNOVATIONS

Safeguarding Adults

- To continue to develop the new partnership with the Ann Craft Trust at the University of Nottingham with signs and symbols for Safeguarding
- To launch the Safeguarding Adults Accessible Screening Tool
- To continue to refine performance reporting through the Safeguarding performance dashboard
- We are developing and embedding Adult Safeguarding Link Workers within each team in the Trust

Safeguarding Children

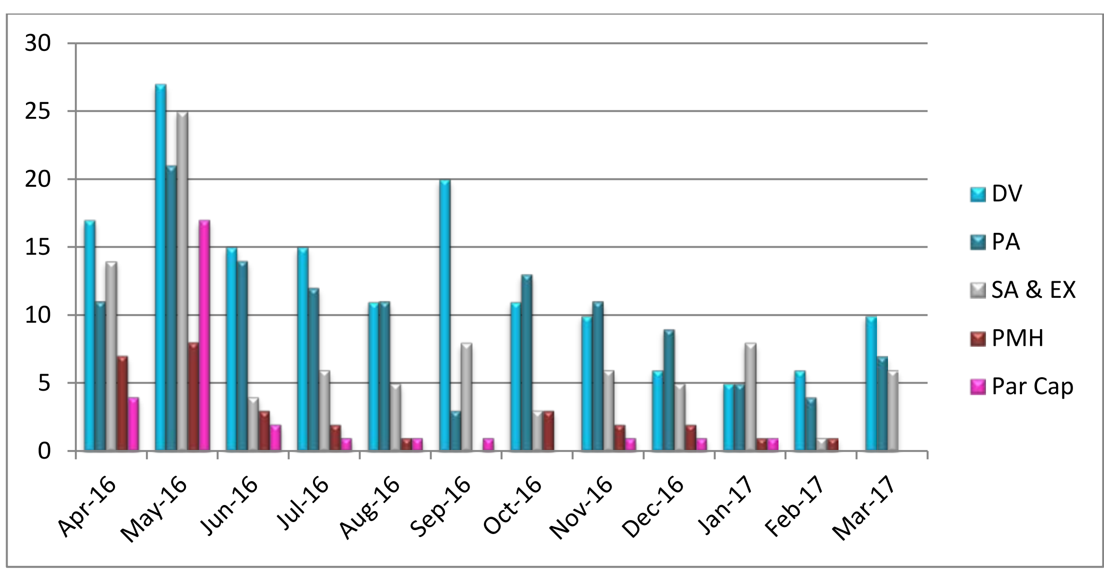
- Safeguarding Children review (Looked After Children) – Good
- Safeguarding Children's Board rated – outstanding by OFSTED / CQC. DHCFT contribution commended

L.1 ADVICE THEMES

As part of our departmental data collection, we have collated information around the kind of advice that is being sought via the Safeguarding Unit – This information gives us strong indicators on future training needs and rising trends and concerns among professionals. Our figures also include S47 discussions with Social Care as within our clinical advice themes. The graph below demonstrates the top five themes that have emerged over the last 12 months:

Key

DV = Domestic Violence; **PA** = Physical Abuse/Injuries; **SA & EX** = Sexual Abuse / Exploitation; **PMH** = Parental Mental Health; **Par Cap** = Parental Skills / Capacity / Basic Care



The top five themes remain unchanged from last year. Over the next 12 months we are expecting to look closely at issues such as Neglect and CSE which are areas that will take on a large significance over the coming months with work being done on serious incidents and complex cases identified over the last year.

In last year's report we confirmed we would be actively monitoring areas of Trust-wide initiatives in FGM, Terrorism/ Radicalisation and Suicide / Self Harm – We have received five calls for advice on FGM and during the period covered by this report and no confirmed referrals have been made by this organisation. We have not received any direct requests for reports around Suicide / Self Harm although this issue remains one of our focussed activities in line with national and local awareness raising and training initiatives. With regards to Terrorism/ Radicalisation advice although this has not generated many calls for advice in the period of this report, we acknowledge that the mandatory E-Learning that has been rolled out this year has meant all staff have benefitted from raised awareness of this issue. However, we are also aware that due to some large scale terrorist attacks outside of this reports' timeframe the Unit has received a massive increase in the support required to the PREVENT and Channel processes – This is covered in more detail in Section M of this report and will feature in subsequent annual reports.

Over 2017-2018, we will be moving the computerised activity of the to a newly developed Safeguarding Unit on TPP – This will allow us to have more defined statistical gathering and we will endeavour to fully use all the data processing functions this system offers in order to increase our understanding of the issues faced by all families in our remit.

L.2 SAFEGUARDING ADULTS ADVICE THEMES

Some data re logs of calls for advice to Safeguarding Lead for Adults:

- The Safeguarding Adults Lead regularly takes calls directly from staff for advice and guidance from across the Trust.
- Calls continue to be logged on a paper log sheet as they are very often taken when the Safeguarding Lead is away from their base. Entries on the Electronic Patient Record then follow.
- Between 01.10.16 and 31.03.17 there were a total of 93 recorded logs of calls for advice and/or guidance.

Sometimes, calls for advice are one-off events and the Clinician takes things forward without further input from the safeguarding lead. Other calls, however, may lead to further episodes of input, assisting with S.42 enquiries, attending strategy meetings or visiting ward areas or teams to discuss issues raised. There are also occasions where involvement of the safeguarding lead is on-going for a period of time, particularly if the issues are complex or a multi-agency commitment is needed but proving difficult to secure.

Whilst an objective for the year ahead will be to carry out a thematic review of calls for advice across a 12 month data period, the current themes are many and varied, for

example, requests for information exchange guidance with other agencies and partners, requests regarding whether a situation requires a referral to be made, thresholds, allegations of patient on patient assaults, allegations against staff members, domestic abuse queries, non-recent abuse disclosures, potential radicalisation early warning signs, signposting requests to sources of information and support, concerns regarding other provider services, concerns regarding staff members from other organisations who have accessed out services and information sharing protocols.

M. BRADBURY (LINK TO STAFFING AND COMPLEX ENQUIRY)

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

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

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

N. SAFEGUARDING – PREVENT AND CHANNEL

The Trust has active membership of local and regional counter terrorism multi agency networks and panels. We have Director representation at Contest and Prevent Strategic Management Board and Assistant Director representation at the local Channel Panel. These meetings take place monthly and are multi-agency forums where referrals are scrutinised in light of potential radicalisation. The purpose of the meeting is to share information from each agency, assess risk and develop action plans to support individuals in a positive and inclusive manner. We work closely with colleagues from all the partner agencies and Derby and Derbyshire are perceived favourably in the region for their wide participation and commitment to the Prevent agenda. Derby City is a priority area and the Heads of Safeguarding for children and the Lead Professional for safeguarding adults have oversight, awareness and understanding of how to recognise and respond to the increasing threat of children and young people being radicalised. This work is supported by a Trust clinical policy and although it is at a relatively early stage of maturity, the system and process are in place to undertake this work safely.

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

- Increasing understanding of radicalisation and the various forms it might potentially take, and develop staff with the skills and abilities to recognise signs and indicators for all staff working with children and young people. This is currently covered in internal Safeguarding Children Training 'it is important to recognise in the work of prevent that though the public perception is more focussed on the risks to vulnerable people through Islamic extremist ideology', the principles and work are based around extremist ideology of all forms and includes significant work in risks to people from extreme right ideology and other extremist views which may expose those with vulnerabilities to the risks associated with radicalisation.

- Identifying a range of interventions – Universal, targeted and specialist, and the expertise to apply these proportionately and appropriately. This requires a multi-agency approach to provide the necessary specialist expertise, and the incorporation of existing projects and interventions (e.g. Channel).

- Taking appropriate measures to safeguard the wellbeing of children and adults at risk living with or in direct contact with known people who may have extremist views by following DSCB policies and procedures.

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

Potential diagnostic indicators identified in the Channel guidance include:

- Use of inappropriate language
- Possession of violent extremist literature

- Behavioural changes
- The expression of the required service and or extend access to psychological therapies for victims of a crime both in childhood and into adulthood.

Our service will continue to support the wider system and our staff in acting upon concerns, safety and effectiveness.

O.1 DHCFT SAFEGUARDING CHILDREN PRIORITIES

O.2 DOMESTIC ABUSE

Between September 2016 and March 2017 a joint targeted area inspection by the Joint Targeted Area Inspection's teams, OFSTED, HMIC (Police), HMI (probation) and CQC was commissioned by the Derbyshire Local Safeguarding Children Board (DSCB). This involved a multi-agency 'deep dive' into the experiences of children and young people living with domestic abuse. In preparation for this a Health Derby City/County prepared an action plan and Derbyshire Safeguarding Children Board undertook a mock inspection during October 2016 in readiness. The Derbyshire Health Care Foundation Trust Safeguarding Children Team was fully engaged in this multi-agency activity.

The review was intended to replicate a Joint Targeted Area Inspection review. 20 cases were selected by the DSCB and Derbyshire County Council (DCC) from a list of children identified as a Child in Need and those on a Child Protection Plan in the 12 months prior to the audit being undertaken. Using the audit tool agreed by the JTIA panel, an evaluation of each case was conducted, looking specifically at the 12 months prior to October 2016.

The inter-agency findings / cases are as follows:-

- 4 - Outstanding
- 3 - Good
- 2 - Requires Improvement
- 1 - Inadequate

Seven of those cases were chosen for a two day multi-agency panel review on 11 and 12 October 2016 which considered the author and JIAT panel's individual evaluations and agreed an overall rating for each of the seven cases. This activity was an extremely time consuming commitment for all the Trust Safeguarding Children team. However, the process proved to be invaluable for learning and an enjoyable multi-agency activity.

Preliminary findings were presented to the DSCB on 11 November 2016.

The review showed some good and outstanding elements of practice – Services 'going the extra mile' to support victims of domestic abuse and their children. In a number of cases the voice of the child was evident, with appropriate focus on their needs. Risks were identified and responded to in some cases. There was good multi-agency partnership working, information sharing, and challenge in some cases.

In a number of cases, the concerns of the agencies involved were specifically explained to the families, as well as the expectations of the services. There was evidence of therapeutic services for children being accessed, practical interventions around home

safety put into place, and unannounced visits (including out of hours) conducted. In a significant number of cases risk assessments were conducted and referrals made to programmes for victims and perpetrators to try to change future behaviour. In a number of cases effective multi-agency information sharing and partnership working was evident. The issues that resulted in cases being rated as requiring improvement or inadequate included delay in progressing cases or responding to referrals, delays in sharing information (particularly in response to requests for police checks and from MARAC meetings), and delays in completing risk assessments. Referrals to services were not followed up and action plans were either not implemented or reviewed.

Conclusions and Recommendations

This review has shown some exemplary multi agency practice, which has made a positive impact on children and families. It has also shown practice which has left or placed children at risk and which will have no meaningful impact in improving their outcomes and life chances. A small number of cases were rated as good compared to the number rates as requiring improvement or inadequate. None were rated as outstanding.

Most of the practice requiring improvement should be addressed by existing systems and policies, if correctly implemented. Supervision has a crucial role to play in quality assuring assessments, analysis, and planning as well as adhering to policies and timescales. There are, however a small but significant number of issues which resulted into recommendations and an action plan.

The following was applicable to DHCFT:

- Managers should be reminded that in supervision they should quality assure work undertaken and in appraisals revisit what training staff have had, reflecting on what they may benefit from

- Existing training provided by the DSCB should be reviewed within the next 6 months by the DSCB to ensure that it covers the impact of domestic abuse on children; victim and perpetrator behaviour (including understanding risk); and what best practice looks like within a 'Think Family' approach including the importance of gathering information from all those working with the family, comprehensive risk assessments, evidence led plans, and review of outcomes for children

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

All actions are now complete:

Domestic Violence JTAI Recommendations	RAG Rating
Organisational structures showing lines of reporting and accountability including details of local health commissioning and/or provider representation at MARAC	
Clinical Commissioning Group (CCG) and provider services with details of who is providing commissioned services, including health visiting and school nursing	

Domestic Violence JTAI Recommendations	RAG Rating
CCG and provider services annual reports on Safeguarding and Child Protection, including for children looked after	
Provider policies relating to children living with domestic abuse including local primary care policies	
Any Commissioner or provider audits and action plans relating to children living with domestic abuse	
Provider policies relating to children living with domestic abuse including local primary care policies	
Any Commissioner or provider audits and action plans relating to children living with domestic abuse	
Risks to children living with domestic abuse are prevented and reduced. The needs of the child, their non-abusive parent and the perpetrator are met at an early stage through timely access to effective help	
Children living with domestic abuse receive the right help and protection because application of appropriate thresholds, effective information sharing and timely intervention takes place. (This includes thresholds for early help, children in need, child protection processes, children becoming looked after and MARAC)	
Risk of harm to children is reduced through the identification and assessment of the risks that perpetrators and adult offenders pose. This leads to appropriate and targeted interventions by all professionals	
Children's welfare is promoted and protected through effective and timely identification, assessment and response to the risks to, and needs of, adult victims of domestic abuse. Professionals recognise that the abuse does not necessarily end when people stop living together and may in fact escalate	
Multi-agency risk assessment conferences support the protection of children through timely sharing of information, assessment of risks to children and through developing effective action plans	
Children and their families living with domestic abuse benefit from evidence-based approaches, tools and services that reduce risks and meet their needs.	

O.3 MULTI AGENCY RISK ASSESSMENT CONFERENCE (MARAC)

MARAC is a Multi-Agency Risk Assessment Conference.

Only high risk domestic violence victims can be referred to MARAC, high risk of homicide or serious harm, a risk that is life threatening and or traumatic and from which recovery whether physical or psychological can be expected to be difficult or impossible (Home Office, 2002; OASYS, 2006).

It is victim led/partnership approach – MARAC is led by Derbyshire Constabulary, but it is a **shared** responsibility of all partnering agencies, and each is equally responsible for the success. The victim and their co-operation with services is key to reducing the risk of harm and homicide. Independent Domestic Violence Advocates and other agency staff work

hard to win the trust of victims and work with them over time to reduce the risk to themselves and their families.

The core objective is to share information, to share accurate, proportionate information to best asses the risk so that appropriate support can be provided.

No single agency can meet a victim's needs, the continued success of MARAC has been the fact all agencies proactively volunteer the actions that would best suit the individual needs of a given victim.

Frequency of MARAC

Derby City has a MARAC meeting every two weeks attended by a DHCFT Named Nurse – Safeguarding Children and a Mental Health representative.

Number of cases

The number of cases discussed at Derby City/Derbyshire County MARAC between 01 April 2017 and 31 March 2017:

City	494
Alfreton	262
Buxton	110
Chesterfield	340
South Derbyshire	87
In Total	1293

OFSTED

OFSTED undertook a review of the effectiveness of Derby City Local Safeguarding Children Board during 06 March 2017–30 March 2017 and reported that:

"Wider partnership groups such as MARAC and multi-agency public protection arrangements (MAPPA) work well in this local authority. The case sampling evidenced that decisions made by MARAC are understood by social workers and incorporated into plans" (report published 13 June 2017).

O.4 CHILD SEXUAL EXPLOITATION (INCLUDING UNACCOMPANIED MINORS AND INCREASED NUMBERS AND LINKS TO CSE, SLAVERY, MISSING, AND FGM)

Following on from national and local investigations Child Sexual Exploitation remains a high priority for both Derby City and County Safeguarding Children Boards. Each area has considered this from a slightly different focus. In April a Child Sexual Exploitation, Children Missing from Home, Care or Education was the focus of a 'Deep Dive' in Derbyshire. This resulted in an Action Plan that DHCFT have been fully engaged with. The action plan was disseminated via the Named and Designated Professional Group with a distinct Health

focus. Investment in CSE has been maintained within the Trust and is reflected in the high level of awareness and commitment. Practitioners are represented on all CSE meetings and sub groups of the SCBs.

Procedures are in place to support front line staff in relation to CSE.

Within Derby City all partner agencies are required to identify CSE champions within their agency and a manager to monitor CSE work. The champions are expected to complete training, induction and targeted workshops throughout the year. They then have responsibility for cascading their learning to their colleagues. Champions also give up to six days per year to assist in the delivery of the CSE action plan. The Trust identified 10 Champions to undertake the role; unfortunately this number has significantly reduced due to staff leaving the organization. Managers have been tasked with the responsibility to identify further individuals.

The work continues to be monitored via the Safeguarding Children Operational Group. Electronic data will be recorded to ensure data collection around CSE is in place for provision to Commissioners when required.

Data collated from SytstemOne April 2016-March 2017 shows there were:

- Victims of CSE -10
- At risk of CSE – 45

DHCFT continues to highlight the use of the CSE Safeguarding Toolkit. An audit is being undertaken by the team to ensure robust staff knowledge and usage of the CSE toolkit.

There is a long standing current ongoing multi agency operation for CSE .The CSE tasking group, Bronze and Gold Commands ensure that all necessary activity is carried out, looking at strategy, policy, procedures, support for victims, prosecution, prevention, people, places and perpetrator’s. DHCFT has representation at all levels and the work commands a high level of resource from the Safeguarding Team.

As we know, Unaccompanied Asylum Seeking Children are at higher risk of being trafficked for CSE or modern slavery. These children are at a high risk also of going missing. All of these safeguarding issues are considered at the Initial Health Assessment or at any other health contact and will be highly pertinent to the Services DHCFT in both City and County. Training and supervision is key to ensure professional awareness and good practice and is addressed in team meetings by the Safeguarding Children team. Policy and procedures and guidance are available to all staff on the Trust intranet and issues covered within training.

