Derbyshire Healthcare NHS
NHS Foundation Trust

Meeting of the Board of Directors

24 June 2015

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

Better together

NOTICE OF BOARD MEETING
WEDNESDAY 24 JUNE 2015
TO COMMENCE AT 1.00 PM IN THE CONFERENCE ROOMS A & B,
RESEARCH & DEVELOPMENT CENTRE, KINGSWAY, DERBY DE22 3LZ

Item	Time	AGENDA	Enc Ref	Discussion led by
1.	1:00	Chairman's Welcome and Opening Remarks and Strategic Theme	**-**	Mark Todd
2.	1:05	My Recovery Story	-	
3.	1:30	Apologies for Absence Declarations of Interest		Mark Todd
4.	1:35	Minutes of Board of Directors meeting, held on 27 May 2015	**A**	Mark Todd
5.	1:45	Matters arising – Actions Matrix	**B**	Mark Todd
6.	1:55	Chairman's Report	**C**	Mark Todd
7.	2:05	Chief Executive's Report	**D**	Steve Trenchard
FINANCE, STRATEGY AND GOVERNANCE				
8.	2:15	Audit Committee Annual Report	**E**	Caroline Maley
9.	2:25	Committee Summary Reports: - Audit Committee (draft minutes) - Quality Committee – including Duty of Candour Policy - Mental Health Act Committee	**F**	Committee Chairs
PATIENTS, QUALITY AND SAFETY				
10.	2:35	Position Statement on Quality - incorporating Complaints Report	**G**	Carolyn Green
11.	2:45	Research & Development Strategy	**H**	John Sykes
B R E A K 3:00				
OPERATIONAL PERFORMANCE REVIEW				
12.	3:15	Finance Director's Report Month 2	**I**	Claire Wright
13.	3:25	IM&T Strategy Updates	**J**	Ifti Majid
14.	3:35	Integrated Performance and Activity Report	**K**	Ifti Majid
15.	3:45	Staff Health Check – deep dive and Staff Survey Update	**L**	Jayne Storey
16.	4:15	I. Board Forward Plan II. Identification of any issues arising from the meeting for inclusion or updating of the Board Assurance Framework III. Discussion on future deep dives IV. Comments from observers on Board performance and content of meeting	**M**	Mark Todd

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

The next meeting is to be held on 29 July 2015, at 1.00 pm in Conference Rooms A & B,
Centre for Research and Development, Kingsway, Derby DE22 3LZ
Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.
Participation in meetings is at the Chairman's discretion. `

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Wednesday, 27 May 2015

MEETING HELD IN PUBLIC

Commenced: 1:00 pm Closed: 4:45 pm

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

PRESENT:	Mark Todd	Chairman
	Steve Trenchard	Chief Executive
	Caroline Maley	Senior Independent Director
	Maura Teager	Non-Executive Director
	Tony Smith	Non-Executive Director
	Jim Dixon	Non-Executive Director
	Phil Harris	Non-Executive Director
	Ifti Majid	Chief Operating Officer/Deputy Chief Executive
	Claire Wright	Executive Director of Finance
	Carolyn Green	Executive Director of Nursing and Patient Experience
	Dr John Sykes	Executive Medical Director
	Jayne Storey	Director of Transformation
	Jenna Davies	Interim Director of Corporate & Legal Affairs
IN ATTENDANCE:	Anna Shaw	Deputy Director of Communications
	Sue Turner	Executive Administrator and Minute Taker
For item DHCFT 2015/078&079	Kate Majid	Head of Transformation & Patient Involvement
For item DHCFT 2015/087	Carolyn Gilby	Divisional Director
For item DHCFT 2015/087	Chris Wheway	Divisional Director
For item DHCFT 2015/087	Peter Charlton	General Manager IM&T
For item DHCFT 2015/087	Vicky Williamson	Information Manager
VISITORS:	John Morrissey	Council of Governors
	Carole Riley	Derbyshire Voice Representative
APOLOGIES:	Graham Gillham	Director of Corporate and Legal Affairs
	Mark Powell	Director of Business Development and Marketing

