Derbyshire Healthcare NHS
NHS Foundation Trust

Meeting of the Board of Directors

24 February 2016

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

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Derbyshire Healthcare NHS
NHS Foundation Trust

NOTICE OF BOARD MEETING
WEDNESDAY 24 FEBRUARY 2016
TO COMMENCE AT 1.00 PM IN THE CONFERENCE ROOMS A & B,
RESEARCH & DEVELOPMENT CENTRE, KINGSWAY, DERBY DE22 3LZ

Item	Time	AGENDA	Enc Ref	Discussion led by
1.	1:00	Chairman's Welcome and Opening Remarks	-	Richard Gregory
2.	1:05	Service Receiver Story – Learning Difficulties		
3.	2:00	Apologies for Absence Declarations of Interest		Richard Gregory
4.	2:05	Minutes of Board of Directors meeting held on 27 January 2016	**A**	Richard Gregory
5.	2:10	Matters arising – Actions Matrix	**B**	Richard Gregory
6.	2:20	Chairman's Update		Richard Gregory
7.	2:30	Acting Chief Executive's Report	**C**	Ifti Majid
PATIENTS, QUALITY AND SAFETY				
8.	2:40	Position Statement on Quality	**D**	Carolyn Green
9.	2:50	CQC Safeguarding Report and Action Plan	**E**	Carolyn Green
B R E A K 3:00				
10.	3:15	Staff Survey Results – embargoed until 23 February	**F**	Jayne Storey
OPERATIONAL PERFORMANCE REVIEW				
11.	3:35	Integrated Performance and Activity Report	**G**	Carolyn Gilby
FINANCE, STRATEGY AND GOVERNANCE				
12.	3:45	Finance Director's Report Month 10	**H**	Claire Wright
13.	3:55	Governance Framework and Action Plan	**I** to follow	Jenna Davies
14.	4:10	Board Committee Escalations: - Quality Committee ratified minutes of meeting held 14 January - Audit Committee draft minutes of meeting held 20 January - Safeguarding Committee – draft minutes of meeting held 22 January - Finance & Performance Committee – verbal update of meeting 25 January - People & Culture Committee – verbal update of meeting held 17 February - Mental Health Act Committee – no meeting this month	**J**	Committee Chairs
15.	4:20	Future relationship between the Trust's Board and Council of Governors	-	Richard Gregory John Morrissey
FOR INFORMATION ONLY				
16.	4:30	I. Board Forward Plan II. January's Service Receiver Story to Board III. Identification of any issues arising from the meeting for inclusion or updating of the Board Assurance Framework IV. Learning Difficulties (including community treatment reviews) will be the theme of the next deep dive at the March meeting V. Comments from observers on Board performance and content of meeting	**K** **L**	Richard Gregory

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

The next meeting is to be held on 30 March 2016, at 1.00 pm in Conference Rooms A & B,
Centre for Research and Development, Kingsway, Derby DE22 3LZ
Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.
Participation in meetings is at the Chairman's discretion.

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Wednesday 27 January 2016

MEETING HELD IN PUBLIC

Commenced: 1pm Closed: 4pm

PRESENT:	Richard Gregory	Interim Chairman
	Caroline Maley	Senior Independent Director
	Maura Teager	Chair and Non-Executive Director
	Jim Dixon	Non-Executive Director
	Phil Harris	Non-Executive Director
	Ifti Majid	Acting Chief Executive
	Claire Wright	Executive Director of Finance
	Carolyn Green	Director of Nursing and Patient Experience
	Dr John Sykes	Executive Medical Director
	Carolyn Gilby	Acting Director of Operations
	Jayne Storey	Director of Workforce OD & Culture
	Mark Powell	Director of Business Development & Marketing
IN ATTENDANCE:	Jenna Davies	Interim Director of Corporate & Legal Affairs
	Anna Shaw	Deputy Director of Communications & Involvement
	Sue Turner	Board Secretary and Minute Taker
	Jay Bevington	Observer from Deloitte
VISITORS:		
For item DHCFT 2016/002	Phil	Service User
For item DHCFT 2016/002	Doro Moore	Community Psychiatric Nurse
For item DHCFT 2016/002	Bev Green	Service Improvement / Covering Head Nurse Hartington Unit
	John Morrissey	Public Governor, Amber Valley South
	Carole Riley	Derbyshire Voice Representative
APOLOGIES:	Tony Smith	Non-Executive Director

DHCFT 2016/001	**INTERIM CHAIRMAN'S WELCOME, OPENING REMARKS AND APOLOGIES** The Interim Chairman, Richard Gregory, opened the meeting by welcoming all present and declared there was no conflict of interest in today's agenda. Richard Gregory explained how confident he felt in moving forwards from some of the difficulties that have challenged the Trust in recent times and that he aimed to reflect best practice in the way the Board operates and with the Board's committees. The number of items on today's agenda had been reduced to focus more on quality to allow more effective discussions and to reflect the range of work which is currently occupying the Board's attention.

DHCFT 2016/002	**SERVICE RECEIVER STORY** Covering Head Nurse at the Hartington Unit, Bev Green, introduced service receiver Phil and Community Drug Worker, Doro Moore who has been working with Phil and his partner Claire (unfortunately Claire could not attend the meeting). Phil described how he and Claire first came into the Trust's service and how they were originally supported as individuals and then as a family by the substance misuse team. When Phil was first involved with the Trust things did not start very well, he was in a dark place and he felt he received a very one sided experience. Phil explained that he and Claire had a baby girl who unfortunately had a heart problem which was operated on when she was just 10 days old but she very sadly died the following day. Phil and Claire have two other two children who were taken away from them at this point which left them feeling as if their lives had ended. Phil and Claire had not progressed very well with social services who they felt made judgements against them. Doro Moore, the clinician started working with Phil and Claire and was very understanding and put Phil and Claire in contact with all the services they needed. Doro made appointments for treatment and support for Phil and Claire and set them in the right direction so they now feel quite well. Phil strongly believed that without Doro, he and Claire would not be where they are today as Doro and the substance misuse services took a family approach to their treatment which was so important to them. Ifti Majid asked Phil if there was anything the Trust could have done better. Phil explained that when you start to work with people who are caring for you it's important to feel comfortable with them. Some people aren't so lucky and have to change support workers or their support worker moves away into other areas and they have to start to build a relationship with someone else. Agency workers only stay for a few months and patients get moved to another person. Phil and Claire refused to change from Doro as they didn't want to start a new relationship with another clinician. They have now been working with Doro for five years and would not want to work with anyone else and although this wasn't the service model, this had been respected by the team and stability in the named worker had been agreed. Richard Gregory understood Phil's message was that it is important to have a relationship with someone you can trust. Doro Moore explained that she and her team carry out a high and low intensity service which in itself can create problems because some clients are more stable and others have a high dependency on drugs and are passed to other workers. Phil and Claire refused to allow this to happen. Doro also described how nice it was for her to have consistency and see the progress achieved with the people she worked with. Maura Teager was interested to know how clients could change their care workers if they were unable to establish an effective relationship with them. Doro explained there are various ways of doing this and it is never seen as an issue if clients request a change of key worker. Doro Moore explained that tension between clients and workers can sometime happen due to the nature of boundary setting in substance misuse management and a balance has to be struck of change and continuity. Richard Gregory felt it took courage for Phil to attend today's meeting and share his story and he hoped Phil's family's progress would continue. Members of the Board offered condolences for Phil's and his partner's loss and thanked Phil for his compelling story and his comments which would serve as a valuable contribution to improving the Trust's services.

	RESOLVED: The Board of Directors expressed thanks to Phil for sharing his story and for providing his observations of the Trust's services.
DHCFT 2016/003	**MINUTES OF THE MEETING DATED 25 NOVEMBER 2015** The minutes of the meeting, dated 25 November 2015 were accepted and agreed.
DHCFT 2016/004	**MATTERS ARISING AND ACTIONS MATRIX** The Board agreed to close all completed actions. Updates were provided by members of the Board and were noted directly on the actions matrix. It was agreed that the matrix would be adapted to provide evidence that actions have been completed when transferred to committees.
DHCFT 2016/005	**ACTING CHIEF EXECUTIVE'S REPORT** Ifti Majid's report provided the Board with some of the key national policy changes or announcements over the last month. The report also provided an update on work within the Derbyshire Health and Social Care Community as well as covering key issues internal to the Trust. The following points were discussed: i. The Trust's north and south units of planning had asked the Board to review its Sustainability and Transformation Planning Footprint and concur with recommendations for a county and city wide footprint. The Board is actively supporting the county wide footprint which would produce a single entity for Derbyshire. Members of the Board welcomed this initiative which will enable mental health provision to allow the integration of primary care with other providers and afford the opportunity to be more flexible. ii. Nottinghamshire's devolution bid is now available in full on Derbyshire County Council's website. The Board has held previous discussions around this under the name of Devolution D2N2, now known as Devolution North Midlands. The bid has altered little from the iteration seen by the Board and will inform an important part of the Board's strategy development discussions. Ifti Majid explained that a decision had not yet been reached on the detail of the boundaries and it is not yet clear how north Derbyshire would work with Sheffield but he would keep the Board informed of aspects of planning as D2N2 will have a huge impact for the health service and people's housing, transport and resilience. The matter of recruitment and resource needs was raised by Caroline Maley and Ifti Majid clarified that the safer staffing reports show this has improved significantly and rolling recruitment would not stop. iii. The Trust's Plans for the industrial action by junior doctors was outlined by John Sykes and the Board supported the contingency plans that have been put in place. Although yesterday's strike action was suspended, a full walk out by junior doctors is expected on 10 February. This action is unprecedented and John Sykes explained that the risk is that although consultants and specialty doctors can be deployed to cover the inpatient units, the competency skill set for consultants is predominantly mental health rather than physical healthcare and they may lack some of the practical skills and knowledge to deal with complex medical situations. The skill set of specialty doctors is closer to what is required so these will be deployed in the front line wherever possible. A major incident approach on the day will be led by Carolyn Gilby, Acting

	Director of Operations. All training will be cancelled and trainers redeployed to clinical areas. An incident room will be staffed to learn the lessons from the previous week's approach. Phlebotomy and IT support will be required to close gaps in skills sets in the cover from senior doctors. John Sykes as Medical Director will oversee communication to all staff and patients and will be available to answer external enquiries. He will liaise with neighbouring Medical Directors and CCGs in efforts to improve overall system resilience and will escalate risks as necessary to the Executive Leadership Team for action and if necessary direct action by the Acting Chief Executive. In most cases consultants and doctors who won't be striking will provide cover and extra help is being secured from GPs and other areas. This will be a major challenge to all health providers. **RESOLVED: The Board of Directors noted the contents of the Acting Chief Executive's report**
DHCFT 2016/006	**<u>POSITION STATEMENT ON QUALITY</u>** Carolyn Green's report provided the Board with an update on the continuing work to improve the quality of services provided in line with the Trust's Strategy, Quality Strategy and Framework and strategic objectives. The independent review of deaths of people with a learning disability or mental health problem in contact with the Southern Health NHS Foundation Trust recognised that not enough deaths were investigated at the Southern Hospital with people with learning difficulties and in their wider mental health and care services. Carolyn Green informed the Board that the Quality Committee had scrutinised the report and the Trust has a plan in place that will ensure good governance in this area and purposeful learning. This information has been shared nationally and other authorities have thanked us for this. Strong assurance on duty of candour has been obtained although there are still national reputational issues that need to be addressed as there are difficult interpretations of investigations but Carolyn Green was confident the Trust has a very strong process of control in this area. Carolyn Green wished to point out that although national suicide rates are rising the Trust had a low suicide rate for 2014/15 and she informed the Board that the Quality Committee will receive information on the new national benchmark on suicide and the Trust's Suicide Prevention Strategy in February. The Inpatient Service Users Survey comparison report was contained in the report which showed positive progress over a period of three years. The Board was pleased to note the areas of positive feedback received from service users throughout 2015 and that the Trust was performing above the national average. The Board noted the trend of the report and Caroline Maley requested caution on the survey findings due to the small sample size. The Trust is working towards becoming a smoke free environment which is very important for the organisation to reduce its mortality rates and improve physical health. The Board recognised this initiative will be a challenge but recognised that other organisations have carried this concept through successfully. The method of reporting risks to the Board was queried by Caroline Maley. The Quality Committee had recently reviewed the process for reporting risks and the Board agreed that a summary of "bottom up" risks from the Quality Leadership Teams would be reported to the Quality Committee and any escalation to Board would be recorded at each meeting.

	ACTION: Summary of "bottom up" risks will be reported to the Board at each meeting. **RESOLVED: The Board of Directors:** **1) Noted the Quality Position Statement Dashboard and trends.** **2) Received the results of the inpatient survey, and noted areas of improvement.**
DHCFT 2016/007	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT** Carolyn Gilby's report defined the Trust's performance against its Key Performance Indicators plus any actions in place to ensure performance is maintained. The report showed compliance with the Trust's performance indicators is being actively monitored and corrective actions are put in place where appropriate. Areas covered in this report included, the Main Performance Indicators, Health Visitors, IAPT and Ward Safer Staffing. Key points noted included: i. The Trust continues to be compliant with all Monitor regulatory indicators ii. The recording of Payment by Result Clusters and Health of the Nation Outcome Scores 12 month reviews continue to be challenging. However, there have been recent improvements and new targets agreed with commissioners iii. The rate of outpatients who did not attend is still causing concern iv. Health visitor performance remains strong v. IAPT recovery rates have gone below target in December vi. The Trust continues to have qualified staffing vacancies in the Hartington Unit that impact on staffing fill rates, Tansley is most adversely effected vii. The report included a 6 month review of staffing levels by ward Carolyn Gilby pointed out that the action plan variance commentary was discussed at the Finance & Performance Committee. The action plan will be actively monitored and it is hoped this will improve performance. The variance commentary also gave a level of confidence in the actions and it was noted that clustering will now improve due to the implementation of the action plan. Discussion took place on exception items and specific areas of interest. Claire Wright had looked at the two months in the comparator table and the previous quarters' returns for CPA seven-day follow up and asked whether this was evidence of a declining position. Carolyn Gilby agreed five occurrences of exceptional circumstances were unprecedented and she described the specific reasons and action taken behind each case. She assured the Board that seven-day follow ups always take place to ensure patient safety because it is recognised that people are more at risk within the first seven days of release. It was agreed that Carolyn Gilby and Claire Wright will discuss outside of the meeting the potential for updating the reporting to increase visibility of alignment with quarterly compliance returns information. The output of outpatient letters was discussed. Carolyn Gilby explained that an action plan was in place to improve output which showed performance was above trajectory although there was a dip during December due to the Christmas holiday period. The Board was of the opinion that holiday periods should not adversely affect the output of letters and was informed that attention is being given to the capacity for staff to type letters during this period for electronic sign off by the doctors to ensure letters are processed within ten working days. The Board noted the IAPT (Improving Access to Psychological Therapies) performance and was assured that the action plan to drive improvement would prevent

	a dip in IAPT performance. The Interim Chairman wondered whether the right establishment was in place for community services. Carolyn Green explained that an inpatient and community skill mix review has taken place in Chesterfield encompassing all community neighbourhood areas and is being monitored by the Quality Committee. Discussions took place on ward safer staffing and vacancy fill rates and the continuous vacancies in particular wards/units and it was pointed out that recruitment is being worked on. Carolyn Green confirmed safer staffing meetings are being carried out three times a week. A challenge was made by Phil Harris who asked whether there was any triangulation with staff sickness and the staff survey. Carolyn Green confirmed that in certain wards there are specific HR processes which will have had an impact. These are the impacts of these issues rather than wider staff Friends and Family Test or staff survey issues. It is clear that when HR process does occur has an impact upon staff satisfaction and staff friends and families tests. Carolyn Green confirmed that specific issues could not be reported in the Public Board session but she was available to brief members of the Board on the specific issues. **ACTION: It was agreed that Carolyn Gilby and Claire Wright will discuss the potential for updating the reporting to increase visibility of alignment with quarterly compliance returns information.** **RESOLVED: The Board of Directors:** **1) Acknowledged the current performance of the Trust** **2) Note the actions in place to ensure sustained performance**
DHCFT 2016/008	**<u>FINANCE DIRECTOR'S REPORT MONTH 9</u>** Claire Wright's report provided the Board with an update on financial performance against operational financial plan as at the end of December 2015. Key points noted included: i. Information received from Monitor on the requirements for an improved financial outturn for this financial year and that the Board has been asked to agree to and to commit to a plan to meet a control total of £1.7m for 2016/17. ii. The Trust has no particular issue with delay on receipt of payment from debtors and no exceptions were reported to last week's meeting of the Audit Committee. iii. The Trust has overridden the allowable cost of qualified nursing agency expenditure ceiling of 3% during November and December. Weekly reports on pay-rate and framework overrides are reported to Monitor on a weekly basis. It is important to understand the clarification of the 3% ceiling and Claire Wright confirmed the Trust has overridden but not breached the rules of the 3% ceiling. In response to Mark Powell's question as to what would be the consequence if nursing agency expenditure was not reduced to the ceiling of 3%, Claire Wright explained Monitor expect improvement in this area for all trusts and will look at this area of performance as part of assessing overall performance of the Trust The Board agreed that it is critical that services must be adequately staffed in order to ensure patient safety and also that the Trust operates within the agency control regime in order to support NHS England's effort to keep down agency costs. **RESOLVED: The Board of Directors** **1) Considered the content of the paper and level of assurance on the current**

	and forecast financial performance for 2015/16. **2) Noted the Monitor agency rule overrides for December**
DHCFT 2016/009	**STRATEGY DEVELOPMENT UPDATE** The Board of Directors has committed to developing a new Trust Strategy for the next three years. Mark Powell's report provided the Board of Directors with a brief update on progress to date and it also provided an update on stakeholder engagement and next steps. Members of the Board were assured that the agreed timeline for strategy development continues to be met, although the timeframe for delivery remains challenging. A meeting has recently taken place with governors to enable them to provide input into the strategy and the strategy will also be a feature of Spotlight on Leaders events. The Board was pleased to note that the Board Development session scheduled for 10 February will increase momentum for the strategy to enter the next stage. **RESOLVED: The Board of Directors noted the content of the Strategy Development Update.**
DHCFT 2016/010	**PEOPLE & CULTURE COMMITTEE TERMS OF REFERENCE** Jayne Storey presented to the Board the draft Terms of Reference for the new People and Culture Board level Committee which demonstrated positive progress in addressing the key people related issues. Jayne Storey had received positive feedback on the responsibilities of the new committee. A number of existing actions would be transitioned to the new People and Culture Committee and key areas aligned to the well led governance review would be scrutinised through the committee. The committee will focus on people and culture and develop a refreshed People Strategy. This will be an enabling strategy and will cover clear workforce issues. The Board agreed that membership of the People and Culture Committee would consist of three Non-Executive Directors. Tony Smith would chair the new committee and core membership would include two further Non-Executive Directors, Phil Harris and Richard Gregory. Executive membership would consist of the Director of Workforce OD & Culture, Medical Director, Director of Corporate and Legal Affairs, and Director of Operations. Other staff or executives will be asked to attend as necessary. The quorum shall be no less than two Non-Executive Directors and one Executive Director. It was expected that the local staff side lead and a member of internal communications would attend the committee on a regular basis. The inaugural meeting of the committee is scheduled to take place on 17 February and members will be expected to attend a minimum of eight meetings a year. It was understood that the Non-Executive Directors would review their commitment to the Board committees and a review of the infrastructure of the Board committees so as to improve capacity will take place at ELT. **ACTION: A review of the capacity of the support for Board committees will take place within ELT.** **RESOLVED: The Board of Directors:** **1) Received and approved in principle the draft Terms of Reference for the People and Culture Committee** **2) Received the actions taken and planned actions in regards to 'Focus on our People'.**

DHCFT 2016/011	**REMUNERATION COMMITTEE TERMS OF REFERENCE** Jenna Davies presented to the Board the Terms of Reference for the Remuneration Committee which would enable the committee to have a wider role in applying guidance, planning and organisation development at senior level. The committee would be chaired by Non-Executive Director, Tony Smith and meetings would be scheduled to take place on a monthly basis. It was agreed the committee's Terms of Reference would be amended as follows: I. Explicitly state that the committee would approve the appointment of the Chief Executive. II. Show more clarity about voting and non-voting members of the Board, both categories will be clarified. III. Compliance with fit and proper principles in point 3.7 should be more explicit and take into account executive appraisals and provide information for NEDs. IV. Definition of senior manager to be clarified to comply with statutory procedures. V. Point 2.3 will be written in a more meaningful way. VI. Standing Financial Instructions to state that any contractual payments should be the responsibility of the committee **ACTION: Jenna Davies to amend the Remuneration Committee's Terms of Reference in line with the above points and resubmit them to the Board.** **RESOLVED: The Board of Directors received and noted amendments to the Terms of Reference for the Remuneration Committee.**
DHCFT 2016/012	**BOARD COMMITTEE MINUTES** **Audit Committee:** Caroline Maley, Chair of the Audit Committee provided a brief summary of assurances obtained from the meeting of the Audit Committee held on 15 December. She was pleased to report that strong assurance was received from discussions held on Board Assurance Framework (BAF) risk 3a, Financial Plan. A good standard of reports was received by the committee. One report of particular added value was from PricewaterhouseCoopers which posed questions to the committee and added dimension to discussions. A deep dive of BAF risk 2c took place at last week's meeting of the committee and useful discussions showed that sometimes these risks need to be split across more than one risk. Good progress was also made on the external audit reports about the way the Trust outsources to GEM for IT infrastructure support. Discussions took place on how disaster recovery was a high risk area and the committee requested this should be escalated within the GEM IT system. **Quality Committee:** Maura Teager, Chair of the Quality Committee provided a brief summary of activity from the meeting held on 10 December which was chaired by Tony Smith in her absence. The minutes of this meeting clearly set out areas of concern escalated to the Board, Finance & Performance Committee and the new People & Culture Committee. Maura Teager wished to escalate to the Board the challenging matter from the January meeting; e-learning targets for safety planning issues set for the end of March and the affect this might have on meeting CQUIN payments. Other areas for escalation related to NICE guidelines and gaps in current performance leading to partial assurance around personalised care planning. **Safeguarding Committee:** The minutes of the October meeting were received in error and were a duplicate of those received at the November meeting of the Board. Maura Teager, Chair of the Committee wished to escalate to the Board a matter from the meeting held on 22 January on "Think Family". The Safeguarding Committee saw evidence of how this concept works but it was clear more pace is required, especially

	where there were issues that required embeddedness within adult mental health services. It was noted that substance misuse services had been commended by the CQC for fully embedding Think Family in their safeguarding children system targeted CQC inspection which should be considered on the Board Assurance Framework and risk register. Carolyn Green informed the Board that work undertaken by the two committee leads, Tina Ndili and Tracey Holtom had resulted in strategies being developed for safeguarding adults and safeguarding children, both of which are clinically enabling strategies. Maura Teager was pleased that some issues of safeguarding fit well into the new People and Culture Committee, in particular safeguarding training. However, she wished to raise concern about the long list of apologies regularly received by the Safeguarding Committee and asked that membership of this committee be reviewed by the Executive Leadership Team. Ifti Majid pointed out that a review of membership of Board committees is currently taking place to reduce executive membership on certain committees as capacity is stretched, especially with the introduction of additional committees and meetings. Executives have to operate as a joint team and it is important that membership consisted of people with the right expertise and make good use of the forward plan to ensure the correct executives and senior managers attend meetings. **Mental Health Act Committee:** In the chair of the committee's absence John Sykes drew the Board's attention to the Mental Health Act Committee's cross reference with other committees by informing the Board that the Approved Clinician Status of Doctors would be reviewed at the next meeting of the Mental Health Act Committee in order to provide the Audit Committee with assurance around the system for testing the accreditation of agency doctors. He also pointed out that the resource capacity for applying the Mental Health Act code of practice requires more governance. **ACTION: Review of membership of Board committees to take place within ELT** **RESOLVED: The Board of Directors noted the contents of the ratified minutes of the Audit Committee, Quality Committee and draft Mental Health Act Committee.**
DHCFT 2016/013	**<u>BOARD FORWARD PLAN</u>** The forward plan was included for information and reference purposes. **The Board of Directors received the forward plan for information.**
DHCFT 2016/014	**<u>COMMENTS FROM THE INTERIM CHAIRMAN</u>** Richard Gregory expressed a desire to have more contact with staff at Board meetings and the location of meetings will be considered and communicated on CONNECT to enable staff contact.
DHCFT 2016/015	**<u>DISCUSSION ON FUTURE DEEP DIVES</u>** It was agreed that Learning Difficulties (including community treatment reviews) will be the theme of the next Deep Dive.
DHCFT 2016/016	**<u>COMMENTS FROM OBSERVERS ON BOARD PERFORMANCE AND CONTENT OF MEETING</u>** John Morrissey, Public Governor, Amber Valley South was pleased that matters relating to the Council of Governors was being addressed at Board meetings and

	although he was not seeking to change the minutes of the previous meeting, he referred to item DHCFT 2015/164 and wished to point out that as the Governor Working Groups were set up by Governors, the definition of the different Working Groups' terms of reference and quorum arrangements should be defined by the Governors in consultation with Jenna Davies. In response Richard Gregory explained that the Trust was reviewing the governance of Council of Governors' Working Groups as part of the Trust's governance action plan and the governance of the Working Groups would be discussed at the special meeting of Governors taking place on 29 January.

The next meeting of the Board held in Public Session will take place at 1pm on Wednesday, 24 February 2016.