O.4 FEMALE GENITAL MUTILATION (FGM)

A FGM Prevalence Standard has now been established. The data set requires all organisations to record and collect information with regards to the prevalence of FGM within the NHS patient population. There is a programme of work led by the Department of Health with an aim of improving the NHS response to FGM and the management of girls at risk and those already identified as victims. The Trust is mandated to report this data centrally and since October 2015 all health care professionals by law have a duty to report

FGM in a girl under the age of 18 years. Within the organisation a number of actions have been undertaken to ensure that staff are equipped and confident to deal with FGM cases:

- Systems and guidance is in place to ensure data submitted to national data set
- Trust wide briefing paper outlining statutory reporting, mandatory data col collection and the Department of Health training resource
- FGM resource available via intra-net site
- Information added to all levels of safeguarding training

The Derby City/Shire FGM Task and Finish Group was established to ensure the agenda is delivered and understood city/county wide and to review current resources to ensure they are adequate to meet the needs of the communities served - This includes working and training with community initiatives in high risk communities.

FGM Contacts April 2016 – March 2017:

2016								2017			
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
7	14	16	10	8	6	5	8	5	2	3	1

0.6 NEGLECT

Derby City Safeguarding Children Board undertook a thematic audit of neglect in 2016.

The neglect multi-agency case file audit set out to examine the effectiveness of multi-agency arrangements in Derby and to test whether early help arrangements helped to address early concerns about neglect. The audit whilst a valuable and enjoyable exercise took an considerable amount of resource and activity for the DHCFT Safeguarding Children Team, This was purely due to the Trust covering a large number of services for both children and adults. The multi-agency audit consisted of six cases. The cases were chosen randomly of children who were recently subject of child protection plans for neglect. This approach was used to seek assurance about practice for those children most at risk of harm arising from neglect and to understand, where possible, the contribution of early help and targeted services. This presented a mixed picture of the quality of the work being undertaken by agencies in Derby at an early stage and as concerns about neglect increase. It was apparent that at the point where the cases were considered at risk of significant harm there were substantial levels of multi-agency activity seeking to prevent further escalation.

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

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

Neglect is complex requiring skills, knowledge and support to provide practitioners with the tools to remain focussed on the needs of the child and rise to the challenges presented by parental needs such as domestic violence, substance misuse, parental mental ill health and learning difficulty. All factors presenting significant complexity within the family and increasing the importance of a 'Think Family' approach.

The Trust has worked extremely hard to promote and implement the 'Think Family' principles mainly via a CQUIN from October 2014 until May 2017. This included a completion of a 'self-Assessment Questionnaire' at various intervals over the period of time. The findings will be addressed and discussed in another section of this report .As the CQINN came to an end the training post was de-commissioned and training ceased. However the commitment of the organisation to 'Think Family' continues, and a new Training post is soon to be recruited to.

As a result of the audit a multi-agency strategy has been developed to drive forward the effectiveness of arrangements to prevent and respond to neglect at an early stage.

The aims of the strategy are:

- To ensure effective supports and education are available to families to prevent neglect occurring
- To ensure neglect of children is identified early in a child's life and early in the duration of any concern
- To ensure effective interventions are put in place to enable parents and/or wider family to provide adequate care for their children, where neglect has been identified
- To ensure that in serious cases of neglect, where interventions have been unsuccessful, children are removed from that environment before long-term damage is done and consideration given to criminal action.
- To enable the LSCB and partner agencies to have a robust understanding of the extent and impact of neglect in Derby, to allow resources to be directed appropriately

Alongside this a multi-agency Neglect Action Plan has been developed and a position statement by each Agency submitted to the DSCB in February 2017. DHCFT is fully compliant and neglect remains one of our main safeguarding priorities. The Government 'Triannual review' 2014 looks at the accumulative effect of neglect and the risk of drift which was covered in the new safeguarding children level three training.

The emphasis for the Trust is that our practitioners are:

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

In addition to this, the Safeguarding Children Team has also completed a self-assessment and gap analysis against the NICE guidance (the neglect section of the ‘when to suspect child maltreatment’).

The recommendations in order to achieve compliance were:

- To ensure maintenance - Staff attend DSCB training on neglect and are aware of the neglect strategy
- To ensure maintenance - Staff attend DHCFT level 1 and level 2 safeguarding training
- To ensure maintenance – Re-emphasise to staff cases which need to be brought to supervision and or escalation
- To ensure maintenance - Neglect audit plan to be completed
- To ensure maintenance - Implement DHCFT recommendations from the DSCB multi-agency case file Neglect audit undertaken in 2016
- To ensure maintenance – Ensure concerns are raised and communicated across DHCFT services with a Think Family approach, which may use different electronic systems

The Trust is fully compliant with the NICE Guidance regarding neglect.

There has been a number of concerning neglect cases that the 0-19 services are have worked with. Sessions have been held with staff in order to look at challenges that have been identified about quality of practice, drift, lack of sharing of information, supervision of particular cases, escalation, what we can learn from this and have a reflection on how we can do things differently in the future. This proved to be extremely helpful and was encouraged to be an open and honest two way challenge. This style of learning is beneficial to teams when cases are so sensitive, to support staff to learn.

We currently have a number of cases under the Serious Case Review process with neglect as a running theme across Derby City/Shire.

The Derbyshire Safeguarding Children Board is also now undergoing a MOCK JTAI. (Joint Targeted Inspection). Since March 2017 DHCFT Safeguarding Children Team has been working alongside the other agencies involved and has been fully engaged in the process again proving to be a challenge in terms of capacity. Cases were chosen randomly of children who were recently subject of child protection plans for neglect. This approach was used to seek assurance about practice for those children most at risk of harm arising from neglect and to understand, where possible, the contribution of early help and targeted services.

An independent Consultant has been commissioned to undertake a report for the DSCB, evaluate the findings and to consider any recommendations/ actions points following on from the audit. In the final report for the DSCB a provisional multi agency action plan will be prepared following the first completion of the report for agencies to complete.

O.7 NEW AND EMERGING COMMUNITIES – CULTURAL ADAPTATION AND STAFF CONFIDENCE

A Serious Case Review (SCR) which took place in Derby City highlighted a considerable number of issues around the ever growing challenges of understanding and working effectively with emerging communities and families; the learning event as a result of the review acknowledged that uncertainty may have made practice more hesitant. A number of solutions to a number of issues which were raised throughout the event as follows:

Working with new emerging communities is a challenge and professionals need to remember that where there are safeguarding concerns these should be considered using the DSCB Threshold Document as with any other family.

Gaining a picture of family life can sometimes be difficult – Where there are language barriers a professional interpreter service should be used. Also the use of a genogram to gain a better understanding of large family structure.

Families will have different beliefs and views about the Police and Social Care, there are different laws and thresholds and may be different in attitudes; this may at times lead to fear, anxiety and suspicion towards agencies.

Due to fear, families who may have something to hide will try to hide from you – Guidance was produced on how to recognise the signs:

a) Parents and carers may be poor historians
b) Practitioners should retain their professional curiosity and ask questions
c) Routinely ask to see ID - Checking ID as part of building the chronology is acceptable to check for spelling and dates of birth
d) Take proactive steps to ensure that children are registered with a local GP
e) International Police relations and protocols exist between European partners and Police have national and international systems to check family members to inform them of criminal records which can be shared as relevant to inform multi-agency assessment
f) When closing a case where there are safeguarding concerns always inform other practitioners involved with the family to ensure that others are aware of the change in circumstance

These challenges and solutions have been addressed with professional within the organisation via training and supervision.

It is important to note that a new Health Visitor post was established 2010 who has a role to work with vulnerable families in new emerging communities in Derby City and this was seen as a positive development. However, subsequently the service has been de-commissioned and the activity taken up by universal services.

A few years on and a further SCR within the city highlights again the challenges and concerns were raised by working with families from New and Emerging Communities. Due to the increase in movement and transient nature of very large families the work load has

increased significantly for all services within the Trust, especially 0-19 services. Many terms struggle with capacity to deal with the safeguarding nature of the work involved.

One key feature of working with Eastern European communities is the language barrier, many families speak Roma however there are no interpreters available locally that speak Roma, only Slovak. Culture is also a significant feature; this was a strong benefit of the specialist team within the Trust as they had knowledge of the communities, their culture and were known by the families.

In the period of this report 2016-17 in Derby City.

- Number of children starting on a **child protection plan in 2016/17; white other European – 43** + 14 Gypsy/Roma
- Number of children as **Children In Need in 2016/17**; white –Other European - **321** + 91 Gypsy/Roma

Increased challenges of a safeguarding nature the DSCB has made Emerging and New Communities a priority and agencies will be working together to look at systems and processes. It is DHCFT's view to re-visit the service specification to review the new and EU Emerging Communities Health Team to consider specific needs based on activity and commissioning of Roma interpreters.

O.8 ONLINE ABUSE

The internet can be extremely beneficial for children; they can use it to learn, communicate, develop, create and explore the world around them. However, young people can also face risks online which need to be addressed. This is a relatively new and emerging area where robust and consistent measures are being developed. Evidence so far tends to concentrate on children aged around eight or nine and above. We know little about the risks and harm experienced by younger children online. Online offences are a global concern and due to the hyper connected nature of the internet, it is difficult to break down offences by geographical location.

The nature of the risk is constantly changing and evolving, for example:

- The development of new apps such as Yellow, a child dating app, and misuse of established apps, for example, What's App or Telegram for radicalisation.
- The exponential increase in the use of the Dark or Deep Web for drug selling, radicalisation, child pornography and chat rooms promoting suicide. For example, in 2016, the Internet Watch Foundation identified over 57,000 URLs containing child sexual abuse images many of which are shared across the world.
- Social networking is the main activity young people aged 16-24 use the internet for. Social media platforms such as Facebook, Twitter and YouTube are used to groom or abuse often with no contact of young people. Social media is increasingly used to radicalise. Kayleigh Haywood was a 15-year-old Loughborough schoolgirl groomed and eventually lured to her death via an unsolicited Facebook message from one of her killers.
- Online gaming allows opportunities to radicalise, for example, adapting the most popular video game of 2012, Grand Theft Auto, ISIL created its own modifications so

that players could role-play as members of ISIL engaged in combat) and communicate via headset. Online communication during Call of Duty allowed a teenager to groom a 14-year-old boy over the internet before slashing his throat in a ‘sexual and sadistic’ attack.
- The rise in the use of the alternative currency the bitcoin making illegal activities harder to trace increasing the use of the Internet by criminal organisations.

The NSPCC estimates:

- 20% of eight to 11 year olds and 70% of 12 to 15 year olds have a social media profile
- 1 in 3 internet users are children
- 1 in 4 children have experienced something upsetting on a social networking site
- 1 in 3 children have been a victim of cyberbullying.

Unsurprisingly online safety is a priority for both City and County Safeguarding Boards. Online harm and abuse is increasingly incorporated into DHCFT safeguarding training and has been identified at workshops around a case where the use of the Dark Net featured to be an area where they would like further training. An online safety lead has been appointed as a key point of contact with the Safeguarding Boards (Dr Kennedy, Safeguarding Children Named Doctor). DHCFT will convene a child online safety task group involving former service users to look at a DHCFT strategy regarding online safety to support staff and Safeguard Children.

O.9 TRAUMA INFORMED SERVICE

This report highlights a number of key areas (child sexual abuse, CSE, domestic abuse and sexual violence, UASC) where in addition to safeguarding there is a need to address the trauma experienced by individuals. Some examples are the requirement of SARCS to provide access to therapeutic services and the treatment needs of adult survivors of Aston Hall. This raises significant questions for DHCFT regarding development expertise in trauma therapies and trauma informed services.

Adverse childhood experiences including all forms of abuse and living with domestic abuse is increasingly linked to a wide range of chronic health problems including cancer, substance misuse, mental health problems including psychosis and increased self-harm.

Only by equipping and developing our workforce with the psychological, social and medical skills to work effectively with trauma at all stages will we have services fit for purpose. This is a challenge to the organisation that needs to be considered widely and beyond Safeguarding MASH (Multi Agency Safeguarding Hub). Derby City and Derbyshire are developing a Victim Support Street triage where the Trust will contribute clinical advice also.

O.10 PHYSICAL & SEXUAL ABUSE MEDICALS

The DHCFT Safeguarding Unit operates the Child Protection Medical Service. We offer child protection medicals for physical and sexual abuse – Community Paediatricians run a rota system for physical abuse medicals and Consultant Paediatricians run a rota system for sexual abuse medicals in conjunction with Derbyshire Constabulary and Derbyshire/Derby City Social Care.

For suspected physical abuse we can see up to three children a day during weekday office hours. Children referred outside of these hours are seen by Royal Derby Hospital (via on-call Paediatrician). The rota for suspected sexual abuse is 24 hours seven days a week and the Consultant on call is also required to respond to unexpected child death for City and south of County cases.

During 2016-2017 the total number of Derby City children seen for suspected physical abuse and sexual abuse was 239 (28 sexual abuse and 211 physical abuse).

During 2016-2017 the total number of Derbyshire children seen for suspected physical abuse and sexual abuse was 67 (11 sexual abuse and 56 physical abuse).

P.1 DERBY CITY MASH – DHCFT STAFF PROVIDING A HEALTH SERVICE

The Derby City MASH (Multi Agency Safeguarding Hub) was established over the summer of 2016. Commissioners supported the development of two Health Advisor posts for safeguarding both children and adults and they were appointed from December 2016.

A development plan has resulted in tangible improvements in communication and information sharing with partners, particularly GP practices. All partners are reporting improvements in the referral and response process.

Racheal Frost, Detective Sergeant has stated:

"From the Police prospective it is a great addition to CRU. There have been many occasions when health have brought to the table information which other agency does not hold and that has been fundamental in the safeguarding we do in here.

The addresses, dates of birth that you have access to really help with us trying to trace family and then research on our systems. The Unit would not function now without health sat in here."

Being based at MASH has enabled information sharing in a more timely manner and strengthens integration between agencies, i.e. Police will often ask if children are still on CP plans or Social care will ask for recorded parents. A total of 148 face to face requests were made by social care and police between January and April 2017.

P.2 MASH ADULTS

Categories of Abuse – Adults

Type of abuse (adult's)	Number of referrals
sexual	8
physical	19
self -neglect	13
DV	13
modern slavery	0
discriminatory	1
financial / material	18
neglect / acts of omission	15
psychological	23
Sexual exploitation	6
forced marriage	0
Organisational	2
HBV	1

Adult safeguarding is continuing to develop and MASH Health have noticed positive changes since being in post.

Specific developments are monitored e.g. Between January and March 2017, the Health Advisors received 103 information exchange forms from adults; of these we only held two strategy meetings.

In May 2017, they received 75 information exchange forms but held 24 strategy meetings.

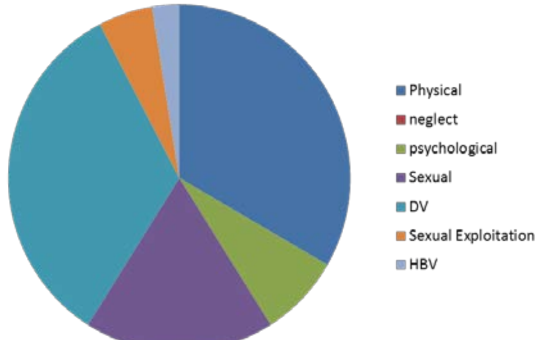
This clearly demonstrates the move towards multi-agency working and the need to share information to make a more informed decision. Initially, Social care were asking specific questions to aid their assessments; however, it was felt that as in children's, MASH Health have the ability to use our clinical judgement to decide what health information is relevant and requires sharing. This has worked well and has saved time for social care and also ensured correct information is being shared.

Liaison with GP's is work in progress. Liaison with the GP will continue with locality team following transfer from MASH. This will support the longer term assessment and safety planning.

P.3 MASH CHILDREN – DHCFT PROVIDING A HEALTH SERVICE

Categories of Abuse – Children

type of abuse (children's)	Number of referrals
Physical	13
neglect	0
psychological	3
Sexual	7
DV	13
Sexual Exploitation	2
HBV	1



Children's safeguarding was already established when the Health Advisors came into post. Prior to commencing the post, MASH Health shadowed the Children's unit to ensure procedures are followed correctly. Since starting the role in January 2016, Health Advisors have strengthened links with other services such as Mental Health services, drug and alcohol and adult social care. It is felt MASH Health have brought a more 'Think Family' approach to the team.

Between January and February 2017, MASH Health attended a total of 99 strategy meeting's for children.

There is evidence that in school holidays, referrals tend to be lower. Between January and April 2017, an average of five referrals was received in school holidays compared to an average of 8.8 in term time per week. This is likely due to children not having as many opportunities to disclose abuse and agencies not physically seeing children to see signs of psychical abuse / emotional distress.

Health has provided information which has been fundamental in supporting a safety plan. On one occasion, a family were not known to other services but health had a wealth of information which raised suspicion around significant domestic violence. Without this information, Children's social care reported they would have closed the case; however, the family are now safe in a refuge.

Kate Twells, MASH Manager has stated that:

"The MASH was launched in June 2013 – at that time – health were compliant in around about 85% - 98% of strategy meetings – i.e. they were getting us the information and sharing in 85% of cases.

I have sent the date to Michelina which evidences that since health have been done in the MASH that there is now 100% compliance with the key performance indicators and has been consistently since January 2017.

In relation to feedback – strategy meetings are always done on time – health come prepared with appropriate research to be shared 0 this includes liaison with CPN, GP and

Royal Derby Safeguarding Team. The information shared is of good quality and is relevant I e safeguarding material or anything which would suggest or support evidence in a referral – so we are not getting reams and reams of date we do not need, i.e. child has numerous colds or trapped finger in a door.

Health always respond to the strategy meetings even if at times, it is very short notice – we always try to give at least an hour but there are times that this needs to be done sooner – if this is the case – health are quick to respond with appropriate health background and research – this is then followed up with any further information required.