DHCFT 2015/071	**CHAIRMAN'S OPENING REMARKS, APOLOGIES, DECLARATIONS OF INTEREST** The Chairman opened the meeting by welcoming all present. No declarations of interest were noted.
DHCFT 2015/072	**MY RECOVERY JOURNEY** Kate introduced herself and informed the Board she was an award winning children's illustrator and designer. She explained that she had been diagnosed with Acute and Transient Psychotic Disorder and since 2005 she had suffered four severe psychotic relapses and several minor episodes. During these episodes she forgets how to eat and loses all track of time, instead her sense of creativeness is heightened and becomes highly stimulated. She copes with this by drawing and recording every moment in a doodle diary and with photography. She wanted to share with the Board how drawing and creativity helps her and suggested using drawing and creativity to help develop the Trust's services. Kate described things and events that made her feel safe and emphasised how drawing, writing and photography helped calm her down and speeded up her recovery. She also uses art as a tool to prevent her becoming ill and records positive things that have happened to her. Kate had many ideas that might improve the Trust's services and help service receivers feel safe. She stressed that feeling safe was very important. She wanted to make the point that service receivers should be reassured by staff and be told they are being looked after and that in time their condition will improve. Kate also believed the use of gentle signs would put patients at ease and suggested the Trust displayed signs to say there are no cameras on the ward or around the hospital as the use of cameras can be very disturbing to some patients. Kate felt that a quiet expressive room where patients could draw and paint on black board or wipe board walls would be an extremely helpful aid to recovery. This would also allow people time off the ward and it would give structure to their day, allow them to relax and pass time in a sociable way. She also provided evidence of a an idea of offering new patients a journal to use so they have something to write or draw in to express their feelings and this could be a good way to help people start to talk to nurses and professionals. Kate also shared other ideas of treatments such as holistic style treatments. She added that she really enjoyed helping and being with people who have suffered similar problems to her and this had helped her recovery. She now wanted to pass on and share what she has learnt through her mental health condition. Steve Trenchard was very taken with the idea of creating spaces for people to draw and express themselves in different ways and suggested that the Innovation Fund could perhaps be used to pursue funding. He thought Kate had some good ideas about creating a safe environment for patients. Carolyn Green agreed it would be good to look at different ideas for using art as part of the Trust's core business. The Chairman was struck by the interaction between art and music and he thought this was a very useful area of therapy. He felt that the messages Kate relayed about safety and wellness definitely resonated with the Board and he hoped she could help the Trust learn how to make people feel safe and help

	people have an easier and quicker journey to wellness. Ifti Majid was keen to take this message forward and suggested that Kate's presentation be shared with Sara Baines the Lead in Recovery and Wellbeing. The Chairman thanked Kate for her presentation and for the work she was carrying out and for the support she was providing for the recovery services. **ACTION: Kate's presentation to be sent to Sara Baines, Recovery and Wellbeing Lead.** **RESOLVED: The Board expressed thanks to Kate for sharing her story and for the ideas she had proposed.**
DHCFT 2015/073	**MINUTES OF DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST BOARD MEETING, HELD ON 29 APRIL 2015** The minutes of the Derbyshire Healthcare NHS Foundation Trust Board meeting, held on 29 April were accepted and approved subject to **DHCFT 2015/068: County CAMHS Staff Levels And Capacity** – wording of the second action "John Sykes and Maura Teager will spend time with the CAMHS team and produce a written report to the Board on specific areas of concern." to be substituted with *"Jayne Storey and Maura Teager will spend time with the CAMHS team and produce a report to the Board on specific areas of concern."*
DHCFT 2015/074	**MATTERS ARISING** Action matrix to be updated in line with the following amended action. **DHCFT 2015/068: County CAMHS Staff Levels and Capacity -** Jayne Storey and Maura Teager will spend time with the CAMHS team and verbally update the Board on their follow up visit prior to producing a report on specific areas of concern. An action plan was discussed at the Quality Committee and provisional dates have been planned. A report on areas of concern will be made at the July Board. CAMHS succession planning will be taken through the People Forum and will be incorporated into the work Jayne Storey and Maura Teager are carrying out. All green completed items to be removed and all other updates were noted directly on the matrix.
DHCFT 2015/075	**CHAIRMAN'S REPORT** The Board noted the Chairman's report which summarised his meetings and visits during the month. The Chairman wished to add that he had also attended the Annual General Meeting of First Steps Derbyshire and this had been a great opportunity to see the work they had carried out at first hand. John Sykes referred to the meeting the Chairman held with Lesley Thompson, Chair of the 21st Century Board and asked how GPs would develop into the integrated care. The Chairman replied that the subject of discussions held with Lesley Thompson had been the emerging process of the 21st Century Plan and wider 21st Century governance arrangements.