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

BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - FEBRUARY 2016						
Date	**Minute Ref**	**Action**	**Lead**	**Status of Action**	**Current Position**	**Enc B**
24.6.2015	DHCFT 2015/099	Staff Health Check	Jayne Storey	Jayne Storey to lead the Cultural Change Programme	An external organisation has been invited to facilitate a board conversation on culture and values. This will take place on the scheduled board development session on 13 April. Following which a programme will be developed and will be presented to the People and Culture Committee.	Green
29.7.2015	DHCFT 2015/126	AOB - Board Development Programme	Jenna Davies	Jayne Storey to provide a clearer definition of the Board Development Programme at the next meeting of the Board in September	The Forward Plan for Board Development together with a clearer definitiion of the constraints and purpose of the Board Development framework is required from Jenna Davies and will be provided at the March meeting.	Yellow
30.9.2015	DHCFT 2015/134	Committee Summary Reports	Jenna Davies	Revised draft of the Raising Concerns at Work (Whistleblowing) Policy and Procedures to be submitted to the Board at the October meeting. Committee minutes to be submitted to the Board in future rather than summary reports.	Waiting for revised national guidance to be released in order to produce a revised draft of the Raising Concerns at Work (Whistleblowing) Policy and Procedures. Agenda item for March meeting.	Yellow
30.9.2015	DHCFT 2015/137	Deep Dive in Managing Sickness and Absenteeism	Jayne Storey	The results of the deep dive in sickness absence will be reported to the People Forum at the next meeting on 13 October. The Finance & Performance Committee will receive a report from the People Forum at its next meeting in November and an update report on the action plan and results from these actions will be provided to the Board at its meeting in November. Monitor to receive an update report by the end of October.	A more detailed action plan was presented to the Finance & Performance Committee in January. Continued monitoring of progress will be through the People and Culture Committee.	Green
28.10.2015	DHCFT 2015/148	Acting Chief Executive's Report	Ifti Majid/ Jayne Storey	People Strategy to be reviewed in line with the Trust Strategy and considered within the People Forum	People Strategy is being reviewed in line with the Trust Strategy and will be monitored through the new People and Culture Committee. This is a key action on the governance and well-led action plan. The People Strategy and supporting People Plan to be in place for the end of April and will be tracked through the People and Culture Committee.	Green
28.10.2015	DHCFT 2015/153	Deep Dive into Suicide Prevention	John Sykes	Trajectory of improved suicide prevention training compliance and update on performance to be received by the Quality Committee. Suicide strategy to be submitted to the Quality Committee, together with confirmation of when the draft will be received.	Suicide Prevention Strategy is still out for consultation following an initial delay in this due to illness etc. Now planned for March Quality Committee agenda.	Green

28.10.2015	DHCFT 2015/155	Integrated H&S Governance Annual Report	Carolyn Green	Improvements in the work programme on workplace stress to be addressed at the Health and Safety Committee and reported to the Quality Committee to give the Board assurance that workplace stress is being attended to and with appropriate action plans.	Received by Quality Committee in December 2015.The report will be escalated to the new People & Culture Committee and to Jayne Storey to align this support alongside sickness trends and be triangulated with the health check and staff survey to identify causal factors and any required service improvements. The People & Culture Committee and Jayne Storey are requested to provide a written report back to the Quality Committee on their progress by March 2016. **This action has transferred to the People & Culture Committee.**	Green
25.11.2015	DHCFT 2015/163	Chairman's Report	Jenna Davies	Jenna Davies to define the governor working group terms of reference and quorum arrangements.	The Trust is reviewing the governance of COG and the working group terms of reference as part of the governance action plan.	Green
25.11.2015	DHCFT 2015/170	Changing Face of the Workforce - People Strategy Update	Ifti Majid/ Carolyn Gilby	Organisational development and gaps in leadership and creation of workforce for the future will be addressed and developed through ELT and monitored through the Finance & Performance Committee.	This action has been superseded. Following the receipt of the 'Yates' report and completion of our well led self-assessment, the Board approved the new Board Committee (People & Culture Committe) at the January Board meeting when the stucture was outlined in the ToR . This new committee will oversee development and delivery of our revised people strategy and will be responsible for overseeing this action via a dynamic workforce plan. **This action has transferred to the People & Culture Committee.**	Green
25.11.2015	DHCFT 2015/171	Annual Patient Survey	Carolyn Green	CQC Safeguarding report has been received by the Board in confidential session. Full report and action plan wil be submitted to the February Board meeting by Carolyn Green	CQC Safeguarding Report and Action Plan is on February Board agenda.	Green
27.1.2016	DHCFT 2016/004	Actions Matrix	Ifti Majid Sue Turner	Actions matrix to be adapted to provide evidence that actions have been completed when transferred to committees.	Actions Matrix indicates when actions have been transferred to committees and status of actions show evidence of completion.	Green
27.1.2016	DHCFT 2016/005	Acting Chief Executive's Report - Industrial Action	John Sykes	John Sykes as Medical Director will oversee communication to all staff and patients and will be available to answer external enquiries. He will liaise with neighbouring Medical Directors and CCGs in efforts to improve overall system resilience and will escalate risks as necessary to ELT for action and if necessary direct action by the Acting Chief Executive.	Industrial action by junior doctors on Wednesday 10 February 2016. No significant incidents to report. Awaiting outcome of further action by NHS Employers/BMA. No notice of further action received	Amber
27.1.2016	DHCFT 2016/006	Position Statement on Quality	Carolyn Green	Summary of "bottom up" risks will be reported to the Board at each meeting.	Now included in the Position Statement on Quality	Green
27.1.2016	DHCFT 2016/007	Integrated Performance And Activity Report	Carolyn Gilby Claire Wright	Carolyn Gilby and Claire Wright will discuss the potential for updating the reporting to increase visibility of alignment with quarterly compliance returns information	Carolyn Gilby and Claire Wright are scheduled to discuss potential for updating the reporting to increase visibility of alignment with quarterly compliance returns information on Tuesday 23 February.	Green

27.1.2016	DHCFT 2016/010	People & Culture Terms of Reference	Jayne Storey Jenna Davies	A review of the capacity of the support for Board committees will take place within ELT.	ELT have discussed membership of each committee. The People and Culture Committee Terms of Reference was agreed at the People and Culture Committee on the 17 February.	Green
27.1.2016	DHCFT 2016/011	Remuneration Committee Terms of Reference	Jenna Davies	Jenna Davies to amend the Remuneration Committee's Terms of Reference and submit to March Board meeting.	Amended Remuneration Committee's Terms of Refernce to be agenda for March meeting.	Yellow
27.1.2016	DHCFT 2016/012	Board Committee Minutes	Ifti Majid Jenna Davies	Review of membership of Board committees to take place within ELT	Membership of Board Committees revised in ELT on 1 February. ACTION COMPLETE	Green

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

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 24 February 2016

Acting Chief Executive's Report

1. Introduction

This report purposely focusses on two key national reports that have been issued in the last week. It provides the Board of Directors with a brief summary of the documents and the key points we should consider and use to inform strategic discussions within the Board meeting. The report also updates on key issues internal to the Trust.

2. National Context

Implementing the Forward View: Supporting Providers to Deliver

This document has already started to be called the 'roadmap' and sets out what is expected of providers to support delivery of the five year forward view. It combines requirements under a number of key areas:

- Delivering value and eliminating unwarranted variation
    - Quality Standards
        - Achieve improvements in CQC ratings (more Good and Outstanding)
        - Respond locally to the National reviews, for our Trust this includes mental health, Dementia, Urgent and Emergency Care
        - Adopt patient safety improvement strategies
        - Develop and deliver plans for 7 day services by 2020
    - Access targets
        - Our Trust will need to have in place improvement trajectories against the new mental health targets and this will need to be captured in the system transformation plan
        - Deliver effective demand and capacity planning including the use of independent sector resources as required
        - Increased focus on data quality and real time data
        - Enhancing operational management within our organisation and jointly across the system with particular regard to flow management.
        - Better referral management and patient choice on referral and service delivery
    - Finances and Efficiency
        - Deliver our control total
        - Adhere to the Monitor agency price caps and consultancy controls
        - Deliver relevant Carter identified efficiencies
        - Optimise estate usage

- Transformation

  Work in collaboration to develop and deliver the STP including involvement and active support for our local devolution programme

  - Understand our role as a Trust in delivering the new models of care and remain actively involved in the Vanguard in Erewash
  - Consider service reconfiguration, discussions already underway between providers and commissioners in Derbyshire to ensure long term sustainability
  - Develop and implement specific staff and patient wellbeing initiatives as part of enhancing prevention and reducing health inequalities.

- Building Capacity

  We will have to demonstrate taking planned and strategic approach to meeting the requirements for rapidly changing workforce requirements, ensuring maximum productivity and wellbeing and nurturing leadership development

  - Leadership and workforce
    - Using outcome measures to drive staffing – care hours per day and staff wellbeing programmes
    - Use of e-rostering
    - Enriching organisation culture with specific regard to equality, diversity and anti-discrimination policies
    - Specific talent and leadership development programmes

  - Technology, Innovation and Research
    - Demonstrate movement towards paperless NHS by 2020
    - Automation of routine tasks – online self-booking portals
    - Increase use of portable devices
    - More rapid implementation of research into practice
    - Improved links with local academic health sciences networks

As part of the document we gain increased clarity on the type and extent of support we as a provider will get from the NHS arm's length bodies such as NHE Improvement that includes:

- System as well as Organisational level support to reduce regulatory burden and streamline data requests
- Collaborative relationships which in effect means more direct involvement when things aren't going well and less involvement as Organisation and system positions improve
- A single regulatory view of success based on the CQC assessment of quality and a joint NHS Improvement/CQC view on performance against the above non quality indicators
- Increased autonomy for strong performers
- Help to support the spread of best practice e.g. Virginia mason productivity, Sign up to Safety

There are some key tasks that we as a Trust need to undertake. We must firstly ensure that our developing strategy and supporting frameworks build in these recommendations as part of clearing setting output and outcome requirements. Secondly we need to establish a benchmark of current activities that support compliance with these newly articulated requirements.

The Five Year Forward View for Mental Health

Firstly you will notice some clear similarities in the themes between this report and implementing the forward view.

Following the publication of the Five Year Forward view Paul Farmer was asked to lead a Taskforce to look into the state of current mental healthcare in the Country. The report, published in February 2016, sets out a vision for improving the mental health of children, young people, working-age adults and older people. In addition to recommendations focused on the NHS and associated arm‘s length bodies (ALBs), the final report also makes a series of wider recommendations aimed more broadly at government and wider partners, including local government.

The report is the most comprehensive review and investment plan since the National Service Framework for Mental Health was released in September 1999. The Task Force recognises that extra investment into the system is required to the tune of £1billion over the next five years

There are 58 recommendations made by the Taskforce all of which have been accepted by NHS England. The priority areas are:

- Supporting people experiencing a crisis
  - Ensuring 24/7 crisis response and adequately resourced home treatment is available in all areas along with the development of a model for children and young people in crisis
  - 24/7 all age liaison services available in acute hospitals. Staffing levels will be defined using the ‘core’ model.
  - Doing more to prevent suicides across the whole community aiming for 10% less people taking their own lives by 2021
  - Learning from all deaths by suicide in NHS funded settings, this will be embedded in the CQC inspection regime

- Improving responses to mental and physical health needs
  - Working with primary care to ensure that collaborative models for early detection and screening of physical health problems are in place to support another 280,000 people to manage physical healthcare problems alongside their mental health difficulties
  - Introduction of new incentive schemes to ensure older adults with mental health problems in older age acute systems have access to liaison services
  - By 2020, Public Health England should prioritise ensuring that people with mental health problems who are at greater risk of poor physical health get access to prevention and screening programmes.]
  - Supporting all mental health units to be smoke free by 2018

- Ensuring that the emotional needs of people of all ages with long term conditions are met using the Vanguard programmes to trial new and innovative approaches to delivery.
- Support an extra 20,000 people back into employment by increasing access to psychological therapies for people with anxiety and depression
- Integrating care and support for people with co-morbid alcohol and drug problems

- Transforming perinatal Care for children and young people
  - The report states NHS England should deliver a "fundamental change" in the way children and young people's services are commissioned and delivered. By 2020/21, it is suggested at least 70,000 more children and young people each year should have access to high-quality mental health care when they need it.
  - Deliver and implement plans outlined in local 'Futures in Mind' programme of improvement
  - Develop and trial new models of care for young people to receive in-patient care (ages 16 – 25)
  - By 2020, NHS England should invest to ensure 30,000 more women each year access evidence based specialist mental health care during the perinatal period.

- Access standards and care pathways
  - NHSE to publish comprehensive set of care pathways including quality standards for all mental health conditions
  - Delivery of the new access standard for first episode psychosis

- Payment
  - The task force recognised that mental health services have traditionally been subject to inflexible block contract arrangements and this has contributed to funding inequities.
  - Payment rewards should be linked to delivery of pathways of care and clinical outcomes rather than 'days of care' approach
  - Payment approached should include access standards
  - Where care delivery needs to be integrated, payment methods should be integrated linking to more capitation or place based contracting
  - Support should be given to develop commissioners expert in mental health commissioning.
  - These new models should be tested by the NHS England led specialist commissioning for perinatal and specialist CAMHS services.

- Acute and Secure Care
  - NHSE and partners to develop clear standards for acute mental health care developing the outcomes of the Independent Commission on Acute Adult Psychiatric Care.
  - The practice of sending people out of area for acute beds must cease by 2021
  - Rates of detention under the mental act should reduce by 2021 with closer monitoring of the use of the MHA with specific attention being given to the over representation of people from a BME background.

  - Existing fragmented pathways in secure care should be tackled through a comprehensive programme of work to increase access to high quality care that prevents avoidable admissions and supports recovery and 'step down' for people of all ages who have severe mental health problems

- Tackling inequalities in access and outcomes in particular areas to be addressed include
  - Access to services early intervention and crisis care
  - Mental health act usage
  - Secure services occupancy – length of stay

- Supporting employment
  - This should be recognised as a health outcome
  - Targeting people with more common mentalhealth problems to access psychological therapies to enable 29,000 more people by 2021 to be back in work.
  - Expanding access to individual placement support scheme to cover an extra 30,000 people resulting in at least 9000 more people with severe mental health problems being back in work

- Transparency revolution
  - improve transparency in data to promote choice, efficiency, access and quality in mental health care, ensuring that all NHS commissioned mental health data is transparent to drive improvements in services.
  - CCGs must be more clearly performance managed around commissioning high quality mental health services with the development of a 5 year forward view mental health dashboard
  - Greater linkage around mental health data to be supported across all sectors.

- NHS Workforce
  - Increase measuring of staff mental health and wellbeing including inclusion of questions in staff survey around confidence in dealing with mental health issues NHSE should introduce CQUIN around staff health and wellbeing Health Education England should work with NHS England, Public Health England, professional bodies, charities, experts by experience and others to develop a costed, multidisciplinary workforce strategy for the future shape and skill mix of the workforce required to deliver both this strategy and the workforce recommendations set out in Future in mind.

- Responsibility of other agencies, the report noticeably details new expectations from a range of partner agencies to support delivery of this strategy including
  - Promoting mental health research
  - Department of work and pensions
  - Health and the criminal justice system
  - National information Board
  - Department of Education
  - Support to tackle stigma in particular Time to Change programme.

What are the things we need to be considering as a Trust Board?

- How does this Taskforce publication shape our strategic direction over the next 5 years
- How can we ensure that these key areas of development are included in the system wide transformation plans
- The need to ensure our staff, people who use our services and key stakeholders are aware of the new requirements and expectations
- Building clear references to these requirements into our contracting round
- Agreeing those areas of expertise where we want to be involved nationally in taking service developments forward.

3. Inside Our Trust

Listen, Learn, Lead

As we continue with the process of improving governance, restoring confidence in the Board and engaging our staff in developing our strategy, sharing concerns and developing best practice it is essential to increase visibility of all Directors. To that end it is my intention to publish by way of this report each month the areas we have visited and key themes emerging

Team Name	Visited by	Date of visit	Themes emerging
North Derbyshire Drug Service	Ifti Majid	23/02/2016	Verbal update due to visit date
Bolsover Recovery Team	Ifti Majid	23/02/2016	Verbal update due to visit date
Radbourne Unit Acute wards	Carolyn Gilby	15/02/16	Unit very busy, acuity on the unit, senior staff feeling regarding ET and 'payout' in particular embarrassment and anger.
Perinatal service	Carolyn Gilby	15/02/16	
Radbourne Unit	Mark Powell	16/02/16	Spoke specifically with a couple of people, key messages from them was about focussing on patients and delivering services and need to move forward rather than focus on past

Board Development Session 10 February

Further development of the new strategy for the Trust which included a more detailed review of the strategic themes emerging from the engagement events in particular discussions around the positioning of the Trust within the health and social care community in Derbyshire and where else we should/could be looking for strategic alignments

The Board reviewed this year's Board Assurance Framework in the light of changes in the health and social care community, recent events following the employment tribunal and associated reports as well as the well led reports from Monitor and Deloitte It was agreed that as we are in the process of developing a new strategy the first iteration of the BAF for 16/17 will use the current live Trust strategy as its starting point with a review of the risks in light of the new strategy around end of quarter 1. The draft risks agreed included:

Staff Engagement Session – Ashbourne Centre 17 February

An open staff engagement session was held to enable staff to talk about how they were feeling with respect to the aftermath of the ET and the recent press coverage. It was also an opportunity for staff to ask questions face to face. The event was attended by about 10 staff members mainly from corporate areas.

The key themes from the session there were:

- Staff in the session spoke about feeling ashamed, embarrassed and angry
- Concerns about finding out information through the media
- Wider methods of communication needed
- Support and recognition of the need for greater Board visibility
- Discussion and differing views about the confidence people had or didn't have in raising concerns and worries about the consequences of raising concerns
- Much discussion about the culture in the Trust, where it came from and comparisons to the culture in predecessor organisations
- The benefits of a formal team briefing system that enables two way communication
- Action is the thing that will change culture not rhetoric, discussion around where we are in the process so it does feel like rhetoric as we gather and synthesize the outcomes of various processes was understood – but action must follow.

During the meeting we agreed a number of actions we would take forward:

1. Re-instigation of a team brief methodology that promoted two way feedback
2. Review methods for communication to extend beyond methods that require internet access or PC usage
3. Further open engagement meetings to be held around the County
4. Update the induction presentation following ST resignation

5. Develop and share a ‘basic fact sheet’ less than 2 sides of A4 that captures issues to date re ET/remedy/Trust actions that staff can use if asked questions

And finally…

Staff have taken the time to spontaneously share with me some of the things they were proud of during the month.

Lisa-Anne Mac from the Crisis Team in North Derbyshire shared some feedback around the delivery of the crisis service in the High Peak area

> *Fantastic Team, support in place under 12 hours from referral, consultant opinion with 24 hours. We as a family found ourselves in a situation that we had never come across before and couldn't understand the reasons why. The time taken by the team was not just for the patient but for the family and we cannot thank the team enough. What a service, in this day and age when you hear of the lack of support or funding for mental health services this service is a credit to Derbyshire.*

Sam Kelly, Nurse Consultant shared with me her reflections after a regional learning event around suicide prevention. It was a day of honest sharing of challenges faced and as part of this evidence of culture in different Organisations emerged – Sam's reflections on some of the defensiveness that emerged were:

> *For the most part I don't think we're like that culturally and I saw a nice gap between us as organisations. However I do think there are pockets of this in our middle management which are perhaps the remnants of a less compassionate culture.*
>
> *I guess my point is firstly that I think a compassionate culture is essential for learning and progression, secondly that I think we are on that road, and thirdly that we still have some work to do.*
>
> *But overall I felt quite proud*

Legal Issues

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

Equality Delivery System

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

Consultation

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

Recommendation

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 24 February 2016

Quality Position Statement

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

Executive Summary

1. SAFE SERVICES

1.1. Summary of risks

1.1.1 Board assurance framework high level operational risks

A report was presented to the January 2016 meeting of the Quality Committee. The report set out the high and moderate operational risks and identified those themes that should be escalated to the Board as part of the quality position statement. A summary of this report is provided below:

Ref.	Title	Description	Level of risk
2329	AT&SS Registered Practitioner Crisis	There are inadequate numbers of registered practitioners to maintain the planned and crisis work undertaken by this Team. *Mitigation plan in place – but not detailed in this report*	Extreme risk
2980	Clinical Risk resulting from delay in Adult Services typing Letters onto Paris system following recent Migration from Care notes	Adult Services migrated over to Paris from Care notes on 13th October. Digital Dictations from Consultants and Junior Doctors working in Community, Crisis and In-Patient Areas (for U&PC) and Perinatal (for Specialist) are being delayed due to outstanding systems issues/user inexperience on Paris. *FPR Board managing risk and mitigation plan*	High risk
3003	Named team - Financial Viability	End of September figures suggest that Business sensitive information SLR deficit £223,000.	High risk
3356	Lack of parking for clinicians at base	Due to the volume of staff based at St Andrews House and the small number of parking spaces available, managers are already noticing a reduction in staff attending base. *Estates and Facilities exploring additional parking and mitigation plan*	High risk
3355	Reduced staffing levels in Neighbourhood Adult Team	Reduced staffing levels due to sickness currently 3.4 wte Band 6. *Mitigation plan in place – but not detailed in this report*	High risk

3301	Medicines Management - Non-Compliance with Medicines Management standards	A review of data and information from a variety of sources has resulted in numerous concerns re medicines management such as training, safe and secure handling of medicines / the management of controlled drugs / the use of medicines in line with the mental health act etc. *Mitigation plan in place including additional resource – but not detailed in this report*	High risk
3302	Pharmacy on-call services	Due to a lack of pharmacists currently contracted to participate on the Pharmacy On-call rota *Mitigation plan in place and change process*	High risk

1.1.2 Summary of moderate operational risks

Clinical - Medication/ Pharmaceutical	3
Clinical - Points of Ligature	8*
Clinical - Staffing levels	7*
Clinical Risk - EPR	1
Clinical risk - Other	11*
Environmental risk - Other	4
Financial risk - other	1
H&S - Display Screen Equipment	1
H&S - Lone Working	3
H&S - Violence and Aggression	3
H&S - Work Equipment	1
H&S - Work Related Stress	11*
H&S - Workplace Health, Safety and Welfare	2
Operational - Business Continuity	5
Operational - Information Security	1
Operational risk - Other	4
Strategic risk - Other	4
Commissioning Risks	2
Totals:	72

*Key * see full report to quality committee for detail*

1.1.3 Summary of themes

The following themes are identified through the high and moderate risks currently recorded on the Trust risk register:

- Staffing levels and capacity
- Migration from paper /Care notes to full EPR (PARIS)
- Car Parking, particularly St Andrews house and Radbourne unit
- Meeting medication standards

1.1.4 We will:

Request the Performance and Contracting overview group to monitor and review the high and moderate risks. We will provide a summary of the risks each month in the future as part of the development of our integrated performance report.

1.2 Full single record update. Improving rapid access to information and patient safety

Good progress is being made towards having all current patient records held electronically through a staged approach over the next few months.

Community and Crisis teams went live in November 2015 followed by CAMHS, Learning Disabilities and Day Hospitals in December 2015. Audrey House and Kedleston Unit went live in January 2016 and Cherry Tree Close soon after. It is planned that Cubley Court will be live by the end of February.

1.2 1. We will:

Continue our roll out with preliminary meetings with the Radbourne and Hartington units and the project team will be focusing on these acute wards shortly to achieve initial implementations during March. A summary highlighting training sessions has gone out to all staff on connect.

We have a clinician leading EPR, working on reducing bureaucracy and establishing a smooth clinical pathway, effective care planning tools in line with the Nursing and quality strategy. We will continue to listen to feedback to our staff on adaptations and improvements to continually adapt our system based on their feedback.

2.3 Sign up to Safety

This is a national campaign aimed at sharing information and best practice on safety. Organisations and individuals can sign up to be part of this network. There are five safety pledges which we would sign up to and base our improvement plan on they are:

1. **Putting safety first.** Commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans
2. **Continually learn**. Make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are
3. **Being honest**. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong
4. **Collaborating**. Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use
5. **Being supportive**. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate progress.

2.3.1 We will:

Await the outcome of our full review in June 2016 and consider ‘Signing up to safety’ as a vehicle for making any improvements identified as part of the review.

2. CARING SERVICES

2.1 Information for professionals about new psychoactive substances (NPS) in Derby

As part of our partnership working with the City Council a newsletter is published which sets out the work being completed to address the on-going problems with new psychoactive substances in Derby. The recent newsletter provided information on:

- How the City Council and key stakeholders have launched the city wide NPS Partnership Strategy and action plan to tackle 'so called legal highs'...
- The establishment of a central location for information on NPS. This enables wider agencies to store, use and distribute information in order for professionals to be kept up to date as possible about NPS. Information is particularly required on trends that agencies may be seeing, particular health harms or behaviours and good practice that professionals would want to share with partner agencies.
- A focus on Synthetic Cannabinoids – 'mamba' or 'black mamba' its effects, use and treatment in summary format for use by professionals.

2.1 We will:

Continue to use the newsletter as part of our response to the ongoing problems. We will learn from other agencies, share the knowledge, skills and experience of our staff.

3. EFFECTIVE SERVICES

3.1 Mental Health Taskforce report

Established in March 2015 the Mental Health Taskforce has published 'The five year Forward view for Mental health'. The report included the views of over 20,000 people and these are reflected in the recommendations. The report states that the fundamental principle is:

"People told us that their mental health needs should be treated with equal importance to their physical health needs, whatever NHS service they are using"

(Taken directly from report).

Eight principles underpin the reform:

1. Decisions must be locally led
2. Care must be based on the best available evidence
3. Services must be designed in partnership with people who have mental health problems and with carers
4. Inequalities must be reduced to ensure all needs are met, across all ages
5. Care must be integrated – spanning people's physical, mental and social needs
6. Prevention and early intervention must be prioritised
7. Care must be safe, effective and personal, and delivered in the least restrictive setting
8. The right data must be collected and used to drive and evaluate progress

3.1.1 We are:

We are currently reviewing the strategy with our commissioners. A Podcast from our Acting Chief Executive Officer to staff on connect included reference to the taskforce, its findings and the strategy. Our Quality Committee will consider the strategy at the March meeting and recommendations will be encompassed into the Quality Strategy.

In addition a theme is education and developing interventions that enable individuals to understand their own conditions and treatments.

The extract is the feedback from some open / drop in forum medicine information sessions. We have scheduled two events open to anyone in April and June at the Ashbourne centre to come in anonymously and ask any questions to enhance their understanding of medicine. This offer would be part of a public health initiative rather than part of core clinical treatment and would be open to Families and carers.

FOUND IT EDUCATIONAL GIVEN THE CHANCE TO ASK QUESTIONS THAT RELATE TO MYSELF WHICH HAS GIVEN ME SOME INSIGHT AND UNDERSTANDING OF WHERE I AM AT IN THIS TIME OF LIFE.

I find these sessions very helpful and am surprised more people do not attend. Perhaps advertise it more?

I found this time very helpful & informative for patients and staff – a friendly, supportive manner. Thank you...

Very helpful and informative, it is interesting to hear from a professional – Rio staff

I found it very helpful

I found the delivery very helpful at helping me to look at stressors and depression from many different aspects and different coping strategies that help each individual – Thank you Tanya (staff)

3.2 Investing in Childrens health

The Centre for Public Health published this report in Janaury 2016. This report based on wide research sets out the evidence on the effectiveness and value for money of interventions for child and adolescent mental health problems.

3.2.1 We will:

Consider this report in our work with children and young people and encompass and effective and efficient interventions into our Trust strategy.

4. RESPONSIVE SERVICES

4.1 Our Quality Account 2015/16

At the beginning of February 2016 NHS England sent a letter to each CEO confirming the arrangements for quality accounts for 2015/16. There are not changes to the overall guidance but they have requested that organisations include information on:

- How they implementing the Duty of Candour
- (where applicable) patient safety improvement plan as part of the Sign Up To Safety campaign; (see previous section on safety)
- The most recent NHS Staff Survey results for indicators KF19 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) and KF27 (percentage believing that trust provides equal opportunities for career progression or promotion) for the Workforce Race Equality Standard.1; and
- Where no CQC rating exists yet, we are required to set out our own view on the five key questions used by the Care Quality Commission in their inspections of services:

We are expected as in previous years to get audit opinion on our quality account.

4.1.1 We will:

Include the additional information requested by NHS England in our Quality account 2015/16. We will request our Governors to choose the indicators for our auditors to review at the March Council of Governors meeting. We will request our Governors at the first meeting of their governance group in April to consider their collective response to the draft quality account to include together with third party comments. In line with the quality account regulations the draft account will be sent to third parties on 1st April 2016 for the required 30 day consultation period.

5. WELL LED

5.1 Quality Visit Programme 2016/17

The quality visit programme is commencing in March 2016. This is the 7th year of this successful programme where every team across all our 80+ locations are visited by a quality team consisting of a Board member, Governor, Commissioner and clinical and non- clinical staff across the trust. Once again platinum team leaders will also be asked to join the quality teams. A new administrator has been appointed to co-ordinate the programme and is currently booking visits up and including quarter one. We will once again be using the five key questions used by the Care Quality Commission as part of their inspection model.

5.1.1 We will:

New Governors will be asked to join the programme and have a place on each visit. Members of the quality team will make them themselves available at the end of the next Governors meeting to talk about the programme and invite individual governors to sign up for visits in quarter one.

We will contact our commissioners to sign up for visits and regular reports will be provided to the Quality Assurance Group.

5.2 Care Quality Commission planned inspection visit

The date for our planned inspection has been confirmed as the week of 6th June 2016. We have completed and submitted information for pack one data and are currently collecting pack 2 data which is very comprehensive. Information has been requested for each of the five key questions. Staff have been informed of the visit date and an outline of what staff can expect to happen and how they can contribute has been cascaded through connect and e mail. Staff can arrange to meet a member of the inspection team in the week they are on site, attend a focus group or drop in session or contribute their views via an on line form. During the week of the inspection the Care Quality Commission will:

- Speak with people who use services.
- Hold a public listening event or a series of smaller focused events to gather the public's views.
- Hold focus groups with separate groups of staff.
- Hold drop in sessions for people who use services and staff.
- Interview individual directors as well as staff of all levels.
- Check that the right systems and processes are in place

5.2.1 We will:

We will re-establish our inspection preparation group whose key role will be to ensure we are as ready as possible for the inspection and that the site visit runs as smoothly as possible. The group will include a member of staff who completes inspections to other trusts so that we can use their experience as part of our learning.

5.3 Well led review

The Care Quality Commission and auditors Delloittes have completed a review of our systems and processes as set out in the requirements of the 'well led' framework. We have received the draft report and are reviewing it for factual accuracy.

5.3.1 We will:

When completed we will share it and finalise the action plan which has been developed to address the recommendations within the report and all quality aspects will be feedback to clinical services.

5.4 Closing the loop – Ward to Board

In November 2015 Kate attended our ward to board session. Kate talked about how she had found peace as an inpatient in our wards, by doodling her thoughts and feelings and using art to understand and manage her emotions. This picture is a cover of a doodle pad which will be issued to all patients to talk about using art to manage feelings and thoughts. This was developed from Kate sharing her experience with the Board and will be available from the 1 April for all inpatients. Inside the front cover is Kate's story.

Strategic considerations

- To continue to learn from national publications and their findings. In particular to consider the mental health task force strategy in our overall strategy going forwards and our refreshed quality strategy.

(Board) Assurances

- The assurance on closing the loop from our ward to board sessions and the changes this results in for patients and their families.
- Plans in place to commence our quality visit programme and the sharing and learning from the showcases presented by our teams this programme provides.
- Confirmation on our planned inspection and the plans we have in place to submit the information required.

Consultation

This paper has not been previously presented

Governance or Legal Issues

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

Equality Delivery System

Any impacts or potential impacts on equality have been considered as part of all our quality work

Recommendations

The Board of Directors is requested to:

- Note the quality position statement
- To consider the operational risks set out in the safety section.
- Give direction or further scrutiny on our current position, work plan or a steer from the Board on additional information to provide Board level assurance.