Communication with agencies is good – at times, there have been times where we could do with knowing in advance dates for supervision or adult strats rather than on the day – however this is accepted this cannot always be achieved at short notice. Equally, at times, other agencies, including social care have other matters that need addressing as a matter of priority.

Contribution to domestic violence triage is also positive, although there has been some issues raised about dates, times changing, social care procedures and roles, this appears to have sorted itself out after a meeting.

There is excellent multi – agency decision making, health always form their own view/opinion and share these in strategy meetings – there is ownership and professionalism in any disagreements within strategy meetings and this is backed up using the threshold document and evidence based practice. All disagreements regarding actions are dealt with in a professional, non-confrontational manner.

Social workers and police report good communication when liaising with you and this is done promptly.

On the ground, health has adapted well to the team and has participated in making the team a team and have not sought to isolate themselves as a separate service.

The MASH strategy meetings have at times only had limited information from social care and Police - however, there have been numerous times when health have been able to provide more information to the strategy meeting which is extremely relevant, and has altered the risk levels, i.e. information we were not aware of.

Health advisors are an extremely important part of this MASH team – having face to face discussions and also being physically part of the strategy meetings is what makes the strategy meeting more realistic, child focused and accurate."

P.4 DOMESTIC VIOLENCE (DV TRIAGE)

Domestic violence triage has developed the most since MASH Health started due to an increase in recourses to make triage more effective.

We have noted a trend during bank holidays and Christmas that there is an increase in referrals. The content of the notifications would suggest this is due to alcohol fuelled arguments and stresses around Christmas. Unfortunately, we did not capture the data following Christmas, however, after May bank holiday; we triaged a total of 105 standard notifications and 19 medium referrals.

Standard notifications

We currently triage standard referrals with Police and Social Care once a week; this is in the process of being reviewed due to Police resources. Police have recently trialled sending the triage list to social care a day prior to triage so they can accept all the open referrals. This has saved time and resources, e.g. on 28.05.17 a total of 57 referrals were received but only 13 required triaging as 44 were already open to social care.

We triaged approximately 450 Standard referrals between January and March 2017. This figure only relates to the notifications that are linked to children.

Medium notifications

The aim of triage is to share information and to offer early intervention in order to prevent cases escalating. Health will now research cases prior to triage; this includes looking at both children and adults involved in the incident. Providing multi-agency research in triage supports initial assessment of risk.

Social Care figures may show an increase in referrals for single assessments from triage. MASH Health would hypothesis that this is due to additional information being shared that would increase risk to a child and/or adult at risk.

MASH Health have provided a more Think Family approach; adults at risk are now identified and the notifications are sent to adult social care for their information.

As part of MASH health role, CPN's and drug and alcohol professionals are now informed to ensure they are aware of the incident for their assessment of the patient but also their own safety when visiting in the community. MASH Health also document outcomes and notify child health teams once discussed in Triage.

Feedback from Laura Oxby, Social Worker who is on the triage panel:

"I think Health within MASH is absolutely priceless! I really think the service that you both provide is fantastic, to have access to health records for our service users enables us to make safer and more appropriate decisions for the families that we work with.

It is my opinion that both Louise and Leanne are super helpful, friendly and supportive to work with. Nothing is too much for either of you, even when you are snowed under with work; you always make time to help out anyone that asks.

I feel that your decision making in relation to domestic violence triage is excellent, your main focus is keeping children safe and this is always the focus of the discussions and decisions made as a multi-agency team."

P.5 MASH - OTHER DUTIES

MASH Health Advisors have taken seven advice calls since starting in January 2017. Ideally this number will increase as people are made aware of the service. A CPN reported she felt "empowered to do her job", moreover, it has taken pressure off the Safeguarding Lead for Adults. Currently the phone being used for MASH Health is a work mobile allocated to one MASH Health Advisor. It is not within the Trust policies to share mobile phones and the signal at base is very weak. We have also encountered problems with professionals being reluctant to call back on a mobile number. A landline would be invaluable given these issues.

MASH Health Advisors have accessed specific training around safeguarding issues including Section 42 enquires, child neglect, modern day slavery, information sharing etc. this has increased skills and knowledge to support excellent clinical decision making. MASH Health were involved in a learning review in January 2017. Both Heath Advisors utilised their background skills in order to analyse and feedback information to the safeguarding unit for future learning.

Overall, from feedback and experience, having Health in MASH has been invaluable and has supported multi-disciplinary decision making in order to ensure robust safety plans. Health has provided closer partnership working and a more co-ordinated approach to safeguarding children and adults at risk in Derby.

Q.1 LEARNING FROM REVIEWS

The Local Safeguarding Children Board (LSCB) commission a Serious Case Review (SCR) when a child dies or is seriously harmed when abuse or neglect is known or suspected to be a factor in the death (or serious harm), and after suspected suicide. The process has been revised in light of 'Working Together' (2015) to direct the focus to analysis and shared learning. Significant Incident Learning Reviews (SILRs) are commissioned for cases that do not meet the threshold for a SCR, but from which significant interagency learning can be drawn. The DHCFT Safeguarding Adults at Risk and Children Committee and the DSCBs receive and monitor progress against Serious Case Reviews and learning from SILPs action plans. There have been three SCRs, one SILR and a homicide review which the Safeguarding Children Team have had significant involvement with over 2016/17.

As part of the SCR processes the team has also contributed detailed information on a number of other cases being reviewed by Safeguarding Boards ahead of a decision on possible SCRs. One of these reviews has been considerable and has proven quite a task for all agencies within Derby City. The DHCFT Safeguarding Adults at Risk and Children Committee and the DSCB's monitor all SCR action plans to full implementation/completion.

All Safeguarding research encourages a culture that supports openness, enquiry and an appropriate level of challenge where learning, including learning from Serious Incidents, is welcomed. Ensuring the workforce takes ownership for continuous learning and self-development is essential. Staff need a clear understanding of their roles and responsibilities within 'Safeguarding Families' ensuring that everyone who works with adults at risk, children, young people and their families understands how safeguarding links to their everyday practice .There have been a number of successful multi-disciplinary internal workshops delivered as a result of Serious Case reviews, learning and homicide reviews with excellent outcomes for professionals to support the change of culture and practice.

Q.2 RECOMMENDATIONS SUMMARIZED FROM SERIOUS CASE REVIEWS

RAG Rating	
Red	Recommendation Not Started
Amber	Recommendation Started
Green	Recommendation In Process
Blue	Recommendation Completed

Recommendation	RAG Rating
Enable DHCFT staff to understand the learning from the SCR and to improve practice and achieve better outcomes for children	Blue
Professionals are working with difficult/non engagement and disguised compliance within services users/families this prevents work being effectively carried out	Blue
Professionals need to be: • Aware of their responsibilities • Aware of the importance of prompt information sharing with partner agencies that children and young people are registered with when families move across geographical areas	Blue
All professionals who form part of a core group when working with families where a child/YP is on a protection plan, Children In Need Plan and/or a Supervision Order are fully aware of their role and their specific action/expected outcome is	Blue
Importance / need to involve birth fathers if they do not live with birth mother but take an active role in the care of the child/YP	Blue
Children's Health Service to share any information related to potential future risk based on patient history should circumstances change, e.g. violence, aggression and its potential response/impact to parenthood	Blue
To improve care planning within CAMHS, focusing on documentation, information gathering and sharing, accuracy, updating risk assessments and analysis	Blue
To improve staff within DHCFTs knowledge around young people who abuse and/ or source drugs, especially legal and/or illegal highs, the risks associated and for staff to feel confident in knowing what to do if faced with a concern. This should include internet and referral thresholds	Green

Recommendation	RAG Rating
Missed medical appointments for children on a child protection or children in need plan should no longer be recorded as DNA (did not attend) but always seen in the context of *'was not brought'* to ensure that parental neglect is considered as a factor. A risk assessment should be considered and appropriate action taken as a result of this classification	
Derbyshire Safeguarding Children Board Partner Agencies should consider how more robust assessments are undertaken when vulnerable parents with children, where there are safeguarding concerns, are housed. These assessments should consider the risks associated with housing being offered and its suitability in relation to the age of child/ren	
Emergency Department and paediatric staff must ensure that they always consider abuse or neglect within their differential diagnosis when considering the reasons for a child's presentation. Where this remains a possibility, this should be recorded and appropriately risk assessed, considering all available information. This is particularly important for young children who present with a seizure, febrile convulsion or ALTE. Consideration should also be given to obtaining an examination of the child's eyes by a paediatric ophthalmologist. This may provide additional clues to the cause of the event, including retinal haemorrhages in the case of shaking	
Derbyshire Safeguarding Children Board Partner Agencies should consider how more robust assessments are undertaken when vulnerable parents with children, where there are safeguarding concerns, are housed. These assessments should consider the risks associated with housing being offered and its suitability in relation to the age of child/ren	
For DHCFT within the Royal Derby Hospital A&E settings to have a better understanding of the thresholds and processes when dealing with young people who are known to be using and/or procuring drugs	
Need to improve the EHA in order for families to receive a more holistic assessment, improve multi agency care plans for staff to have a better understanding of analysis and formulation of risk	
To reduce the potential risks to children and young people when/if DHCFT are to go through transformational change which affects the resource and capacity of the workforce	
The need to improve the quality of referrals to and knowledge of other professionals of when, where and how to refer young people into the CAMHS service	
To ensure support is available for young people who have dual pathology of drug dependence and mental health problems. And that professional are aware also	
All Health Visitors and Midwives need to ensure that all children in the family are linked at the antenatal visit and need to specifically record information about who the children in the family are, where all children of the family are living, contact arrangements, and why children are living away from their birth parents	
All professionals involved with family members should be part of any multi-agency safeguarding process in order to identify any impact on children and young people.	

Recommendation	RAG Rating
To continue with the implementation of the electronic patient record	
All patient discussion and action from multi-disciplinary meetings to be entered into the record	
To investigate the issue of locking down of patient records on PARIS within the organisation and to issue a recommendation	
To clarify the use of process notes by psychology teams and impact for record keeping	
To ensure that all clinical staff are trained in Think Family	
To audit staff awareness/knowledge of the historical sexual abuse policy	
For the Trust to consider/review the availability/allocation of a CPA care coordinator in all community based care where patients have complex needs	

R. OUR KEY RELATIONSHIPS WITH OUR SAFEGUARDING BOARDS

DHCFT are committed and continue to work in partnership with Derby City and Derbyshire Safeguarding Children's Boards. There is a member from the organisation on each sub group of the Board; attendance is monitored as is shown in the chart below. There has been difficulty in ensuring membership and full attendance due to staff sickness and changes in role. There is DHCFT represented and attendance has improved - This will be monitored and assured by the Safeguarding Children Operational Group. Safeguarding depends on strong partnerships within and with other agencies and the Safeguarding Board and a culture of consistent, respectful cooperation and representation to the Board and its sub-groups across the City and Shire is essential.

Attendance at Derby City Safeguarding Children Board and sub groups - From April 2016 to March 2017:

Meeting	Date	Attendee
Derby City Safeguarding Board	08.06.16	
	14.09.16	√
	07.12.16	√
	17.01.17	√
	08.03.17	√
SCR Panel	25.04.16	√
	25.07.16	
	22.08.16	√
	17.10.16	√
	21.11.16	√
QA	16.05.16	√
	10.08.16	√
	23.11.16	√
	08.02.17	√
P & P	27.04.16	√
	13.07.16	

	09.11.16	√
	25.01.17	√
VYP	21.04.16	
	18/07/16	√
	10/10/16	√
	23/12/16	√
CSE	21.03.16	√
	25/05/16	√
	14/07/16	√
	29/09/16	√
	20.11.16	

Attendance at Derbyshire Safeguarding Children Board

Board Meeting:

24 Jun	14 Sep	15 Dec	10 Mar	16 Mar
✔	✔	✔	✔	✔

Quality and Performance Committee:

10 May	09 Aug	08 Nov	09 Feb
✔	✔	✔	✔

SCR Panel:

13 Apr	11 May	13 Jul	06 Sep	05 Oct	23 Nov	19 Jan	01 Mar
✔	✔	✔	✔	✔	✘	✔	✔

Review of the effectiveness of the Local Safeguarding Children Board by Ofsted

- Inspection date: 06 March 2017 – 30 March 2017
- Outcome – Outstanding

Derby's Local Safeguarding Children Board is making a sustained and significant positive difference to how well the agencies in the city protect children and promote their welfare. It is a highly influential strategic partnership. The board is very well led. A culture of respectful challenge, in which enquiry is expected and there is no place for complacency, is modelled by the board's highly capable and experienced independent chair, is owned by board members and is used to drive continuous improvement. Suitably senior

representatives of all key agencies sit on the board. They are clear about the responsibilities and expectations of a board member.

All DSCB subgroups have representation from DHCFT as is highlighted in the above chart. All members are committed and try and make attendance their priority.

S. AUDITS

Audit programmes are in place and designed to monitor improvement and effective change in practice to improve outcomes for children, young people and their families. DHCFT Safeguarding Children develop an Audit plan each year with audits as a result of the various case reviews and serious incident reviews undertaken.

Recommendations are made from audit and implemented both internally and externally as necessary via action plans.

A summary of completed Audit Recommendations 2016/2017:

Audit Title: Safeguarding Children Escalation Policy Awareness

Recommendations:

- Continue highlighting safeguarding as a priority issue
- Ensure staff are aware that an escalation policy for child safeguarding is available
- Reference is made to children's safeguarding during the mandatory adult safeguarding training and this should remain
- Simplify the steps needed to access policy on the intranet & discuss possible redesign of page
- Ensure staff are aware of their responsibility to cooperate with audits

Audit Title: Engaging Males in the Household

Recommendations:

- Findings of this audit are to be shared at relevant strategic and professional/ clinical meetings within the Trust

Actions:

- Liz Holmes (Named Nurse Safeguarding Children) has met with 0-19 Public Nurses Service Manager to feedback outcome of this audit, and agreed that the outcome of this random audit will be shared at clinical meetings and the HV Professional Meetings by the Clinical Managers
- Safeguarding Children Advisor/ Named Nurse Safeguarding Children to share outcome of audit at Trust Safeguarding Operational Group

Audit Title: DHCFT Staff's Quality of Case Conference Reports & Documentation of Attendance & Outcomes

Recommendations:

- Support through training - relevant staff to access DSCB training on case conference attendance
- All relevant staff to use the Case Conference template as per DSCB, to maximise compliance
- A checklist to be incorporated on the records to improve and reinforce compliance in accordance with the DSCB procedures on case conference reports
- The Case Conference report template to be made accessible on different electronic systems and if not compatible, a downloadable version to be made available

Audit Title: To assess the competency and confidence of the Child & Family Teams' IT skills since the implementation of the electronic record keeping and to assess the uniformity of recording information within the child's record

Recommendations:

- Staff teams need further training on recording safeguarding information
- The SystemOne process document 17 requires updating and an aide memoir should be developed
- A further audit should be undertaken once teams have received further training

T. THINK FAMILY ANALYSIS AND FINDINGS

Since the Think! Family has been in place there has been significant change in culture and practice within the organisation.

This enhanced consideration of children and families is evidenced in team self-assessment questionnaires that were completed at the beginning of the improvement work and again in August 2016, with a doubling of respondents from 52 to 106.

There seems to be a linear view in relation to Think Family with some groups of staff, for example some older adult staff: one view indicated that service users with Dementia are not able to recall details of grandchildren, and indicated Think Family is not a core part of their work. However, there were some very good examples demonstrating how some teams embed Think Family in practice.

Think Family is broader than only considering the needs of children, although this appears to be the focus when speaking with staff and in accordance with some of the comments from the repeat questionnaire (August 2016), as a number of staff have indicated Think Family is about safeguarding children. Therefore, staff working with adults who do not have regular contact with children, may not make wider consideration regarding impact: for example, the impact on a Carer and their family of supporting a person open to our services, whether or not they reside with the service user.

A number of respondents made reference to challenges in engagement with individuals and their families; difficulties in multi-agency working regarding attitudes and beliefs in relation to certain client groups, and a lack of understanding regarding how specialist services function. These issues do need to be addressed, given these themes have also been identified within Domestic Homicide Reviews.

Recommendations:

- DHCFT to consider amending alignment of Think Family within the Trust to ensure the wider understanding of Think Family incorporates the needs of adults and carers of any age
- Trust to consider facilitating Think Family workshops for identified staff groups, to explore blocks and barriers to Think Family, and facilitate an understanding of their role and importance of Think Family as a golden thread running through the care we provide as a Trust, in accordance with our values

Think Family in Practice

Whilst the CQUIN for Think Family has now ended, work to ensure Think Family is embedded within the Trust continues.

The safeguarding children team have also had a considerable increased amount of advice calls from the adult teams regarding safeguarding children issues, which highlights that teams are considering the whole family more routinely.

Our safeguarding inspection also found that the Substance Misuse services had fully embedded Think Family principles and evidenced that this had been maintained through 2016.

A referral pathway is now in place between adult substance misuse and children's services in the city – children's services are now notified if a parent / carer accesses the adult service and they have children between the ages of 0-19.

U. MAKING IT HAPPEN

The Trust made a strong commitment to Safeguarding by reviewing its Safeguarding Governance structures in line with the 'Safeguarding Children: 'Roles & Competences for Healthcare Staff, Intercollegiate Document 2014'. Safeguarding Leads, Named Nurses and Doctors directly reports to the Executive Lead for Safeguarding Children. The 'Safeguarding Adults at Risk and Children Committee' now directly reports to the 'Trust Board'. This has been a very constructive move and has resulted in improved Scrutiny, Quality and Assurance that Safeguarding is and remains our number one priority.

V.1 TRUST SAFEGUARDING CHILDREN WORK PLAN

The Safeguarding Children work plan is presented to the Safeguarding Adults and Children's Committee every year for scrutiny and positive challenge. The work plan sets out the strategic direction and timescales of the work to be completed by the Safeguarding Children Team, Service Line Managers and Operational Managers in order to deliver the Safeguarding Children strategy and agenda.