	RESOLVED: The Board received and noted the Chairman's report.
DHCF 2015/076	**CHIEF EXECUTIVE REPORT** Steve Trenchard presented his regular monthly report and drew attention to speculation on funding for mental health services now that the new government has been announced. He emphasised the fact that the Trust's services remain extremely busy and that a huge demand is made on staff to ensure services are maintained at safe levels. He was pleased to report that in-patient services had reduced as had the amount of people treated outside the Derbyshire area. Maura Teager asked what lessons could be learned from this and how could capacity be planned in the medium and longer term. Ifti Majid replied that twice-weekly operational meetings had continued in response to the increased demand on staff and discussions were held about the structures that are in place. Flexibility of staff movement had been crucial and had provided an understanding of where staff needed to be recruited and this level of flexibility needed to be sustained. Carolyn Green made the point that regulators would consider the Trust was under significant pressure with a bed capacity rate over 85% and she asked when this was being looked at and whether a review of the risks and potential mitigations had been put in place. Steve Trenchard replied that the thrust of the transformation programme would be to bulk up services to address capacity in the community and this would reduce occupation of beds. In addition the Finance & Performance Committee would be looking at issues around bed occupancy and this was also an issue that the executive team will work together on. Kate Majid pointed out that this was also a piece of work that the Sim:pathy project would be reporting on to gain independent modelling to increase assurance that the proposed service changes are viable and safe. It would also form part of the report that the Finance & Performance Committee would look at and this would also be brought to the Board in November. Discussions took place around the demands on people and whether the leadership teams were capable of managing the transformation process and at the same time also manage front line issues. The Board agreed they needed to be assured that the executive team has resolutions to run the transformation programme but decided they could not be assured of this yet as the big challenge would be for the clinical leadership to carry the transformation programme forward. Members of the Board agreed they should be prepared to understand the risks within the operation and be aware of any potential for harm to service receivers. **RESOLVED: The Board of Directors received and noted the Chief Executive's Report.**
DHCFT 2015/077	**STAR BOARD FIVE YEAR STRATEGY** The purpose of this report is to share with Trust Board the five year strategy produced by KPMG on behalf of STAR Board for the South unit of Planning. The extensive report set out: • The case for change

	• Financial analysis case for change • Strategy for the future (transformational priorities) • The enablers to making the change happen • A review of governance processes • Next steps Members of the Board considered the content of this five year strategy alongside the Trust's five year plan to ensure there is alignment and gained assurance of the progress being made. Ifti Majid made the point that he considered this to be an acute hospital rescue plan and stressed that it was important to establish whether it posed a risk to mental health services and the Trust's parity of esteem. He asked the Board to focus on how to link this plan into the (BAF) Board Assurance Framework and the organisation's financial planning. The Board welcomed the focus on governance contained in this exercise and it was agreed that the executive team would explore ways of working with primary care to provide this service. Steve Trenchard pointed out that the content of this five year strategy should be adjusted in line with the 21st Century Plan and the Trust's refreshed strategy to ensure they are aligned. **ACTION: It was agreed that the alignment of the STaR and 21st Century plans and the wider health economy following the election be tested with the Trust's refreshed strategy.** **RESOLVED: The Board of Directors discussed and noted the report.**
DHCFT 2015/078	**STRATEGIC REIVEW** Kate Majid presented this paper to provide the Board of Directors in order to provide assurance of progress against the strategic outcomes. The strategy set out the organisation's plans for 2013 to 2016 and has at its heart the people who use the Trust's services, their families and carers. The report reflected the current position across the organisation with regard to the Trust's achievement of the strategic outcomes and pillars of delivery. The report also provided examples of evidence of progress. The Board considered the report showed evidence of triangulation, useful charts and this should continue. Caroline Maley commented that she was pleased to see references to the compassionate care training. It was recognised that strategy progress reporting is currently being refreshed by the executive team in preparation for Q1 assurance reporting. Discussions were held on the style of the reportand its relationship to CQC inspection requirements. **RESOLVED: The Board of Directors noted the content of the report and received assurance on progress to date against the Trust's strategic outcomes.**
DHCFT 2015/079	**INTEGRATED SERVICE DELIVERY** This paper was presented by Kate Majid to provide the Trust Board with assurance of progress against the Strategic Outcomes with respect to Integrated