Report prepared by: **Clare Grainger**
Head of Quality and Performance

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

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 24 February 2016

Update CQC action plan February 2016

Purpose of Report
The purpose of the DHCFT CQC action plan is to ensure and provide evidence to show that the recommendations are being met adequately to timescale or to show progress on the recommendations.

Executive Summary
- The purpose of the Derby City Children Looked After and Safeguarding Review July 2015 Action Plan is to inform the Trust of the findings of the review undertaken by the CQC under Section 48 of the Health and Social Care Act 2008 .
- The review looks at the effectiveness of Health Services for Looked After Children and the effectiveness of safeguarding arrangements within Derby City Health Services for children.
- The review seeks to ensure that Health Care Organisations are working in accordance with their responsibilities under section 11 of the Children Act 2004
- The Action Plan outlines the areas of improvement for the Trust, in the form of recommendations, an identified lead and timescale to provide evidence to show progress made.
- The Action Plan will be monitored by a formal meeting each month, attended by the Identified Leads, who will update the Action Plan and provide evidence.
- The Action Plan and Evidence will be submitted to the CCG on a monthly basis, alongside the partner Health Providers servicing Derby City, This will be collated into an Amalgamated Action Plan and submitted to the CQC.

Strategic considerations
- The CQC used various methods to gather information, interviews; groups which were possible included speaking to children and young people.
- Individual cases were tracked where there had been safeguarding concerns, early help assessments and where families had been referred, or not, to children's social care.
- In total 109 children and young people's experiences were tracked.
- A comprehensive report was published in November 2015 by the CQC inspectors.
- The report follows the child's journey reflecting the experiences of the children, young people and their families/carers.
- A number of recommendations for improvement are outlined within the report at the end, which formulates the Action Plan we are working to.

Assurances
- The committee can be assured that the recommendations made by the CQC in their report are being met.
- The monthly meetings will ensure that Action Plan is up dated and evidence **collated** and that timescales are met.
- This is monitored by the Safeguarding committee

Consultation

- The Action Plan was jointly developed by the DHCFT safeguarding, quality and management teams, alongside the Clinical Commissioning Group and Royal Derby Hospital.
- The action Plan has been submitted and signed off by the CQC Inspectors.

Governance or Legal issues

- The review was undertaken in line with section 11 of the children Act 2004 and Working Together to Safeguard Children 2015.

Equality Delivery System

- None

Recommendations

The Board of Directors are requested to:

1) Monitor the progress of the CQC Action Plan to ensure compliance.
2) To receive assurance that the Action Plan is being developed within the set timescales and evidence and/or a progress report is completed
3) To receive the CQC report and be assured of on-going actions and improvements being made and request the Safeguarding committee to lead all future monitoring of this external audit and assurance the implementation of the learning and recommendations

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

Report prepared by: **Tina Ndili**
Head of Safeguarding Children

Enc E

Derby City Children Looked After and Safeguarding Review

Date of Review 27th July – 31st July 2015 – Action Plan

Health Organisation included:

NHS England
NHS Southern Derbyshire Clinical Commissioning Group (SDCCG)
Derbyshire Community Health Services NHS Trust (DCHS)
Derbyshire Healthcare NHS Foundation Trust (DHCFT)
Derby Teaching Hospitals NHS Foundation Trust (DTHFT)
Derby City Public Health

ACTION PLAN

The embedded documents contained in the action plan can be provided on request

Recommendation 1.1 **Support Primary Care in standardising READ codes to identify vulnerability.**	
Lead: **Southern Derbyshire Clinical Commissioning Group**	
Success Criteria **The production and implementation of a recommended READ code list that Primary Care should use to identify vulnerabilities in children, young people and families.**	**Evaluation** **Copy of agreed READ codes list.** **Audit of use and compliance.**

Actions	Lead Person	Completion Date	Monitored By	Progress
To undertake a review of what READ codes are currently being used or available for Primary Care to identify vulnerability.	Dr Jenny Evennett and Helen Cawthorne	**March 2016**	Southern Derbyshire CCG Quality Assurance Committee	
To consult with stakeholders (IT, Information Governance, Head of Primary Care, GP Safeguarding Leads) on the production of a recommended READ code list for use in Primary Care.	Dr Jenny Evennett and Helen Cawthorne	**March 2016**	Southern Derbyshire CCG Quality Assurance Committee	
To implement the recommended READ code list within Primary Care.	Dr Jenny Evennett and Helen Cawthorne	**June 2016**	Southern Derbyshire CCG Quality Assurance Committee	
To undertake an audit to ensure that Primary Care are aware of and are using the recommended READ code list	Dr Jenny Evennett and Helen Cawthorne	**September 2016**	Southern Derbyshire CCG Quality Assurance Committee	

Recommendation 1.2 **Evaluate and monitor the interim arrangements for the Named GP and continue to prioritise recruitment to the post that will support the development of safeguarding practice in Primary Care**.
Lead: **Southern Derbyshire Clinical Commissioning Group**

Success Criteria	**Evaluation**
To appointment to the Named GP sessions to cover Safeguarding Children arrangements across Derby City.	**Successful appointment of the relevant number of Named GP sessions for Derby City.**

Actions	**Lead Person**	**Completion Date**	**Monitored By**	**Progress**
To continue to campaign and re- advertise for the post of the Named GP sessions for Derby City leading to successful recruitment.	Dr Jenny Evennett	**March 2016**	Southern Derbyshire CCG Quality Assurance Committee	
To review alternative arrangements should SDCCG be unsuccessful in recruiting a Named GP for Derby City.	Dr Jenny Evennett	**June 2016**	Southern Derbyshire CCG Quality Assurance Committee	
For SDCCG to monitor the gap in capacity by ensuring that this remains on SDCCG risk register and reviewed by SDCCG Quality Assurance Committee.	Lynn Woods	**December 2015**	Southern Derbyshire CCG Quality Assurance Committee	*The gap in the Named GP position for Derby City has been added to the SDCCG risk register and progress regarding this is discussed at the SDCCG Quality*

				Assurance Committee. **Enc E** *There is an active recruitment process underway to appoint a Named GP for Primary Care for Derby City. Contingency arrangements have been made in the South to Support the Designated Dr and Nurse in the City if there is a requirement*.

Recommendation 1.3 **Ensure Primary Care Practitioners are aware of and are competent in the use of the CSE toolkit**.	**Enc E**
Lead: **Southern Derbyshire Clinical Commissioning Group.**	
Success Criteria **Primary Care Practitioners are aware of and are competent in the use of the CSE tool kit.**	**Evaluation** **Audit findings to demonstrate that Primary Care Practitioners are awareness of and are able to effectively use the CSE tool kit.**

Actions	Lead Person	Completion Date	Monitored By	Progress
To raise awareness and demonstrate the use of the CSE tool kit through Safeguarding Children training sessions for GP's	Dr Jenny Evennett	**December 2015**	Southern Derbyshire CCG Quality Assurance Committee	
The Designated Dr to support the Safeguarding GP leads within Primary Care to share the use of the CSE tool kit within their team and obtain feedback on how the CSE tool has been disseminated within the team.	Dr Jenny Evennett	**February 2016**	Southern Derbyshire CCG Quality Assurance Committee	
To undertake a snap shot audit of Primary Care Practitioners awareness and use of the CSE tool kit.	Dr Jenny Evennett	**April 2016**	Southern Derbyshire CCG Quality Assurance Committee	
To undertake an audit of the number of referrals made to Social Care by Primary Care regarding Children and Young People at risk of CSE.	Dr Jenny Evennett	**April 2016**	Southern Derbyshire CCG Quality Assurance Committee	

Recommendation 2.1 **Ensure that the paediatric and adult records used in Emergency Department are reviewed so that the needs of adults and children are differentiated and support an appropriate assessment of safeguarding, vulnerability and harm and that there are notices to indicate information sharing protocols.**
Lead: **Southern Derbyshire Clinical Commissioning Group and Derby Teaching Hospitals NHS Foundation Trust (DTHFT)**

Success Criteria	**Evaluation**
That the Paediatric and Adult Emergency Department have record keeping arrangements which support Practitioners in their assessment of risk and vulnerability of children, young people and adults.	**SDCCG to undertake a quality site visit of both Emergency Departments post completion date of the actions identified to ensure compliance.**

Actions	**Lead Person**	**Completion Date**	**Monitored By**	**Progress**
To review the current recording systems in use in the Paediatric and Adult Emergency Departments.	Trust informatics Lead/ Jane O'Daly-Miller and Dr Julie Mott	**Completed**	Trust Safeguarding Lead/ DTHFT Safeguarding Committee and Southern Derbyshire CCG Quality Assurance Committee	*EDIS electronic patient record has been reviewed as part of the Trust wide review. EDIS will be replaced by Lorenzo in a phased project commencing in Autumn 2016.* *Lorenzo electronic patient record does have safeguarding fields but requires some minor amendments; action in this regard is underway.*

To further develop Lorenzo electronic patient record to incorporate the safeguarding assessment which includes both (but separately) vulnerability and risk factors for adults and children.	Informatics Lead and Pam Herod	**Initial roll out in Midwifery expected in March 2016 and Emergency Department in October 2016**	Trust Safeguarding Lead/ DTHFT Trust Safeguarding Committee and Southern Derbyshire CCG Quality Assurance Committee	*EDIS electronic patient record has been reviewed as part of the Trust wide review. EDIS will be replaced by Lorenzo in a phased project commencing in Autumn 2016.* *Lorenzo electronic patient record does have safeguarding fields but requires some minor amendments; action in this regard is underway.*
To develop notices /posters/ family and patient leaflets which inform Patients about information sharing requirements. These notices will be available in both Children and Adult Emergency Departments.	Trust Safeguarding Lead (Jane O'Daly – Miller) and Safeguarding Liaison Nurse	**February 2016**	Trust Safeguarding Lead/ DTHFT Trust Safeguarding Committee and Southern Derbyshire CCG Quality Assurance Committee	
Audit compliance by SDCCG undertaking a quality site visit of the Emergency Departments.	Michelina Racioppi	**July 2016**	Southern Derbyshire CCG Quality Assurance Committee	

Recommendation 2.2 **Ensure that there are plans in place to continue with the ongoing support across Emergency Departments (Children and Adults) through an effective Paediatric Liaison Service.**
Lead: **Southern Derbyshire Clinical Commissioning Group and Derby Teaching Hospitals NHS Foundation Trust, To include Derbyshire HealthCare Foundation Trust as the Provider of this Service (DHCFT)**

Success Criteria	**Evaluation**
The appointment of an effective Paediatric Liaison Service.	**DTHCFT can demonstrate that there is an effective information sharing process with relevant cross border partners and Primary Care about children and Young people who attend the Hospital.**

Actions	**Lead Person**	**Completion Date**	**Monitored By**	**Progress**
DHCFT to work with the commissioners in order to appoint a Paediatric Liaison service based at DTHFT which covers both Adult and Children Emergency Departments.	David Tucker	**January 2016**	DHCFT Contract Monitoring Group and Southern Derbyshire CCG Quality Assurance Committee	Janette Beard has been appointed in to the role on a temp basis and will commence on 01/02/16. Lesley Smales will commence recruitment in to the permanent post.
The Implementation of a Paediatric Liaison Service which includes supporting Adult Emergency Department with cases that do not meet the threshold to refer to Social Care but would benefit from a referral to the Health Visitor and School Nurse service for additional support.	David Tucker	**April 2016**	DHCFT Contract Monitoring Group and Southern Derbyshire CCG Quality Assurance Committee	Lesley Smales has worked with commissioners to develop an updated Job Description incorporating this change to service delivery, which has been used to appoint Janette Beard.

Audit of compliance through SDCCG that the post has been appointed to and assurance is obtained by undertaking a quality site visit of the Emergency Departments.	Michelina Racioppi and Dr Jenny Evennett	**May 2016**	Southern Derbyshire CCG Quality Assurance Committee	**Enc E**

Recommendation 2.3 **Ensure that Midwives discussions with women about domestic violence are recorded and retained in records.**
Lead: **Southern Derbyshire Clinical Commissioning Group and Derby Teaching Hospitals NHS Foundation Trust**

Success Criteria	**Evaluation**
That all Midwives have discussed domestic violence with women and that is reflected and recorded within their records.	**DTHFT Maternity Services are able to demonstrate within the records that women have had discussions about domestic violence during the antenatal and postnatal period.**

Actions	**Lead Person**	**Completion Date**	**Monitored By**	**Progress**
To continue to raise awareness during training that is rolled out within the Trust about the Midwifery Domestic Violence Guidelines and Trust Policy.	Jane Haslam / Pam Herod	**March 2016**	DTHFT Trust Safeguarding Committee and Southern Derbyshire CCG Quality Assurance Committee	
Midwives to ensure that women are seen alone on at least one occasion and on at least three occasions there has been a discussion about domestic violence. This information to be recorded in the maternal recorded and shared appropriately.	Jane Haslam / Pam Herod	**March 2016**	DTHFT Trust Safeguarding Committee and Southern Derbyshire CCG Quality Assurance Committee	

To develop Lorenzo Electronic Patient record to incorporate safeguarding assessment that includes separately both vulnerability and risk factors for children and adults.	Trust Informatics Lead, Jane Haslam / Pam Herod	**Initial roll out in Midwifery expected March 2016 and Emergency Department in October 2016**	Trust Safeguarding Lead/ DTHFT Trust Safeguarding Committee and Southern Derbyshire CCG Quality Assurance Committee	*Lorenzo has Safeguarding Fields but requires some minor amendments which are underway*.
To continue to undertake ward assurance audits of Maternity records to demonstrate compliance of the Midwifery Domestic Violence Guidelines / Trust Policy and to share the findings with SDCCG.	Jane Haslam / Pam Herod	**June 2016**	Southern Derbyshire CCG Quality Assurance Committee	

Recommendation 2.4 **Ensure that child protection medical examinations of children are carried out in family friendly appropriate private space/room.**
Lead: **Southern Derbyshire Clinical Commissioning Group and Derby Teaching Hospitals NHS Foundation Trust**

Success Criteria	**Evaluation**
Children who are seen at DTHFT for Child Protection Medicals are examined in suitable family friendly environment.	**Children requiring child protection examinations are seen in Family friendly private environment.**

Actions	**Lead Person**	**Completion Date**	**Monitored By**	**Progress**
To review current arrangements of where child protection medicals are undertaken at DTHFT.	Jane O'Daly-Miller and Dr Julie Mott	**Completed**	Safeguarding Lead/ DTHFT Trust Safeguarding Committee and Southern Derbyshire CCG Quality Assurance Committee	*Child Protection Medicals are undertaken in room 6 in the Children Emergency Department which is a private child/ family friendly room*.

To ensure that child protection medicals are always undertaken in a family friendly private setting and to ensure that the above recommendation is made explicit in the Trust Safeguarding policy	Trust Paediatric Business Unit / Jane O'Daly-Miller and Dr Julie Mott	**February 2016**	Safeguarding Lead/ DTHFT Trust Safeguarding Committee and Southern Derbyshire CCG Quality Assurance Committee	
To undertake an audit of Child protection medicals that take place out of hours in order to review the need and urgency to undertake Child protection medicals out of normal working hours.	Dr Julie Mott	**February 2016**	Safeguarding Lead/ DTHFT Trust Safeguarding Committee and Southern Derbyshire CCG Quality Assurance Committee	
To undertake a family /user feedback survey in relation to the child / family experience of the child protection medical.	Dr Julie Mott / Jane O'Daly - Miller	**May 2016**	Safeguarding Lead/ DTHFT Trust Safeguarding Committee and Southern Derbyshire CCG Quality Assurance Committee	
Audit of compliance through SDCCG by undertaking a quality site visit.	Michelina Racioppi / Dr Jenny Evennett	**July 2016**	Southern Derbyshire CCG Quality Assurance Committee	

Recommendation 3.1 **Ensure that the Safeguarding and Think Family training priorities are implemented and that all staff working in healthcare settings, including those who predominantly treat adults, receive training to ensure they attain the competences appropriate to their role.**
Lead: **Southern Derbyshire Clinical Commissioning Group and Derbyshire Healthcare NHS Foundation Trust**

Success Criteria	**Evaluation**
All Front line staff who work directly with children, young people and adults undertake level three training which will includes Think Family.	**DHCFT will be able to demonstrate that all front line staff have been trained to level three safeguarding children via the training compliance figures.**

Actions	**Lead Person**	**Completion Date**	**Monitored By**	**Progress**
DHCFT training passports are updated to reflect all staff levels of Safeguarding children requirements are in line with '*Safeguarding Children and Young People Roles and Competences for Healthcare Staff – Intercollegiate Document (2014).*	Tina Ndili	**December 2015**	DHCFT safeguarding Vulnerable Adults and Children Committee / DHCFT Contract Monitoring / Derby City Public Health Contract/ Performance meetings and SDCCG Quality Assurance Committee	Email sent on 22.12.15 to request progress report. Contacted training department on 31.12.15 and was assured that the update of the training passport is in progress but has not yet been completed. Educational E-source Developer on annual leave.

Think Family Training (level 3) is mandatory for all DHCFT Clinical staff to undertake.	Tina Ndili	**October 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee / DHCFT Contract Monitoring / Derby City Public Health Contract/ Performance meetings and SDCCG Quality Assurance Committee	
SDCCG to be provided assurance by DHCFT that the training requirement has been completed.	Tina Ndili	**November 2016**	DHCFT Contract Monitoring Group/ Derby City Public Health Contract/ Performance meetings and Southern Derbyshire CCG Quality Assurance Committee	
SDCCG to be provided the DHCFT safeguarding Children training strategy and Programme.	Tina Ndili	**January 2016**	DHCFT Contract Monitoring Group / Derby City Public Health Contract/ Performance meetings and Southern Derbyshire CCG Quality Assurance Committee	 Training framework 2015-2016 (12 Janua

Recommendation 3.2 **Ensure that adult in-patients in mental health services are supported by thorough discharge plans and an allocated care coordinator prior to discharge.** **Ensure that children and young people who require help with emotional and mental health needs are able to access appropriate CAMHS services in a timely way.**
Lead: **Southern Derbyshire Clinical Commissioning Group and Derbyshire Healthcare NHS Foundation Trust**

Success Criteria	**Evaluation**
• **Adult in- patients receiving Mental Health Service will have a discharge plan and have an allocated care Coordinator prior to discharge.** • **Children and Young People requiring CAMHS Services will be seen within Commissioned timescales.**	• **DHCFT can demonstrate that all adults discharged from in-patient care have a discharge plan and an allocated care coordinator prior to discharge.** • **DHCFT can demonstrate that children and Young People requiring CAMHS Services are seen within agreed timescales.**

Actions	**Lead Person**	**Completion Date**	**Monitored By**	**Progress**
To continue with the roll out of the Purposeful Inpatient Admission model (PIPA) to ensure timely and effective discharge process for all patients.	Hannah Burton/ Richard Morrow / Sam Kelly	**April 2016**	Data analysis dashboard/ weekly Operations operational Forum/ DHCFT Contract Monitoring Group and Southern Derbyshire CCG	

			Quality Assurance Committee	
To review and identify any gaps in the adult in- patient discharge process (including increased length of Stays) and raise any relevant issues in service provision with the Lead Commissioner for Adult Mental Health Services.	Richard Morrow/ Hannah Burton	**April 2016**	DHCFT Contract Monitoring Group and Southern Derbyshire CCG Quality Assurance Committee	
DHCFT and Lead Commissioner to work together to ensure that adult mental health patients who require a Care Coordinator are allocated one prior to discharge from Hospital.	Richard Morrow/ Jim Connolly	**June 2016**	DHCFT contract Monitoring Group and Southern Derbyshire CCG Quality Assurance Committee	
Care coordinators in their assessment of the adult consider the needs of children within the family and make appropriate referrals to support the family.	Tina Ndili	**April 2016**	DHCFT Contract Monitoring Group and Southern Derbyshire CCG Quality Assurance Committee	
To roll out the Single Point of Access for both Derby City and South Derbyshire so that Children and Young People receive the most appropriate level of service to meet their individual needs in a timely manner.	Frank McGhee/ Helen McMahon	**July 2016**	DHCFT Contract Monitoring Group and Southern Derbyshire CCG Quality Assurance Committee	The Derby City Single Point of access is now fully embedded. The Full South Derbyshire roll out planning stage is completed. This was launched 4/11/15.

DHCFT and the Lead Commissioner for CAMHS services to work together to agree on timescales which enable children and Young people to receive appropriate level of CAMHS service. To monitor reduction in waiting times through DHCFT Contract Monitoring Group.	Frank McGhee/ David Tucker	**April 2016**	DHCFT contract Monitoring Group and Southern Derbyshire CCG Quality Assurance Committee	Using service transformation and Future in Mind investment interim targets for referral to intervention will be determined depending on the young person's needs. Frank advised that he would like David Tucker to work with Sheila McFarlane regarding these issues. Meeting held on 08/01/16. We agreed to clarify the current reporting framework. This has been obtained. Arranged to meet again on 28/02/16 to establish how we proceed.
To utilise Children's services transformation and Future in Mind Plan to offer early help with the aim to build resilience. To reduce demand for Specialist Services including Tier 3 CAMHS, acute hospital admissions and Tier 4 admission. .	Frank McGhee/ David Tucker	**December 2016**	DHCFT contract Monitoring Group and Southern Derbyshire CCG Quality Assurance Committee	This work will be progressed through workstream 1. David Tucker to attend future workstream 1 meetings.
To develop effective performance monitoring of the access to CAMHS services with clear agreement around how breaches in meeting set timescales are highlighted and managed.	David Tucker /Sheila McFarlane	**May 2016**	DHCFT contract Monitoring Group Southern Derbyshire CCG Quality Assurance Committee	Frank advised that he would like David Tucker to work with Sheila McFarlane regarding these issues. Meeting held on 08/01/16. We agreed to clarify the current reporting framework. This has been obtained. Arranged to meet again on 28/02/16 to establish how we proceed.

Recommendation 3.3 **Ensure that all Looked after Children have timely and high quality holistic assessments of their physical, emotional and mental health needs informed by SMART health plans which reflect the child's voice.**	
Lead: **Southern Derbyshire Clinical Commissioning Group and Derbyshire Healthcare NHS Foundation Trust**	
Success Criteria **All Looked after children have timely, high quality holistic statutory health assessments and SMART health plans (initial and review) which reflect the child's voice.**	**Evaluation** **SDCCG will have a quality assurance audit programme which can demonstrate that health assessments are carried out meeting the required quality.**

Actions	Lead Person	Completion Date	Monitored By	Progress
To continue to undertake quality assurance audits which effectively monitor and review the standard of health care assessments and SMART health care plans (IHA and RHA) which reflect the child voice.	Lesley Smales and Dr Corina Teh	**December 2015**	Southern Derbyshire CCG Quality Assurance Committee	 Quality audit for review health assessı Audit of the initial health assessment to be undertaken in January 2016.
The findings from the quality assurance audits to be shared with SDCCG Quality Assurance	Lesley Smales	**March 2016**	Southern Derbyshire CCG	

Committee on a quarterly basis with any identified actions required.			Quality Assurance Committee	

The Task and Finish Group to coordinate the timeliness of the Strengths and Difficulty Questionnaires (SDQs)to inform the review health assessments	Lesley Smales	**April 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee / DHCFT Contract Monitoring and SDCCG Quality Assurance Committee	01.12.15 **Enc E** A new process has been agreed with the Local Authority to ensure the timeliness of the SDQ to inform the review health assessment.
CAMHS Service to report to the Corporate Parenting Board on the numbers of Looked after Children with mental healthcare needs accessing the CAMHS Service	Lesley Smales and Helen McMahon	**July 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee / DHCFT Contract Monitoring and SDCCG Quality Assurance Committee	Helen has a planned meeting with Lesley to access list of CIC and check against CAMHS records on PARIS . City first. Plan needed with county Designate of similarly do for County needs to be agreed . Helen to explore if PARIS can develop a flagging system .
DHCFT to develop a Service Policy regarding meeting the needs of Looked after children with mental health concerns in line with the NICE Guidelines for Looked after Children.	Lesley Smales and Helen McMahon	**June 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee / DHCFT Contract Monitoring and SDCCG Quality Assurance Committee	Helen and Lesley to review NICE requirements for looked after children and identify the service gap analysis for service development

Recommendation 4.1 **Ensure that health records are complete and comply with professional standards and organisational policy.**
Lead: **Southern Derbyshire Clinical Commissioning Group, Derby Teaching Hospitals NHS Foundation Trust and Derbyshire Healthcare NHS Foundation Trust**

Success Criteria	**Evaluation**
Records are fully completed and comply with record keeping professional standards.	**Both DTHFT and DHCFT can demonstrate that effective record keeping is in line with Professional and Organisation standards by undertaking regular record keeping audits.**

Actions	**Lead Person**	**Completion Date**	**Monitored By**	**Progress**
DTHFT and **DHCFT** to undertake a review of the Organisations record keeping guidance and standards.	Cathy Winfield/ Carolyn Green	**January 2016**	DTHFT Trust Safeguarding Committee / DHCFT safeguarding Vulnerable Adults and Children Committee DHCFT Contract monitoring Group and Southern Derbyshire Quality Assurance Committee	Carolyn Green has recommended changes to the health records policy and has sent a briefing of recommended changes out to the Trust for comments through its information governance, these changes will be briefed out to the organisation.

DTHFT to ensure that all staff are reminded of their professional responsibility and to adhere to record keeping standards.	Cathy Winfield	**January 2016**	DTHFT Trust Safeguarding Committee / Southern Derbyshire Quality Assurance Committee	
DTHFT have an effective programme of safeguarding record keeping audits which results in a plan in identify any shortfalls in record keeping practices.	Jane O'Daly-Miller	**March 2016**	DTHFT Trust Safeguarding Committee / Derby City Public Health Contract/ Performance meetings and Southern Derbyshire CCG Quality Assurance Committee	
Further development of DTHFT Lorenzo electronic patient record and the incorporation of a safeguarding field which results in all safeguarding liaison, contacts and outcomes being recorded on the patient record.	Informatics Trust Lead/ Pam Herod/ Jane O'Daly- Miller	**1ST stage March2016** **2nd stage October 2016**	DTHFT Trust Safeguarding Committee and Southern Derbyshire CCG Quality Assurance Committee	

DHCFT Assessments and Care plans to include documentation of the CQC recommendation within the Professional Standards and Organisational Policy. Templates to be amended and developed in line with the recommendation.	Richard Morrow/ Sam Kelly	**April 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee / DHCFT Contract Monitoring Group/ Derby City Public Health Contract/ Performance meetings and Southern Derbyshire Quality Assurance Committee	CAMHS is part of the monthly care plan development meeting to develop and co-ordinate the strategy to improve care planning across the organisation and will focus on the operational structural and philosophical changes in approach and develop a work plan to bring about necessary changes. The DH Passport care plan is being piloted in the Rise team All templates are being reviewed against best practice as Part of the CAMHS PARIS mobilisation plan
DHCFT to roll out training and workshops to address record keeping and care planning standards and requirements.	Faith Sango and Nursing /Quality Team / Richard Morrow / Sam Kelly	**June 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee/ DHCFT Contract Monitoring Group / Derby City Public	A national e-learning training on record keeping is available. A suggestion to be made to the DHCFT Training board to make it mandatory. Meeting held 22.01.16 re care plan strategy.

			Health Contract/ Performance meetings and Southern Derbyshire Quality Assurance Committee	

DHCFT to undertake a record keeping audit once the changes have been implemented.	Sarah Butt	**Audit cycle 2016-2017**	DHCFT safeguarding Vulnerable Adults and Children Committee / DHCFT Contract Monitoring Group / Derby City Public Health Contract/ Performance meetings and Southern Derbyshire Quality Assurance Committee	
DHCFT and **DTHFT** to share the findings of the record keeping audits and actions with SDCCG.	Tina Ndili and Jane O'Daly - Miller	**September 2016**	Southern Derbyshire CCG Quality Assurance Committee	

Recommendation 4.2 **Ensure that information sharing between agencies is underpinned by national and local protocols and that families are copied into any relevant plans.**
Lead: **Southern Derbyshire Clinical Commissioning Group, Derby Teaching Hospitals NHS Foundation Trust and Derbyshire Healthcare NHS Foundation Trust**

Success Criteria	**Evaluation**
DHCFT and DTHFT follow information sharing guidance/ procedures and that the family are kept informed of relevant plans.	**There is evidence within the records that information sharing has taken place in a timely manner and that families have received relevant plans.**

Actions	**Lead Person**	**Completion Date**	**Monitored By**	**Progress**
Professionals and families are made aware of the need to share information with other health professionals and Partner agencies for the purpose of safeguarding the child and Young person.	Tina Ndili and Jane O'Daly-Miller	**January 2016**	DTHFT Trust Safeguarding Committee / DHCFT safeguarding Vulnerable Adults and Children Committee/ Derby City Public Health Contract/ Performance meetings and Southern	 Important Message from Tina Ndili Head (Email sent 30.12.15 Also evidenced within the training slides for Think Family and Level 2 Safeguarding Children.