The Committee were advised that the purpose of the Safeguarding Children Work plan is to identify the outcomes that the Trust is required to achieve in order to keep children and young people safe from harm and to achieve their full potential. The plan sets out the actions to be completed, the timescales required and the responsible person or persons to achieve the outcomes. The plan also identifies the progress/position of the organisation against the required outcome. A detailed review of the work plan took place by the Committee members and Non-Executive Directors, some minor amendments and suggestions were made. The committee were assured that all actions are followed up with the Operational Group until completed. On completion of a substantial review of the Safeguarding Children Work plan the Committee agreed that significant assurance had been obtained for the timeframe covered.

V.2 SAFEGUARDING CHILDREN WORK PLAN – POSITION REPORT 2016-2017

RAG Rating	
Red	Recommendation Not Started
Amber	Recommendation Started
Green	Recommendation In Process
Blue	Recommendation Completed

Recommendation	RAG Rating
1) The Head of Safeguarding will ensure that systems and structures for safeguarding children are maintained in conjunction with the wider team. it will include a review of the Health contribution into the MASH both from a children's and adults perspective. The safeguarding team has invested in the recruitment of extra staff on both a permanent and fixed term contract basis	Blue
2) The Safeguarding Children Team will continue to maintain the profile and analyse the safeguarding children's advice and to monitor the types of enquiries and advice given, monitoring the number of calls and activities. This will include a review of enquiries and directly linking this learning into the training plan for professionals learning requirements	Blue
3) The Head of Safeguarding will work with the Training Manager and the Safeguarding Children Trainer to revise the training offer in line with any statutory changes to the safeguarding children's procedures and review that all changes associated with intercollegiate guidance issued in specifically gaining assurance that all health staff must have the competences to recognize child maltreatment and to take effective action as appropriate to their role. Staff must also clearly understand their responsibilities, and should	Green

Recommendation	RAG Rating
be supported by their manager to fulfill their duties	
4) The Head of Safeguarding will continue to work closely with the training Manager to ensure Safeguarding children training compliance is achieved by ensuring provision and access to safeguarding training on all levels	
5) The Head of Safeguarding will ensure that Safeguarding Children supervision and the advice system is provided across all services via varied options and that recording shows compliance	
6) The Head of Safeguarding will continue to ensure audits are completed to show the impact on practice, the changes of historical serious case and learning reviews to ensure that clinical practice recommendation have been subject to sustained change and that any risks still found are mitigated and restorative actions are put in place associated to full compliance with Safeguarding children's procedures. Learning from their findings and readjusting procedures and or practice to learn from cultural or persistent service improvement issues	
7) To understand and embed the collaborative requirements of making the 'Think Family' agenda and move the service from a reactive service to continual in reach into clinical services to make sustained impact on preventative measures in children's and adult services	
8) To fully contribute to the Derby City and Derbyshire safeguarding agendas within the Trust resources	
9) To develop a Safeguarding Children's Monitoring System to spot early warning signs of professional or organisational abuse, acting swiftly to prevent harm to children in our care	
10) To review the new soon to be published CQC standards 2015 and 2016 for Safeguarding Children and ensure full compliance and in addition, although there are specific standards that relate to safeguarding and safety, effective safeguarding also requires compliance with a range of other standards as well. For example, robust recruitment and vetting processes for staff; having enough well-trained, competent and supported staff; providing effective and appropriate treatment; having systems in place to enable people who use services and their representatives to feedback concerns; and ensuring that people using the service are respected and as fully involved as possible in their care and support	
11) The Head of Safeguarding will ensure the whole organisation Think Family audit is repeated and analysed to capture the change in practice as a result of the Think Family CQUINN. From the audit hotspots, challenges will be highlighted. This will enable a gap analysis to be completed informing further areas for improvement and training	
12) The Head of Safeguarding will ensure that the Safeguarding Children strategy and Work plan are implemented operationalised and progress and challenges reported back in to the committee as requested	
13) The Safeguarding teams across children and adults will develop an action plan in line with the Bradbury enquiry and ensure compliance and report back on any challenges to the committee	
14) The Head of Safeguarding will ensure action plans are implemented, updates and reported into the committee to give reassurance and assurance to the Trust Board that actions are completed or they are in progress. This	

Recommendation	RAG Rating
includes all SCR/ Learning Review Action Plans, CQC Action Plans, the Safeguarding Children Work plan, The Markers of Good Practice Action Plan, Neglect Action Plan	
15) Ensure DHCFT systems and structures of the Safeguarding Children team are in place	
16) To ensure safeguarding internal training at level 1 (Induction) level 2 is delivered to a high standard and updated as required, also to design bespoke training/workshops as the need arises. Increase training compliance statistics	
17) The Safeguarding Children team engages with the transformational project to ensure Safeguarding practice is a fundamental part of planning and delivery of services as well as restriction of services within the local authority	
18) To ensure that the Looked After Children agenda is captured within the Safeguarding Children Agenda fully	
19) Establish effective arrangements for capturing and embedding the voice of children and young people	
20) Analysis of the risks/impact of workforce issues/resources on Safeguarding Processes and practice	
21) To ensure DHCFT has safe recruitment processes in place	
22) Close working relationship between Safeguarding Children and Safeguarding Adults to promote more effective safeguarding	
23) Support the City/County DSCB agenda around children and YP at risk of Child Sexual Exploitation, Missing Children, Substance Misuse, Trafficking and Human Slavery, Suicide and Self Harm, Radicalisation, Gangs, Domestic Abuse, Sexual Violence and Female Genital Mutilation	
24) DHCFT are compliant with Section 11 of Children Act	

W. TRUST SAFEGUARDING ADULTS WORK PLAN

RAG Rating	
[Red]	Recommendation Not Started
[Amber]	Recommendation Started
[Green]	Recommendation In Process
[Blue]	Recommendation Completed

Strategic Aims	RAG Rating
Make Safeguarding Adults integral to patient care and to seek partnership working with our patients:	
Provide two Safeguarding Leads to offer formal advice and sign post to other services	[Amber]
Safeguarding Lead to offer supervision particularly where the safeguarding concerns are complex and distressing	[Green]
Ensure that up to date information is available for patients and staff via the inter/intranet and leaflets	[Amber]
Monitor training compliance through our Safeguarding Committee	[Green]
Monitor telephone and email advice for trends and patterns as well as to inform the safeguarding training plan	[Green]
Ensure that the Trust adheres with Safeguarding Adults Assurance Framework and PREVENT returns Safeguarding Lead to ensure compliance within the timeframes and include feedback to Safeguarding Committee and annual report	[Green]
Safeguarding Lead to support Trust strategy and initiatives on reducing restrictive practices across the organisation Ensure involvement in working groups and influence agenda in reducing restrictive practices and organisational harm To advise on least restrictive options within the safeguarding context	[Green]
Improve carer experience To provide leadership and support to staff in order to embed the Triangle of Care, family inclusive practice initiatives monitoring actions and feedback from carers, reporting how we are doing to the Safeguarding Committee	[Green]

Strategic Aims	RAG Rating
Benchmark assessment of DHCFT against NICE Guidelines on domestic violence and abuse: How health services, social care and the organisations they work with can respond effectively (Q5116) Report on benchmarking results and action plan to improve our clinical practice and minimise any clinical variation (Assign this action to MASH Health Advisors)	
Leadership, Assurance and Accountability Our primary focus will be on providing a positive and therapeutic culture/ making safeguarding personal will be embedded in routine practice Safeguarding Lead to ensure that the markers for best practice are met by the organisation. We horizon scan the national agenda in this arena and embed any national and local practice changes into our clinical standards and requirements for our staff	
Boards must maintain and be accountable for overarching Safeguarding Adults Strategy The Safeguarding Committee is the responsible committee and this is a board level committee. Board summary reports are and will be received at the public session of the Trust Board	
Governance structures and transparent polices around the Care Act and Safeguarding Adults will be in place The Safeguarding Committee is the responsible Committee and will have oversight of all sub groups	
Providers must have clear local policy requirements and ensure these are available and accessible to users of services and carers This policy and SAPP will be consulted upon and ratified by the Safeguarding Committee	
Our Trust will report on the use of Safeguarding Adults processes to service Commissioners, who will monitor and act in the event of concerns The Trust currently reports all incidents and concerns and this will be scrutinised in our inspections by our CCGS and regulators	
Boards must receive and develop actions plans in response to service failures in safeguarding adults care The Trust Board will have oversight of the whole Safeguarding Adults	

Strategic Aims	RAG Rating
Strategy and interventions will receive the annual audit of any service failures and associated service improvement plans through the Safeguarding Committee	
Executive Director of Nursing and Safeguarding Adults Lead to participate at Safeguarding Adults Boards for Derby City and Derbyshire County Councils Attend Safeguarding Boards for Adults. Safeguarding Lead to continue to participate at Safeguarding Adult sub groups	
Development of the Safeguarding Adults Doctor role and associated job plan To re-visit the Safeguarding Adults Doctor job description, work plan and key objectives	
Providers must ensure that internal audit programmes include reviews of the quality, design and application of safeguarding adult support plans, or their equivalents	
Accurate internal data must be gathered, aggregated and published by providers including progress against the 'Care Act' and SA requirements in the Annual Report	
Accurate internal data must be gathered, aggregated and reported on Safeguarding Adults concerns, action and learning	
Goddard compliance Raise awareness of Goddard across the Trust from 'board to ward' Ensure that information is retained in line with Goddard requirements	
Care Quality Commissions (CQC) monitoring and inspection against compliance with the regulation on Safeguarding Our Trust welcomes openness and transparency into the care we provide. We will benchmark against the safeguarding CQC regulations as part of this strategy and we will review any areas to improve as recommendations to be added to our work plan	
CQC will review organisational progress We welcome this approach and we will include this in our reviews of our work and areas to review and continually improve	

X. NEW INITIATIVES/OBJECTIVES 2017/2018

Safeguarding Children:

- To ensure the new 'applicable quality requirements' (KPIs) are collated and submitted to the Designated Nurse to be monitored on a quarterly basis and submitted to the CCG contract monitoring and Designated Nurse
- To ensure that succession planning and development for staff interested in Safeguarding Children is made available to develop expertise within the workforce
- To consider compassion and resilience within Safeguarding Children Practice
- To continue to work towards further integrating safeguarding adults at risk and children within the Trust
- To continue to be fully engaged, undertake and to review the action plans and any future developments or recommendations that emerge from SCR's, SILR's, internal incidents and homicide reviews
- To continue to collate data, review and evaluate the DHCFT input within the MASH to ensure current funding for the two Health Advisor positions permanently
- To work on an option paper and submit to commissioners for extra resource for Safeguarding Adults and Complex Case Team
- Development of Safeguarding Unit of SystemOne
- Derby City wishes to become the first 'Modern Slavery Free City'. DHCFT will be a full and active partner within the wider partnership. An option paper needs to be developed and agreement made within the Trust on the way forward
- Due to the increased challenges of a safeguarding nature the DSCB has made Emerging and New Communities a priority and agencies will be working together to look at systems and processes. It is DHCFT view to recommend the recommission of the New and Emerging Communities Health team and to recommend the commissioning of Roma interpreters.

Safeguarding Adults:

- To focus the efforts of the safeguarding adults operational group on the identification and continuous development of link workers within each team or speciality area
- To submit a business case for additional resource within the adult part of the team to ensure delivery of 2017/2018 objectives
- To support the prevention of abuse agenda through participation in a full review of the Care Programme Approach in adult services that will seek to integrate person centred approaches, effective safety planning and well informed assessment and care planning with an underpinning appreciation of the impact and presentation of trauma in individual patient profiles
- To continue to develop the Trust's safeguarding adults performance dashboard with a full progress report to Committee each quarter and inclusion in the 2017/2018 annual report
- To carry out a thematic review of calls for advice to the Safeguarding Adults Lead over a 12 month period from 01 April 2017 to 31 March 2018 with a report back to the Trust Safeguarding Committee in June 2018

- To continue to lead and support the work of the Triangle of Care Steering Group to achieve the second accreditation star from the Carer's Trust. From there to endeavour to achieve the ‘whole service approach’ that is the requirement of the third and final star
- To apply lessons learned from Complex Case 1 and vigorously support the development of Trauma Informed Approaches (TIA) across mental health services. A multi-agency conference hosted by DHCFT and Derbyshire Constabulary is planned for October 2017
- To continue to develop confidence and be able to provide assurance that the Trust is able to fulfil its public protection duties effectively. The Safeguarding Adults Lead is working with clinical, operational and IT leads to assist in the ongoing management and support of some of our most complex patients with forensic profiles by designing a public protection repository for MAPPA, MARAC and Prevent within the electronic patient record. The aim is to enable far more effective reporting, recording and retrieval of information, assessments and practice protocols specifically for those with significant offending behaviours and/or vulnerability to radicalisation and extremist ideology
- To continue to support our partner agencies in efforts to safeguard local adults at risk and assist in the realisation of aspirations to ensure that phenomena such as modern day slavery are proactively tackled and prevented
- SMART Action Plan with delivery dates will follow the strategy.
- To continue to work in partnership with the Anne Craft Trust to improve the accessible safeguarding screening tool (ASSIST), led by the Assistant Director of Safeguarding Adults.

REPORT PREPARED BY:

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Derbyshire Healthcare NHS Foundation Trust
Report Board of Directors - 27 September 2017

Equality Delivery System (EDS2) update, DRAFT Workforce Race Equality Standard (WRES) Action Plan 2017 and DRAFT Interim Equality, Diversity & Inclusion Strategy overview 2017

Purpose of Report

The purpose of this paper is threefold, firstly to provide an Equality Delivery System (EDS2) update. Secondly, Draft Workforce Race Equality 2017 Action plan setting out how we are going to act on the findings following our annual WRES submission (approved by the Board of Directors on the 27th July, 2017). This is published on our external website. Finally, present and seek approval of our DRAFT Interim Equality, Diversity & Inclusion Strategy overview which sets out our approach and how we intend to deliver our equality objectives and embed ED & I. This also is an initial framework to be used to do bottom up engagement and build strategy.

Executive Summary

1. **Equality Delivery System (EDS2) 2017/18 update**

EDS2 annual grading process is progressing in accordance with our EDS2 implementation plan (approved June 2017). The grading for Goals 1 & 2 for service delivery, experience and outcomes is taking place on the 23rd November 2017 at the R & D Centre. This will be focused on the core corporate key performance indicators and metrics i.e. patient feedback from REGARDS groups. With regards to service improvement, we will continue with our plan to systematically undertake EDS2 assessment across all our services, so that over time all our services have had the opportunity to be graded. This year's equality deep dive will focus on Children Services lead by Hayley Darn, General Manager. Work is underway to begin to gather the evidence to support self-assessment and subsequent grading by external stakeholders.

EDS2 16/17 update: Perinatal and Neighbourhoods (Clay cross, Bolsover and City) 'You said, we did' update will be shared by Kath Lane, Deputy Director of Operations with stakeholders by end of September and at our EDS2 event in November.

EDS Goals 3 & 4 : good employer, inclusive leadership and culture

Workforce annual grading is due to take place in January 2018 and the date will be agreed with workforce team over the coming weeks This process will proactively include engagement with diverse staff and particularly the BME Staff Network.

- LGBTQ Board champion – Claire Wright, Deputy Chief Executive and Director of Finance has eagerly agreed to take on this role and very committed to progress this key agenda. The Trust participated in this year's Gay Pride on the 9th September, 2017 to promote equal rights and LGBTQ culture.

- Bi Visibility Day is on the 23rd September each year and has been marked around the world since 1999 – also known as International Celebrate Bisexuality Day. The day is a call for the bisexual community, their friends and supporters to recognise and celebrate bisexual history, bisexual community

and bisexual people. This year we have promoted via screensaver, poster and distributed purple mugs to encourage staff to talk about bi-sexuality.
- Black History month is taking place from 1st October to 31st October 2017 and celebrates its 30th anniversary. The BME Staff Network launch has been organised to coincide with this event (3rd November 2017) in recognition of how staff from different backgrounds bring unique knowledge, skills and experience to the Trust.

2. **WRES Action Plan headlines: the steps we are going to take to address the variations. (Appendix 1)**

A Draft WRES action plan has been developed to address the disproportion and will be refined in partnership with BME Staff Support Network, to help us understand the root causes, as opposed to making assumptions and addressing the symptoms. The step change required in implementing the WRES is in requiring organisations to collect data, but to analyse and act on it. This will require performance management at an operational level within existing systems if we are to make year on year tangible improvements and deliver outcomes:

a) Strategic - the aim is to build BME talent pipeline, leadership capacity and capability in the Trust.

b) Initiate operational accountability to encourage managers to build and maintain BME diversity representation across the bands to ensure our BME talent is 'succession ready'. Managers to work with workforce team and BME network to ensure BME staff from each relevant band/profession are selected for acting up, shadowing, secondments, project leadership, mentoring and coaching opportunities.

   The Board of Directors have agreed to seek assurance when papers are presented to consider if workforce reflects the local neighbourhood, fair employment (address glass ceiling) and that we are leveraging the talents/assets and community knowledge of our workforce. This needs to be reinforced and monitored within existing performance management mechanisms and quality visits (as discussed at Quality Committee 7 September 2017 and People & Culture 22nd September 2017).

c) BME Staff Support Network and priorities dovetail with WRES action plan. Network Chair/Deputy invited to be a member of the Equalities Forum, People and Culture Committee and Staff Engagement Fourm. The BME Staff Support network and Reverse Mentoring pilot is championed by Ifti Majid Trust, Acting Chief Executive.