	Service Delivery and provided an update against several key advances in the development of Neighbourhood working. The Board recognised these were all very complex issues. Kate Majid highlighted the challenges contained in the report and confirmed progress was on track for the transformation leadership team to be in place for July and she ran through the timelines for the transition of the project teams. She also pointed out that an update on the skills mix and transition plan would be reported to the Finance & Performance Committee at its next meeting in July. Caroline Maley made the point that a deep dive of the transformation process risk was due to take place at the July meeting of the Audit Committee. She suggested that a Board Development session be held to cover the strategic risk of transformation and the Chairman and Tony Smith echoed this suggestion. **ACTION: Jayne Storey to plan a Board Development Session to cover the strategic risk of the transformation change process.** **RESOLVED: The Board of Directors received assurance from the paper in respect to achievement of and alignment to the Trusts Strategic Outcomes as outlined above regarding the development of a Model of Integrated Service Delivery.**
DHCFT 2015/080	**<u>PEOPLE STRATEGY</u>** The purpose of this report is to share with the Board the Trust's planned approach to delivering the People Strategy, with particular focus on its values: • We deliver excellence • We involve our people in making decisions • We focus on our people • We put our patients at the centre of everything we do Jayne Storey emphasised that the People Strategy has five primary aims, one being focussed on educating and developing people and this month it focussed on delivery of the education strategy and an update on the Trust's key people metrics. The Board discussed various aspects of the report and Phil Harris asked if all managers have the opportunity to undertake "management of people" training. In response, Jayne Storey replied that she would have to check this detail and it was pointed out by Maura Teager that joint training on performance management and effectiveness with Staffside representatives was very beneficial. Jayne Storey informed the Board that the strategy will be in place by January 2016 and will involve all aspects of the "people". Talent management will run through from recruitment through to retirement and the support of peoples' career paths would be more visible. Succession planning will also be developed further to involve a range of key posts. In addition, the health check would identify what needs to be done and a plan developed to support. **RESOLVED: The Board of Directors:** **1) Acknowledged the continuing delivery of the People Strategy with**

	particular emphasis on progress of the Education Strategy **2) Noted the key metrics and proposed actions**
DHCFT 2015/081	**COMMITTEE SUMMARY REPORTS** **I. Audit Committee:** The summary report of the meeting of the Audit Committee held on 28 April, together with the minutes of the meeting was noted by the Board. It was agreed that in future the full minutes of the Audit Committee would be presented to the Board as a matter of course. The Audit Committee Annual Report will be presented to the Board at its next meeting. **II. Quality Committee:** The Board noted the summary report of the meeting of the Quality Committee held on 7 May and recognised that the meeting had a very complex agenda and was well attended. **III. Safeguarding Committee:** The Board was pleased to note from the summary report of the meeting of the Safeguarding Committee held on 17 April that funding for a named doctor in adult safeguarding had been approved. **RESOLVED: The Board of Directors noted the contents of the Committee Summary Reports.**
DHCFT 2015/082	**BOARD ASSURANCE FRAMEWORK** The purpose of this report is to meet the requirement for Boards to produce an Assurance Framework. The Board Assurance Framework (BAF) is a high level report which enables the Board of Directors to demonstrate how it has identified and met its assurance needs, focused on the delivery of its objectives, and subsequent principal risks. The BAF provides a central basis to support the Board's disclosure requirements with regard to the Annual Governance Statement (AGS), which the Chief Executive signs on behalf of the Board of Directors, as part of the statutory accounts and annual report. Carolyn Green made the initial presentation of the Board Assurance Framework to the Board for 2015/16 and highlighted amendments that were made to the BAF when it was presented to the Audit Committee on 22 May. It was agreed that the Audit Committee would focus on risks rated high or catastrophic and these will be included on agenda during 2015/16. It was agreed that the timing of the BAF would be realigned with the timing of the meetings of the Audit Committee for next year. **RESOLVED: The Board of Directors:** **1) Agreed the new Board Assurance Framework for 2015/16** **2) Agreed for the Board and Audit Committee to continue to receive a formal update on the BAF three times a year during 2015/16** **3) Supported the 'deep dive' review and challenge by the Audit Committee of only risks graded high, with lower graded risks being reviewed by the relevant named responsible committee.**
DHCFT 2015/083	**POSITION STATEMENT ON QUALITY**