			Derbyshire Quality Assurance Committee	Information Sharing Slides.pptx **Enc E**
Professionals working with families ensure that families are informed of the Safeguarding plan and there is evidence that they have contributed towards the plan.	Tina Ndili and Jane O'Daly-Miller	**March 2016**	DTHFT Trust Safeguarding Committee / DHCFT safeguarding Vulnerable Adults and Children Committee/ Derby City Public Health Contract/ Performance meetings and Southern Derbyshire Quality Assurance Committee	

To ensure that the outcome of case conferences and the outline child protection plan is copied into the child health record (SystmOne/ PARIS /Lorenzo electronic patient record).	Tina Ndili and Jane O'Daly-Miller	**March 2016**	DTHFT Trust Safeguarding Committee / DHCFT safeguarding Vulnerable Adults and Children Committee/ Derby City Public Health Contract/ Performance meetings and Southern Derbyshire Quality Assurance Committee	**Enc E**
DHCFT to stress the importance and the need for Information Sharing a learning outcome in Safeguarding Children Level 2 and Think Family training.	Tina Ndili	**January 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee/ DHCFT Contract Monitoring Group/ Derby City Public Health Contract/ Performance meetings and and Southern Derbyshire Quality Assurance Committee	Evidence in training slides.  Information Sharing Slides.pptx

DHCFT to develop a person centred care plan template to capture content and consent. The template will be formatted in a portable document for Young people and families.	Richard Morrow	**May 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee/ DHCFT Contract Monitoring Group/ Derby City Public Health Contract/ Performance meetings and and Southern Derbyshire Quality Assurance Committee	**Enc E**

Recommendation 4.3 **Ensure that a care pathway is developed to ensure that children and young people who have mental health problems, and who are subject to admission to the paediatric ward, have a comprehensive assessment of their needs to ensure that they are supported by an appropriately skilled and experienced practitioner.**	
Lead: **Southern Derbyshire Clinical Commissioning Group, Derby Teaching Hospitals NHS Foundation Trust and Derbyshire Healthcare NHS Foundation Trust**	
Success Criteria **There is a care pathway in place that reflects that children will have a comprehensive assessment and care plan in place which identifies the child / young person individual needs and that they will be supported by an appropriate trained practitioner.**	**Evaluation** • **Care Pathway produced implemented and adhered to.** • **DTHFT can demonstrate that children with mental health conditions admitted on Paediatric wards are assessed and supported by CAMHS and cared for by appropriately trained staff.**

Actions	Lead Person	Completion Date	Monitored By	Progress
Develop a care pathway for children who have mental health needs/ conditions who have been admitted onto an acute paediatric ward and that there has been liaison with Clinical Psychology.	Helen McMahon, Dr Jo Kennedy and Sheila McFarlane	**March 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee DHCFT Contract Monitoring Group and Southern Derbyshire Quality Assurance Committee	*The Team Manager Chris Kirk has offered regular training to staff on Puffin ward including secondment opportunities* *Comprehensive assessment are undertaken by the RISE Team f 7 days/week 8-11* *The Rise team is represented at all weekly complex planning meeting*

				on Puffin ward **Enc E** *The Second on call Dr attached to RISE Team and Joint work with Psychology* *Draft care pathway has been developed by Team Manager* *Weekly discharge planning meeting with CAMHS RISE, Hospital Paediatrics and Clinical Psychology now in place*

Ensure that the Care pathway is implemented.	Helen McMahon	**March 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee DHCFT Contract Monitoring Group and Southern Derbyshire Quality Assurance Committee	*Care pathway currently under development* *Chris is working with Vicky Moss to complete.*
Ensure that children and young people who are inpatients and have mental health problems have a comprehensive assessment that is regularly reviewed to ensure their needs are being met and they are being cared for by appropriately trained staff.	Helen McMahon /Dr Jo Kennedy	**January 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee DHCFT Contract Monitoring Group and Southern Derbyshire Quality Assurance Committee	*All children undergo a comprehensive assessment by the RISE Team Liaison team* *CAMHS RISE are on ward every day to undertake reviews and support careplans and care plan reviews* *CAMHs Rise join the Weekly complex discharge meeting*

Enc E

To recruit staff to join the CAMHS Liaison Service in order to extend the service to 24/7 in order to meet increasing demand and reduce Hospital admission/ usage. .	Helen McMahon	**February 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee DHCFT Contract Monitoring Group and Southern Derbyshire Quality Assurance Committee	**Enc E**

To develop a fully operational Community based CAMHS Liaison team that will facilitate the development of person centred individual package of care.	Helen McMahon	**July 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee DHCFT Contract Monitoring Group and Southern Derbyshire Quality Assurance Committee	*Outwardly facing model is the planned approach of this new service as part of Phase 2 developments* *Core CAMHs service pathway developments is crucial to this development*
DTHFT and **DHCFT** to deliver training to ward staff on self –harm and Young Minds Mental Health.	Chris Kirk	**May 2016**	DTHFT Trust Safeguarding Committee and Southern Derbyshire CCG Quality Assurance Committee	*Completed by Chris Kirk and on-going as part of Team role*
DTHFT to offer Safeguarding supervision / support to Emergency Department and Paediatrics staff.	Jane O'Daly - Miller	**April 2016**	DTHFT Trust Safeguarding Committee and Southern Derbyshire CCG Quality Assurance Committee	
DTHFT to undertake an audit of staff awareness of the self-harm guidance.	Jane O'Daly - Miller	**June 2016**	DTHFT Trust Safeguarding Committee and Southern Derbyshire CCG Quality Assurance Committee	

Recommendation 4.4

Ensure that health practitioners' record when they have seen children and young people alone and that they have been asked about caring responsibilities as part of the information gathering process when accessing services.

Lead:
Southern Derbyshire Clinical Commissioning Group, Derby Teaching Hospitals NHS Foundation Trust and Derbyshire Healthcare NHS Foundation Trust

Success Criteria	**Evaluation**
Routine enquiry of children and Young people takes place to ascertain if they have caring responsibilities and that this is recorded in the records.	**DHCFT and DTHFT undertake record keeping audits to ensure that this information is ascertained and being reflected within the records.**

Actions	**Lead Person**	**Completion Date**	**Monitored By**	**Progress**
Ensure that records reflect that when a child or Young Person has been seen on their own/ the reason why they have been seen on their own and if they have any caring responsibilities.	Tina Ndili and Jane O'Daly-Miller	**March 2016**	DTHFT Trust Safeguarding Committee / DHCFT safeguarding Vulnerable Adults and Children Committee/ Derby City Public Health Contract/ Performance meetings and Southern Derbyshire Quality Assurance Committee	

DHCFT to continue to deliver the updated record keeping and care planning training and workshops	Faith Sango and Nursing /Quality Team	**June 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee DHCFT Contract Monitoring Group/ Derby City Public Health Contract/ Performance meetings and Southern Derbyshire Quality Assurance Committee	**Enc E**
DHCFT to include in the electronic patient record /EPR (Paris and Systm One) details which ascertain carer/ family structure and any caring responsibilities.	John Staley	**January 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee/ Derby City Public Health Contract/ Performance meetings and Southern Derbyshire Quality Assurance Committee	 CQC recommendation 4.4  Derby City Children Looked After and Saf

DTHFT to continue to develop Lorenzo Electronic Patient record and the incorporation of the safeguarding field which will enable the assessment of vulnerability and risk to be ascertained.	Informatics Lead and Jane O'Daly- Miller	**October 2016**	DTHFT Trust Safeguarding Committee and Southern Derbyshire Quality Assurance Committee	
DHCFT and **DTHFT** to undertake record keeping audits to ensure that the above information is being sought, recorded and acted upon	Tina Ndili and Jane O'Daly-Miller	**September 2016**	DTHFT Trust Safeguarding Committee / DHCFT safeguarding Vulnerable Adults and Children Committee/ Derby City Public Health Contract/ Performance meetings and Southern Derbyshire Quality Assurance Committee	

Recommendation 4.5

Ensure the demographics and full family histories are completed and that there is an agreed process of care planning that accurately reflects those; and that children and young people are involved with age appropriate informed consent.

Lead:

Southern Derbyshire Clinical Commissioning Group, Derby Teaching Hospitals NHS Foundation Trust and Derbyshire Healthcare NHS Foundation Trust

Success Criteria	**Evaluation**
Records are fully and correctly completed reflecting all patient details. **Informed consent has been sought from Children and Young People who are of an appropriate age and understanding to do so.**	**DHCFT and DTHFT to undertake record keeping audits to ensure that all details have been accurately completed and where appropriate informed consent has been sought from the child or Young person.**

Actions	**Lead Person**	**Completion Date**	**Monitored By**	**Progress**
DHCFT to amend the assessment and care plan template to ensure all demographic details and family histories is obtained and completed on the electronic patient records (PARIS and SystmOne)	Richard Morrow and Tina Ndili	**June 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee/ DHCFT Contract Monitoring Group/ Derby City Public Health Contract/ Performance	

			meetings and Southern Derbyshire Quality Assurance Committee	**Enc E**
Children and Young People who have the appropriate level of understanding provide informed consent and take an active part in their care planning. This will be demonstrated within the care planning documentation.	Dr Jo Kennedy and Tina Ndili	**June 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee/ DHCFT Contract Monitoring Group/ Derby City Public Health Contract/ Performance meetings and and Southern Derbyshire Quality Assurance Committee	Assessment of capacity is being integrated in to new assessment and care plan developments Care plans include the voice of the child.

DHCFT Looked after Children Team to be granted access rights to Liquid Logic (IT system for Children's Social Care) to ensure that Part A of the BAAF form for initial and review health assessments are completed in full and shared in a timely manner.	Lesley Smales/ Sheila McFarlane	**June 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee/ DHCFT Contract Monitoring Group/ Derby City Public Health Contract/ Performance meetings and and Southern Derbyshire Quality Assurance Committee	
DTHFT to explore the need to review processes/ records / care plans of admissions to Paediatric areas/ wards	Jane O'Daly-Miller	**February 2016**	DTHFT Trust Safeguarding Committee and Southern Derbyshire Quality Assurance Committee	

DTHFT to review the Safeguarding children policy to ensure issues of consent are clearly identified including relationships between Mental Capacity Act and Fraser Competency.	Jane O'Daly-Miller	**March 2016**	DTHFT Trust Safeguarding Committee and Southern Derbyshire Quality Assurance Committee	
DTHFT and **DHCFT** to undertake service user feedback on the young person's involvement in their decision making and care planning.	Jane O'Daly-Miller and Lesley Smales	**June 2016**	DTHFT Trust Safeguarding Committee / DHCFT safeguarding Vulnerable Adults and Children Committee/ Derby City Public Health Contract/ Performance meetings and Southern Derbyshire Quality Assurance Committee	

Recommendation 4.6 **Ensure that a review of all recording systems and record keeping is undertaken with a focus on family inclusive practice.**	
Lead: **Southern Derbyshire Clinical Commissioning Group, Derby Teaching Hospitals NHS Foundation Trust and Derbyshire Healthcare NHS Foundation Trust**	
Success Criteria **That all recording systems enable the practitioner to make a holistic and inclusive assessment.**	**Evaluation** • **DHCFT and DTHCFT have effective electronic patient records which enable Practitioners to complete a full holistic assessment.** • **Recording Keeping audit to evidence family inclusive practice.**

Actions	Lead Person	Completion Date	Monitored By	Progress
DHCFT to audit records to evidence that voice of the child has been sought and their views recorded in each health assessment. For each recommendation on their health care plan to have a clear timeframe and a named professional responsible.	Lesley Smales	**January 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee/ DHCFT Contract Monitoring Group / Derby City Public Health Contract/ Performance	 Quality audit for review health assessr

			meetings and and Southern Derbyshire Quality Assurance Committee	**Enc E**
To ensure the effective and timely transfer of information between DHCFT and Local Authority around the health of Looked after Children for example through access to the Local authority electronic system called 'Liquid Logic'.	Lesley Smales/ Sheila McFarlane	**June 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee/ DHCFT Contract Monitoring Group / Derby City Public Health Contract/ Performance meetings and and Southern Derbyshire Quality Assurance Committee	

DHCFT and **DTHFT** to raise awareness within their Organisation regarding the need to follow up verbal referrals to Social Care in writing using the standard Multiagency referral form.	Tina Ndili and Jane O'Daly-Miller	**January 2016**	DTHFT Trust Safeguarding Committee / DHCFT safeguarding Vulnerable Adults and Children Committee/ Derby City Public Health Contract/ Performance meetings and Southern Derbyshire Quality Assurance Committee	*DHCFT have sent out a whole Organisation Communication email to remind staff that all Safeguarding children referrals to Social Care must be followed up in writing and a copy of the referral forwarded to the Trust Safeguarding Children service for information and audit purposes.*
DHCFT Adult Mental Health Services to contribute to safeguarding children systems / plans and services.	Tina Ndili and Tracey Holtom	**September 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee/ DHCFT Contract Monitoring Group and Southern Derbyshire Quality Assurance Committee	

DTHFT to continue to develop Lorenzo Electronic Patient record incorporating safeguarding assessment and recording fields.	DTHFT Informatics Lead and Jane O'Daly-Miller	**October 2016**	DTHFT Trust Safeguarding Committee and Southern Derbyshire Quality Assurance Committee	**Enc E**

Recommendation 4.7

Ensure that the capacity of the role of Safeguarding Link is strengthened to reflect areas of responsibility.

Lead:
Southern Derbyshire Clinical Commissioning Group, Derby Teaching Hospitals NHS Foundation Trust and Derbyshire Healthcare NHS Foundation Trust.

NB. This recommendation only pertains to Derby Teaching Hospital Foundation Trust because Derbyshire Healthcare Foundation Trust does not have Safeguarding links.

Success Criteria	Evaluation
The Safeguarding Links within DTHFT are clear about their role and responsibilities and have the capacity to undertake this role.	**DTHFT to review the role and ensures that the Safeguarding Links have clear roles and responsibilities and sufficient capacity to undertake this role.**

Actions	Lead Person	Completion Date	Monitored By	Progress
DTHFT to review the Safeguarding Link role and explore the possibility for inclusion in the appraisal process.	Jane O'Daly-Miller/ Deputy Director of Workforce Management / Chief Nurse and director of Patient Experience.	**January 2016**	Safeguarding Lead/ DTHFT Trust Safeguarding Committee and Southern Derbyshire CCG Quality Assurance Committee	

Recommendation 4.8 **Strengthen supervision practice for all healthcare staff and ensure that discussions and action plans from supervision are clearly documented in the patient records.**	
Lead: **Southern Derbyshire Clinical Commissioning Group, Derby Teaching Hospitals NHS Foundation Trust and Derbyshire Healthcare NHS Foundation Trust**	
Success Criteria **Safeguarding Supervision arrangements are clearly embedded and that all safeguarding supervision discussions and actions are recorded in the patient record.**	**Evaluation** **DHCFT and DTHFT to undertake regular supervision audits to review the quality of supervision and that there is evidence that thorough and clear recording takes place for both 1:1 and Group supervision.**

Actions	Lead Person	Completion Date	Monitored By	Progress
Safeguarding children Supervision arrangements within Midwifery to be reviewed and where necessary strengthened	Pam Herod	**January 2016**	Safeguarding Lead/ DTHFT Trust Safeguarding Committee and Southern Derbyshire CCG Quality Assurance Committee	

DTHFT to undertake a review of supervision practice; options and proposals to be developed and consulted on.	Jane O'Daly - Miller	**March 2016**	Safeguarding Lead/ DTHFT Trust Safeguarding Committee and Southern Derbyshire CCG Quality Assurance Committee	
DTHFT to review the Supervision Policy and re-launch the Policy via a Communication Strategy.	Jane O'Daly – Miller	**April 2016**	Safeguarding Lead/ DTHFT Trust Safeguarding Committee and Southern Derbyshire CCG Quality Assurance Committee	
DHCFT to undertake a review of the Safeguarding children supervision arrangements within Adult Mental health and CAMHS Service.	Tina Ndili and Dr Jo Kennedy	**January 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee/ DHCFT Contract Monitoring Group and Southern Derbyshire Quality Assurance Committee	Complete – to commence new model of Safeguarding Supervision with CAMHS service, Substance Misuse and Adult Mental Health in January 2016. This will take the form of a combination of group supervision, open door sessions (also by appointment) and via the on call system.

DHCFT to review and update the Supervision Policy so that it is in line with the CQC recommendation.	Angie Balwacko / Bev Greene	**January 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee/ DHCFT Contract Monitoring Group and Southern Derbyshire Quality Assurance Committee	Currently out for consultation to be taken to Quality Committee in March for ratification.
DHCFT to develop a revised supervision recording template to facilitate supervision processes across the Organisation.	Angie Balwacko / Bev Greene	**January 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee/ DHCFT Contract Monitoring Group and Southern Derbyshire Quality Assurance Committee	Currently out for consultation to be taken to Quality Committee in March for ratification.

DHCFT and **DTHFT** to undertake Safeguarding Supervision audits to review the quality and recording of all safeguarding supervision and ensure adherence to the Supervision Policy. To share findings of the audits with SDCCG.	Tina Ndili and Jane O'Daly-Miller	**July 2016**	DTHFT Trust Safeguarding Committee / DHCFT safeguarding Vulnerable Adults and Children Committee/ DHCFT Contract Monitoring Group and Southern Derbyshire Quality Assurance Committee	

Recommendation 5.1 **Ensure that Health professionals are clear about their role, task and expected outcomes when working with families as part of a child protection plan.**	
Lead: **Derbyshire Healthcare NHS Foundation Trust**	
Success Criteria **Health professionals are clear of their role and responsibilities for children on their caseload who are subject to a child protection plan.**	**Evaluation** **DHCFT to undertake audits to ascertain Health professionals understanding of their safeguarding children role and responsibilities.**

Actions	Lead Person	Completion Date	Monitored By	Progress
All Clinical Health Professionals to attend Level 1 and 2 Safeguarding Children training and other Mandatory safeguarding children training identified on their Training passport.	Tina Ndili	**June 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee/ DHCFT Contract Monitoring Group / Derby City Public Health Contract/ Performance meetings and Southern Derbyshire Quality Assurance Committee	

All Child and Family teams including CAMHS to attend Derby City Safeguarding Children multi-agency training on case conferences and core groups. Other Health Professionals working with children and families should prioritise attending Derby City Safeguarding Children multi-agency training on case conferences and core groups.	Tina Ndili	**June 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee/ DHCFT Contract Monitoring Group/ Derby City Public Health Contract/ Performance meetings and Southern Derbyshire Quality Assurance Committee	
DHCFT to undertake two specific audits : • Staff understanding of their roles; responsibility and specific actions when involved in the child protection process. • Quality of case conference reports, outcomes of case conference and attendance of Derbyshire Healthcare Foundation Trust Staff.	Tina Ndili	**June 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee/ DHCFT Contract Monitoring Group / Derby City Public Health Contract/ Performance meetings and Southern Derbyshire Quality Assurance Committee	

DHCFT Safeguarding Children Service to continue to support and offer guidance to all newly qualified Child and Family Health Professionals in regard to Safeguarding children processes in the first year of their appointment. Other Health Professionals working with children and families to access advice and support with regard to safeguarding children processes on needs led basis.	Tina Ndili	**Ongoing Service Provided**	DHCFT safeguarding Vulnerable Adults and Children Committee/ DHCFT Contract Monitoring Group / Derby City Public Health Contract/ Performance meetings and Southern Derbyshire Quality Assurance Committee	
All new starters to be offered the opportunity to attend Eastmead safeguarding children Induction.	Tina Ndili	**September 2016**	DHCFT safeguarding Vulnerable Adults and Children Committee/ DHCFT Contract Monitoring Group / Derby City Public Health Contract/ Performance meetings and Southern Derbyshire Quality Assurance Committee	22.12.15 – Email sent to Named Nurses and Operational Managers to inform all staff of the invitation from Eastmead . 31.12.15 - Information for New Starters including invitation updated on CONNECT

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 24 February 2016

NHS National Staff Survey Results 2015

Purpose of Report
To present to the Board a high level overview of the annual NHS National staff survey results.

Executive Summary

Introduction

Questionnaires were sent to a sample population of staff, 800 staff were invited to participate. Our response rate was **41%** which is average for mental health/learning disability trusts in England, the response rate in the 2014 survey was **45%**.

The survey was structured around 4 of the seven pledges to staff in the NHS Constitution which was published in March 2013 plus three additional themes:

Staff Pledge 1: To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities

Staff Pledge 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.

Staff Pledge 3: To provide support and opportunities for staff to maintain their health, well-being and safety.

Staff Pledge 4: To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.

Additional themes: Equality and diversity, Error and incidents, Patient experience measures

The Staff Survey Results

The survey covers 32 Key Findings (KFs). As in previous years, there are two types of Key Findings (KF)

- Percentage scores i.e. the % of staff giving a particular response to one, or a series of, survey questions
- Scale summary scores, calculated by converting staff responses to particular questions into scores, these are scale summary scores, the minimum score is always 1 and the maximum score is 5

Staff engagement

Possible scores range from 1-5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged

Trust Score 2015	3.73
National 2015 average combined MH/LD & community trusts	3.81
Trust Score 2014	3.75

Top five ranking scores

KF29. % of staff reporting errors, near misses or incidents witnessed in the last month

Trust Score 2015	96%
National 2015 average combined MH/LD & community trusts	92%
Trust Score 2014	92%

KF27. % of staff / colleagues reporting most recent experience of harassment

Trust Score 2015	57%
National 2015 average combined MH/LD & community trusts	48%
Trust Score 2014	50%

KF16. % of staff working extra hours

Trust Score 2015	67%
National 2015 average combined MH/LD & community trusts	72%
Trust Score 2014	70%

KF15. % of staff satisfied with the opportunities for flexible working patterns

Trust Score 2015	60%
National 2015 average combined MH/LD & community trusts	56%
Trust Score 2014	-

KF28. % of staff witnessing potentially harmful errors, near misses or incidents in the last month

(the lower the score the better)

Trust Score 2015	21%
National 2015 average combined MH/LD & community trusts	22%
Trust Score 2014	26%

Bottom ranking scores

KF3. % of staff agreeing that their role makes a difference to patients / service users

Trust Score 2015	87%
National 2015 average combined MH/LD & community trusts	89%
Trust Score 2014	-

KF12. Quality of appraisals

Trust Score 2015	2.89
National 2015 average combined MH/LD & community trusts	3.05
Trust Score 2014	-

KF32. Effective use of patient /service user feedback

Trust Score 2015	3.37
National 2015 average combined MH/LD & community trusts	3.69
Trust Score 2014	3.54

KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

Trust Score 2015	3.64
National 2015 average combined MH/LD & community trusts	3.72
Trust Score 2014	-

KF24. % of staff / colleagues reporting most recent experience of violence**

Trust Score 2015	67%
National 2015 average combined MH/LD & community trusts	74%
Trust Score 2014	79%

Largest local changes since the 2014 Survey

Where staff experience has deteriorated**

KF11. % of staff appraised in the last 12 months

Trust Score 2015	83%
Trust Score 2014	91%

KF32. Effective use of patient /service user feedback

Trust Score 2015	3.37
Trust Score 2014	3.54

Our Organisation

A number of questions feed into KF1 '**Staff recommendation of the organisation as a place to work or receive treatment'**

Q		Our Trust 2015	Average for combined MH/LD & community trusts	Our Trust 2014
21a	Care of patients/service users is my organisations top priority	68%	73%	68%
21b	My organisation acts on concerns raised by patients/service users	69%	75%	74%
21c	I would recommend my organisation as a place to work	46%	57%	54%
21d	If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	63%	67%	60%
KF 1	Staff recommendation of the organisation as a place to work or receive treatment	3.54	3.70	3.59

Our overall results when ranked, compared with all combined MH/LD and community trusts in 2015 identify:
4 KF above (better than) average
5 KF above (worse than) average
10 KF Average
13 KF below (worse than) average

Results with negative findings, where the trust is worse than average or where it is not as good as 2014 (Trust score for 2015 in brackets)

- Staff recommendation of the organisation as a place to work or receive treatment (3.54)
- Staff satisfaction with the quality of work and patient care they are able to deliver (3.78)
- Staff agreeing that their role makes a difference to patients / service users (87%)
- Staff motivation at work (3.86)
- Staff appraised in the last twelve months (83%)

- Quality of appraisals (2.89)
- Quality of non-mandatory training, learning or development (4.01)
- Staff feeling pressure in the last twelve months to attend work when feeling unwell (64%)
- Staff experiencing physical violence from patients, relatives or the public in the last 12 months (17%)
- Staff experiencing physical violence from staff in last twelve months (3%)
- Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last twelve months (31%)
- Staff experiencing harassment, bullying or abuse from staff in last twelve months (22%)
- Staff reporting good communication between senior management and staff (27%)
- Staff believing that the organisation provides equal opportunities for career progression or promotion (84%)
- Fairness and effectiveness of procedures for reporting errors, near misses and incidents (3.64)
- Staff confidence and security in reporting unsafe clinical practice (3.56)
- Effective use of patient / service user feedback (3.37)

And finally….

Generally speaking there has been has been a marginal decline from the 2014 survey and it is recognised that there is some work to be done in a number of areas.

Next Steps
Proactive work will be undertaken to explore the results further and analyse by service line, occupational groups, and Workforce Race Equality Standard (WRES). This detail will be shared with the People and Culture Committee in March 2016, senior leadership team and will be supported by a specific action plan.

Strategic considerations
'We Focus on Our People' is a core value for our Trust. The annual staff survey is one indicator of how our staff feel in their day to day working environment – our future strategy and activities will be informed by the results of the annual survey.