   - Visible leadership and other programmes facilitated by the East Midlands Leadership Academy are being monitored by the Head of Workforce to ensure BME staff is taking up this opportunity. This will shared as part of the annual EDS workforce grading event.
   - BME Staff Network launch taking place on Friday 3rd November- this will include external coaching workshop focussing on career and confidence building to support staff with interviewing skills, celebrating Black History Month and EDS2 feedback.

d) Driving culture change - Reverse Mentoring for Equality, Diversity and Inclusion (ReMeDI Pilot in (action research) in partnership with University Of Nottingham and BME Staff Support Network. All Directors have been extremely keen to support this and expressed a formal interest in being mentored by a BME colleague commencing November 2017.

e) Improve BME Board representation – Trust has agreed for BME Non-Executive Directors placement (NExT Director Programme delivered by NHS Improvement). This has been championed and initiated by Caroline Maley, Acting Chair.

3. **The DRAFT Interim Equality, Diversity & Inclusion Strategy overview on a page and delivering our equality objectives** (Appendix 2)

This is our overarching framework and our way of sharing our ethos and approach to delivering and embedding equality, diversity and inclusion. It has been developed following a recent Board equality development session to develop the strategic potential and direction for equality and our top 6 equality objectives/priorities. It is underpinned by our values and will be delivered and framed using the national NHS equality and diversity performance framework called the Equality Delivery System (EDS2) and four goals. It is hoped that this will help leaders to easily and consistently articulate and reinforce our commitment, share our REGARDS inclusion brand and our approach with stakeholders. It is based on the principle of living our values and being 'consciously inclusive and culturally competent' and demonstrating progress through robust governance, effective performance management within existing mechanisms and holding leaders to account, particularly reinforcing the role of line managers to demonstrate services and employment are equally good for all groups.

This is a draft document that will be used as an invitation to engage and develop a consolidated framework and refined action plan through a bottom up approach by listening and learning from our stakeholders - staff, those who use our services, carers, families and our local community.

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

- WRES 2017 submission was approved by Board 27th July 2017 and subsequently sent to NHS England via UNIFY2 and uploaded on our external website before 1st August 2017 deadline.
- The Equality Forum together with Quality Assurance and People and Culture (PCC) Committees will ensure the Trust meets its statutory duties under the Human Rights Act (1998). Equality Act (2010) and Public Sector Equality Duty. This includes the Annual Diversity workforce demographic report, WRES action plan, FFT and staff survey.
- Public Sector Equalities Duty & EDS2 17/18 implementation and work plan (approved by Board 28th June 2017)/ PSED report due to be updated January 2018.
- Board Equality Action Plan top priority 2: Board developing engaging and inclusive leadership (approved 28th June 2017)
- Equality Objective 4: better understand the profile and experiences of our employees and achieve a diverse workforce.
- Board Assurance Framework risk 3d is regularly presented to Equality Forum and PPC to discuss control. Controls to ensure data completion (85% target)
- CQC evidence, CCGs and Standard Contract - Quality Assurance Schedule 2017/18 reporting e.g. EDS2, WRES, publishing equality information on website.

Consultation

Ifti Majid, Acting Chief Executive and Amanda Rawlings, Director People and Organisational Effectiveness and other Executive Board members have met with BME Staff Support Network to hear at first hand, their experiences of the workplace.

The Trust has re-established and resourced the BME staff support network as an important source of knowledge, support and experience. This has included an annual conference (17th March 2017) and network action plan which dovetails with the WRES action plan. The Trust will continue to engage and involve BME staff support network in identifying the challenges in making continuous improvements against the WRES indicators. This involves engagement and evaluation with University of Nottingham as part of Reverse Mentoring pilot.

BME staff network mission: to achieve open and fair access to opportunities, development and progression to ensure equality in career outcomes.
Objectives: Representation, having a voice and visibility (to be heard, seen and listened to). BME staff and wider staff reporting positive working experience and environment. Ensure BME people no longer feel bullied. Diverse, skilled, talented and experienced workforce providing quality service based on individual need. To have a happy and healthy workforce and community. Equality and fairness - recognition by Trust and accessibility.

Governance or Legal Issues
WRES is considered as part of the "well led" domain in the Care Quality Commission (CQC) inspection for both NHS, independent and voluntary providers. All providers subject to the NHS standard contract except primary care are expected to implement the WRES. Schedule 6 Requirements 2017 / 2018 – WRES compliance. Showing "due regard" in using the WRES in helping to improve workplace experiences and representation at all levels for their own BME staff. Equality Act 2010 - the legal duty to comply with the Public Sector Equality Duty (PSED). Under the Equality Act, public sector bodies have a duty to publish evidence on how they have: eliminated discrimination against protected groups, advanced equal opportunities for protected groups, and fostered good relations between those in protected groups and those outside of them. There is also a duty to set equality objectives every 4 years. The data and analyses for the WRES indicators will assist organisations when implementing EDS2, in particular, with the outcomes under EDS2 Goals 3 and 4, as shown below: • EDS2 Goal 3: Empowered, engaged and well supported staff and Workforce Race Equality Standard *(Is the Trust a good and fair employer for all REGARDS groups)* • EDS2 Goal 4: Inclusive leadership *(leaders, showing strong and sustained commitment to promoting equality within and beyond organisation. Engaging and responding to the needs of the diverse REGARDS groups).* • EDS2 Outcome 4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination.

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 of REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation) and Public Sector Equality Duty & Equality Impact Risk Analysis.	
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 gaps/inequalities are outlined below, with the appropriate action to mitigate or minimise those risks.	x
Actions to Mitigate/Minimise Identified Risks BME population statistics -Derbyshire County 4% and 24% City (Local census 2011) WRES indicators and variations between White and BME staff are outlined in the key findings section of the report. The step change required in implementing the WRES is in requiring organisations to collect data, but to analyse and act on it. This is completely consistent with the approach taken in the Equality Act 2010 and the Public Sector Duty 2011. There has been significant research in recent years including West, M (2011) and	

Dawson, J (2009) linking the experience of staff and the care provided to patients and cost to both employers and patient of not treating staff well. Professor West developed these themes further with regards to the experience of the Black, Minority and Ethnic (BME) workforce and the care of patients. More recent research, Kline, R (2014) has demonstrated that the treatment and experience of BME staff within the NHS is significantly worse, on average than white staff. In the Snowy White Peaks in the NHS (2014), Kline demonstrated that BME staff were absent from the leadership of many NHS organisation including areas such as London, where organisations provided services to large BME populations.

Research suggests the likelihood of BME staff being appointed from a shortlisting is significantly less than that of White staff (Kline, R, 2013, 'Discrimination by Appointment'), with white staff being 1.74 times more likely to be appointed from a shortlist that BME staff. It has also been demonstrated that BME staff are twice as likely to enter disciplinary processes and more likely to be disciplined for similar offences. (Archibong et al, 2010).

The WRES action plan and BME Staff Network action plan will focus on addressing workforce and employment journey differences between white and BME staff, including understating barriers, intervention/opportunities to encourage progression and minimising potential bias in recruitment and glass ceiling highlighted through this analysis. This will include the Reverse Mentoring Pilot intervention, which will help to us to understand the reported variations in BME staff lived experience in the work place and promote good relations between different groups of people. This will inform the People Plan and Board Equality Action Plan priorities.

Recommendations

The Board of Directors is requested to:

1) Note annual EDS2 Grading event taking place 23rd November, 2017.
2) Note and approve Draft WRES 2017 action plan
3) Note the importance of holding officers to account to ensure workforce diversity and our BME talent pipeline is 'succession ready' through existing performance management mechanisms and quality visits.
4) Discuss and approve the DRAFT Interim Equality, Diversity & Inclusion Strategy overview and next steps.

Report presented by: Harinder Dhaliwal, Assistant Director for Engagement & Inclusion

Report prepared by: Harinder Dhaliwal, Assistant Director for Engagement & Inclusion

Appendix 1: DRAFT DHCFT WRES 2017 Action Plan 2017
Appendix 2: DRAFT Equality, Diversity & Inclusion Strategy overview on a page
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Appendix 1 : DRAFT DHCFT Workforce Race Equality Action Plan 2017

WRES 2017 submission http://www.derbyshirehealthcareft.nhs.uk/standards/equality-diversity/wres/

WRES Indicator	Action	Target date	Expected outcomes	By whom (accountable lead)
Indicator 1 – percentage of staff in each of AfC bands 1-9 and VSM (including executive Board for both white and BME staff groups. The data indicates under-representation but an increase for both white and BME staff groups. Clinical staff increase – white 0.71 percentage points and BME 2.39 percentage points. Non-clinical staff shows a slight increase with white 0.71 percentage point and BME 0.01 percentage point Table1 on page 8 shows under-representation and proportionately lower number of BME	As part of DHCFT Workforce Plan we need to understand what may be happening for each band boundary, talent pool and succession planning. a) Undertake analysis of the ethnic profile of staff for each Agenda for Change/pay band structure and for each of the staff groups. b) Enhance operational accountability in the system to proactively address BME under-representation across the bands and build BME pipeline so it is 'succession ready'. c) Teams/neighbourhoods set their own targets perhaps based on the diversity of their local geographical areas as a minimum. d) To ensure all BME staff has appraisal and PDP. e) Ensure equity of access to external training and development that supports career advancement. f) Positive action to improve team profile. g) Promote and monitor BME access to NHS national programmes, Leadership Academy and ILM programmes that aim to build leadership capacity amongst BME staff. h) Continue to develop and monitor BME access to internal and external* leadership development, coaching and mentoring programmes that aim to	Progress on all actions to be demonstrated by 30th June 2018, in time for the next WRES submission	Ensure that BME staff are equally represented at middle and senior management positions and 'succession ready'. Address the under-representation of BME staff at middle and senior management positions Create a level playing field for senior management positions. .	Head of Education Deputy Director of Operations & Management teams to set targets. Board to seek assurance of that workforce reflects the local neighbourhood population, fair employment and that we are leveraging the talents/assets and community knowledge of our workforce Head of

WRES Indicator	Action	Target date	Expected outcomes	By whom (accountable lead)
staff in the relevant bands April 2017. The highest non-clinical BME percentage is Band 1 (catering, domestic assistants and porters). BME Consultants continue to be over-represented at our senior clinical positons. Linked to: EDS2 Evidence Board Equality Objective BME Staff Network Objectives, People Plan and Workforce Plan (see end of document)	build BME leadership capacity and capability in the Trust (build talent pool and pipeline). *East Midlands Leadership Academy. i) To launch BME staff network and set up BME Career Development Task Group (subgroup of BME Network and Equalities Forum) to work with managers to ensure BME staff from each relevant band/profession are selected for career development, acting up, shadowing, secondments, project leadership, mentoring and coaching opportunities. j) BME access to mentorship programmes with at least two undergoing external mentorship. k) Work with BME Network to host events for BME staff to identify their training and development needs and they would like to progress their careers (various staff groups clinical/non-clinical including facilities and estates staff) l) Drive cultural change through implementing the Reverse Mentoring for Equality, Diversity and Inclusion (ReMeDI Pilot in (action research) in partnership with University Of Nottingham. Developed following BME Network workshop and dialogue with board/senior leaders to enhance cultural competence		BME staff have the opportunity to gain practical experience at band 7 & 8a Clearly identified route for anyone requiring education and support. Chief Nurse is able to demonstrate that all BME nursing staff receive their annual appraisal as part of the CPD.	Education

WRES Indicator	Action	Target date	Expected outcomes	By whom (accountable lead)
	m) BME Staff Network championed by Acting CEO - strengthened, resourced and representation at key decision making committees - People & Culture, Equalities Forum and staff engagement forum. Terms of reference and membership enhanced to ensure BME voice. WRES linked to network action plan as baseline. Annual conference externally facilitated to identify issues, barriers, develop network purpose, mission and goals.			Assistant Director for Engagement & Inclusion BME Network, Network Chair/Deputy Executive Directors
Indicator 2: White shortlisted job applicants are 1.47 times more likely to be appointed from shortlisting than BME shortlisted applicants, who remain noticeably absent from senior grades within Agenda for Change (AfC) pay bands. However, data indicated a decrease from last year by 0.16% points.	a) As part of our Workforce Plan we need to understand what may be happening for each band boundary, talent pool and succession planning. b) Audit shortlisting and appointments by ethnicity and department. Involve BME network in this process. c) BME Network - staff to be trained to participate in the recruitment process. d) To monitor the recruitment process. e) The Trust is providing a suite of training for managers to upskill in people management and effective application of policies. f) Provide REGARDS and respect - unconscious bias and cultural competence training for trainers and for recruitment managers and managers involved in disciplinary processes. The aim is to help them to critically reflect on their practices and become better		To achieve a fair and equitable recruitment and selection process. Address the potential bias in the recruitment process To have more diverse recruitment panels. At least one BME nominated by the BME Network to be on interviews for senior posts.	Head of Education Recruitment & Retention Group multidisciplinary team chaired by Deputy Director of Operations. Co-ordinated by Workforce Team Assitant Director for Engagement & Inclusion

WRES Indicator	Action	Target date	Expected outcomes	By whom (accountable lead)
	aware of their conscious and unconscious attitudes towards equality and reflect on the impact of organisational culture on equality outcomes.			
Indicator 3: BME staff 1.60 times more likely to be disciplined than white staff members. This has increased from last year 0.43. This requires further exploration.	a) Disseminate learning from conduct cases to enable organisational learning and processes. b) To ensure Trust policies are applied equally to all staff		Fairness in application of Trust policies irrespective of ethnicity. Procedural justice. Cases resolved fairly. understanding of the consequences of racial discrimination Reduction in racial discrimination and increase knowledge Current leadership is upskilled to effectively deal with issues. Race equality included in annual appraisal.	Senior Workforce Team Assistant Director for Engagement & Inclusion
Indicator 4: Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff 0.97. This is a 0.12 difference compared to last year 0.85. A figure below '1' would indicate that white	a) Further work needs to be done to explore and understand this data, including career development and progression opportunities such as funding/sponsorship, acting up, projects and secondments between different groups		Parity	Head of Education

WRES Indicator	Action	Target date	Expected outcomes	By whom (accountable lead)
staff members are less likely to access non-mandatory training and CPD than BME.				
Indicator 5: KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months appears to have decreased by 5.42% white staff and 8.49% for BME staff. White 27% (32.42% 2016) and BME 29% (40.91% 2016).	a) Further exploration is required to understand this difference and triangulated with internal Datix system reporting. b) Monitor all race-related Datix reports occurring at DHCFT and their outcomes. c) The Trust's position on zero tolerance to be regularly communicated on the Trust intranet, via training, induction, mandatory and team meetings by line managers.		Effective reporting and handling of racial abuse incidents and staff supported	Assistant Director of Engagement & Inclusion Workforce Team
Indicator 6: KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months has increased by 2.2 % points for BME staff 21% (18.8% 2016) compared to white staff decrease by 0.53 percentage points at 22% (22.53% 2016).				

WRES Indicator	Action	Target date	Expected outcomes	By whom (accountable lead)
Indicator 7: KF 21. The percentage of staff believing the trust provides equal opportunities for career progression or promotion has fallen for both white and BME staff groups compared to last year. The white group 8.57 % points show a greater difference compared to BME staff 7 % points. White BME staff 7 % points. White staff 75% (83.57% 2016) compared to BME 73% (80.0% 2016).				
Indicator 8: Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues. This has decreased across both groups -	As above			

WRES Indicator	Action	Target date	Expected outcomes	By whom (accountable lead)
White 6% (6.85 % 2016) and BME 10% (13.64% 2016). The difference is white by 0.5 percentage points and greater drop BME 3.41 percentage points.				
Indicator 9 - compare the difference for white and BME staff: Percentage difference between (i) the organisations' Board voting membership and its overall workforce and (ii) the organisations' Board executive membership and its overall workforce. This data indicates the percentage of BME Voting Board Members is 8.3% compared with the Trust 12.3% (this includes NEDS voting members of the Board). This is a difference of 4 percentage points. Cross reference to	a) Aim to build BME talent pipeline, leadership capacity and capability in the Trust, so BME staff are succession ready. Positive action programmes to support BME staff to progress within the organisation, including increasing representation at the Board. b) Reverse mentoring- the Board has signed up to this to raise the confidence and profile of BME staff in the Trust and consider the contribution this might make to increase the diversity of the leadership. This intervention will enable senior leaders (initially Executives as mentees) to gain insight into the lived experience of BME staff and support development of cultural competence, inclusive culture and environment c) Improving board diversity and NExT Director Scheme for Non-Executive Directors - Trust agreed to host NED placement (championed by Acting Chair). NHS Improvement initiative to help people from under-represented groups who have the skills and expertise necessary to make a real contribution to NHS to take that final step into the board room.		Boards are expected to be broadly representative of the population they serve.	Board to seek assurance of that workforce reflects the local neighbourhood populations, fair employment and that we are leveraging the talents/assets and community knowledge of our workforce

WRES Indicator	Action	Target date	Expected outcomes	By whom (accountable lead)
EDS2 Goals and Board Equality Objectives/top 6 priorities.				

Table 1: indicates under-representation and proportionately lower number of BME staff in the relevant bands. The highest non-clinical BME percentage is Band 1 (catering, domestic assistants and porters). BME Consultants continue to be over-represented at our senior clinical positons.

Consultant	89% BME 34 from 38 staff
Executive	25% BME (1 from 4 staff)
Band 9	0%
Band 8D	0% BME (0 from 5 staff)
Band 8C	0% BME (0 from 20 staff)
Band 8B	4.34% BME (1 from 23 staff)
Band 8A	7.84% BME (8 from 102 staff)
Band 7	9.17% BME (20 staff from 218)
Band 6	10.45% BME (55 from 526 staff)
Band 5	14.64% BME (47 from 321 staff)
Band 4	5.78% BME (10 from 173 staff)
Band 3	15.17 % BME (49 from 323 staff)
Band 2	18.66% BME (28 from 150 staff)
Band 1	30.76% BME (12 from 39 staff)

BME population statistics -Derbyshire County 4% and 24% City (Local census 2011)

WRES cross referenced to the following:

1. Board Equality Objectives 2017 -2019/Top 6 Priorities Completion of data (across the nine protected characteristics) for services and workforce – target 85% by March 2018. Developing engaging and inclusive leadership. Allocate corporate resources to progress the equality and inclusion agenda within DCHFT. Demonstration of 'due REGARDS' relating to strategy, policy and decision-making. Develop refined community engagement mechanisms. EDS2 assessment – no red (undeveloped) rated by 31st March 2018 and 70% green (achieving grade) by 2019 and 100% by 2020.