	The purpose of this report is to provide the Trust Board of Directors with an update on the continuing work to improve the quality of its services in line with the Trust Strategy, Quality Strategy and Framework and strategic objectives. Carolyn Green reported that the Quality Report had now been completed and positive feedback had been received from commissioners. Claire Wright asked that the Council of Governors' comments on the Quality Report be captured in a more formal way next year-end. Carolyn Green explained that the inclusion of a joint agreed statement from the Council of Governors had not been written into the guidance this year but had been requested by the auditors. She appreciated Claire Wright raising this point and she assured the Board that she and Jenna Davies would ensure that the Council of Governors could provide their agreed statement on the Quality Report next year. Steve Trenchard suggested that the Chairman holds discussions with the lead governor to ensure authority of the entire Council of Governors. **ACTION: Jenna Davies will timetable a meeting for Council of Governors to receive the Quality Report 2015/16 to enable a collective response from governors.** **RESOLVED: The Board of Directors:** **1) Noted the Quality Position Statement** **2) Board members were able to offer the Executive Directors additional direction on any aspects of quality listed in this report or additional information that would be beneficial to the Board, to be assured that the Trust executive leaders understand the Quality issues and were fully briefed on the Trust's approach to quality management and the delivery of the Trust's quality strategy.**
DHCFT 2015/084	**<u>UPDATE ON COACHING COMMUNICATION DIFFICULTIES WITHIN AUTISM</u>** John Sykes provided a verbal update on the communication training that would be introduced in the north and the south to help medical practitioners communicate with people suffering within the autism spectrum disorder. A small group of people with expertise in specialist communication will coach clinicians to work through these challenges. Maura Teager made the point that it would be interesting to see when the effects of this training would show an improvement in the service. Carolyn Green added that a report had been submitted to the Quality Committee on autism, that set out the statutory requirements that came into effect at the end of March 2015 and knowledge acquisition would be enabled through the redesign of an eLearning package and additional training, **RESOLVED: The Board of Directors was content with this update and considered responsible action had been taken and good progress had been made.**
DHCFT 2015/085	**<u>FINANCE DIRECTORS REPORT MONTH 1</u>** This paper provided the Trust Board with an update on current financial performance against the Trust's operational financial plan as at the end of April 2015.

	Claire Wright made the Board aware of new financial reporting that would take place in the Finance & Performance Committee to assist in challenging key strategic aspects of financial performance and financial risks. She explained that the Executive Leadership Team now also receive additional financial performance information listing all key assumptions in the financial forecast. Reference was made to the new Continuity of Service Risk Rating headroom graph (CoSRR) that served to illustrate the impact of improving or worsening revenue and cash. Claire Wright highlighted the work carried out by Rachel Leyland to show the metric range and the Board recognised that a great deal of work had been carried out by the finance team in bringing this report together. **RESOLVED: The Board of Directors considered the content of the paper and considered their level of assurance on the current and forecast financial performance for 2015/16.**
DHCFT 2015/086	**REFERENCE COST SIGN OFF** The Department of Health guidance relating to Reference Cost submissions for 2014-15 requires that the Trust Board or other appropriate sub-committee is required to approve the costing processes that support the reference cost submission. Claire Wright explained that there were no changes to the costing principles previously audited by CAPITA. The costing and information capture systems have not changed from the previous year's submission and the last CAPITA audit. Also contained in the report is the check list which is required to be completed as part of the submission along with the rationale for the chosen responses. Claire Wright also highlighted the provider licence requirements for costing information and standards **RESOLVED: The Board of Directors confirmed they considered that:** **1) Costs have been prepared with due regard to the principles and standards set out in Monitor's Approved Costing Guidance** **2) Appropriate costing and information capture systems are in operation** **3) Costing teams are appropriately resourced to complete reference costs** **4) Procedures are in place such that the self-assessment quality check list will be completed at the time of the reference cost return**
DHCFT 2015/087	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT AND SAFER STAFFING** Ifti Majid presented his report that defined the Trust's performance against its Key Performance Indicators and actions put in place to ensure performance is maintained. The report showed that 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. In addition the report took a longitudinal look at performance compliance and explored reporting styles used by other organisations. Ifti Majid was pleased to note good performance in month one. DNAs (Did Not Attend) have improved which suggests that text message reminders have been effective and cancellations were now within target and the team was considering