Board Assurances
The results and actions from the staff survey will be presented to the People and Culture Committee. We will be introducing a pulse check survey on a quarterly basis to track progress of interventions

Consultation
This paper has not been previously submitted to any committee or group

Governance or Legal issues The annual staff survey will support the governance improvement action plan

Equality Delivery System
Further analysis will be undertaken of the results to ascertain any impact and be explicit of future action required

Recommendations
The Board of Directors is requested to:

- Receive the high level annual national staff survey results and agree the monitoring and tracking of the action plan through the People and Culture Committee

Report presented by: **Jayne Storey, Director of Workforce, OD and Culture**

Report prepared by: **Jayne Storey, Director of Workforce, OD and Culture**

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 24 February 2016

Trust Performance Report

Key Performance Indicators Compliance

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

Executive Summary

- The Trust continues to be compliant with all Monitor regulatory indicators and a quarterly view has been included within the summary section
- The recording of Payment by Result Clusters and Health of the Nation Outcome Scores 12 month reviews continue to be challenging however there have been recent improvements and new targets agreed with Commissioners
- The rate of outpatients who did not attend has improved in January and the rate of trust cancelled outpatients is under target and has been impacted by the Junior Doctor action
- Health Visitor performance remains strong
- IAPT recovery rates have improved in January and are above target for the year to date
- Length of Stay Benchmarking based on the NHS Benchmarking results 14/15 have been included in this document

Strategic considerations

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

(Board) Assurances

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

Consultation

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

Governance or Legal issues

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

Equality Delivery System

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

Recommendations

The Board of Directors is requested to:

1) To acknowledge the current performance of the Trust
2) To note the actions in place to ensure sustained performance

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

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

Performance Summary Dashboard February 2016

Performance Dashboard (Monitor & Exceptions)

Performance Dashboard 15-16	Target	Q1	Q2	Q3
- Monitor Targets				
- CPA 7 Day Follow Up	95.00%	97.70%	97.69%	96.55%
- CPA Review in last 12 Months (on CPA > 12 Months)	95.00%	96.40%	96.44%	96.08%
- Delayed Transfers of Care	7.50%	0.70%	0.48%	1.51%
- Data Completeness: Identifiers	97.00%	99.34%	99.41%	99.35%
- Data Completeness: Outcomes	50.00%	93.49%	94.09%	95.17%
- Community Care Data - Activity Information Completeness	50.00%	91.28%	90.90%	91.34%
- Community Care Data - RTT Information Completeness	50.00%	92.31%	92.31%	92.31%
- Community Care Data - Referral Information Completeness	50.00%	72.99%	72.91%	72.19%
- 18 Week RTT Less Than 18 Weeks - Incomplete	92.00%	95.44%	95.78%	97.45%
- Early Interventions New Caseloads	95.00%	126.50%	108.70%	102.90%
- Clostridium Difficile Incidents	7	0	0	0
- Crisis GateKeeping	95.00%	100.00%	100.00%	100.00%
- IAPT Referral to Treatment within 18 weeks	95.00%	99.45%	99.02%	99.49%
- IAPT Referral to Treatment within 6 weeks	75.00%	87.22%	89.47%	93.39%
- Locally Agreed				
- Patients Clustered Regardless of Review Dates	96.00%	95.45%	94.81%	94.87%
- CPA HoNOS Assessment in last 12 Months	90.00%	80.04%	83.04%	88.68%
- Schedule 4 Contract				
- Consultant Outpatient Appointments DNAs	15.00%	16.35%	16.68%	15.79%
- Outpatient Letters Sent in 10 Working Days	90.00%	73.08%	60.38%	78.87%
- Outpatient Letters Sent in 15 Working Days	100.00%	86.99%	84.57%	90.97%
- Inpatient 28 Day Readmissions	10.00%	7.93%	10.86%	10.84%

Safer Staffing(January 2016)

Ward name	Day		Night	
	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)
Audrey House Residential Rehabilitation	100.0%	98.4%	100.0%	100.0%
Child Bearing / Perinatal Inpatient	107.7%	151.7%	103.1%	167.7%
CTC Residential Rehabilitation	100.0%	98.8%	100.0%	100.0%
Enhanced Care Ward	96.3%	100.5%	96.8%	116.0%
Hartington Unit Morton Ward Adult	102.2%	102.3%	70.0%	134.1%
Hartington Unit Pleasley Ward Adult	98.9%	107.0%	100.0%	100.0%
Hartington Unit Tansley Ward Adult	88.2%	123.8%	69.6%	119.2%
Kedleston Unit - Curzon Ward	97.5%	102.7%	100.0%	104.1%
Kedleston Unit - Scarsdale Ward	97.6%	100.0%	100.0%	98.4%
KW Cubley Court Female	103.7%	93.4%	100.0%	99.3%
KW Cubley Court Male	99.4%	93.1%	96.8%	97.4%
LRCH Ward 1 OP	100.7%	89.4%	92.2%	109.3%
LRCH Ward 2 OP	100.7%	96.6%	97.9%	98.1%
RDH Ward 33 Adult Acute Inpatient	99.5%	101.9%	97.8%	111.1%
RDH Ward 34 Adult Acute Inpatient	95.2%	107.3%	64.5%	184.4%
RDH Ward 35 Adult Acute Inpatient	102.7%	106.8%	90.5%	124.3%
RDH Ward 36 Adult Acute Inpatient	92.4%	110.2%	92.3%	106.9%

IAPT Recovery Rates

Indicator name	Dec-15	Jan-16	YTD
Recovery Rates KPI 6 / (KPI 5 - KPI 6b)	47.19%	56.28%	53.68%
Partial and Full Recovery Rates	66.45%	73.22%	71.40%

Health Visitors

15-16 Health Visitor Dashboard	Target	Dec-15	Jan-16
% 10-14 Day Breastfeeding coverage	95.00%	100.00%	97.90%
% 6-8 Week Breastfeeding coverage	95.00%	98.50%	97.30%
% Still Breastfeeding at 6-8 Weeks	65.00%	75.00%	69.60%

Variance Commentary

Indicator	Target	Over/under Performance	Rationale for Variance	Actions	Confidence in Actions
Patients clustered regardless of Review Dates	96%	Under	Patients not cluster and clusters not reviewed to required timescale	Working with teams to address under-performance and increasing training.	Low
Consultant Outpatient trust cancellations	5%	Under	Clinics cancelled within 6 weeks of anticipated attendance date	Clinics were cancelled due to Junior Doctor action	Medium
Outpatient Letters sent in 15 working days	100%	Under	Letters not completed to agreed timescales	To implement and monitor the agreed action plan against recovery trajectory	Medium
Safer Staffing	Between 90% and 125 % of planned roster	Under	Staff vacancies and increased observations	Recruitment currently underway. Ongoing work to migrate the source from Safer Staffing solution to eRostering.	Medium

Derbyshire Healthcare NHS FT
Key Performance Indicators Compliance Report
Based on January 2016 Information

Introduction

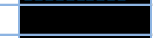
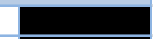
The following Performance Compliance report is organised into the following sections;

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

1 Trust Performance Dashboard

Key to colour coding	
Compliant with target	
Target exception	

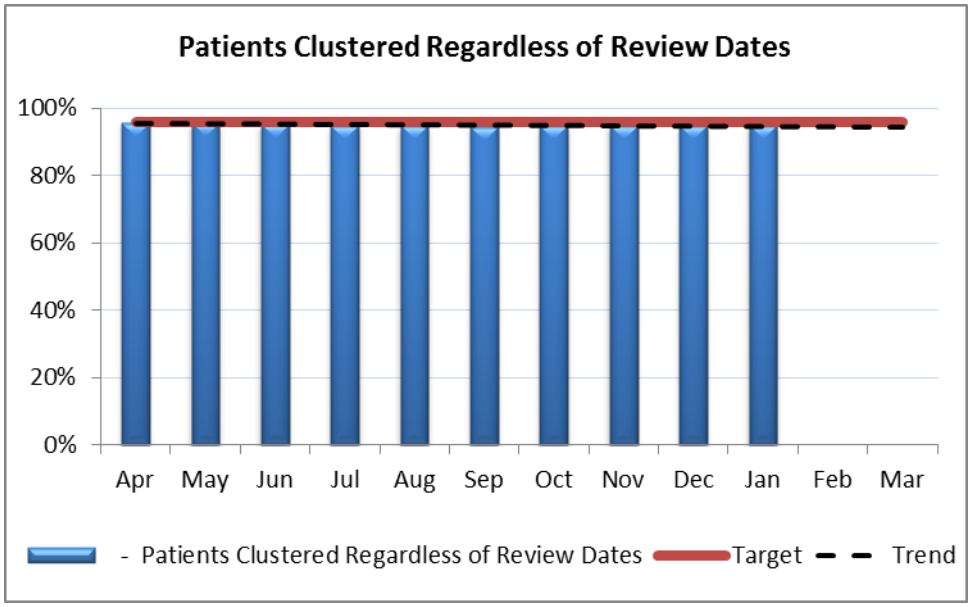
15-16 Performance Dashboard	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Trend
- Monitor Targets														
- CPA 7 Day Follow Up	95.00%	96.12%	97.59%	99.16%	97.20%	98.96%	97.22%	99.13%	96.05%	93.94%	95.51%			
- CPA Review in last 12 Months (on CPA > 12 Months)	95.00%	96.86%	96.38%	96.40%	96.36%	96.78%	96.44%	95.98%	95.44%	96.08%	95.51%			
- Delayed Transfers of Care	7.50%	0.75%	0.67%	0.68%	0.69%	0.41%	0.35%	0.79%	1.59%	2.18%	2.23%			
- Data Completeness: Identifiers	97.00%	99.28%	99.26%	99.34%	99.36%	99.38%	99.41%	99.36%	99.34%	99.35%	99.37%			
- Data Completeness: Outcomes	50.00%	94.22%	93.75%	93.49%	93.61%	93.76%	94.09%	94.95%	95.09%	95.17%	95.01%			
- Community Care Data - Activity Information Completeness	50.00%	91.49%	91.35%	91.04%	90.97%	90.84%	90.88%	91.44%	91.26%	91.32%	91.26%			
- Community Care Data - RTT Information Completeness	50.00%	92.31%	92.31%	92.31%	92.31%	92.31%	92.31%	92.31%	92.31%	92.31%	92.31%			
- Community Care Data - Referral Information Completeness	50.00%	73.22%	72.90%	72.87%	73.39%	73.42%	72.26%	72.46%	72.38%	71.63%	71.41%			
- 18 Week RTT Less Than 18 Weeks - Incomplete	92.00%	95.62%	94.59%	96.16%	95.76%	96.17%	95.36%	96.90%	97.71%	97.71%	98.30%			
- Early Interventions New Caseloads	95.00%	163.60%	130.40%	126.50%	119.60%	115.80%	108.70%	107.80%	100.00%	102.90%	100.90%			
- Clostridium Difficile Incidents	7	0	0	0	0	0	0	0	0	0	0			
- Crisis GateKeeping	95.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%			
- IAPT Referral to Treatment within 18 weeks	95.00%	99.44%	99.41%	99.48%	99.05%	98.98%	99.01%	99.51%	99.38%	99.61%	99.31%			
- IAPT Referral to Treatment within 6 weeks	75.00%	89.22%	86.67%	85.84%	87.96%	91.22%	89.62%	91.79%	93.69%	94.90%	92.94%			
- Locally Agreed														
- CPA Settled Accommodation	90.00%	99.28%	99.13%	98.94%	98.90%	98.85%	98.52%	98.13%	97.97%	97.54%	97.52%			
- CPA Employment Status	90.00%	99.43%	99.29%	99.26%	99.22%	99.11%	98.87%	98.62%	98.46%	98.30%	98.38%			
- Data Completeness: Identifiers	99.00%	99.28%	99.26%	99.34%	99.36%	99.38%	99.41%	99.36%	99.34%	99.35%	99.37%			
- Data Completeness: Outcomes	90.00%	94.22%	93.75%	93.49%	93.61%	93.76%	94.09%	94.95%	95.09%	95.17%	95.01%			
- Patients Clustered not Breaching Today	80.00%	74.76%	75.09%	75.51%	75.71%	76.18%	77.03%	78.74%	80.92%	81.22%	81.59%			
- Patients Clustered Regardless of Review Dates	96.00%	95.67%	95.53%	95.16%	94.90%	94.86%	94.67%	94.87%	94.93%	94.82%	94.84%			
- CPA HoNOS Assessment in last 12 Months	90.00%	81.86%	80.64%	80.04%	80.53%	81.23%	83.04%	86.79%	87.64%	88.68%	88.05%			
- 7 Day Follow Up – All Inpatients	95.00%	95.90%	97.80%	98.55%	97.76%	97.35%	96.97%	98.43%	93.26%	94.50%	96.12%			
- Ethnicity Coding	90.00%	94.61%	95.64%	96.15%	95.85%	95.63%	95.22%	94.52%	94.12%	93.15%	91.67%			
- NHS Number	99.00%	99.84%	99.92%	99.95%	99.96%	99.96%	99.97%	99.98%	99.98%	99.98%	99.98%			

15-16 Performance Dashboard	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Trend
- Schedule 4 Contract														
- Consultant Outpatient Appointments Trust Cancellations (Within 6 Weeks)	5.00%	3.40%	2.96%	4.48%	3.57%	5.99%	5.26%	6.17%	3.72%	3.59%	5.88%			
- Consultant Outpatient Appointments DNAs	15.00%	15.89%	15.72%	17.26%	17.62%	15.61%	16.60%	14.99%	15.90%	16.54%	14.20%			
- Under 18 Admissions To Adult Inpatient Facilities	0	0	0	0	0	0	0	0	0	0	0			
- Outpatient Letters Sent in 10 Working Days	90.00%	77.92%	69.17%	72.27%	65.90%	58.32%	57.05%	73.67%	86.06%	76.02%	93.22%			
- Outpatient Letters Sent in 15 Working Days	100.00%	88.15%	85.58%	87.15%	85.58%	85.03%	83.41%	89.23%	92.41%	91.17%	96.85%			
- Inpatient 28 Day Readmissions	10.00%	11.97%	5.88%	5.44%	11.84%	10.40%	10.34%	16.44%	7.75%	7.86%	8.21%			
- MRSA - Blood Stream Infection	0	0	0	0	0	0	0	0	0	0	0			
- Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0			
- 18 Week RTT Greater Than 52 weeks	0	0	0	0	0	0	0	0	0	0	0			
- Discharge Fax Sent in 2 Working Days	98.00%	98.52%	100.00%	97.04%	98.67%	100.00%	98.68%	99.17%	100.00%	100.00%	98.97%			
- Fixed Submitted Returns														
18 Week RTT Greater Than 52 weeks	0	0	0	0	0	0	0	0	0	0	0			
18 Week RTT Less Than 18 weeks - Incomplete	92.00%	93.66%	92.94%	94.48%	94.35%	95.00%	94.48%	96.90%	98.18%	96.31%	98.30%			
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0			
Completion of IAPT Data Outcomes	90.00%	98.33%	97.65%	96.35%	96.66%	98.36%	97.36%	98.36%	94.47%	95.68%	94.15%			
Ethnicity Coding	90.00%	93.62%	94.75%	95.64%	95.26%	95.10%	94.67%	94.05%	93.54%	92.18%	92.18%			
NHS Number	99.00%	100.00%	100.00%	99.99%	99.99%	99.99%	99.77%	99.99%	100.00%	100.00%	100.00%			

1.1 Exception Items and Specific Areas of Interest

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

1.1.1 Locally Agreed – Patients clustered regardless of Review Dates



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

We now have an added driver to improve compliance in that monitor are pressing for outcomes-based payment systems to be introduced. In light of this we are implementing performance management for cluster compliance

Medical Director's Bulletin December 2015 briefed the medical staff regarding these new Monitor clustering requirements and has resulted in the Payment by Results Advisor receiving more requests for help and support with clustering

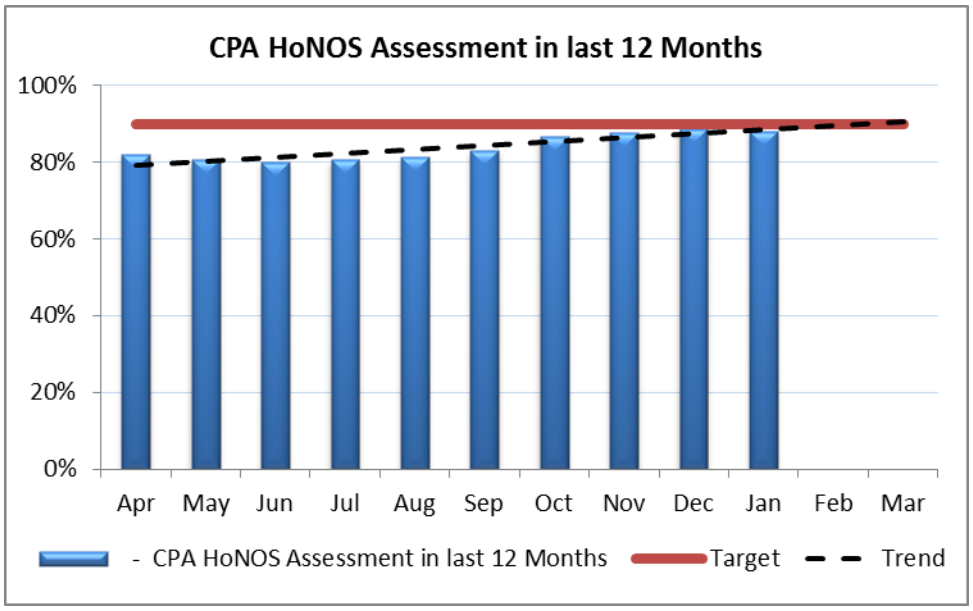
An e-learning package on mental health currencies and payment was recently developed and went live on 12th January 2016.

The position continues to improve.

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

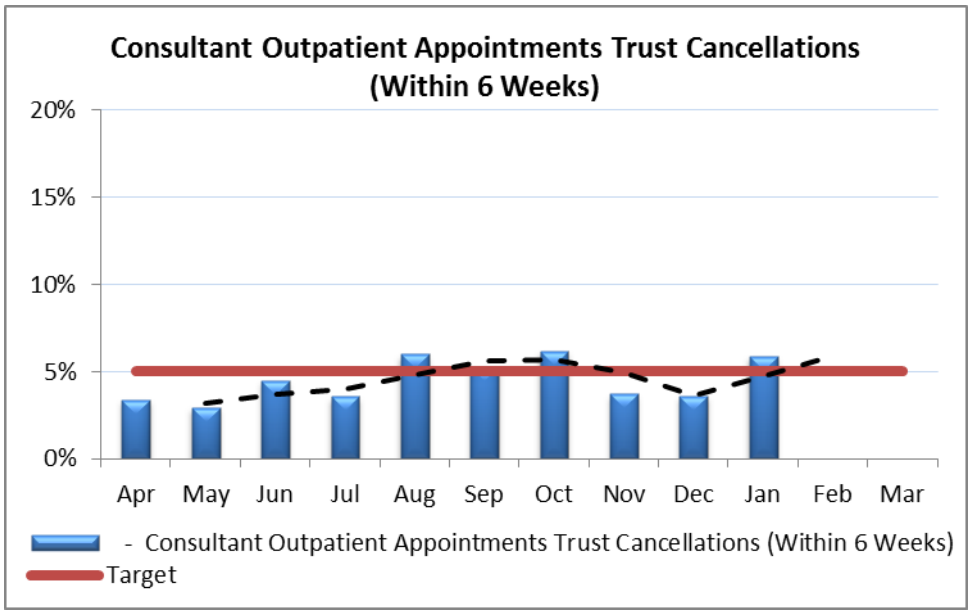
- To data cleanse
- Make improvements in practitioner clustering
- Highlight to staff responsible for clustering the issues needing to be resolved
- Monitoring performance
- Team based training

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



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

1.1.3 Schedule 4 – Consultant Outpatient Trust Cancellations

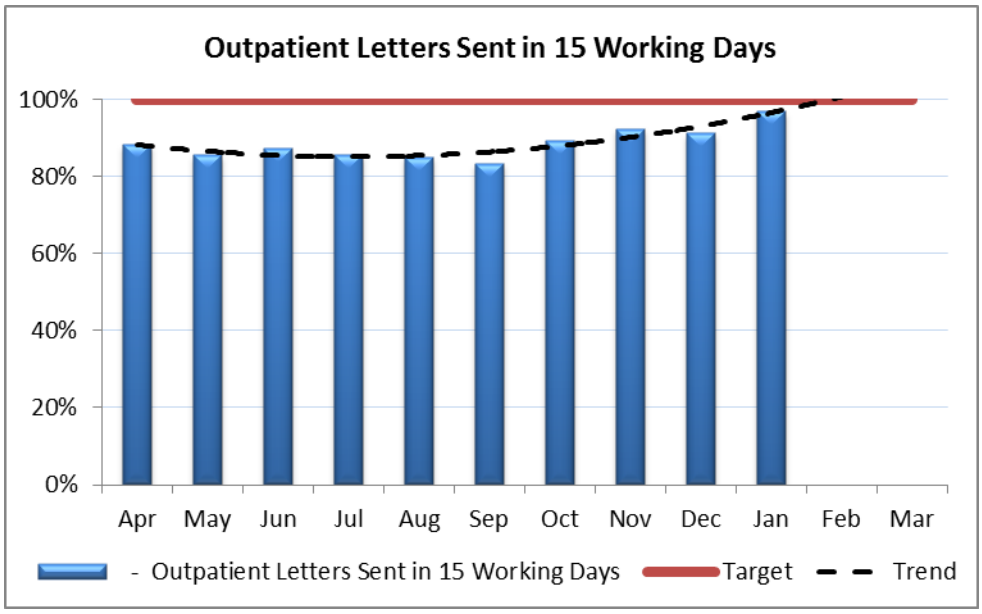


A manual audit of cancellations found that the main reasons for cancellation were the junior doctor's strike and medic sickness/other absence.

Action Planned:

- Associate Clinical Directors to review cancellation reasons and discuss with consultant concerned where the reason does not appear valid, if applicable.
- List of cancellation reasons to be agreed and added to Paris to enable easy reporting and monitoring.

1.1.4 Schedule 4 –Outpatient Letters Sent in 15 Working Days



The action plan is being implemented. We continue to perform above trajectory.

Action planned:

- To continue to implement and monitor the action plan against recovery trajectory

2 Health Visitor Dashboard

2.1 Key Performance Indicators

15-16 Health Visitor Dashboard	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Health Visitors (FTE) in Post ESR	N/A	69.85	68.72	67.65	67.36	67.36	71.07	71.88	70.21	71.21	71.12		
Health Visitors in Post (Headcount)	N/A	82	81	80	79	79	83	84	82	83	83		
Number of Student Placements (Headcount)	N/A	9	9	9	9	9	11	11	11	11	9		
Number of Student Placements (FTE)	N/A	9	9	9	9	9	11	11	11	11	9		
Number of mothers receiving antenatal check	N/A	211	157	219	245	176	212	205	189	131	162		
% Births that receive NBV within 10-14 days	N/A	88.00%	88.41%	92.00%	91.47%	92.84%	87.94%	91.50%	92.93%	90.94%	85.50%		
% NBVs undertaken after 15 days	N/A	12.00%	10.20%	8.00%	6.10%	6.00%	9.90%	7.30%	6.10%	5.90%	12.10%		
% Children who received a 3-4 month review	N/A	5.30%	11.40%	7.80%	9.60%	9.50%	6.90%	9.60%	11.70%	9.50%	7.90%		
% Children who received a 12 month review	N/A	97.70%	98.40%	98.20%	97.60%	98.20%	98.00%	97.30%	96.60%	96.70%	98.10%		
% Children who received a 12 month review at 15 months	N/A	97.50%	95.10%	97.30%	97.70%	98.40%	98.20%	98.80%	98.20%	97.70%	97.50%		
% Children who received a 2 to 2.5 year review	N/A	94.90%	95.40%	97.60%	98.50%	97.70%	98.40%	97.60%	98.00%	93.90%	96.90%		
% Staff who have received child protection training	N/A	63.40%	63.00%	62.50%	63.30%	63.30%	61.40%	60.70%	59.80%	60.20%	60.20%		
% 10-14 Day Breastfeeding coverage	95.00%	100.00%	99.40%	100.00%	100.00%	100.00%	100.00%	99.40%	99.70%	100.00%	97.90%		
% 6-8 Week Breastfeeding coverage	95.00%	99.60%	100.00%	100.00%	99.40%	99.00%	100.00%	99.30%	99.70%	98.50%	97.30%		
% Still Breastfeeding at 6-8 Weeks	65.00%	65.20%	71.00%	71.90%	73.50%	66.30%	69.50%	73.00%	67.40%	75.00%	69.60%		

2.1.1 Exception Comments

No exceptions

3 IAPT Services Dashboard

3.1 Dashboard

Total Derbyshire CCSs AQP KPI and Activity Data 2015/16

Indicator no.	Indicator name	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
3a	The number of people who have been referred for Psychological Therapies (during the reporting quarter)	997	936	966	1132	931	1200	1173	1177	859	1062	0	0	10433
3b	The number of active referrals who have waited more than 28 days for treatment	427	384	352	266	251	274	336	499	562	614	0	0	
4	The number of people who have entered Psychological Therapies	817	733	855	861	753	882	762	890	743	717	0	0	8013
5	The number of people who have completed treatment (for any reason)	535	511	577	629	488	606	606	646	505	534	0	0	5637
6	The number of people who are "moving to recovery"	274	253	313	294	249	316	288	295	218	269	0	0	2769
6b	The number of people completing treatment who did not achieve caseness at the commencement of treatment	38	51	38	48	48	50	51	56	43	56	0	0	479
7	The number of people moving off sick pay and benefits	35	40	45	42	42	54	53	49	36	36	0	0	432

	Recovery Rates KPI 6 / (KPI 5 - KPI 6b)	**55.13%**	**55.00%**	**58.07%**	**50.60%**	**56.59%**	**56.83%**	**51.89%**	**50.00%**	**47.19%**	**56.28%**			**53.68%**
	Partial and Full Recovery Rates	**75.45%**	**72.17%**	**75.32%**	**68.50%**	**72.05%**	**74.64%**	**68.83%**	**67.97%**	**66.45%**	**73.22%**			**71.40%**

3.1.1 Exception Comments

No exceptions

4 Ward Safer Staffing

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

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

Ward name	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
Audrey House Residential Rehabilitation	100.0%	98.4%	100.0%	100.0%	No	Not required
Child Bearing / Perinatal Inpatient	107.7%	151.7%	103.1%	167.7%	Yes	We have broken the current fill rate tolerances for care staff due to clinical observations, long term sickness absence and backfill for vacancies.
CTC Residential Rehabilitation	100.0%	98.8%	100.0%	100.0%	No	Not required
Enhanced Care Ward	96.3%	100.5%	96.8%	116.0%	No	Not required
Hartington Unit Morton Ward Adult	102.2%	102.3%	70.0%	134.1%	Yes	We are still carrying x 4 Band 5 vacancies and so are not able to commit to x 2 Band 5 nurses on night duty every shift.
Hartington Unit Pleasley Ward Adult	98.9%	107.0%	100.0%	100.0%	No	Not required
Hartington Unit Tansley Ward Adult	88.2%	123.8%	69.6%	119.2%	Yes	The ward continues to carry significant band 5 vacancies despite a rolling recruitment programme. This has a negative affect on our ability to staff every day shift with our target of 3 x band 5 nurses and the night shifts with 2 x band 5 registered staff. The increase in care staff is as a result of the increased use of bank HCA's to cover the registered staff deficit. However there are were no occurrences of there being less than a minimum of 2 Registered nurses on both the late/early shifts.
Kedleston Unit - Curzon Ward	97.5%	102.7%	100.0%	104.1%	No	Not required
Kedleston Unit - Scarsdale Ward	97.6%	100.0%	100.0%	98.4%	No	Not required
KW Cubley Court Female	103.7%	93.4%	100.0%	99.3%	No	Not required

Ward name	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
KW Cubley Court Male	99.4%	93.1%	96.8%	97.4%	No	Not required
LRCH Ward 1 OP	100.7%	89.4%	92.2%	109.3%	Yes	The night fill rate has been dictated by short sickness levels and covered by Bank Staff (regular care staff are booked familiar with the ward). Efforts are made to rotate staff over a 24 hour period but flexible working agreed prove difficult to reorganise rota at short notice. Registered Nurses flex to cover deficits. There are periods when where patient numbers are reduced and staff are utilised in other areas. The Temporary Staffing department cannot always backfill requests made.
LRCH Ward 2 OP	100.7%	96.6%	97.9%	98.1%	No	Not required
RDH Ward 33 Adult Acute Inpatient	99.5%	101.9%	97.8%	111.1%	No	Not required
RDH Ward 34 Adult Acute Inpatient	95.2%	107.3%	64.5%	184.4%	Yes	NONE RECEIVED
RDH Ward 35 Adult Acute Inpatient	102.7%	106.8%	90.5%	124.3%	No	Not required
RDH Ward 36 Adult Acute Inpatient	92.4%	110.2%	92.3%	106.9%	No	Not required

Action planned:

- Ongoing work to migrate the source from Safer Staffing solution to eRostering.

5 Inpatient Length of Stay Benchmarking

2014/15 Benchmarking Results	DHCFT	All MH Trusts	DHCFT Difference to all MH Trusts	Lower Quartile	Upper Quartile
Adult Average LoS Including Leave					
Average LoS unadjusted for outliers	49	36.6	12.4	29.8	43.7
Median LoS unadjusted for outliers	30	17.7	12.3	13	21.9
Average LoS MHA admissions unadjusted for outliers	57	51.5	5.5	41	61
Median LoS MHA admissions unadjusted for outliers	37	28.1	8.9	24	33
Average LoS adjusted for outliers	25	20.4	4.6	17.6	22
Median LoS adjusted for outliers	22	17.3	4.7	13.2	18.8
Average LoS MHA admissions adjusted for outliers	26	23.6	2.4	22.4	25.2
Median LoS MHA admissions adjusted for outliers	24	20.8	3.2	18.1	23.5
Adult Average LoS Excluding Leave					
Average LoS unadjusted for outliers	42	32.3	9.7	26.3	38.2
Median LoS unadjusted for outliers	26	15.9	10.1	12.8	20
Average LoS MHA admissions unadjusted for outliers	51	45.8	5.2	36	54
Median LoS MHA admissions unadjusted for outliers	31	24.4	6.6	19.8	28.3
Average LoS adjusted for outliers	22	19.6	2.4	17	20.7
Median LoS adjusted for outliers	19	16.5	2.5	12.5	17
Average LoS MHA admissions adjusted for outliers	24	23.5	0.5	21	24.4
Median LoS MHA admissions adjusted for outliers	22	20.8	1.2	17	22
Older Average LoS Including Leave					
Average LoS unadjusted for outliers	92	81	11	61	91
Median LoS unadjusted for outliers	76	56.7	19.3	46	63
Average LoS MHA admissions unadjusted for outliers	104	83.1	20.9	67.3	97
Median LoS MHA admissions unadjusted for outliers	85	60.8	24.2	51.8	71.3
Average LoS adjusted for outliers	50	38.6	11.4	31	44
Median LoS adjusted for outliers	48	37.8	10.2	30.5	43.5
Average LoS MHA admissions adjusted for outliers	52	39.5	12.5	33.3	45
Median LoS MHA admissions adjusted for outliers	50	37.5	12.5	32	44.5
Older Average LoS Excluding Leave					
Average LoS unadjusted for outliers	85	76	9	58	89
Median LoS unadjusted for outliers	68	51.4	16.6	52.8	60.3
Average LoS MHA admissions unadjusted for outliers	97	79.1	17.9	64	93
Median LoS MHA admissions unadjusted for outliers	82	57.9	24.1	49.8	66.3
Average LoS adjusted for outliers	48	36.4	11.6	29.6	42
Median LoS adjusted for outliers	46	34.6	11.4	28	42
Average LoS MHA admissions adjusted for outliers	49	38.5	10.5	31	44
Median LoS MHA admissions adjusted for outliers	46	37	9	31.5	42.5

Derbyshire Healthcare has a longer length of stay for both Acute and Older People beds regardless of whether the information is adjusted for outliers, home leave or patients detained under the Mental Health Act. The definition NHS Benchmarking use for outliers is Adults who have a length of stay less than 3 or more than 60 days, Older People who have a length of stay less than 7 or more than 90 days.