2. BME staff network action plan and mission: to achieve open and fair access to opportunities, development and progression to ensure equality in career outcomes. Objectives: Representation, having a voice and visibility (to be heard, seen and listened to). BME staff and wider staff reporting positive working experience and environment. Ensure BME people no longer feel bullied. Diverse, skilled, talented and experienced workforce providing quality service based on individual need. To have a happy and healthy workforce and community. Equality and fairness - recognition by Trust and accessibility.
3. Equality Delivery System national equality performance toolkit and annual grading. EDS2 Goal 3: Empowered, engaged and well supported staff *(Is the Trust a good and fair employer for all REGARDS groups).* EDS2 Goal 4: Inclusive leadership *(leaders, showing strong and sustained commitment to promoting equality within and beyond organisation. Engaging and responding to the needs of the diverse REGARDS groups).*
4. Public Sector Equality Duty – aims 1) Eliminate discrimination and harassment 2) Advance Equality of Opportunity, 3) Foster good relations. report April 2017

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Appendix 2 : (DRAFT) Interim Equality, Diversity & Inclusion Strategy overview on a page

Our Vision: To provide services that meet the needs of the individuals and communities we serve, working with our people and partners to achieve a collaborative approach

Why Equality, Diversity & Inclusion matters to us : We will be postiviely inclusive by working with 'due REGARDS' and respect in DHCFT so everyone can be the best they can be

How we are going to implement and mainstream Equality, Diveristy & Inclusion in DHCFT.

STRATEGY
Trust Strategy & Priorities
Quality Priorities
'Divisional Plans on a Page'
Workforce Plan & People Plan

STRUCTURE
Governance & Leadership accountability at all levels
Integrated Performance Reporting & Key Performance Indicators to measure/demonstrate equitable outcomes & experience REGARDS

SYSTEMS
Equality Delivery System (EDS2) – ED&I strategy framed & underpinned by *Goals 1-4: equally good outcomes, experience, employment & Inclusive leadership*
Equality Monitoring data & evidence base - via feedback & Paris /systems
Equality Impact Risk Analysis
Workforce Race & Disability Standard
Reverse Mentoring & Reverse Commissioning

OUR SHARED VALUES

SKILLS
E& D training, learning & Development
Inclusive Leadership
Cultural Competence
REGARDS evidence & Equality Impact
Identifying barriers
Service Improvement

STAFF
Fair & diverse employment practice
Build & maintain a diverse talented workforce at all levels
Staff Networks
Champions/Allies
Staff engagement

STYLE
Organisational Development
Managers reinforcing inclusion within teams
Behaviours /attitudes to REGARDS people
Positive action
Advice & Guidance
Open & Engaging

McKinsey 7S Framework

What we are going to do to make a difference.

Equality Action Plan & Equality Objectives/top 6 priorities 2017 - 2020

- Understanding our patients and staff -completion of data (across the nine protected characteristics) to improve service and workforce outcomes – target 85% by March 2018.
- Developing engaging and inclusive leadership.
- Allocating corporate resources to progress the equality and inclusion agenda within DCHFT.
- Demonstration of 'due REGARDS' relating to strategy, policy and decision-making.
- Developing refined community engagement mechanisms.
- EDS2 assessment – no red (undeveloped) rated by 31st March 2018 and 70% green (achieving grade) by 2019 and 100% by 2020. Corporate & local services EDS2 improvement plans

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 27 September 2017

Pulse Check Results and 2017 Staff Survey Plan

Purpose of Report

To update the Board of Directors on the latest Pulse Check Results and inform on the Staff Survey Plan for 2017

Executive Summary

- Q1 Pulse Check (April – July 2017) showed an improvement in the response rate and also an improvement in the two main questions:
  - How likely are you to recommend this organisation to friends and family if they needed care or treatment – showed that 73% of respondents would likely or extremely likely to recommend.
  - How likely are you to recommend this organisation to friends and family as a place to work – showed that 57% of respondents would likely or extremely likely to recommend.
- All other questions showed an increase in % other than:
  - I am able to make suggestions to improve the work of my team/department, and
  - Time passes quickly when I am working.
- Positive comments describe commitment and compassion and 'going the extra mile' whereas the negative comments primarily describe lack of resources which we know is being proactively addressed.
- Managers have received their own area reports.

Attached for information is the 2017 Staff Survey Plan which is being progressed.

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

Assurances

Pulse Check is showing improvements and there is a plan in place to support the staff survey for 2017.

Consultation

Not applicable

Governance or Legal Issues

Not applicable

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 of REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation) and Public Sector Equality Duty & Equality Impact Risk Analysis.	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 – not applicable	

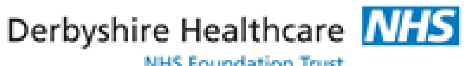
Recommendations

The Board of Directors is requested to:

1) Note the improvement can be seen from the continued quarterly pulse check.
2) Note the 2017 staff survey plan.

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

Report prepared by: **Garry Southall & Ian Shepherd**

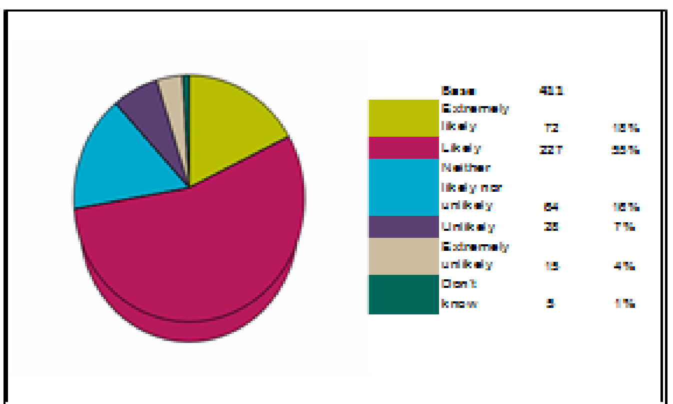


Initial Feedback Pulse Survey

April - July 2017

Key question 1

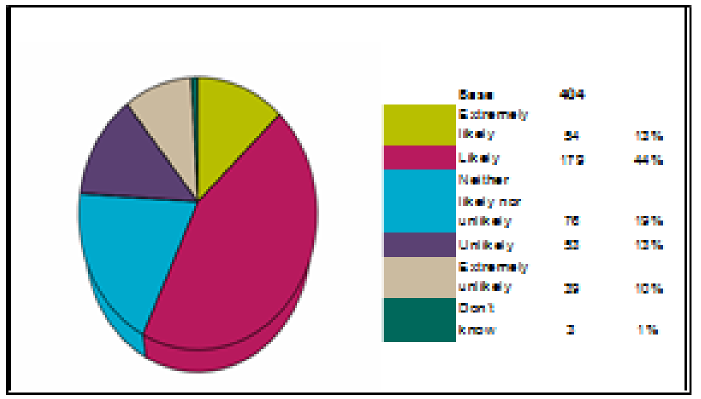
How likely are you to recommend this organisation to friends and family if they needed care or treatment?



Improvement from last quarter 5%
Response rate 17.8%

Key question 2

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



Improvement from last quarter 7%

Other questions

Questions:	Base	Score %	Lowest score	Highest score	Change
Care of patients/service users is the trust's top priority.	392	78%	77%	87%	1%
I am able to make suggestions to improve the work of my team/department.	393	75%	75%	71%	-2%
There are frequent opportunities for me to show initiative in my role.	397	76%	70%	70%	6%
I am able to make improvements happen in my area of work.	391	69%	63%	63%	6%
I think that it is safe to speak up and challenge how things are done	401	61%	57%	67%	4%
I look forward to going to work.	398	63%	55%	69%	8%
I am enthusiastic about my job.	397	75%	67%	73%	8%
Time passes quickly when I am working.	403	77%	77%	64%	0%

Sample comments:

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

- Likely:
  - The commitment, compassion that staff show. The extra mile staff will go to support those who need it most.
  - Our staff really care about patients and their families
  - Had a relative admitted and a very good experience
  - Patient care is main focus for clinical staff.
  - Level of dedication from staff, quick, supportive, reliable.
- Unlikely:
  - Not enough qualified staff on the wards
  - Although the staff try their best they are not able to provide the best care due to staff shortages and too much red tape.
  - To many staff shortages to receive appropriate care
  - Under funded and under staffed. Wards feel chaotic and environment not therapeutic
  - Feel that staff morale is low and certain teams are going through the motions rather than delivering the care they used to. I think teams are running short staffed, underfunded, exhausted, time poor and stressed in a nutshell.

Sample comments:

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

- Likely:
  - Its a good place to work, although capacity is a challenge across all services, there is on-going support for staff to do their jobs
  - Very supportive team and management
  - It is a good place to work for and it gives care and support to both patients and their family
  - Lovely teams. Great trust which is widespread so able to get out and about.
  - Although under significant pressure at times, I feel supported by my manager and colleagues.
- Unlikely:
  - Staff are are overworked and undervalued. We are constantly pushed to give more but are rarely thanked when we do
  - low staff morale / not feeling appreciated / managers having favourites
  - Due to lack of staff
  - Too many changes, knee jerk reactions, staffing, moral, confidentiality, uncertain future
  - Unsupportive management.

Better together

Areas scoring 50% or less positive

Pharmacy	Universal Children's Service	Locality 2 OSER
Campus	Child Therapy and Complex needs	Locality 3 OSER
Centre for R&D	Med Secs	
Facilitation Group	Patient Records	
County South Neighbourhoods	Ryknold CBT	
Hartington Campus	Pediatrics Admin	
Kingsway Campus	Psychology Neighbourhods	
Psychological Therapies	MGT + Admin OSER	

2017 Staff Survey Plan

Date	Step of NHS Staff Survey
Late August / Early September	Determine survey content – all organisations must include the core questionnaire. ***The Trust will be using the same format (80:20 electronic and paper) as last year with the same additional questions to ensure comparison can be made.***
Early September onwards	Promote the survey to staff. Posters have been received. ***Ian Shepherd is discussing communication strategy.***
Fri 1st September	Draw down staff list. ***Liam Carrier has completed this.***
By Wed 6th September	Submit staff list to Picker using the secure online portal: https://home.pickereurope.ac.uk/app. Your access to the site will be sent separately before 1st of September. ***See above***.
By Fri 8th September	Additional content (edited NHS England letter, local questions, etc.) send to Picker. ***The Trust will be using the same format as last year with the same additional questions to ensure comparison can be made with 2016 survey.***
Fri 15th September	Final NHS deadline for staff list submission
Mid-September - 9th October	Launch survey! ***Survey to be launched on 4th October 2017***
One week after survey launches	For online and mixed mode surveys, a list of emails that have bounced back (failed to send) will be forwarded by Picker.
Wed 1st November	Invoice received.
Fri 24th November	Final date to send any leavers or ineligible staff to be removed from the survey. ***Liam Carrier to provide information.***

Fri 1st December	Fieldwork ends and survey closes
By Fri 8th December	• Core questionnaire frequency tables produced by Picker • Data to the NHS Coordination Centre submitted by Picker
Mid-late December	Draft management report published.
January - February	Standard reports published by Picker: • Final Management Report • Executive Summary • Staff Engagement Report • Locality Reports and Spider Charts • Local Question Reports (for those with local questions)
Early February	National workshops – ***representative(s) from the Trust to attend. Attendees dependant on how new HR structure is operating.***
Mid-February to early March	The embargo on results set by the Coordination Centre ends and results are released to the public.

Derbyshire Healthcare NHS Foundation Trust
Report to the Trust Board - 27 September 2017

Board Effectiveness Survey
March 2017

Purpose of Report

This report provides the Trust Board with the results of the Board Effectiveness Survey conducted in March 2017.

Executive Summary

As part of the Deloitte review of Trust governance arrangements in January 2016, a Board Effectiveness Survey was undertaken and the results of that survey were used to inform some of the Deloitte recommendations. After Board discussions it was agreed that the Board would continue to use the survey in order to assess improvements and also gauge how effective the Board believes it is and to triangulate other information on Board effectiveness. Results of the second survey, undertaken in September 2016, were presented to a Board Development Session in September and then the Board in October 2016.

A third survey was undertaken in March 2017 (Appendix 1). The survey includes opportunity for free comments from respondents and was completed by all 15 Board members. Responders were not able to skip any questions. Comments were obtained and were reviewed in detail at the Board Development session in April 2017. These comments have been incorporated into the summary presented for each question.

The Board Development session in April noted significant assurance relating to the perception of Board members on effectiveness across the range of areas. No areas were noted to be required to take forward directly to inform Board Development, but it was noted that key areas of lower scoring were already being progressed as part of renewed focus (eg staff and Board engagement) and that for example duplication of business across Committees was now 'business as usual' in terms of regular review and oversight at the Committee Chairs/NEDs quarterly meetings.

There has been significant change in the membership of the Trust Board since the last survey in September 2016. Non-Executive Directors have been recruited and there are two new Executive Directors. This equates to 47% of current Board members who were either not in post or asked to participate in the last survey.

We have received 100% response rate with 15 responses. This is a 50% increase in responses received to the September 2016 survey. Highlights to note are as follows:

Q1 – All Board members act as Corporate Directors, demonstrating the ability to think strategically and contribute to areas outside their specialist field

There is a high degree of support for this statement with 93% of respondents either stating that they agree or strongly agree. This is also an area which is being

reviewed by the Chief Executive in relation to further developing these skills for Executive Directors through 1:1's and development plans where this is relevant.

Q2 - As a Board we have considered our future skills requirements and succession planning is in place

This links to Core 6, Recommendation 4 of the Deloitte report; Deloitte found that no formal succession plans were in place for Board members and only three directors had 'true' deputies. However, there has been a continued increase in positive response. When first surveyed in January 2016 the majority of Board members, 83%, neither agreed nor disagreed. The March result demonstrates a 67% positive response. Succession planning has been discussed at the Remuneration & Appointments Committee as part of GIAP Action RR1. Quarterly updates are in train for the Executive Leadership Team with update scheduled to the Remuneration and Appointments Committee in October 2017.

Q3: - We operate as a Unitary Board

90% of respondents felt that the Trust Board operated as a Unitary Board - where all directors are collectively and corporately accountable for organisational performance.

Q4 - As a Board we have established clear values for the Trust and Q5 – Values for this Trust are consistently role modelled by the Board members and senior managers

- Both of these reflect significant agreement that the Board has established clear values and these are consistently role modelled by Board members and senior managers. One respondent commented that 'I think this a real positive area for the Board and that our values play an important role in our decision-making'. The focus on values will be important in the Board's role in the priority of staff and engagement to be taken forward by the Trust.

Q6 - I am confident we have systems to ensure that inappropriate behaviours and performance are identified and responded to

80% of respondents supported this statement reflecting confidence in the systems in place.

Q7 - The Board does not operate in an 'ivory tower' – it proactively engages staff and staff feel able to approach Board members to discuss any concerns they might have

In September 2016 90% agreed with this statement. The March results show a reduction to 67%, with 20% disagreeing. The comments received reflect that efforts are made to be available and seen as approachable, but that perception of staff doesn't reflect this - and this is also reflected in the 2016 staff survey. This result reinforces the need for the renewed focus on staff engagement which includes ensuring visibility and opportunity to approach Board members. Activities undertaken since March 2017 have included continued deep dive presentations to the Board and Board member participation in quality visits, as well as range of engagement events

with the Executive team and Chief Executive where concerns and issues are encouraged to be raised. The result also reinforces the importance of ongoing work to promote staff to raise concerns (to line management, Freedom to Speak up Guardian and Board members alike) with the confidence that these will be listened to and acted upon.

Q8 - There are sufficient levels of engagement between the Board and the Council of Governors

This now stands at 100%. Following the results of the September survey it was agreed to triangulate responses with the outcome of the Annual Effectiveness Survey of the Council of Governors, which was undertaken in September 2016.

Nine governors responded, representing 50% of the then complement of 18 governors. The response is below.

14. The Council of Governors have sufficient opportunity for contact, and good communication, with the Board of Directors:

	Strongly agree	Agree	Don't know	Disagree	Strongly disagree	Response Total
With the Executive Directors	0.0% (0)	66.7% (6)	0.0% (0)	33.3% (3)	0.0% (0)	9
With the Non-Executive Directors	0.0% (0)	88.9% (8)	11.1% (1)	0.0% (0)	0.0% (0)	9

The governor survey will be repeated in September 2017 and results shared with Board members.

Q9 - After a decision has been made by the Board it is clear who is responsible for implementing it and by when.

Supported by a 100% positive response and comments reflect the improvements seen and demonstrates the embeddedness of the work taken to ensure actions are clearly articulated, recorded, carried out in a timely manner and individuals held to account for delivery.

Q10 There is minimal duplication between the work of the various Board Committees.