	extending the text message reminder system across the Trust's services. The report showed that IAPT (Improving Access to Psychological Therapies) recovery rate remains good and Ifti Majid felt this was a good indication of the hard work the teams have put in over the last few months. The Chairman sought assurance on how breaches of particular doctors on letter-writing were being addressed. Ifti Majid replied that new software had provided better detail on individual performance and management issues were being dealt with and progress was being made. Claire Wright cited that the overall performance of IAPT services in financial terms was not fully assured, in contrast to the good recovery rate where assurance was achieved. Carolyn Gilby, Chris Wheway, Peter Charlton and Vicky Williamson attended the meeting and summarised their analysis of performance reporting carried out by other organisations by stating that the Trust was performing well if the other 10 comparison reports were used as a benchmark. The Board recognised that staff have been very resilient and had not let performance slip away. There is evidence that people are working together and issues being raised from the staff survey would be good indicators of problems to be addressed. Carolyn Green believed that the Trust's work carried out on safer staffing would be enviable to other trusts and credit should be given to the team as evidence showed that problems were being managed whilst they were under pressure. Steve Trenchard made the point that it was evident that people feel they are working harder, teams are under resourced and working under stress and the report demonstrates how complex these issues are. He felt the challenge would be to empower leaders to understand and deal with situations relating from this audit to make a difference and suggested this should be built into the people strategy. He added that discussions were taking place at the Executive Leadership Team meetings (ELT) on trajectory and staff rates and this would also be reported through the Finance & Performance Committee. Ifti Majid pointed out that the analysis identified many differing approaches to the way performance is reported to other trusts' boards. Discussion took place on combining activity performance, key performance indicators and finance and giving consideration to delegating the finer detail through a smaller committee. It was agreed that Ifti Majid would work with Jenna Davies to study the best examples of good practice carried out by other organisations to redesign the structure of the Trust's performance reporting but the Board were aware that any significant changes should be introduced post CQC visit. In addition it was agreed that Ifti Majid would meet with Jim Dixon to look to overlay a summary dashboard on the Finance & Performance Committee activity report. **ACTION: Ifti Majid and Jenna Davies will take some of the best examples of reporting from the analysis and create a narrative using benchmarking where possible to redesign performance reporting within the Trust to be introduced post CQC visit.** **ACTION: Ifti Majid and Jim Dixon to consider the summary dashboard on the Finance & Performance Committee activity report.**

	RESOLVED: The Board of Directors: **1) Acknowledged the current performance of the Trust** **2) Noted the actions in place to ensure sustained performance** **3) Considered the longitudinal study and growing performance risk** **4) Considered the feedback from other organisations performance reporting structures and agreed changes they would like to see.**
DHCFT 2015/088	**FOR INFORMATION** **I. Board Forward Plan** • Audit Committee Annual Report was due to have been presented to today's meeting and is now deferred to June. • Committee Annual Reports will be reported to the Audit Committee in May for 2016/15. The Executive Leadership Team will look at the issue of timing of the annual reports of the committees. • Carolyn Green forewarned the Board that the Safeguarding Adults report might need to be deferred to July. • It was suggested by Jayne Storey that the Communication Strategy be brought back to the Board six-monthly for progress and impact. **II. Board Assurance Framework:** No additional risks to be added to the Board Assurance Framework **III. Deep Dive Selection:** It was agreed that the next deep dive would be a Staff Health Check and would be conducted by Jayne Storey.
DHCFT 2015/070	**CLOSE OF THE MEETING** The Chairman thanked all of those present for their attention and comments and closed the public meeting at 4:45 pm.
DATE OF NEXT MEETING The next meeting of the Board in public session is scheduled take place on Wednesday, 24 June 2015 at 1.00 pm. in Conference Rooms A & B, R&D Centre, Kingsway Site, Derby, DE22 3LZ (confidential session to commence earlier at 10.30 am).	

BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - JUNE 2015						
Date	**Minute Ref**	**Action**	**Lead**	**Status of Action**	**Current Position**	**Enc B**
28.1.2015	DHCFT 2015/010	Committee Summary Reports	Jenna Davies	Actions to address consistency and level of detail of the summary reports would form part of the governance framework exercise.	16.3.2015 Discussed at Board Development on 11 March and agreed to trial a new model. Additionally short life task and finish group to be established to review integrated options for some Board Committees. 20.4.2015 The short life working group will need to complete its review of board governance before the final framework is completed for ratification by the Board. Initial date has now been set and the July Board is realistic timeframe for this work to be competed.	Yellow
25.2.2015	DHCFT 2015/030	NHS National Staff Survey Results	Jayne Storey	The results of the survey would be submitted to the next ESEC meeting in May and transparency of actions would be submitted to the Board also in May	Healthcheck completed and a number of staff invited to June board to feedback. The healthcheck was shared at the Spotlight on Leaders event in June.	Green
25.3.2015	DHCFT 2015/041	Chief Executive's Report	Anna Shaw/ Jenna Davies	Governors are required to undergo DBS checks. Anna Shaw to lead the Governors' DBS exercise.	Governors have all been requested to complete the DBS documentation. Action ongoing. 29.4.2015 This is 50% complete. Status will be provided at next Board Meeting. 19.6.15 All but one of the public governors have returned their DBS paperwork. Jenna Davies is leading the process for appointed governors.	Yellow
25.3.2015	DHCFT 2015/050	Integrated Performance and Activity Report and Safer Staffing	Carolyn Green	Carolyn Green to propose holding an administration excellence event to the Training Board	Verbal update will be available in June. 19.6.2015 No progress at this time, priority of training board has been mandatory and statutory training review and quality priorities. Carolyn Green will liaise with Training Board on this suggestion which was proposed from a quality visit.	Yellow
29.4.2015	DHCFT 2015/061	People Strategy Update	Jayne Storey	Appraisal compliance to be reported to the Finance & Performance Committee in July with an interim update report submitted to the Board in May/June.	Monthly metrics provided to Board, with detail discussed within the People Forum and F&P scheduled for July.	Yellow
29.4.2015	DHCFT 2015/064	Corporate Governance Framework	Jenna Davies	Jenna Davies will lead the development of an improved Corporate Governance Framework	Improved version of Corporate Governance Framework will be available at July Board.	Yellow
29.4.2015	DHCFT 2015/068	County CAMHS Staff Levels and Capacity	Mark Powell	Mark Powell will support the CAMHS team to take up opportunities in services development without compromising the core services.	Mark Powell will report process through F&P Committee.	Green
29.4.2015	DHCFT 2015/068	County CAMHS Staff Levels and Capacity	Jayne Storey/ Maura Teager	Jayne Storey and Maura Teager will spend time with the CAMHS team and produce a written report on specific areas of concern	Verbal update will be provided to the Board. A report on areas of concern will be made at the July Board. CAMHS succession planning will be taken through the People Forum and will be incorporated into the work Jayne Storey and Maura Teager are carrying out. Maura Teager and Jayne Storey attended the CAMHS team and a verbal update will be offered to board.	Yellow