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 24th February 2016

Finance Director's Report Month 10

Purpose of Report

This paper provides the Trust Board with an update on financial performance against our operational financial plan as at the end of January 2016.

Recommendations

The Board of Directors is requested to consider the content of the paper and consider their level of assurance on the current and forecast financial performance for 2015/16.

Executive Summary

- This month's report includes a new summary dashboard which shows actual and forecast performance including trends to compare to previous months performances.
- All financial measures are better than plan with the exception:
    - Capital expenditure is currently £1.0m behind plan year to date and is forecast to be less than plan at the end of the financial year by £0.2m. This is due to the reprioritisation of schemes during the year and revised start dates.
    - In month the qualified agency nursing expenditure was above the ceiling of 3% at 3.7% for the month of January.
- The Financial Sustainability Risk Rating is a 4 year to date and forecast to achieve a 4 at the end of the year.
- There is a favourable performance at the end of January, we are ahead of plan by £1.5m with a current surplus of £2.5m, and the forecast is to exceed the planned surplus of £1.3m by £0.6m.
- The forecast has improved slightly this month by £65k.The forecast includes a set of assumptions based on knowledge and expectations at this point in time and the potential range is shown in the chart in the Income and Expenditure section.
- There is a notable change in the run rate of the income and expenditure surplus, from £2.5m year to date to £1.8m by the end of the financial year. This is due to additional non-recurrent expenditure forecast in the last two months of the financial year.
- Cash is currently above plan and is forecast to be slightly better than plan due to lower capital expenditure and increased surplus (some components of which are non-cash items).

- Net Current Assets are above plan both year to date and forecast which is driven by the levels of cash and assets held for sale.

- The forecast assumes continued full achievement of all CIP efficiencies, with £1.1m found non-recurrently. Due to the phasing of the replacement schemes the 'in month' position is behind plan but year to date remains ahead of plan.

Strategic considerations

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

Board Assurances

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

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

Consultation

- The Executive Leadership Team discuss and agree the key assumptions contained in the forecast financial position and agreed risk management actions to enable delivery of the planned financial surplus.

- Finance and Performance Committee challenges key strategic aspects of financial performance and financial risks and receives additional financial performance information to support its assessment of assurance in financial plan delivery.

- Performance and Contracts Overview Group regularly discuss many aspects of financial performance and forecast assumptions.

- Capital Action Team oversees delivery of the capital programme.

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

Governance or Legal issues

The information reported in this report is consistent with the information contained in the month 10 compliance return sent to Monitor on 19th February 2016 which does not require Trust Board sign off.

A Financial Improvement return has also been submitted to Monitor on the 19th February which tracks the improvement in forecast related to some particular key areas.

The 3% qualified agency nursing ceiling has been exceeded this month.

Equality Delivery System

This report has a neutral impact on REGARDS groups.

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

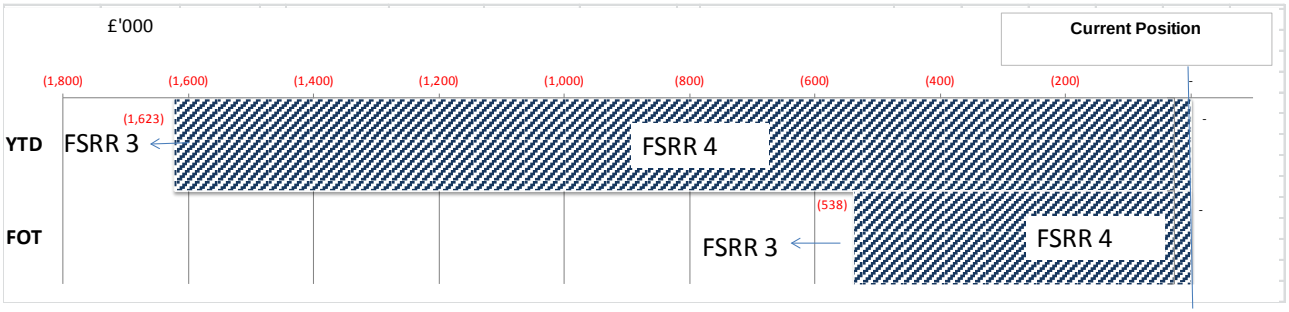
Report prepared by: **Claire Wright Executive Director of Finance and Rachel Leyland, Deputy Director of Finance**

FINANCIAL OVERVIEW – JANUARY 2016

Enc H

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Governance	FSRR	Financial Sustainability Risk rating	YTD	3	4			Overall FSRR better than plan at 4. No change to the overall FSRR or the individual metrics this month. Overall FSRR forecast remains at a 4.
			Forecast	3	4			
		Debt Service Cover	YTD	3	3			
			Forecast	3	3			
		Liquidity	YTD	4	4			
			Forecast	4	4			
		Income and Expenditure Margin	YTD	3	4			
			Forecast	3	4			
		Income and Expenditure Margin Variance	YTD	3	4			
			Forecast	3	4			
I&E and profitability	Income and Expenditure	Income and Expenditure position £'000	In-Month	159	436	277		Forecast surplus has improved again this month by £66k compared to last month. EBITDA continues to be better than planned due to lower operating expenses.
			YTD	964	2,481	1,517		
			Forecast	1,271	1,836	565		
	Profitability	Profitability - EBITDA £'000	In-Month	728	1,125	397		
			YTD	6,736	8,513	1,777		
			Forecast	8,181	8,934	754		
		Profitability - EBITDA%	In-Month	6.6%	10.1%	3.4%		
			YTD	6.1%	7.8%	1.7%		
			Forecast	6.2%	6.9%	0.7%		
Liquidity	Cash	Cash £m	YTD	9.901	13.182	3.281		Cash remains ahead of plan due to the surplus and lower capital expenditure. Capex variance to plan has increased in January compared to the previous month. Forecast remains under plan by £200k.
			Forecast	10.097	10.566	0.469		
	Net Current Assets	Net Current Assets £m	YTD	1.331	4.795	3.464		
			Forecast	1.545	3.095	1.550		
	Capex	Capital expenditure £m	YTD	2.784	1.737	-1.047		
			Forecast	3.450	3.250	-0.200		
Efficiency	CIP	CIP achievement £m	In-Month	0.415	0.383	-0.032		CIP is different to plan in month and year to date due to phasing of schemes. Qualified nursing agency expenditure above the ceiling and remains at the same level as the previous month.
			YTD	3.394	3.457	0.063		
			Forecast	4.200	4.200	0		
			Recurrent	4.200	3.087	-1.113		
	Temporary staffing	% of qualified nursing expenditure from agencie	In-Month	3.0%	3.7%	0.7%		
			YTD	3.0%	4.5%	1.5%		

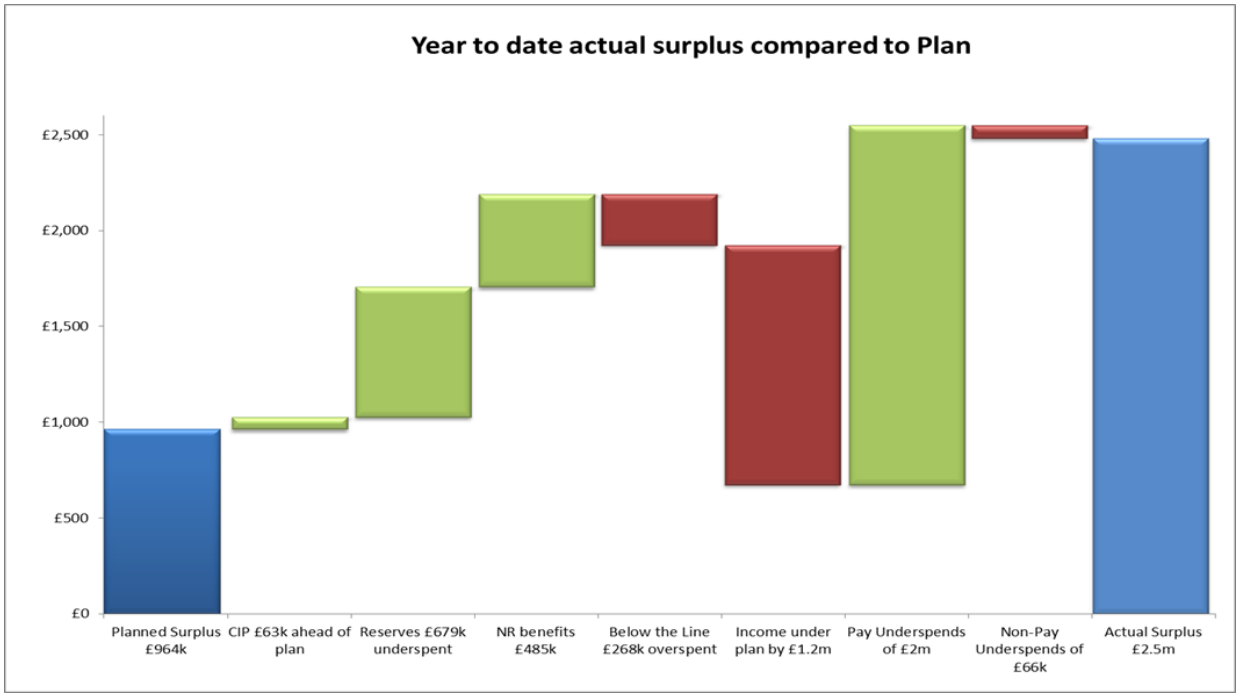
The headroom in £'000s, to a FSRR of 3 is shown in the chart below, both for year to date (YTD) and forecast outturn (FOT). This is for indicative use, based on a set of assumptions. It serves to illustrate the impact of improving or worsening revenue and cash, but there would be other variables that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



Income and Expenditure and Profitability

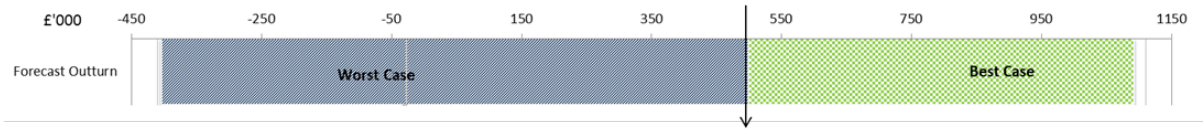
STATEMENT OF COMPREHENSIVE INCOME **JAN 2016**

	Current Month			Year to Date			Forecast		
	Plan	Actual	Variance Fav (+) / Adv (-)	Plan	Actual	Variance Fav (+) / Adv (-)	Plan	Actual	Variance Fav (+) / Adv (-)
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical Income	10,164	10,425	261	101,578	100,315	(1,263)	121,914	120,430	(1,485)
Non Clinical Income	832	751	(81)	8,584	8,325	(260)	10,248	9,891	(357)
Pay	(8,153)	(7,837)	316	(82,018)	(79,375)	2,644	(98,335)	(95,855)	2,481
Non Pay	(2,114)	(2,214)	(100)	(21,408)	(20,752)	656	(25,646)	(25,532)	115
EBITDA	**728**	**1,125**	**397**	**6,736**	**8,513**	**1,777**	**8,181**	**8,934**	**754**
Depreciation	(280)	(360)	(81)	(2,830)	(3,016)	(187)	(3,389)	(3,437)	(48)
Impairment	0	0	0	(100)	(0)	100	(300)	(300)	(0)
Profit (loss) on asset disposals	0	0	0	0	31	31	0	31	31
Interest/Financing	(181)	(177)	4	(1,859)	(1,791)	69	(2,221)	(2,133)	88
Dividend	(108)	(152)	(43)	(1,083)	(1,256)	(173)	(1,300)	(1,559)	(259)
Net Surplus / (Deficit)	**159**	**436**	**277**	**864**	**2,481**	**1,617**	**971**	**1,536**	**565**
Technical adj - Impairment	0	0	0	(100)	(0)	100	(300)	(300)	(0)
Underlying Surplus / (Deficit)	**159**	**436**	**277**	**964**	**2,481**	**1,517**	**1,271**	**1,836**	**565**



Forecast Range

Best Case	Likely Case	Worst Case
£1.1m favourable variance to plan	£0.6m favourable to plan	£0.2m adverse variance to plan



NB: Position of arrow shows current likely case forecast outturn

Summary of key points Enc H

- Overall favourable variance to plan in the month due to the phasing of income related to a service development which was previously included in the forecast, along with pay underspends.
- Income remains behind plan year to date and is forecast to be under plan at the end of the financial year which is driven by the phasing of service developments and lower occupancy and activity levels in cost per case services, some of which have corresponding expenditure reductions.
- Expenditure is underspent year to date and is forecast to be underspent at the end of the financial year due to service development phasing, lower occupancy levels, uncommitted reserves and some non-recurrent benefits.
- The surplus is forecast to reduce over the coming months from £2.5m at month 10 to £1.8m at the end of the financial year. This is due to non-recurrent additional expenditure forecast in the last two months of the financial year.
- The forecast surplus is £0.6m better than plan with the range shown in the graph to the left. It is important to note that the forecast range is based on an accumulation of either all the worst case or all best case scenarios happening together rather than a combination of a small group of scenarios.

Liquidity

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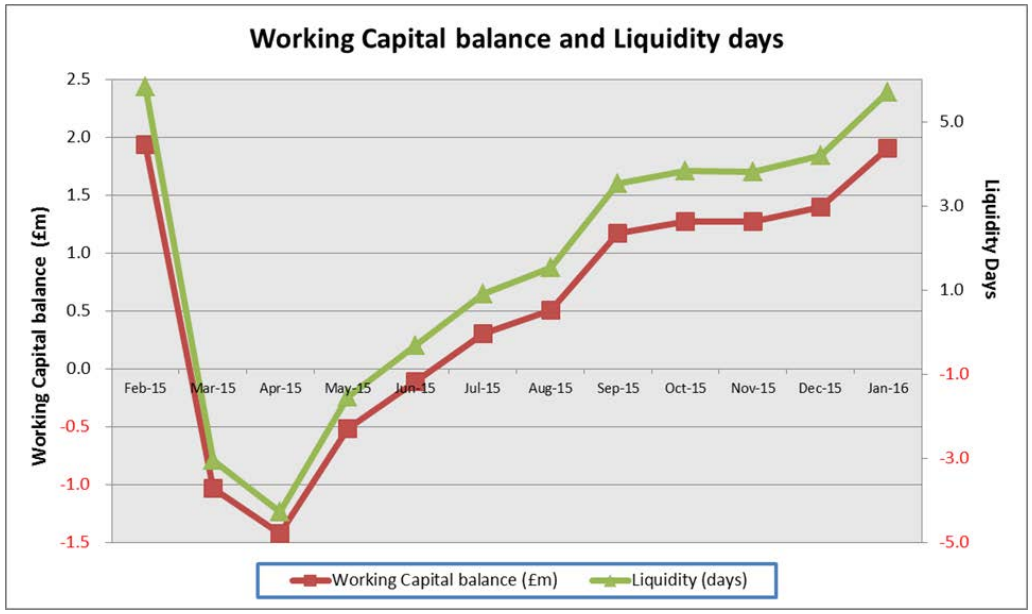
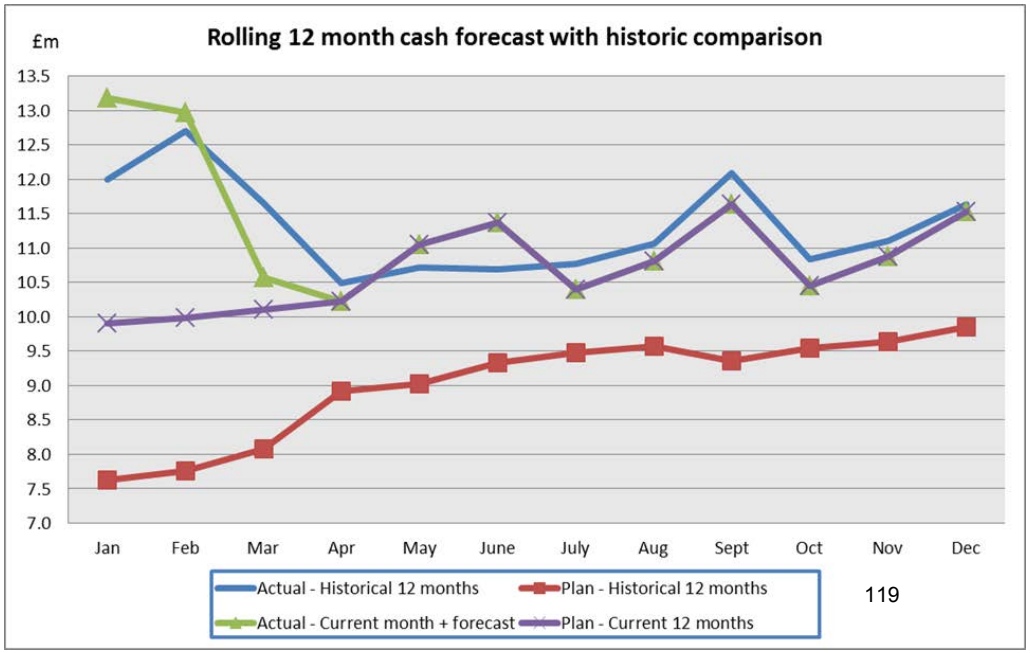


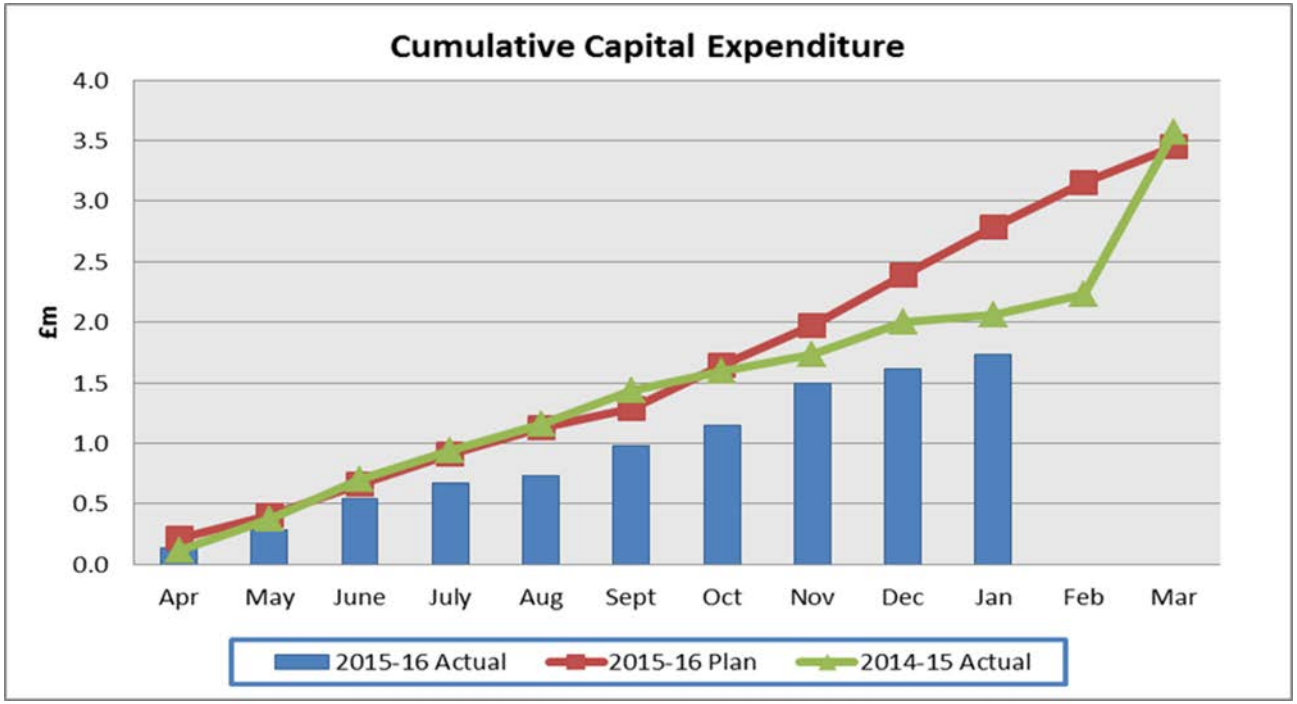


The first graph shows the working capital balance (net current assets less net current liabilities adjusted for assets held for sale and inventories) and how many days of operating expenses that balance provides.

The downward trend in March 15 related to yearend adjustments for provisions and a reduction in the levels of cash. During this financial year working capital has continued to improve due to improved cash levels.

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

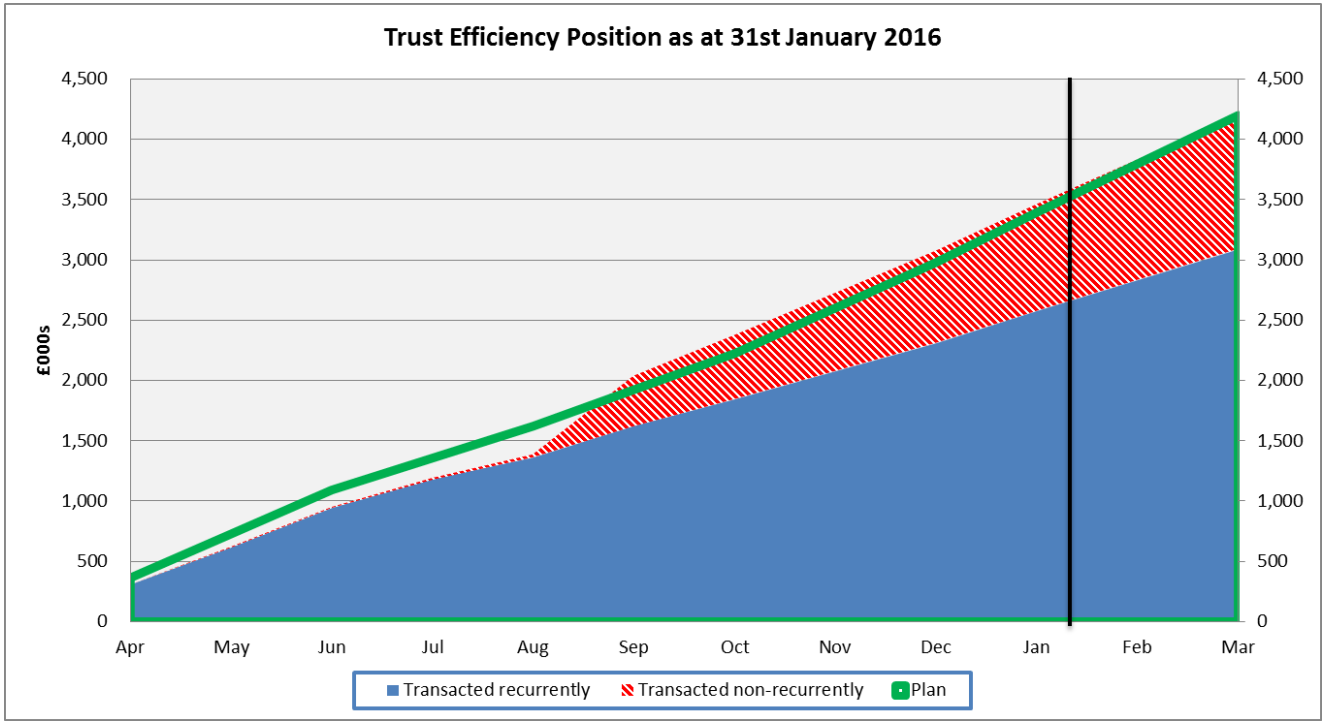
Cash is currently at £13.1m and is forecast to be at £10.5m at the end of the financial year due to the catch up in capital expenditure, the payment of PDC and some large invoices at the end of the year.



Capital Expenditure is £1.0m behind the plan at the end of January. Following the review of schemes for urgent clinical priorities, capital expenditure is forecast to be behind plan by £0.2m at the end of the financial year.

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

Cost Improvement Programme (CIP)



Year to date CIP achieved is £3.5m which is ahead of plan by £63k (1.9%). The reason for the CIP being ahead of plan is due to replacement schemes having a different phased delivery than that of the original schemes.

The full programme has been assured which is reflected in the forecast.

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

Temporary staffing

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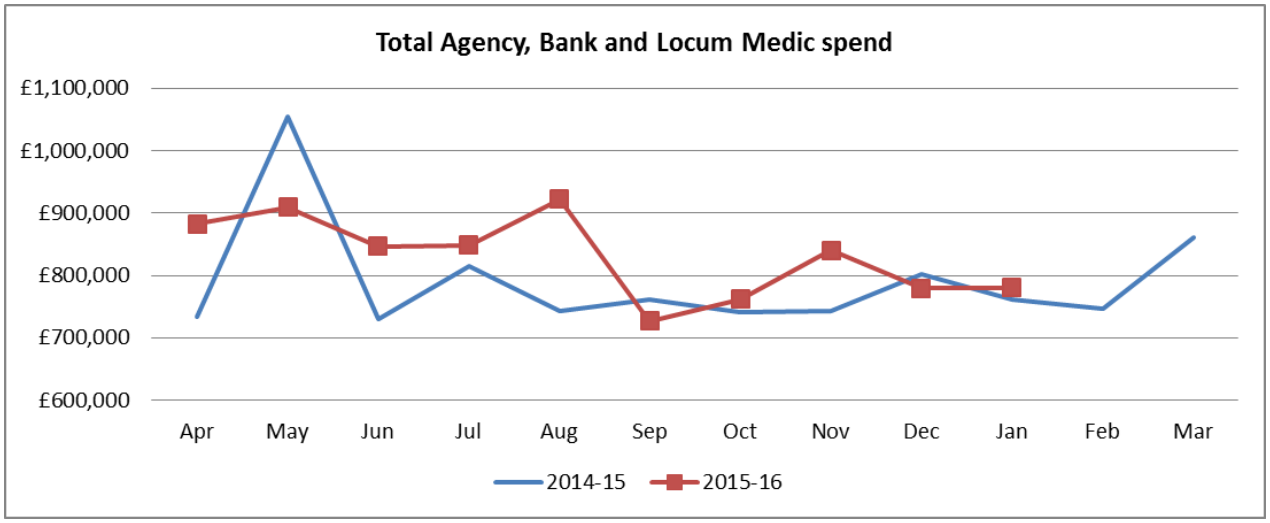

The graph shows the level of expenditure across all temporary staff for this financial year along with a comparison to last financial year.

Expenditure started to increase in March 2015 due to emergency planning and has continued at those higher levels during the first half of this financial year. From September 2015 expenditure has started to reduce back down to the previous year's levels.

Temporary staffing information is reported in more detail on a regular basis to Finance and Performance Committee.

Qualified Agency Nurse ceiling

The cost ceiling for our Trust is 3%, which is based on the Trust average for last financial year. For January we have exceeded the ceiling with qualified nursing agency expenditure of 3.7%, however this is a significant improvement on the earlier months of the financial year.