There is a broad range of perception on this question. This question links to the GIAP recommendation *Review the operation of all committees seeking to minimise duplication*. This issue has been a topic of discussion at the Quarterly Board Committee Chairs/NEDs meetings and remains an ongoing area for development and debate between Board Committee Chairs and their Executive Leads. Whilst it is important that key issues are discussed at relevant committees, it is important to avoid duplication of debate and promote sharing of assurance across Board Committees. It was agreed at the last Quarterly Board Committee chairs/NED meeting that should any duplication be noted, that this should be flagged and discussed to clarify the focus of respective Committees in discussing common topics with a view to ensuring clarification of purpose, seeking cross-committee assurance

on issues where appropriate and thereby avoiding duplication of debate. This will be monitored on an ongoing basis by the Board Committee chairs/NED meetings. Annual collective review of terms of reference for Committees helps to ensure clarity of role and remit of Committees' business. One respondent commented that 'There is some overlap of topics, which is entirely appropriate and necessary, and Committees continue to work to ensure unnecessary duplication of debate does not take place'.

Q11 – We routinely invite members of staff and other key stakeholders to present to the Board

94% of respondents agreed or strongly agreed with this statement. This is evidenced through Board standing items of a patient story and team deep dives which are felt to be effective. Further consideration was suggested relating to inviting wider stakeholders to Trust Board meetings (eg third sector).

Q12: When corrective action is taken, changes made are embedded. It is rare for our Trust to have issues that reoccur

There was a mixed response to this question which was explored in the Board Development session discussion. It was reiterated that Board members were determined that changes are embedded and agreed that much challenge at Board is about embeddedness and continuity of change – that is the Board has purposely moved to a compliance overview approach instead of periodical audits to further evidence this. Newer board members noted that they had been influenced by their lack of time in their role in responding to this question.

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

Assurances

This paper should be considered in relation to key risks contained in the Board Assurance Framework and core elements of the GIAP.

Consultation

Board Development Session April. Considered comments also for each question.

Governance or Legal Issues

This paper links directly to the NHS improvement enforcement action and associated licence undertakings, having been used in the Deloitte review February 2016.

Equality Delivery System

Consideration has been given to the equality impact on the nine protected characteristics (REGARDS people). No adverse effects have been identified.

Recommendations

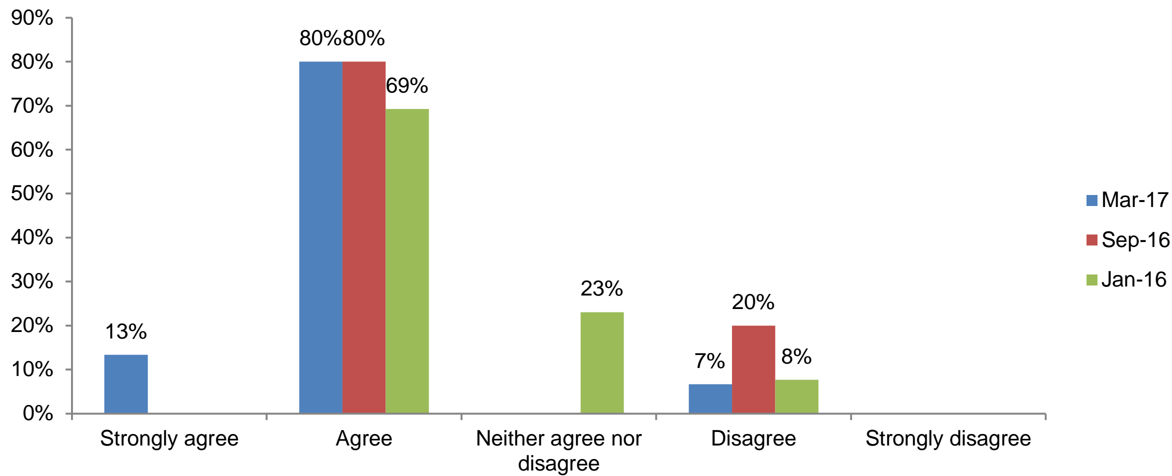
The Trust Board is requested to:

1. Note the outcome of the Board Effectiveness Survey March 2017.
2. Consider the responses including how further improvements are being taken forward as part of planned action by either the Board itself, Board Committees or the wider Trust.
3. Agree that the survey should be completed again in October 2017.

Report presented by:	**Samantha Harrison, Director of Corporate Affairs & Trust Secretary**
Report prepared by:	**Samantha Harrison, Director of Corporate Affairs & Trust Secretary** **Donna Cameron, Assistant Trust Secretary**

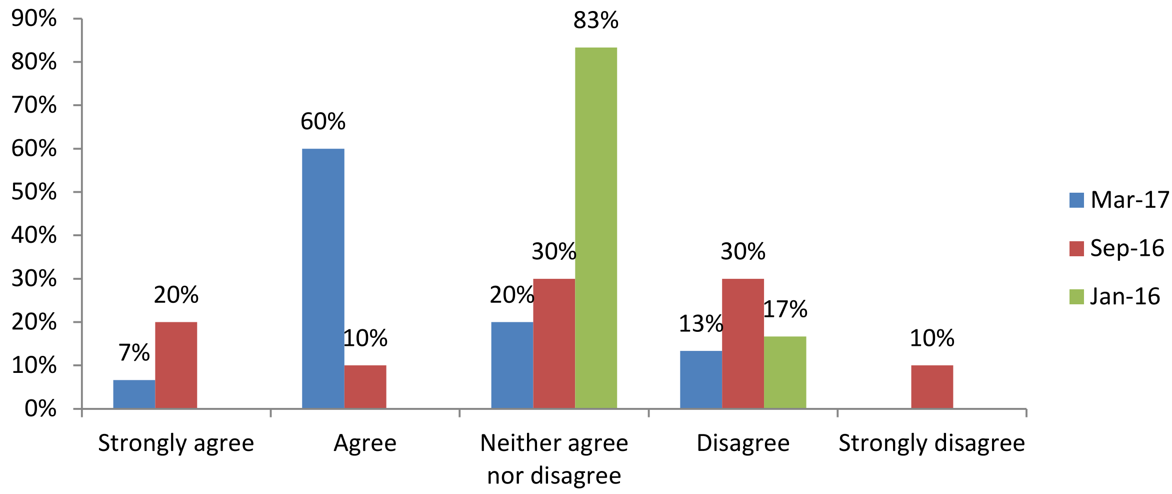
APPENDIX 1

Q1 All Board members act as Corporate Directors, demonstrating the ability to think strategically and contribute to areas outside their specialist field



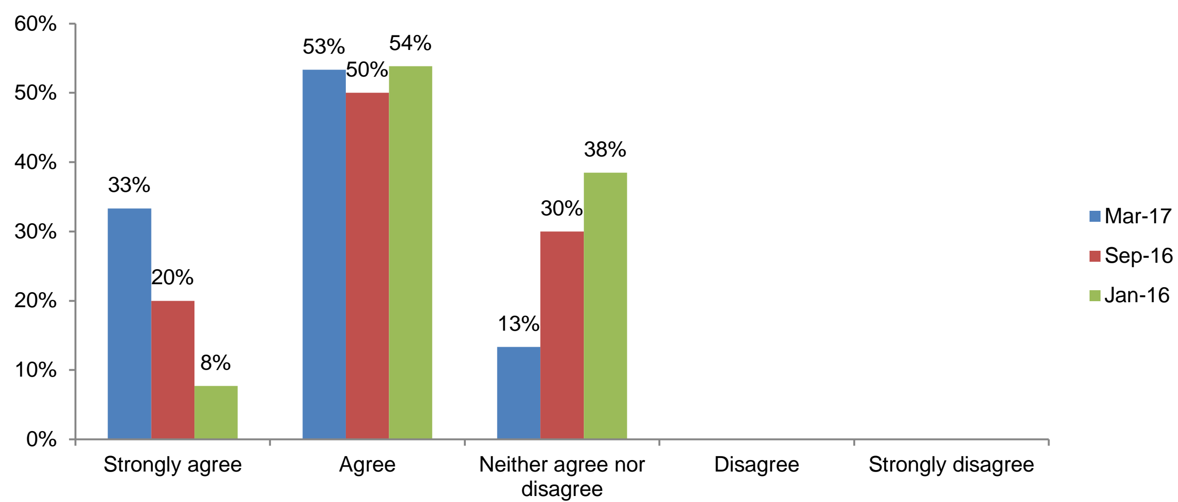
Question 1		March 2017	September 2016	January 2016
1	Strongly agree	2	0	0
2	Agree	12	8	9
3	Neither agree nor disagree	0	0	3
4	Disagree	1	2	1
5	Strongly disagree	0	0	0
Total Responses		**15**	**10**	**13**

Q2 As a Board we have considered our future skills requirements and succession planning is in place



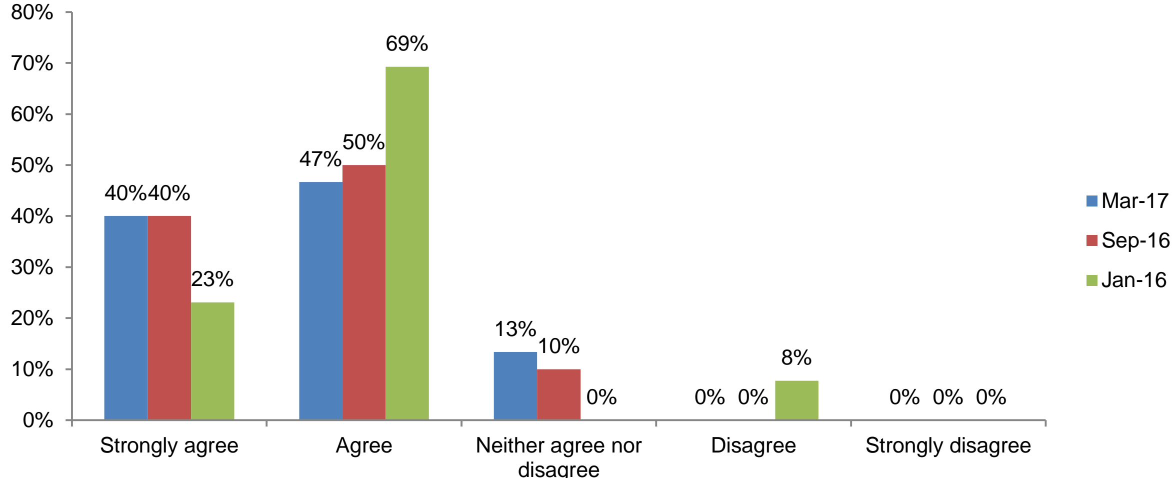
Question 2	March 2017	September 2016	January 2016
1 Strongly agree	1	2	0
2 Agree	9	1	0
3 Neither agree nor disagree	3	3	10
4 Disagree	2	3	2
5 Strongly disagree	0	1	0
Total Responses	**15**	**10**	**12**

Q3 We operate as a Unitary Board



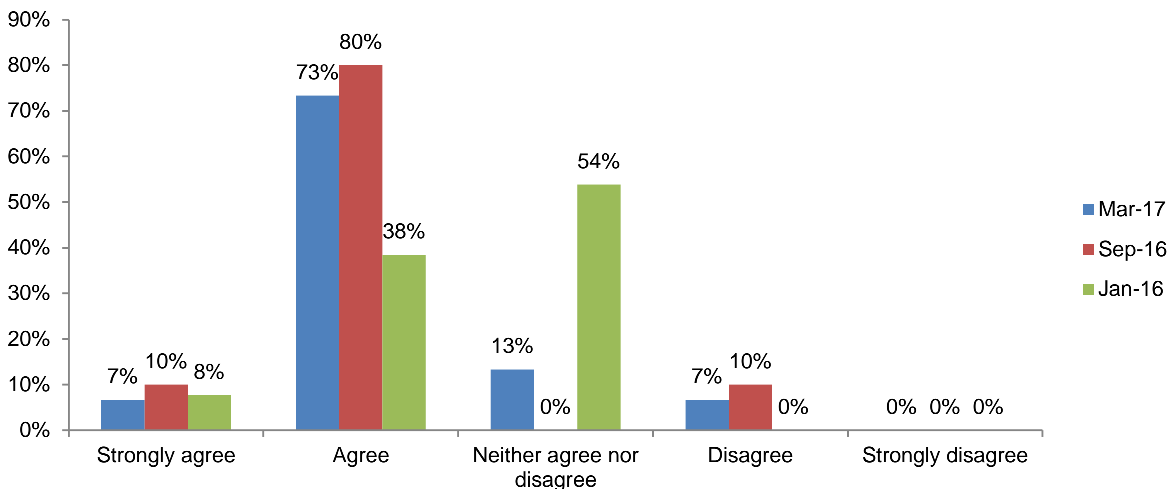
Question 3	March 2017	September 2016	January 2016
1 Strongly agree	5	2	1
2 Agree	8	5	7
3 Neither agree nor disagree	2	3	5
4 Disagree	0	0	0
5 Strongly disagree	0	0	0
Total Responses	**15**	**10**	**13**

Q4 As a Board we have established clear values for the Trust



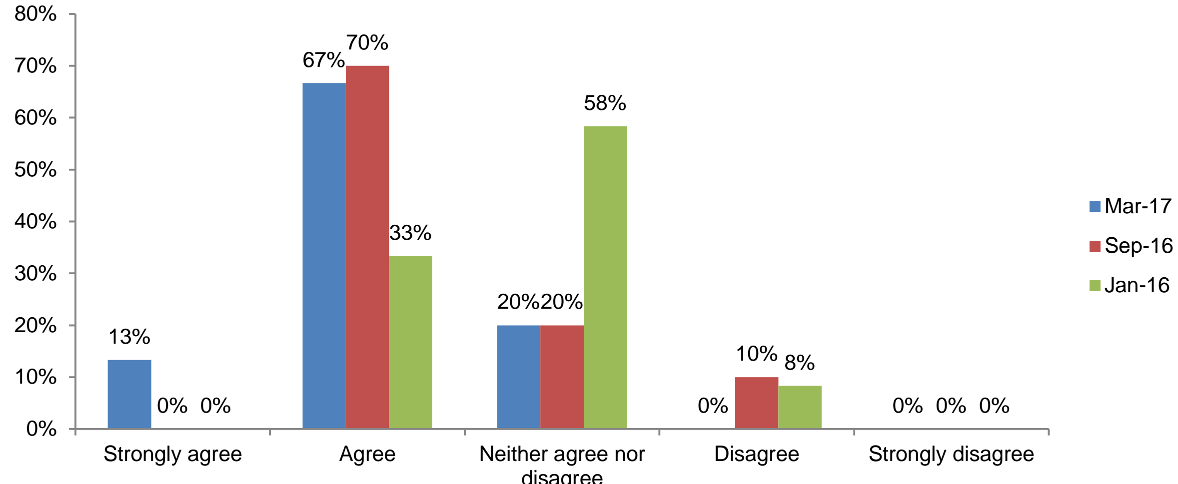
Question 4	March 2017	September 2016	January 2016
1 Strongly agree	6	4	3
2 Agree	7	5	9
3 Neither agree nor disagree	2	1	0
4 Disagree	0	0	1
5 Strongly disagree	0	0	0
Total Responses	**15**	**10**	**13**

Q5 Values for this Trust are consistently role modelled by Board members and senior managers



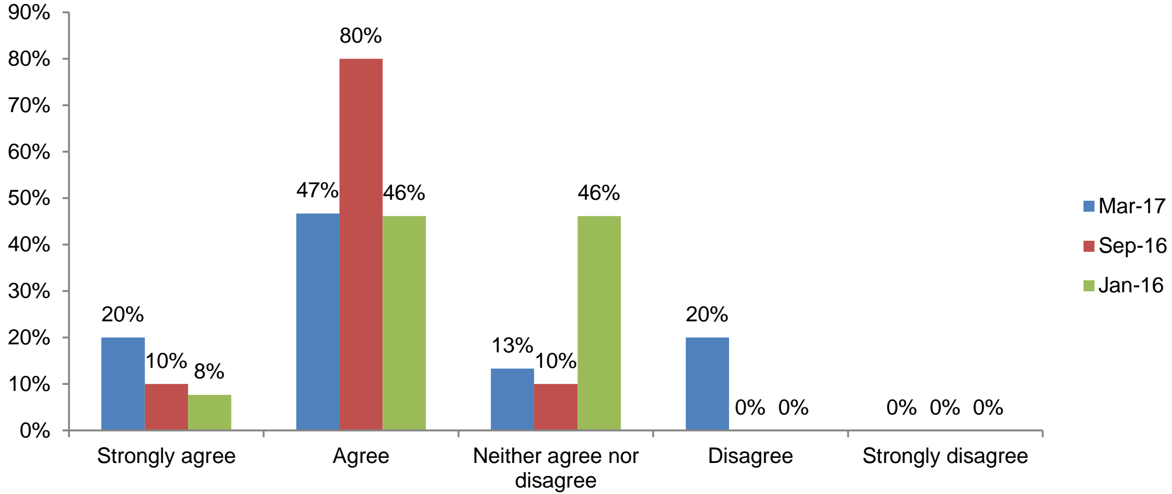
Question 5	March 2017	September 2016	January 2016
1 Strongly agree	1	1	1
2 Agree	11	8	5
3 Neither agree nor disagree	2	0	7
4 Disagree	1	1	0
5 Strongly disagree	0	0	0
Total Responses	**15**	**10**	**13**

Q6 I am confident we have systems to ensure that inappropriate behaviours and performance are identified and responded to