2015-16 (£000s)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Total
Total qualified nursing	3,037	3,134	2,914	2,941	3,044	2,927	2,922	2,922	3,015	2,914	29,769
Agency qualified nursing	165	171	116	139	199	112	135	93	110	107	1,348
	5.4%	*5.5%*	*4.0%*	*4.7%*	*6.5%*	*3.8%*	*4.6%*	*3.2%*	*3.7%*	*3.7%*	*4.5%*

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE QUALITY COMMITTEE

Held in Meeting Room 1, Albany House, Kingsway, Derby DE22 3LZ

Thursday, 14 January 2016

PRESENT:	Maura Teager	Chair and Non-Executive Director
	Tony Smith	Non-Executive Director
	Phil Harris	Non-Executive Director
	Carolyn Green	Director of Nursing and Patient Experience
	Claire Wright	Executive Director of Finance
	Dr John Sykes	Executive Medical Director
	Carolyn Gilby	Acting Director of Operations
	Clare Grainger	Head of Quality & Performance
	Emma Flanders	Lead Professional for Patient Safety
	Jayne Storey	Director of Transformation
	Deepak Sirur	Consultant Psychiatrist in Substance Misuse
	Jenna Davies	Interim Director of Corporate & Legal Affairs
	Rachel Kempster	Risk & Assurance Manager
For item QC/2016/009	Karen Wheeler	Acting Lead Occupational Therapist, Urgent & Planned Care
IN ATTENDANCE:	Sue Turner	Board Secretary and Minute Taker
	Daniele Sweeney	Observer from Deloitte
APOLOGIES:	Sangeeta Bassi	Chief Pharmacist
	Sarah Butt	Assistant Director of Clinical Practice and Nursing
	Petrina Brown	Consultant Clinical Psychologist
	Wendy Brown	Clinical Director
	Pam Dawson	Carer Forum
	Bev Green	Releasing Time to Care Lead (Service Improvement)
	Catherine Ingram	Chief Executive, Derbyshire Voice

QC/2016/001	**WELCOME AND APOLOGIES** The chair, Maura Teager, opened the meeting and welcomed everyone.
QC/2016/002	**MINUTES OF THE MEETING DATED 15 DECEMBER 2015** The minutes of the meeting, dated 15 December 2015 were accepted and agreed with the exception of the fourth paragraph of item QC/2015/174 Serious Incident Report. Maura Teager asked for this paragraph to be amended to clarify the three person and two person investigations. This paragraph would be substituted with "*Carolyn Green pointed out that although more incidences were being investigated they are not of such a serious nature that they required a three person investigation. It was noted that many outstanding investigation recommendations have been completed and closed. This is due to focused work in this area."*
QC/2016/003	**ACTIONS MATRIX** The committee agreed to close all completed actions. Updates were provided by members of the committee and were noted directly on the actions matrix.
QC/2016/004	**MATTERS ARISING**

	QC/2015/177: Serious Incident Report – At the last meeting John Sykes was asked to ensure that TMAC's (Trust Medical Advisory Committee) group of sudden death addressed training in physical and mental healthcare and invite Emma Flanders to the next meeting. In the event this coincided with a serious incident group. John Sykes will take this issue around SI investigations to TMAC and will then invite Emma Flanders to a meeting of the Mortality Group to develop this work further.
QC/2016/005	**SAFETY PLAN/CQUIN UPDATE** John Sykes' report provided the Quality Committee with an update on the safety plan/CQUIN return. John Sykes explained that clinicians had produced the safety planning report which showed Quarter 3 progress and was favourably received by commissioners. Pilots of the safety plan have been completed in the Kedleston Unit and Substance misuse service. Service user feedback has been obtained and informed development of the plan. Documents have been agreed and the associated policy ratified. The safety plan approach will help develop clinical practice and service user autonomy. It is a key plank in plans to improve patient safety. An e-learning package and PowerPoint presentation has been developed. This became live in December and has been completed by over 50 staff in a road test. It is now included in the Electronic Service Record and will shortly be included on the staff clinical passport. There was a delay in this because of an overhaul of a national system. In terms of being able to facilitate the clinical risk, this is being managed by operational staff who will drive this along with the roll out of the e-learning. Discussions centred around the risks to CQUIN achievement and the amount of money secured on this if the training roll out slips to April or May. Claire Wright explained that this would affect the final quarter's CQUIN payment. The Finance & Performance Committee is assuming full achievement of CQUIN income and will be pursuing the delivery plan. Tony Smith suggested that some face to face supplementary question could be made during quality visits to assess how the new approach to training is progressing as a sub set question rather than the theme of the visits. The committee understood the high risk in completion of e-learning training and agreed the risk involved in the roll out of e-learning to all clinical staff before 31 March 2016 deadline should be escalated to the Trust Board. **RESOLVED: The Quality Committee:** **1) Noted the content of the CQUIN return and the progress made regarding safety planning.** **2) Noted the risk involved in the roll out of e-learning to all clinical staff before 31 March 2016 deadline.**
QC/2016/006	**SERIOUS INCIDENT REPORT** Emma Flanders, Lead professional for Patient Safety, provided the Quality Committee with information relating to all Serious Incidents (SIs) occurring during December 2015. The report showed there has been an increase (by 3) in the number of incidents reported externally during December 2015 compared to November 2015. The report also showed there has been a decrease the number of major incidents occurring in December 2015, although the number of catastrophic incidents remains the same. There are no specific patterns or issues arising within the analysis of the major/ catastrophic incidents reported in December. There are currently 7 overdue actions from SIRI investigations. Duty of Candour has been reported on, both in the feedback from the individual investigations in section 4 and in section 7, the extract

	from the Contractual Duty of Candour report to commissioners. Section 7 illustrates there have been no breaches in discharging our statutory Duty of Candour reported to commissioners at the end of December 2015. Themes from SIRI investigations show improvement issues in sharing of good practice, record keeping, review of practice around appointments and Think Family. Maura Teager asked about progress with a physical care initiative (physical care has been a recurring theme from sudden unexpected deaths). Dr Kumar had previously presented to the Quality Committee a report on a pilot scheme for physical care and cardiac screening, a the scheme which was going to focus on vulnerable patients in the city. Claire Wright pointed out that the scheme had not yet been funded and feedback had not been received following the submission of a joint bid currently in process to the Academic Health Science Network. Maura Teager expressed her disappointment as this project had been supported by the Quality Committee and wished for a further update on the status of the bid. There were no overdue high priority actions as of the end of December 2015. The committee was positively assured by the fact that the SI Group continues to monitor overdue actions on a monthly basis with priority actions being actively followed up by the Patient Safety team. All overdue actions have been highlighted to the responsible individuals in each area to ensure prompt closure. Out of the overdue actions, 4 of these became over due on the 31st December 2015. The committee was pleased to note that the children's death rate for Derby city for CAMHs and children's services is well below the national average. The Child Death Overview Panel predominantly scrutinises infant mortality from neonatal or early loss and the Trust has a safeguarding representative on the panel. It was recognised in the Southern Report that not enough deaths were investigated of people with learning difficulties and their wider mental health and care services. The committee welcomed the flow chart on Reporting Deaths within the Trust that showed proposals for a pilot scheme that will report on expected and unexpected deaths. All deaths will be scrutinised to determine whether an expected death was actually early or avoidable. It showed a practical solution focused approach to serious untoward incident management and how the Trust will ensure good governance in this area which is also supportive of purposeful learning. The committee understood this will focus on areas where additional information is required which will enable the SI Group to see if any particular issues can be used to develop the process further. This would provide an approach to all deaths with a view to prioritising where a full investigation into the most significant issues is required whilst maintaining full governance on all aspects of mortality. It is recognised that additional resource is required for this exercise and Carolyn Green confirmed that the Executive Leadership Team (ELT) are considering endorsing the need for a technician position to support this work. Discussions took place on the graphs that highlighted actions due for completion and the overall view of deaths within the Trust over the last 12 months and it was agreed that the specific detail will be broken down for future reports. Carolyn Green asked that a summary of this report be placed on CONNECT and requested John Sykes and Emma Flanders to produce a podcast that could also be placed on CONNECT that would feature SI reporting, a culture of learning, and would show how SIRI works to break down some cultural issues associated with investigation analysis and learning. The committee welcomed the additional layering and scrutiny contained in the report and was pleased to note the progress made on reporting of ligature incidents.

	ACTION: Summary of the SI report to be placed on CONNECT. John Sykes and Emma Flanders to produce a podcast on SI reporting and learning. **ACTION: Update on the status of the bid for a City pilot scheme for physical care and cardiac screening in process to the Academic Health Science Network to be provided to Maura Teager.** **RESOLVED: The Quality Committee evaluated the report and accepted the level of assurance in the processes involved of emergent and current issues under a monitoring brief by the SIRI Group.**
QC/2016/007	**HEALTHWATCH DERBY TREND ANALYSIS OVERIVEW** The Healthwatch Derby Trend Analysis Overview also formed part of the Patient Experience Report (discussed later in item 8) and provided the committee with substantial assurance. Areas of key work were highlighted by Carolyn Green. The committee was pleased to note that a lot of compliments have been received and the Patient Experience team is now working with the family liaison team to resolve historical issues. The committee recognised the complex nature of some complaints and understood the process was being reviewed to establish how the management of these complex complaints can be improved. Phil Harris challenged the report by stating that in reality it was not good enough to accept these patient experience complaints. Carolyn Green responded by saying that her analysis showed that Trust staff were not setting out realistic expectations of service levels and waiting times. Staff attitude and conduct was not the Trust's biggest risk, it was access to services and that a conflation of issues that complaints relating to communication may not be attitudinal. People not being able to access the Trust's services in a timely way was seen as the most common reason for complaint. The committee considered that poor communication was a theme with many complaints, usually due to the differing level of expectations of some complainants who expect a weekend and evening community service, and a formal family mediation service neither of which the Trust is commissioned for. In developing neighbourhoods and campus the Transformation Group is working on developing mutual expectations, a covenant / agreement to be embedded in the operational design of services, letters, care plans and communications will give a balanced expectation of what the patients can expect from the service...Communication of service receivers' expectation and care plans will be integral to the training plan being commissioned for care planning as well as setting expectations and the realities of service offers. At the request of Carolyn Green, Non-Executive Directors Tony Smith and Phil Harris agreed to carry out a review of complex complaints to assess the casework which will then be recorded by the Patient Experience Group. It was noted that a response from all complainants will be received from Samragi Madden of Healthwatch Derby and will be submitted to the Quality Committee in March. **ACTION: Phil Harris and Tony Smith to carry out a complex complaints review.** **ACTION: Training plan to be commissioned for care planning and conflict.** **RESOLVED: The Quality Committee noted the report and received substantial assurance on the Trust's performance and ongoing progress.**
QC/2016/008	**RISK ESCALATION PROPOSAL AND INITIAL REPORT**

	Rachel Kempster's report proposed a process for the regular escalation of high level risks from the Trust's risk register to the Quality Committee and onto the Board of Directors. The aim of this escalation report is to provide the Quality Committee and Board with assurance on the processes for managing high level risks raised in the Trust and an oversight of what these risks are. The report will progress to identify any emerging themes evolving from risks currently graded as moderate. The report also provided the committee with an initial escalation report identifying key themes of high level risks, with a recommendation that a more detailed report be provided in February and to be escalated through the monthly Quality Position Statement to the Board of Directors at the February meeting. Rachel Kempster explained how the process works as a complete risk management system and how Trust captures risks within this system and through the Board Assurance Framework (BAF) as well as individual risks. Operational risks are reviewed on a regular basis and are reviewed at TOMM (Trust Operational Management Meeting) by Carolyn Gilby. The committee understood this was an initial report that would be received at three monthly intervals that illustrated the start of the process that will ensure that throughout the organisation people will be aware of risks and escalations. For this reason the committee did not consider that the report provided substantive assurance that all risks were being controlled. Rachel Kempster suggested that the report should reflect on operational risks and give more information on controls and actions of these risks which would provide the committee with the assurance it seeks and demonstrate a greater flow of risks throughout the organisation. Maura Teager was fearful that reports would contain too much detail. The committee recognised that risks were "bottom up" and were aligned with TOMM (Trust Operational Management Meeting) and the Quality Leadership Teams (QLT) for accountability and ownership. The QLT reports should contain BAF and risks escalation showing "bottom up" issues and clinical risks as well and show where responsibility lies. Rachel Kempster agreed to consider this process in liaison with Carolyn Green and Carolyn Gilby to complete the process map. **ACTION: Rachel Kempster will liaise with Carolyn Green and Carolyn Gilby to complete the process for accountability and ownership of risks within the QLTs.** **ACTION: Forward Plan to show Risk Escalation Report received by the committee on a quarterly basis.** **RESOLVED: The Quality Committee:** **1) Agreed to receive a 3 monthly report, providing a summary of high level risks and a summary of emerging themes identified through moderate graded risks** **2) Agreed for a summary of this paper to be included in the Quality Position Statement escalated to Board.**
QC/2016/009	**<u>RECOVERY AND WELLBEING PROGRESS REPORT</u>** In the absence of Sara Bains, Karen Wheeler presented the committee with Sara Bains' a progress report regarding Recovery and Person Centred Approaches that showed work being carried out both within and outside of the Trust regarding: • Recovery Education • Peer Support Work • Community Resilience • Person centred and Wellbeing Approaches • Hope and Resilience Hub

	Karen Wheeler outlined the teams and people involved in the neighbourhood teams and across all groups involved in recovery and public heath helping people to stay well. Maura Teager was curious to know what was allowing people to live well without the Trust's services in the north and it was considered that this might be because the Chesterfield team had started more groups working in Hartington and Bolsover. The committee noted the report and agreed that the report did not contain outcome measures of the Trust's systems approach to recovery, social recovery, neither did it show the clinical outcome needs pre and post service measures that were required and minuted in the last meeting. The committee requested that a further report be received in March that will show evidence of recovery outcomes based in any trust setting or either of the hubs and Carolyn Green and Carolyn Gilby will speak to Sara Bains to ensure she is aware of what is expected from the next report. It was agreed that Sara Baines' report would be signed off by Carolyn Green or Carolyn Gilby prior to submission. Carolyn Green asked the Quality Leadership Team for Urgent and Planned Care to carry out a performance monitoring exercise on recovery and wellbeing until evidence of better control is received. **ACTION: Sara Bains to submit to the committee in March a further report on evidence of recovery outcomes as part of her Trust wide role.** **ACTION: Quality Leadership Team for Urgent and Planned Care to carry out a performance monitoring exercise on recovery and wellbeing.** **RESOLVED: The Quality Committee noted the contents of the report but was not assured by its purpose and agreed that a further report would be received at the March meeting, following scrutiny and sign off prior to submission.**
QC/2016/010	**<u>QUALITY AND EVALUATION FOR EFFICIENCIES PROGRAMME 2016-17</u>** This report proposed steps to improve the assurance of Quality in the Efficiencies Programme for 2016-17. The paper set out proposals for improvement in the process, including: • Updating the recording fields on Cora ProjectVision and adding in new "Approvals" to ensure Quality ownership and sign-off • Re-introducing Quality Leads on clinical projects • Asking QLTs to identify key quality elements to monitor • Asking the Service Receiver and Carer Group to identify key quality elements to monitor • Development of the new Clinical dashboards – Neighbourhood and Campus • Revision of the Quality Dashboard The report set out the Trust's statutory duties and intended progress against its priorities for 2015/16 and the priorities for the coming year. The committee noted that the paper was discussed at the Programme Assurance Board (PAB) on 30 November, where it was supported and recommended that it be presented to the Quality Committee. Carolyn Green suggested there be a change on how the impact of transformational change is measured. She has asked the Transformational Group to produce a more specific process which would result in Trust wide information on quality impacts. Tony Smith saw this as a positive step forward and hoped this process would include service user and carer involvement. It was noted that this process is currently being reported through the Programme Assurance Board and red rated risks will be reported to the Quality Committee.

	The committee was assured by the rigour and scrutiny of the report and understood that the current inconsistency of approach to the efficiencies programme was challenging and looked forward to the next stage in the programme. **RESOLVED: The Quality Committee received the report and noted the increased level of assurances being developed that these proposals will provide against each of the standards set.**
QC/2016/011	**PATIENT EXPERIENCE REPORT** This report enabled the Quality Committee to consider the contents of the report on complaints, concerns and compliments and to have an overview of the complaints system and process. The committee noted the contents of the report and agreed that discussions carried out in the previous item QC/2016/007 Healthwatch Derby Trend Analysis Overview were covered and relevant to this report. **RESOLVED: The Quality Committee:** **1) Noted the report, scrutinised the content and accepted the recommendations for capacity.** **2) Noted that improvement work and monitoring would be carried out through the Executive Team, Quality Committee and or Audit Committee.**
QC/2016/012	**UPDATE ON EVALUATION OF CARE PLANNING** Sarah Butt's report updated the Quality Committee on progress on personalised care planning within the Trust and is linked directly to the Quality Strategy. The committee understood that full assurance of care planning could not be received yet as this was still a work in progress and work will be progressed within the QLTs. Sarah Butt explained that a full clinical records audit is currently being carried out against the principles of core care standards and person centred care approaches and will be completed by the end of the January and the actions will be embedded by the end of February. This is key to achieving person centred involvement and encouraging service receivers to be engaged and will be modified so carers can be more involved. Person centred work will be supported across training programmes. Statements of wishes and feelings will be also embedded in the EPR and included in block training and will take time to complete. The committee noted that care planning is a quality priority and understood limited assurance was obtained due to care planning being a work in progress and looked forward to the next step. **RESOLVED: The Quality Committee received the report with limited assurance but accepted the recommendations of the report.**
QC/2016/013	**NICE GUIDANCE UPDATE** Rachel Kempster's report updated the Quality Committee on progress against the plans presented to the Quality Committee for improving the Trust systems and processes for monitoring the effectiveness of implementation of NICE guidance and advice. The Trust has a process in place for managing NICE guidance through the QLT's taking clinical leadership for receiving and monitoring implementation. There are 120 guidelines that have been identified to the Trust and there is a lot of work to do in

	terms of identifying gaps within the relevant guidelines. The Care Pathway Standards and Outcomes Group links with this work. Rachel Kempster, Carolyn Green and Deep Sirur had looked at ways of filtering these guidelines and will ensure this works within the plan and pathways that have been designed. It was noted that it had been declared in the Annual Governance Statement that false assurance had been obtained in the detail and some of the audits of NICE guidelines in the past. Carolyn Green was not convinced there is enough detail or enough audits to show this is covered. It was agreed that once more ownership should be obtained from the QLTs and checks should take place to ensure the lead professionals are monitoring compliance. This is captured as risk in the Board Assurance Framework.. John Sykes confirmed that when this work progresses we will identify gaps and will establish if these are gaps we can close or if they need to be closed by commissioners. Deep Sirur agreed that the QLT should raise issues and ensure mechanisms are place to monitor compliance. The committee agreed there was lack of assurance on how well this process is being managed by the QLTs and assurance was required around clinicians taking this forward and this will be escalated to the Board. A returned performance report would be received by the committee through the QLT in April. **ACTION: Further performance report will be received by the committee in April that will include QLT accountability.** **RESOLVED: The Quality Committee:** **1) Agreed the progress reported and plans to improve allocation and review of NICE guidance** **2) Agreed to a further report on progress and include QLT accountability in April 2016**
QC/2016/014	**<u>INPATIENT SURVEY RESULTS</u>** This report showed the results of the Inpatient Survey carried out by the Trust and showed a year on year comparison to baseline 2012 data which when the Quality Strategy commenced. The committee noted that across all sections of the survey, 72% of the results have improved when compared to the baseline of 2012. There was also 11% improvement of people rating the Trust survey as outstanding, based on inpatient services received. The Trust scored above national average in every question regarding confidence in nursing staff/consultants, dignity and nurses time. **ACTION: Clare Grainger as Head of Quality will send the report analysis and summary of inpatient survey to inpatient areas and the Trust as a whole and will feedback to staff how pleased the committee was to note the improvements shown within the survey.** **RESOLVED: The Quality Committee received and was assured by the Inpatient Survey Results.**
QC/2016/015	**<u>ITEMS INCLUDED FOR INFORMATION</u>** The following items were received and noted by the committee:

	• Quality Assurance Group Report and Issues Log • Specialist Services Quality Leadership Team minutes • Urgent and Planned Care Quality Leadership Team minutes
QC/2016/016	**FORWARD PLAN** The forward plan would be updated in line with today's discussions and presented for reference at the next meeting of the committee.
QC/2016/017	**ITEMS ESCALATED TO THE BOARD OR OTHER COMMITTEES** • E-learning buy in of safety planning CQUIN - risk involved in the roll out of e-learning to all clinical staff before 31 March 2016. • NICE guidance accountability with QLTs and CRGs. The committee did not receive the required level of assurance that this is being prioritised by QLT and CRG. • Personalised care planning.
QC/2016/018	**ANY OTHER BUSINESS** Deep Sirur informed the committee that due to a change in his role he would no longer be attending the committee's meetings and would be replaced in the interim by Richard Morrow. Maura Teager thanked him for his commitment and the progress he had developed within the QLTs.
QC/2016/019	**EFFECTIVENESS OF THE MEETING** The meeting finished on time. Members of the committee felt clear on escalations to Board and welcomed the stance to not receive too much detail in reports. Carolyn Green indicated she would provide feedback to help Sara Bains produce a further report and added that she felt it would be helpful for reports to be endorsed before being received by the committee.
Date and Time of next meeting: The next meeting of the Quality Committee will take place on: **Thursday, 11 February 2016 at 2.15 pm** ***Venue: Meeting Room 1 – Albany House, Kingsway, Derby***	

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MINUTES OF THE AUDIT COMMITTEE HELD ON WEDNESDAY, 20 JANUARY, 2016 AT10.30 AM HELD IN MEETING ROOM 1, ALBANY HOUSE, KINGSWAY, DERBY DE22 3LZ

PRESENT:	Caroline Maley	Chair/Senior Independent Director
	Tony Smith	Non-Executive Director
IN ATTENDANCE:	Ifti Majid	Acting Chief Executive
	Claire Wright	Executive Director of Finance
	Carolyn Gilby	Acting Director of Operations
	Jenna Davies	Interim Director Corporate and Legal Affairs
	Alison Breadon	PricewaterhouseCoopers
	Mark Stocks	Engagement Lead Grant Thornton
	Joan Barnett	Engagement Manager Grant Thornton
For item AUD2016/011	Penny Gee	Acting Assistant Director, Counter Fraud Services
	Sue Turner	Board Secretary and Minute Taker
APOLOGIES:	Phil Harris	Non-Executive Director

WELCOME AND APOLOGIES

The Chair, Caroline Maley opened the meeting and welcomed everyone present and apologies were noted above.

AUD 2016/001	**MINUTES OF THE AUDIT COMMITTEE MEETING DATED 15 OCTOBER 2015** The minutes of the meeting held on 15 October were accepted and approved as an accurate record of the meeting.
AUD 2016/002	**ACTION MATRIX** All updates provided by members of the committee were noted directly to the matrix.
AUD 2016/003	**BOARD ASSURANCE FRAMEWORK TIMELINE AND MOVEMENT OF BAF RISKS** The committee noted the schedule for planned 'deep dives' for risks identified in the Board Assurance Framework (BAF) that would be undertaken by the relevant committees. Ifti Majid informed the committee that BAF training and development will be held for executives during the February Board Development session. This session would also be used to hold an annual review of the 2014/15 BAF. The 2016/17 BAF will also be reviewed and agreed and will capture wider governance issues, new risks arising from the well led review and results of the recent investigation process. This will allow the 2014/15 BAF to be closed and the 2016/17 BAF opened in March. **RESOLVED: The Audit Committee noted the rescheduling of planned deep dives of risks identified in the Board Assurance Framework.**

AUD 2016/004	**BAF DEEP DIVE OF RISK 2c REGULATORY COMPLIANCE** **BAF Risk 2c: "There is a risk the Trust may not be able to maintain its regulatory compliance due to identified gaps in its governance systems and processes."** Ifti Majid's presentation set out the key controls, policies and procedures that are in place and showed how this risk had evolved since it was first recorded. Ifti Majid highlighted the new controls that were set up to assist in securing delivery of the new objective. This included the appointment of a senior and experienced Interim Trust Chair with a strong background in governance and leadership of Council of Governors. A number of Board members are in regular touch with both Monitor and the CQC, providing assurance around actions, discussing investigation approaches and monitoring of key regulatory compliance. The committee recognised this was improved control but was in a process of transition and would need to be readdressed in the future. The committee also considered that the number of interim posts within the organisation would feature as a risk to leadership continuity. Ifti Majid outlined the gaps in control. It was considered that Gap 3 should include escalating governance support and culture change which has arisen from the Yates report and show how people "buy into" governance and policies. The committee was pleased to note that risk assessment will take place in the new People and Culture Committee. Positive feedback had been received on Gap 5 around the current open and honest style of communication and it was proposed that this should be removed as a gap in assurance. However, the Chair hesitated and suggested waiting until the Deloitte report had been received. Tony Smith considered this was linked to engagement and communication with staff and senior management and could be moved to risk 4b to encapsulate behaviour and culture. This was discussed further by the committee and it was agreed that this risk and descriptor would be redefined during the Board Development session on the BAF to cover issues and processes around culture and behaviour. It was also suggested that this gap could be split between two risks to ensure there is no detrimental impact on the Trust's licence. The committee agreed that the new Gap 6 "A culture of informality leading to a risk of not following policies and procedures" was appropriate and should be included. The committee accepted that risk management systems were very strong. The new risk that Committee Highlight Reports be provided to the Board and give a month on month view on escalation issues, content of committee, functioning and outcomes would be a new risk in recognition of assurances rather than a suggestion of a new process. Action to cover gaps in assurance will be tied up in the Governance Action Plan and will be referenced in the BAF. This will form a clear reference to a well-managed action plan that reports progress regularly and will be the evidence that is required for gaps in assurance. Alison Breadon confirmed PwC would support the actions that resulted from Ifti Majid's presentation of BAF risk 2c. The Chair felt this had been an open and honest assessment of risk 2c and she supported Ifti Majid's assessment which showed that systems and processes were being developed. The committee recognised that the conclusions contained in Ifti Majid's presentation were a sign that a very robust plan was developing that showed a clear account of the current

	situation. **RESOLVED: The Audit Committee noted and received the assessment of BAF risk 2c.**
AUD 2016/005	**REVIEW ASSURANCE FROM OTHER COMMITTEES** The committee noted that no committee meetings had taken place since the last meeting of the Audit Committee on 15 December. Although the Quality Committee had met on 14 January, it was accepted that this timeframe had not allowed an assurance summary to be made available for today's meeting.
AUD 2016/006	**EXCEPTION REPORTING** The committee noted there were no exceptions to report on Losses and Compensations, Hospitality and Sponsorship or Debtors and Creditors.
AUD 2016/007	**REVIEW CHANGES TO ACCOUNTING POLICIES** The Trust's accounting policies for Annual Accounts have been reviewed and were presented to the Audit Committee for agreement. This paper contained the full proposed accounting policies narrative as well as a table which summarised any changes between the 2014/15 and 2015/16 policies. It was proposed that the 2015/16 accounting policies remain largely unchanged from 2014/15. The committee noted that the accounting policies were compiled with due regard to Monitor's published Annual Reporting Manual 2015/16 (published December 2015). It was also noted that the main change in the Annual Reporting Manual applicable to Trust's accounts related to the Introduction of IFRS 13 Fair Value and changing the Plant, Property and Equipment. The committee was content that the Accounting Policies had been produced in line with the Annual Reporting Manual and understood that if any accounting policy changes are required as a result of either Auditor review or further updates to Monitor's ARM, a summary of changes will be provided to the next meeting of the Audit Committee in March. **RESOLVED: The Audit Committee reviewed and agreed the draft accounting policies for annual accounts 2015.16.**
AUD 2016/008	**REVIEW YEAR END PLANNING TIMETABLE** The Audit Committee noted the dates contained in the High Level Planning Timetable. Rachel Leyland pointed out that a report will be received by the committee in February that will show changes to the Annual Report driven by Monitor. The committee noted that Anna Shaw will provide a draft of the Annual Report which will be received by the committee on 16 March. **ACTION: First draft of the Annual Report to be an agenda item at the March meeting.** **RESOLVED: The Audit Committee noted the dates contained in the High Level Planning Timetable.**

AUD 2016/009	**UPDATE ON INTERNAL AUDIT PROGRESS AND REVIEW OF REPORTS** **Internal Audit Progress Report:** Alison Breadon ran through the summary that updated the committee on internal audit activities and was pleased to report progress was on track to ensure work would be completed by the end of the financial year. **Approved Clinician Status:** Despite a number of breaches in Approved Clinician Status identified by the Trust over the past year, Alison Breadon confirmed that in all cases doctors now have the correct accreditations and appropriate processes are in place to ensure passports are correct. It was agreed that in order to provide the committee with assurance around the system for testing the accreditation of agency doctors this process would be tested and the results would form a report to be received at the next meeting in March. Tony Smith, Chair of the Mental Health Act Committee added that Approved Clinician Status of Doctors would be an agenda item for the next meeting of the Mental Health Act Committee to be held in February. **ACTION: Process for testing accreditation of agency doctors to be checked and reported to the March meeting of the committee by PwC.** **ACTION: Approved Clinician Status of Doctors will be placed on the agenda item for the next meeting of the Mental Health Act Committee in February.** The Medical Director had asked PwC to confirm whether the Trust has a clear understanding on whether doctors employed by the Trust who undertake MHA assessments are required to possess their own indemnity insurance or whether this is covered by the Trust's policy. It was agreed that Jenna Davies will provide a report to the next meeting of the committee that will clarify the issue of indemnity insurance and how this can be resolved and will include any actions that are required to be undertaken. **ACTION: Report on Indemnity Insurance to be provided to the March meeting of the committee by Jenna Davies.** **ICT Infrastructure Resilience and Recovery:** PwC's review looked at the Trust's resilience and disaster recovery controls for IT infrastructure against industry practice. It was noted that the contractual mechanisms for the Paris System meet industry practice although there is a key component of this system managed under the GEM contract. The committee recognised this is a contractual issue and not a service issue with GEM and regular contract management meetings take place with GEM to manage performance and requirements. It was pointed out that the GEM contract does not have any Service Level Agreements. High risk SLA components are being renegotiated with GEM by Peter Charlton and it was agreed that Carolyn Gilby will monitor progress. The committee was satisfied with this report but recognised the ICT contract contains weaknesses from a national perspective that are difficult to control. **ACTION: Carolyn Gilby to monitor progress of SLA renegotiations.** **Data Quality:** Alison Breadon informed the committee that PwC was satisfied that testing of data quality showed there were no issues with IAPT times for treatment by qualified therapists. **Information Governance Tool Kit and readiness for inspection:** Phase 2 IG scope will be signed off by Jenna Davies and the results will be received by the committee at the

	March meeting. The committee noted that e-learning meets the requirements of the training. To attain level 2 compliance on the toolkit, 95% completion of the training is required and it is expected that this level will be at 95% by the final submission date. **ACTION: Phase 2 IG Scope to be an item on the March agenda to be led by PwC.** The Chair thanked Alison Breadon for producing a good set of reports and she looked forward to receiving the final end of year report. The Chair requested that the effectiveness review of internal and external audits takes place at the March meeting to enable her to produce the Audit Committee's Annual Report to the Board. **ACTION: Effectiveness review of internal and external audits to be an agenda item for March meeting.** **RESOLVED: The Audit Committee received and noted the update reports from PwC.**
AUD 2016/010	**EXTERNAL AUDIT UPDATE** The External Audit Report provided the committee with a report on progress as well as a summary of emerging national issues and developments relevant to the Trust. Joan Barnett highlighted the key areas of Grant Thornton's work plan and the committee was pleased to note that agreed dates had been set aside with the finance team and with Anna Shaw to discuss the annual report requirements. Detailed work is to include early testing of healthcare revenues non healthcare revenues, employee remuneration and operating expenses. Grant Thornton will also be reviewing property revaluations and asset verification which will be completed by the end of March as well as a review of the Trust's updated PFI model and accounts disclosures. Joan Barnett reminded the committee that at the December meeting David Roper gave an overview of changes to Grant Thornton's value for money (VFM) approach. Joan Barnett was currently working on self-assessments which will be submitted to Claire Wright. She further explained there were first time risks around the VFM calculation and Claire Wright and Mark Stocks would discuss informed decision making and how VFM fits around the Trust's governance. Attention was drawn to the cross-sector review of Audit Committee effectiveness which was considered to be of useful note. The committee also noted the Code of Audit Practice contained in the report and it was recognised that the Trust was fully compliant. The Chair confirmed she was assured by Grant Thornton's report and by targeted dates for reporting to the Audit Committee. **RESOLVED: The Audit Committee received and noted the report from Grant Thornton.**
AUD 2016/011	**COUNTER FRAUD REPORT** The Counter Fraud report advised the committee of work completed to date in respect of

	the 2015/16 Counter Fraud, Bribery and Corruption Operational Plan for the Trust. Penny Gee informed the committee of a disciplinary investigation that was currently taking place regarding an over payment of £8,200 to a former employee of the Trust who had taken up work whilst on sick leave. Although the Trust has since received a payment of £8,200 by bank transfer, discussions are still taking place between the Crown Prosecution Services and defence lawyers. Penny Gee also pointed out that Work on a National Fraud Initiative proactive detection exercise of falsely claiming sick pay whilst working elsewhere was ongoing. The committee noted that risk based face to face training had been carried out with the Finance Team. Counter fraud training will be provided to HR in due course and this training will also be mandatory to all staff. Penny Gee was pleased that the Trust will promote this training internally and on CONNECT and regarded this as positive engagement. **RESOLVED: The Audit Committee received and noted the Counter Fraud update report.**
AUD 2016/012	**REVIEW OF FORWARD PLAN** The Chair requested that the committee had a single point of support for formulating the forward plan and it was agreed that Jenna Davies will provide a new version of the forward plan at the next meeting in March. **ACTION: Jenna Davies to formulate the forward plan for 2016/17 for submission at the next meeting in March.**
AUD 2016/013	**MEETING EFFECTIVENESS** The committee felt the agenda allowed effective discussions on all items. It was agreed that the next meeting in March will start thirty minutes earlier at 10am run to 1pm to allow for longer discussions relating to internal and external audit effectiveness. **ACTION: Agenda for March meeting to extend from 10am to 1pm**
AUD 2016/014	**CLOSURE OF THE MEETING** The Chair thanked all those present for their attention and attendance and closed the meeting at 12:45 pm. **Date of next meeting:** Wednesday, 16 March at 10:00am. Venue: Meeting Room 1 – Albany House, Kingsway, Derby DE22 3LZ.

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE SAFEGUARDING COMMITTEE

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

Friday, 22 January 2016

PRESENT:	Maura Teager	Chair and Non-Executive Director and Deputy Trust Chair
	Tony Smith	Chair, Non-Executive Director
	Carolyn Green	Director of Nursing and Patient Experience
	Tina Ndili	Head of Safeguarding Children
	Deepak Sirur	Consultant Psychiatrist in Substance Misuse
	Lesley Smales	Designated Nurse for Children In Care
	Tracey Holtom	Service Line Manager
	David Tucker	General Manager, Special Services
	Michelina Racioppi	Southern Derbyshire CXG
	Jayne Storey	Director of Transformation *
	Bill Nicol	Southern Derbyshire CCG
For item SC/2016/019	Joanne Kennedy	Consultant Child & Adolescent Psychiatrist
IN ATTENDANCE:	Sue Turner	Board Secretary
APOLOGIES:	Carolyn Gilby	Acting Director of Operations
	Jenna Davies	Interim Director of Corporate & Legal Affairs
	Gulshan Jan	Consultant Psychiatrist in Learning Disability
	Tracy Shaw	Training Manager
	John Sykes	Executive Medical Director
	Andrew Stokes	Crime Support, Derbyshire Constabulary
	Samragi Madden	Healthwatch Derby
	Brenda Rhule	Interim Head of Nursing
	Wendy Brown	Consultant Psychiatrist and Clinical Director
	Richard Morrow	Service Manager
	Hamira Sultan	Consultant in Public Health, Children and Young People
	Kate Sargeson	Divisional Nurse
	Garry Southall	Principal Workforce & OD Manager

* Director of Workforce, OD & Culture since 25 January

SC/2016/001	**WELCOME AND APOLOGIES** The Chair, Maura Teager welcomed everyone to the meeting. Introductions were made around the table and apologies noted as listed above.
SC/2016/002	**MINUTES OF THE MEETING DATED 23 OCTOBER 2015** The minutes of the meeting, dated 23 October were accepted and agreed.
SC/2016/003	**ACTIONS MATRIX** The committee agreed to close all completed actions. Updates were provided by members of the committee and noted directly on the actions matrix.

SC/2016/004	**MATTERS ARISING** **CAHMS** Joanne Kennedy circulated a paper that updated the committee on why CAMHS were not accessing the Safeguarding unit for advice; the last performance report on access demonstrated that CAMHS was a cold area or an area of low activity. Jo Kennedy had listened to feedback on the varying reasons. This included feeling competent, not sure of receiving CAMHS specific advice, as well as generalised issues. Discussion ensued on reasons and rational of the possible skill mix of the safeguarding team and wider systems issues The committee noted Jo Kennedy's participation and the current position and agreed the next step would be to involve the operational team and CAMHS SLM to strengthen the analysis and for the Safeguarding unit to provide an in-reach model to enable teams to work together, share information and become more engaged. Maura Teager asked whether members of the safeguarding team could attend existing CAMHS meetings and to organise drop in sessions in order for information to be shared. **ACTION: David Tucker to lead the engagement and feedback from the operational team with CAMHS and introduce a Safeguarding Children in-reach service within CAMHS.** **RESOLVED: The Safeguarding Committee noted the progress made on the issues surrounding how some services accessing the safeguarding unit.**
SC/2016/005	**SAFEGUARDING CHILDREN STRATEGY** The Safeguarding Children Strategy 2015/16 was presented by Tina Ndili. She informed the Safeguarding Committee of the priorities to be agreed and set by the Trust for the continual improvement of the culture, workforce, quality of practice, leadership, performance management and quality assurance to achieve better outcomes for children, young people and their families. Carolyn Green emphasised the importance of complying with NICE Guidelines on domestic abuse and the need for each part of the safeguarding unit to own the Safeguarding Children NICE Guidance and this will be embedded into the work plan. Tony Smith and Tina Ndili felt there was more work required to align the clinical and enabling Safeguarding Children Strategy with the Safeguarding Adult Strategy. This was debated and separate strategies were authorised in a period of unprecedented change in the safeguarding adults agendas. However, at strategy reviews the potential to amalgamate the strategies would be reconsidered. The committee agreed the consultation section contained in the strategy should be amended to include the inputs of Non-Executive Directors and the Chair of the committee. • Tina Ndili – Head of Safeguarding Children. • Dr Jo Kennedy – Named Doctor for Safeguarding Children • Carolyn Green – Director of Nursing and Patient Experience • Chair – Maura Teager • Non-Executive Director – Tony Smith The Safeguarding Children Strategy which see the Trust implementing safeguarding as a priority area and ensure it is adopted by the workforce, this should be cross referenced to the work plan of the People and Culture Committee.

	ACTION: Safeguarding Children agenda is a fundamental part of the workforce agenda and will be cross referenced to the People and Culture Committee **RESOLVED: The Safeguarding Committee:** **1) Positively challenged the detail and content of the report and agreed the priorities of the strategy.** **2) Gave appropriate feedback and suggested that the consultation includes Non-Executive Directors of the committee.** **3) Agreed the strategy and shared the vision.** **4) Received assurance that the Safeguarding Children agenda is a fundamental part of the Workforce agenda and will be cross referenced to the People and Culture Committee.**
SC/2016/006	**DRAFT SAFEGUARDING CHILDREN – WORK PLAN** The Safeguarding Children Work Plan gave a clear strategic direction with timescales of the work to be completed by the Safeguarding Team, SLMs and operational managers in order to deliver the Safeguarding Children strategy and agenda. Discussions took place on the green status of actions on the work plan and agreed that the rag rating for the work plan would be shown as follows: Red Update Overdue Amber Action ongoing Green Resolved / completed The committee felt there were inconsistencies within the work plan and asked that progress and operational issues contain a narrative as evidence of progress and suggested that Yvonne Stevens be contacted to advise Tina Ndili on the project management side of progressing the work plan. The committee accepted the work plan and recognised that that further work would progress the rag rating to use the same standard as the Trust board model. It was agreed that the work plan would be received by the committee twice a year and this would be reflected in the forward plan. **ACTION: Tina Ndili to adopt rag rating for the work plan to show progress of actions.** **ACTION: Forward Plan to reflect the work plan being submitted to the committee twice a year.** **RESOLVED: The Safeguarding Committee:** **1) Positively challenged the work plan in order to improve the content.** **2) Gave appropriate feedback** **3) Agreed the work plan** **4) Received assurance of the work within DHCFT around safeguarding children and young people and the continued 'Think Family' agenda operational level planning and performance.**
SC/2016/007	**UPDATE ON SAFEGUARDING CHILDREN TRAINING REPORT** In Tracy Shaw's absence Jayne Storey presented the report which provided the Safeguarding Committee with an update on the safeguarding children training position. The committee were not assured by the report because it did not reflect accurate data

	and asked that the report be refreshed and re-circulated to members of the committee. However, the committee noted that a much higher level of compliance is expected to be achieved in safeguarding children level 3 training by March 2017. Safeguarding will be reinforced through education, communication and training and this would also be promoted by sharing examples of good safeguarding practice with "Think Family" on CONNECT and feedback from the training courses showing how people "get it". There is also some traction in staff understanding the implications and considering what they need to do when they return to their clinical settings.. Tracy Shaw would be asked to develop communication of training with the Trust's Communications Officer. Carolyn Green informed the committee that she will ask the CCG if they will consider continuing support of the "Think Family" concept. She believed this training was still on the quality schedule and expected to achieve 85% compliance although this was not a CQUIN requirement. It was agreed that Jayne Storey will progress the support of "Think Family" training within the new People & Culture Committee. The committee agreed people have a work place responsibility for safeguarding and that visible leadership will make a difference to compliance within safeguarding children training. The committee understood that progress with compliance has improved and asked that the errors noted in the report be corrected and the report re-circulated. **ACTION: Errors in Safeguarding Children Training report to be corrected and the report re-circulated to the committee.** **ACTION: Think Family training to be addressed at the People & Culture Committee** **ACTION: Examples of Think Family good safeguarding practice to be shown on CONNECT. Tracy Shaw to develop communication of the Think Family training with the Trust's Communications Officer.** **RESOLVED: The Safeguarding Committee** **1) Noted the concern of the current errors in relation to training passports and training compliance reporting due to changes in training standards not activated and the report is to be circulated prior to the next meeting.** **2) Noted the maintenance of level 1 and 2 training internally.** **3) Noted the ongoing provision for Think Family training** **4) Received a verbal up-date on the Education team adjustments to the training passports**
SC/2016/008	**<u>SERIOUS CASE REVIEWS KN15 AND ADS15</u>** The Serious Case Review reports provided the Safeguarding Committee with an update on the progress made within two Serious Case Reviews and illustrated how learning and recommendations are developed within the Serious Case Review Panel. The committee recognised that Serious Case Reviews involve an agency wide process and was assured by the progress obtained so far and by the learning events that take place after each serious case review. The committee observed there was a misunderstanding of what neglect means for some practitioners as neglect by the parents played a part in the young girl who took

	her own life. Both cases implied isolated working and assumptions that other team members were dealing with matters. There were also missed parts of record keeping and evidence of poor information sharing. The committee sought assurance that the team is engaged and suggested that narrative should show that recommendations are being monitored and what progress is being achieved to embed changes in practice. The committee suggested that performance management advice on supervision and training in EPR and retaining supplementary notes be included in the appraisal process of the two clinicians involved in these cases. The committee's challenging discussion of the two cases provided the committee with some evidence to assure the Board that the organisation is engaged in learning from the Serious Case Review process. However, there was limited assurance that thisis embedded. It was agreed that in order for improvements to be made to strengthen the outcomes for children, Tina Ndili will speak to Carolyn Green to devise outcomes of specific learning that will be captured within and cross referenced with SI actions. Tina Ndili will also review and widen the expertise within the Serious Case Review panel b identifying the broader specialist skill set available within the organisation. **ACTION: Training will be developed by Carolyn Green and Tina Ndili to capture specific learning and widen the expertise within the Serious Case Review Panel.** **ACTION: Action plan containing milestones and narrative to show how cases are being monitored and will be developed for April.** **RESOLVED: The Safeguarding Committee** **1) Noted the SCR process and progress.** **2) Received assurance that the Trust has engaged in the process and the learning and recommendations have been identified** **3) Monitored the progress of the SCR KN15 and ADS15**
SC/2016/009	**MARKER OF GOOD PRACTICE** A verbal update was received from Michelina Racioppi on markers of good practice. Good progress had been made and future requirements of providers and named nurses in this Section 11 audit will be to explore the learning and knowledge of front line practitioners. This will be achieved through a simple questionnaire and survey which will look at practitioners' perspectives around information sharing and establish who named professionals are. The committee noted that when the audit is received and the information is analysed a quality site visit will then take place to run through the findings and any ongoing actions. This will be the process for 2016/17 assurance and Tina Ndili was thanked for her work in organising this to date. Michelina Racioppi informed the committee that by end of the year it is hoped that the Safeguarding Boards will have received the Section 11 document and she will continue to pursue this. **RESOLVED: The Safeguarding Committee received the verbal update of Markers of Good Practice in Safeguarding.**
SC/2016/010	**CQC ACTION PLAN UPDATE** The purpose of the Derby City Looked After Children and Safeguarding Review July 2015 Action Plan was to inform the Trust of the findings of the review undertaken by the CQC under Section 48 of the Health and Social Care Act 2008. The review looked at the effectiveness of health services for looked after children and the effectiveness of

	safeguarding arrangements within Derby City health services for children. The action plan outlined the areas of improvement for the Trust in the form of recommendations, an identified lead and timescale to provide evidence to show progress made. The action plan will be monitored at a formal meeting each month, attended by identified leads who will update the action plan and provide evidence. The action plan and evidence will be submitted to the CCG on a monthly basis, alongside the partner Health Providers servicing Derby City, This will be collated into an amalgamated action plan and submitted to the CQC. The committee recognised the actions are not easy to close and received some assurance that actions were being progressed and supported and that named people are taking responsibility for their actions. The committee recommended that escalations take place through the operational routes to General Managers. Bill Nicol reminded the committee that early and effective sharing of information between professionals and local agencies is essential for actual identification, assessment and service provision and is the key to providing effective early help where there are emerging problems. At the other end of the continuum, sharing information is essential to effective child protection services. **RESOLVED: The Safeguarding Committee:** **1) Supported the monitoring of progress of the CQC Action Plan to ensure compliance** **2) Received some assurance that the Action Plan is being developed within the set timescales and evidence and/or a progress report is completed.** **3) Noted the actions that have been completed as per the December 2015 deadline.**
SC/2016/011	**<u>SAFEGUARDING ADULTS STRATEGY</u>** Tracy Holtom provided the Safeguarding Committee with the first draft of the Safeguarding Adults Strategy which focused on incidents and cases that have occurred within the Trust and the community and considering wider learning taken from the review of deaths of people with learning difficulties in the Southern Health Trust. The strategy described the priorities the Trust was committed to and its responsibilities to the Care Act 2014 and how it would provide assurance to the CCGs and CQC that the strategy complies with statutory requirements and regulations. Tracey Holtom highlighted the following most common forms of enquiry to the Safeguarding Adults team which the strategy will reflect in its strategic aims and work plan: • Concerns about historical abuse • Institutional abuse • Care concerns – possible neglect, lack of services • PREVENT referrals – to identify possible risk of radicalisation • Public protection – the links with offender care, the responsibility to the individual and the wider community • MARAC (Multi-Agency-Risk-Assessment-Conference) a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and non-statutory services Tracey Holtom explained how the Safeguarding Adults Team would provide a compassionate approach tailored to the individual needs and requirements in line with

	making safeguarding personal. The committee recognised this is a growing agenda and understood the importance of allowing the Safeguarding Adults Team to develop and the need to have a separate Safeguarding Adults and Safeguarding Children Strategy at this current time. The committee also agreed that legislation will take time to be embedded in the Trust and that the strategy and work plans around the strategic aims would set clear direction. A SMART action plan with key timescales will be reported to the Safeguarding committee and will be scheduled twice a year on the committee's forward plan to provide further assurance. Tony Smith considered the strategy was transparent and captured the Trust's values and he looked forward to seeing the performance in the action plan and hoped additional resources if required would be provided to support the strategy. Maura Teager acknowledged the work that had taken place in developing the strategy and would like to see some joined up approaches between children and adult safeguarding and hoped resources can be used resourcefully to develop and implement both strategies so that in the future they can be aligned naturally. She asked that any comments or responses relating to the Safeguarding Adults Strategy be forwarded directly to Tracey Holtom so they can be included in an updated version of the strategy that will to be brought to the next meeting in April, together with the developed work plan identifying progress. Maura Teager confirmed that both the Adults Safeguarding and Children Safeguarding be recommended to the Board at the March meeting. **ACTION: Committee members to forward comments or responses relating to the Safeguarding Adults Strategy directly to Tracey Holtom by the end of February. Amended version to be received at the next meeting, together with the developed work plan.** **ACTION: A SMART action plan with key timescales will be reported to the Safeguarding committee and will be scheduled twice a year on the committee's forward plan.** **ACTION: Adults Safeguarding and Children Safeguarding be recommended to the Board at the March meeting.** **RESOLVED: The Safeguarding Committee:** **1) Acknowledged the position of Adult Safeguarding and the need to support families.** **2) Supported the work plan for safeguarding and timescales to deliver.** **3) Acknowledged and supported the reporting schedule and requirements.** **4) Acknowledged the challenging and evolving national agenda around safeguarding adults.**
SC/2016/012	**<u>UPDATE REPORT ON SAFEGUARDING ADULTS TRAINING REPORT</u>** This report provided the Safeguarding Committee with an update on the safeguarding adults training position. The committee felt the report was limited and did not demonstrate trend or changes in performance and although the report did provide assurance that PREVENT training was available, it was clear that training passports need to be mapped and there was a need to a return to the former report format. It was agreed that Carolyn Green will ask Tracy Shaw to revert to the original style of reporting and ensure the version submitted to the committee in April is of the required quality.

	Bill Nicol pointed out that both the County and City Safeguarding Boards sub-groups are reviewing how they work and standardising compliance and training offer and would provide a higher level of training level through the multi-agency training offer which could assist with compliance and he hoped to see some benefits which will start to show an improvement. The report did not provide the committee with the level of assurance required and requested that more comparable data containing trend is contained in future reports. **ACTION: Carolyn Green will send an email to Jayne Storey to ensure training passports are mapped and on the quality of the reports.** **RESOLVED: The Safeguarding Committee:** **1) Noted the maintenance of level 1 and 2 training** **2) Noted the ongoing plan for safeguarding adults level 3 to increase compliance.** **3) Noted the PREVENT training was occurring but was not fully assured by the ongoing plan for PREVENT wrap 3.**
SC/2016/013	**CQC UPDATE** Work with CQC will take place alongside the work plan and more detail will be provided at the next meeting in April.
SC/2016/014	**TRIANGLE OF CARE UDPATE** Wendy Slater provided the Safeguarding Committee with an update on the progress of the Triangle of Care, and membership of the national scheme. The committee noted that senior support for the Triangle of Care has been led by Clare Grainger, and that a meeting was held in November involving senior leaders from Operational services and the Nursing and Patient Experience Directorate and Ruth Hannan, the national lead from Carers UK to talk about what happens next. The committee was briefed on the need to accept ownership across the organisation and an action plan had been agreed which will begin implementation by the end of February. This will start to address concerns and will be submitted to the committee to provide further assurance. It was noted that the Care Act endorses the Triangle of Care and the committee requested that the next report includes the following: • That the committee report receives details on Family inclusive practice initiative which contribute to the Safeguarding families agenda • Transformation work in family inclusive practice • That complaint from families where they feel they have not been supported which will show gaps should be included in the report so areas for improvement can be targeted. The committee noted the progress and the clear lines of accountability through senior involvement with the Care Act and looked forward to seeing growing evidence of progress and embeddedness in future reports. **ACTION: The next report will be submitted to the committee in August and this will be reflected in the forward plan.** **RESOLVED: The Safeguarding Committee noted the update on the Triangle of**

	Care and approved the actions and plans so far.
SC/2016/015	**WORKING WITH AND SUPPORTING CARERS POLICY AND PROCEDURE FOR RATIFICATION** The Safeguarding Committee agreed to ratify the Working with and Supporting Carers Policy and Procedure for a six month period recognising that the policy had been significantly updated to include other groups within the Trust and could now be considered to be a Trust wide care policy that was compliant with the Care Act. The committee also agreed that Wendy Slater would ensure the Quality Leadership Teams had opportunity to comment and contribute to the policy. **ACTION: Wendy Slater to ensure the QLTs have an opportunity to comment and contribute to the Working with and Supporting Carers Policy and Procedure.** **RESOLVED: The Safeguarding Committee ratified the Working With and Supporting Carers Policy and Procedure for a six month period to enable wider involvement.**
SC/2016/016	**PUBLIC HEALTH NURSING PRACTICE POLICY/ ONE WORKER FOR RATIFICATION** The Public Health Nursing Practice Policy was submitted to the committee for approval. However, the committee rejected the policy and recommended that it be returned by Carolyn Green and Tina Ndili to the children's and CAMHS CRG to be re-considered whether this policy was out dated, added any value and was still required as committee members believe the majority of the content had been superseded by the Safeguarding Children procedures. **ACTION: Policy to be returned to the children's and CAMHS CRG to ask their opinion on value by Tina Ndili and Carolyn Green** **RESOLVED: The Safeguarding Committee rejected the Public Health Nursing Practice Policy**
SC/2016/017	**FORWARD PLAN** The forward plan will be updated with actions arising from today's meeting (Joanne Kennedy's CAMHS Training Presentation will be considered at the next meeting in April). The forward plan will be populated by Tracey Holtom, Tina Ndili and Carolyn Green to agree the schedule of reports. **ACTION: Forward Plan to be populated by Executives and Safeguarding Adults and Safeguarding Children Leads.** **ACTION: CAMHS Training Presentation will be considered an agenda item for April**
SC/2016/018	**SAFEGUARDING COMMITTEE DATES 2016/17** The 2016/17 meeting dates were noted by members of the committee.
SC/2016/019	**ANY OTHER BUSINESS** The committee noted that due a change in his role, this would be the last meeting

	Deepak Sirur would be attending as representative of the Specialist Services Quality Leadership Team. The committee agreed that a named representative allocated by Wendy Brown would replace him as a member of the Safeguarding Group. Carolyn Green alerted the committee to exploration of alleged incidents that took place in the 1960s. This matter has been escalated to the CCG and NHS England and to the Derbyshire Safeguarding Children's Board and the police. The Trust would carry out a full investigation and offer individual support. Joanne Kennedy drew the committee's attention to a thematic review of cases of familial child sexual abuse that will represent the first report of the Children's Commissioner's inquiry into child sex abuse within the family and its network. She explained that the report was a critical analysis of the scale and nature of this form of child sex abuse and the committee agreed to include this as an agenda item at the next meeting in April. **ACTION: Assessment of child sexual abuse in the family network to be an agenda item at the April meeting.**
SC/2016/020	**MATTERS TO BE ESCALATED TO THE BOARD OR OTHER BOARD COMMITTEES** • Both the Adults Safeguarding Strategy and Children Safeguarding Strategy will be escalated to the Board at the March meeting. • Think Family as this is a much broader issue and should not be judged purely as a Safeguarding concern. • Historical abuse contained in the Adult strategy. • Amount of apologies regularly received during meetings to be addressed at ELT to ensure key members are in attendance.
SC/2016/021	**MEETING EFFECTIVENESS** It was recognised that this is a new committee there were some very helpful discussions and good contributions. However, the committee needs to be more structured to gain full assurances. It was appreciated that David Tucker and Jayne Storey were present at this meeting as that this had added value to disucssions. The amount of apologies received reinforced the need to look at committee membership and representation. It was agreed that the adult agenda would form the first part of the meeting at the April meeting.
Date and Time of next meeting: The next meeting of the Safeguarding Committee will take place on: **Friday, 15 April 2016 at 1.00 pm** ***Venue: Meeting Room 1 –Albany House, Kingsway, Derby***	

2015-2016 Board Annual Forward Plan

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

2015-2016 Board Annual Forward Plan

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	Apr-15	May-15	Jun-15	Jul-15	Sep-15	Oct-15	Nov-15	Jan-16	Feb-16	Mar-16	Apr-16
CW/CG	Annual Accounts and Annual Report and Quality Report & Annual Governance Statement (sign-off of final versions is delegated to Audit Committee annually)	FT Constitution	*Drafts* to be issued to Board for comment	Summary of key changes raised at Audit Com		Annual audit letter			Board to consider deleg'n of sign off to Audit Com				*Drafts* to be issued to Board for comment
IM	Strategic review/quarterly progress to include Transformation Board update	Strategic Outcomes (all)		X					X			X	
MP	IM&T Strategy Updates that will include update on optimisation of EPR	Strategic Outcome 1 Strategic Outcome 2			X					X			
MP	Information Governance Updates	Strategic Outcome 1 Strategic Outcome 3 Information Gov toolkit	X					X				X	
MP	Communications Strategy - Yearly Report	Strategic Outcome 3					X						Next one Sept 2016
JSt	People Strategy / Updates	Strategic Outcome 4 Licence Condition FT4		X		X			X		X		
JSy	Research & Development Strategy	Strategic Outcome 1 and 3			X					X Progress Report			
JSt	Staff Survey Results & Follow up activity	Strategic Outcome 3 and 4			Progress Report		Progress Report				X Results		
JD	Review S.O.'s, SFI's, SoD	FT Constitution Standing Orders					X						
JD	Trust Sealings	FT Constitution Standing Orders	X										
JD	Annual Review of Register of Interests	FT Constitution Annual Reporting Manual	X										
CG	Board Assurance Framework Update	Licence Condition FT4		X				X				X	
JD	Raising Concerns (whistleblowing)	Strategic Outcome 1 Public Interest Disclosure Act			X					X		X	
JD	Whistleblowing Policy - annual nomination of NED role (one year rotation)	Francis Report								X			

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

2015-2016 Board Annual Forward Plan

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	Apr-15	May-15	Jun-15	Jul-15	Sep-15	Oct-15	Nov-15	Jan-16	Feb-16	Mar-16	Apr-16
CG	Annual Patient Survey	Clinical Practice CQC						X					
CG	CQC Update - Verbal unless report required *Confidential*	Monitor Risk Assurance Framework (RAF)	X	X	X	X	X	X	X	X	X	X	X
JSy	Re-validation of Doctors	Strategic Outcome 3			X								