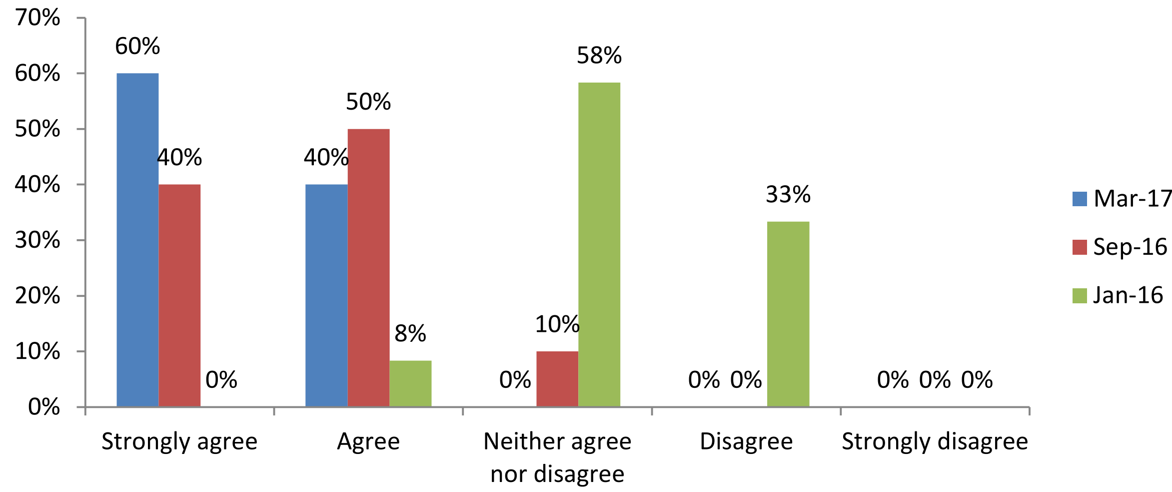
Question 6	March 2017	September 2016	January 2016
1 Strongly agree	2	0	0
2 Agree	10	7	4
3 Neither agree nor disagree	3	2	7
4 Disagree	0	1	1
5 Strongly disagree	0	0	0
Total Responses	**15**	**10**	**12**

Q7 The Board does not operate in an 'ivory tower' – it proactively engages staff and staff feel able to approach Board members to discuss any concerns they might have



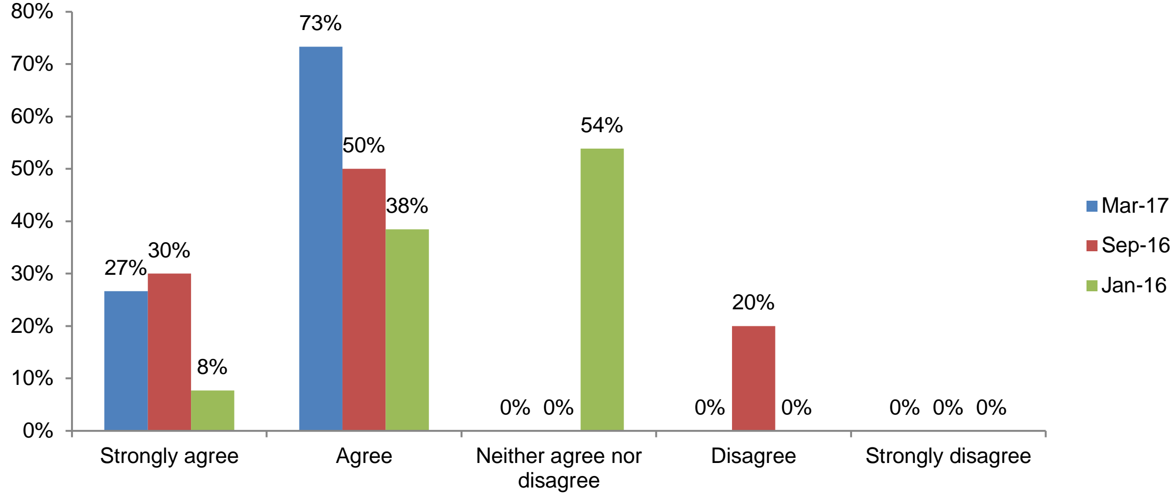
Question 7	March 2017	September 2016	January 2016
1 Strongly agree	3	1	1
2 Agree	7	8	6
3 Neither agree nor disagree	2	1	6
4 Disagree	3	0	0
5 Strongly disagree	0	0	0
Total Responses	**15**	**10**	**13**

Q8 There are sufficient levels of engagement between the Board and the Council of Governors



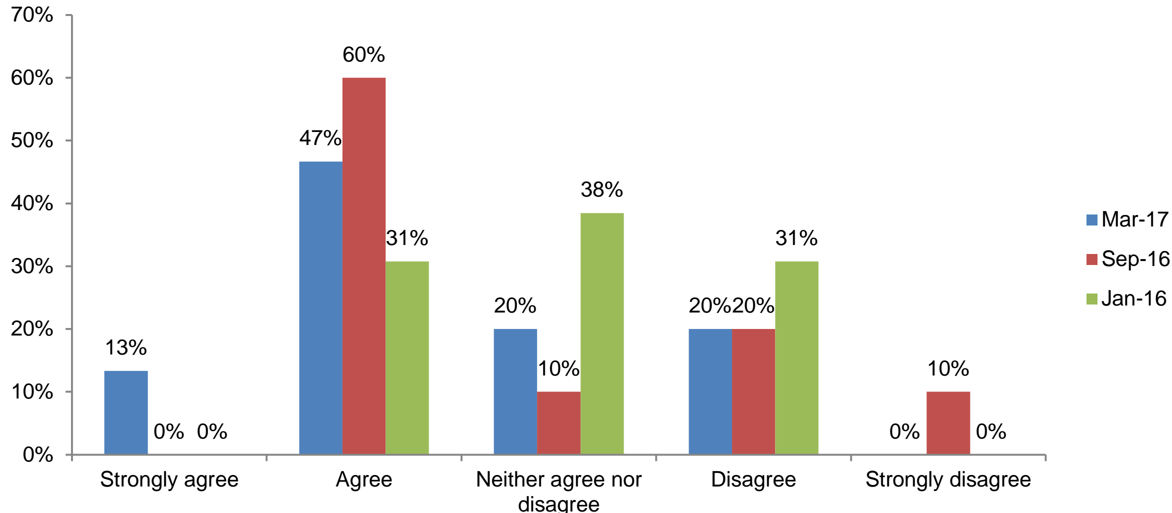
Question 8	March 2017	September 2016	January 2016
1 Strongly agree	9	4	0
2 Agree	6	5	1
3 Neither agree nor disagree	0	1	7
4 Disagree	0	0	4
5 Strongly disagree	0	0	0
Total Responses	**15**	**10**	**12**

Q9 After a decision has been made by the Board it is clear who is responsible for implementing it and by when



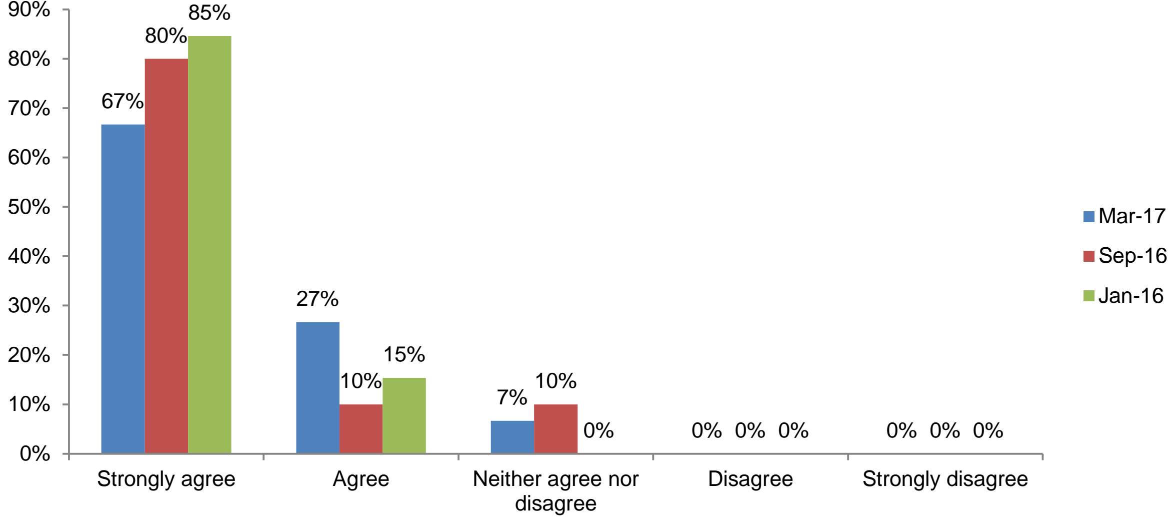
Question 9	March 2017	September 2016	January 2016
1 Strongly agree	4	3	1
2 Agree	11	5	5
3 Neither agree nor disagree	0	0	7
4 Disagree	0	2	0
5 Strongly disagree	0	0	0
Total Responses	**15**	**10**	**13**

Q10 There is minimal duplication between the work of the various Board committees



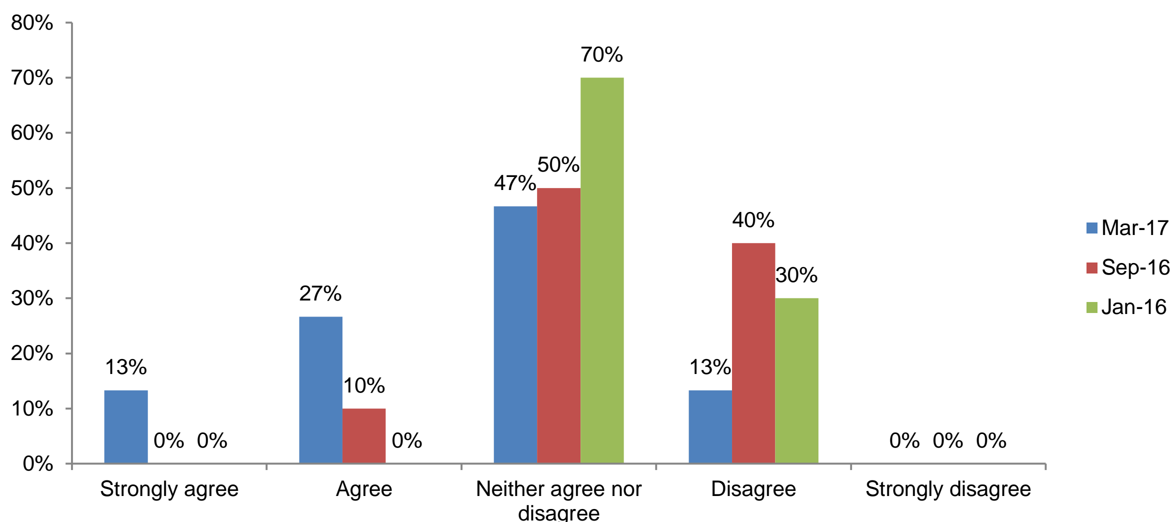
Question 10	March 2017	September 2016	January 2016
1 Strongly agree	2	0	0
2 Agree	7	6	4
3 Neither agree nor disagree	3	1	5
4 Disagree	3	2	4
5 Strongly disagree	0	1	0
Total Responses	**15**	**10**	**13**

Q11 We routinely invite members of staff and other key stakeholders to present to the Board



Question 11	March 2017	September 2016	January
1 Strongly agree	10	8	11
2 Agree	4	1	2
3 Neither agree nor disagree	1	1	0
4 Disagree	0	0	0
5 Strongly disagree	0	0	0
Total Responses	**15**	**10**	**13**

Q12 When corrective action is taken, changes made are embedded. It is rare for our Trust to have issues that reoccur



Question 12	March 2017	September 2016	January 2016
1 Strongly agree	2	0	0
2 Agree	4	1	0
3 Neither agree nor disagree	7	5	7
4 Disagree	2	4	3
5 Strongly disagree	0	0	0
Total Responses	**15**	**10**	**10**

Summary of Board Assurance Framework Risks 2017/18 - Issue 3.0

Ref	Principal risk	Director Lead	Current rating (Likelihood x Impact)
Strategic Outcome 1. We will deliver quality in everything we do providing safe, effective and person centred care			
1a	Failure to achieve clinical quality safety standards required by our regulators	Executive Director of Nursing and Patient Experience	HIGH (4x4)
1b	Failure to achieve clinical quality standards required by our regulators in relation to providing effective care for our patients	Executive Director of Nursing and Patient Experience	HIGH (4x4)
1c	Failure to fully comply with the statutory requirements of the Mental Health Act (MHA) Code of Practice and the Mental Capacity Act (MCA)	Medical Director	HIGH (4x4)
1d	Risk of inadequate systems to ensure business continuity is maintained in the event of a major incident	Acting Chief Operating Officer	MODERATE (4x3)
Strategic Outcome 2: We will develop strong, effective, credible and sustainable partnerships with key stakeholders to deliver care in the right place at the right time			
2a	Inability to deliver system wide change due to changing commissioner landscape and financial constraints within the health and social care system	Interim Director of Strategic Development	EXTREME (4x5)
Strategic Outcome 3. We will develop our people to allow them to be innovative, empowered, engage and motivated. We will retain and attract the best staff			
3a	Ability to attract and retain high quality clinical staff across all professions	Director of People and Organisational Effectiveness	EXTREME (4x5)
3b	There is a risk to staff engagement and wellbeing by the trust not having supportive and engaging leaders	Director of People and Organisational Effectiveness	HIGH (4x4)
3d	There is a risk that the Trust does not operate inclusively and may be unable to deliver equity of outcomes for staff and service users	Director of People and Organisational Effectiveness	MODERATE (4x2)
3e	Potential turnover of board members	Director of Corporate Affairs and Board Secretary	HIGH (3x4)
Strategic Outcome 4. We will transform services to achieve long-term financial sustainability			
4a	Failure to deliver financial plans	Executive Director of Finance	EXTREME (4x5)
4b	Failure to deliver internal transformational change at pace	Interim Director of Strategic Development	EXTREME (4x5)

Derbyshire Healthcare NHS Foundation Trust
Report to the Trust Board – 27 September 2017

Report from Extraordinary Meeting of Council of Governors 13 September 2017

Purpose of Report

To provide a summary of the extraordinary meeting of the Council of Governors held on 13 September 2017.

Executive Summary

An extraordinary meeting of the Council of Governors was called for 13 September 2017 in order to receive and consider a recommendation from the Governors' Nominations & Remuneration Committee relating to the appointment of the Trust Chair.

John Morrissey, Lead Governor, presented a report which highlighted the process undertaken for recruitment, including the interview and stakeholder group evaluation which had been conducted on 6 September.

The recommendation to appoint Caroline Maley was proposed in confidential session and carried, following a ballot of governors present. Arrangements were made for Caroline to commence the role on 14 September 2017.

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

Assurances

The recruitment process followed had been supported by an external recruitment consultancy - NHS Leadership Academy Executive Search, with additional in-house support and advice received from the Interim Director of People & Organisational Effectiveness with governance oversight from the Director of Corporate Affairs.

Consultation

Governors, through the Nominations & Remuneration Committee and the extraordinary meeting of the Council of Governors have been involved in oversight of the recruitment process and directly involved in longlisting, shortlisting and interview. Other governors and Trust staff have also been involved in stakeholder sessions with candidates. Each stakeholder group fed back to the interview panel prior to formal interview.

Governance or Legal Issues

The Governors' Nomination & Remuneration Committee conducted its respective role in line with its terms of reference and statutory role.

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 of REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation) and Public Sector Equality Duty & Equality Impact Risk Analysis.

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 gaps/inequalities are outlined below, with the appropriate action to mitigate or minimise those risks.	

Actions to Mitigate/Minimise Identified Risks

Recruitment processes were set in place through the NHS Leadership Academy Executive Search to ensure no adverse effects on applicants from protected characteristic.

Recommendations

The Trust Board is requested to note the outcome of the Council of Governors Meeting.

Report presented by: **Margaret Gildea, Senior Independent Director and Chair of the Governors' Nominations and Remuneration Committee for the purpose of Trust Chair recruitment**

Report prepared by: **Samantha Harrison**
Director of Corporate Affairs & Trust Secretary and
Donna Cameron
Assistant Trust Secretary

2017-18 Board Annual Forward Plan

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 *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 Strategic Outcome 3 Information Gov toolkit	AR					IR				
AR	Staff Survey Results and Action Plan	Strategic Outcome 3 and 4	X									
AR	Equality Delivery System2 (EDS2) & Workforce Face Equality Standard (WRES) Submission * (Jul & Sep 2017)	Strategic Outcome 3 and 4	AR		X *	X *	X Update					
AR	Pulse Check Results and Staff Survey Plan						X					
AR	Approval of Equality Delivery System2 (EDS2) 2017/18	Strategic Outcome 3 and 4					X					
SH	Review SOs, SFIs, SoD	FT Constitution Standing Orders					AR					
SH	Trust Sealings	FT Constitution Standing Orders	AR									

2017-18 Board Annual Forward Plan

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
SH	Annual Review of Register of Interests	FT Constitution Annual Reporting Manual	AR									
SH	Board Assurance Framework Update	Licence Condition FT4	X				X		X		X	
SH	Raising Concerns (whistleblowing)	Strategic Outcome 1 Public Interest Disclosure Act			X							
SH	Committee Assurance Summaries (following every meeting) - Audit & Risk Committee - Finance & Performance - Confidential - Mental Health Act Committee - Quality Committee - Safeguarding Committee - People & Culture Committee	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			X					
SH	Report from Council of Governors Meeting		X	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 Monitoring		X			X		X			X	
LWS	Measuring the Trust Strategy			X								
OPERATIONAL PERFORMANCE												
CG, CW, AR, MP	Integrated performance and activity report to include Finance, Workforce, performance and Quality Dashboard	Licence Condition FT 4 Strategic outcome 1 Strategic Outcome 3	X	X	X	X	X	X	X	X	X	X

2017-18 Board Annual Forward Plan

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
QUALITY GOVERNANCE												
CG	Position Statement on Quality (Incorporates Strategy and assurance aspects of Quality management) Quarterly publication of specicified information on death in September Includes Annual Review of Recovery Outcomes in November and Annual Looked After Children Report in December	Strategic Outcome 1 CQC and Monitor	X	X	X	X	X	X	X	X	X	X
CG/JS	Safeguarding Children & Adults at Risk Annual Report	Children Act Mental Health Standard Contract					AR					
CG	Control of Infection Report	Health Act 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 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