27.5.2015	DHCFT 2015/072	My Recovery Story	Carolyn Green	Kate Smith's Presentation to be sent to Sara Baines, Recovery and Wellbeing Lead	Communication with Sara Baines on the Board presentation and possible outcomes and service improvements including scribble books, have been included. ACTION COMPLETE	Green
27.5.2015	DHCFT 2015/077	Star Board 5 Year Strategy	Steve Trenchard	It was agreed that the alignment of the STaR and 21st Century plans and the wider health economy following the election be tested with the Trust's refreshed strategy	Refreshed strategy will address the 2 board programmes . Star Board vision of joined up care is on agenda for June.	Green
27.5.2015	DHCFT 2015/079	Integrated Service Delivery	Jayne Storey	Jayne Storey to plan a Board Development Session to cover the strategic risk of the transformation change process	Session scheduled for 15 July.	Green
27.5.2015	DHCFT 2015/083	Position Statement on Quality	Jenna Davies	Jenna Davies will timetable a meeting for Council of Governors to receive the Quality Report 2015/16	This will be added to the timetable of the Annual Report/Quality Report.	Green
27.5.2015	DHCFT 2015/087	Integrated Performance and Activity Report and Safer Staffing Deep Dive	Jenna Davies/ Ifti Majid	Ifti Majid and Jenna Davies will take some of the best examples of reporting from the analysis and create a narrative using benchmarking where possible to redesign performance reporting within the Trust to be introduced post CQC visit.	Initial trial of revised executive summary report to be used in F&P with lessons learned being used to inform changes to the Board paper - aim for September Board to imlement lessons learned in Board paper.	Yellow
27.5.2015	DHCFT 2015/087	Integrated Performance and Activity Report and Safer Staffing Deep Dive	Ifti Majid	Ifti Majid and Jim Dixon to consider the summary dashboard on the F&P committee activity report.	Meeting held – proposal agreed. 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 – 24th June 2015

Chairman's Report

Background

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

Key Themes

The following substantial meetings/visits have been made during the month:

Attended First Steps AGM on 26 May
Attended the Social Care Exhibition in Derby – 'Do What You Want 2015' on 28 May
Attended Mental Health Act Committee meeting on 29 May
Visited Derby CAB and Law Centre on 8 June
Attended the Quality Committee meeting on 11 June
Attended Council of Governors meeting on 16 June
Attended a Quality Visit at CAMHS City on 17 June
Attended the Southern Derbyshire CCG Leadership Group on 18 June
Attended the North Derbyshire MH Carers Forum Open Day on the 23 June.

I was on leave from 1 to 5 June.

1. I also held documented one-to-ones with 6 Governors based around our new, more formal approach. The Council of Governors received an initial paper summarising points made. We are at an early stage in this exercise but it's reasonably clear that one theme is how better to support governors in representing our members. There is a strong desire among many public governors to have more contact with members in their area through a variety of means. This is part of their statutory purpose.

2. The Trust was represented at the Social Care Exhibition and recruited some members.

3. The Council of Governors meeting heard presentations on mental health in schools from a teacher and the future of dementia care. It agreed new arrangements for governor expenses. It also discussed and agreed how it would perform its functions in scrutinising the Board's handling of employment tribunals and the learning from them. We welcomed one of our new governors, Annaf Katoon.

4. The First Steps AGM heard some marvellous stories of the support offered by the charity to those who have had eating disorders. The Trust is in partnership with the charity and discussions have taken place on extending the service. I heard the charity's perspective on these opportunities and have pursued these points.

5. I pursued how better to secure the executive ownership of recording the work of the Mental Health Act Committee after the meeting

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

Equality Delivery System
There are no specific impacts on REGARDS groups arising directly from this report. The Social Care Exhibition showcased a variety of services of value to REGARDS groups and I was glad to see some Trust representation.

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

Recommendation

The Board of Directors are requested:
1) To note the paper and challenge me on any item.

Report Prepared by: **Mark Todd**
Chairman

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 24th June 2015

Chief Executive's Report

1. Introduction

This is my regular monthly report to the Derbyshire Healthcare NHS Foundation Trust Board of Directors. It provides a context to the issues the Board will be considering at the meeting, a brief résumé of what we have been working on in the month, and a guide to the agenda and papers. It is written as a communication aide for those reading our papers online or attending the meeting in person.

2. Context, strategy (vision and execution) and updates from the month

National Context

2.1 The government remains committed to delivering seven day services across the whole of the NHS. The detail of this ambition has yet to be worked through, in terms of the clinical delivery models nor the resources to finance the improvements expected.

2.2 Monitor has increased its focus on all Foundation Trusts announcing that two day site visits will be held with all Trusts in deficit, which includes Derby Royal Hospital.

2.3 Monitor and the NHS Trust Development Authority published the provider performance reports, showing a net provider sector deficit of £822 million for 2014/15.

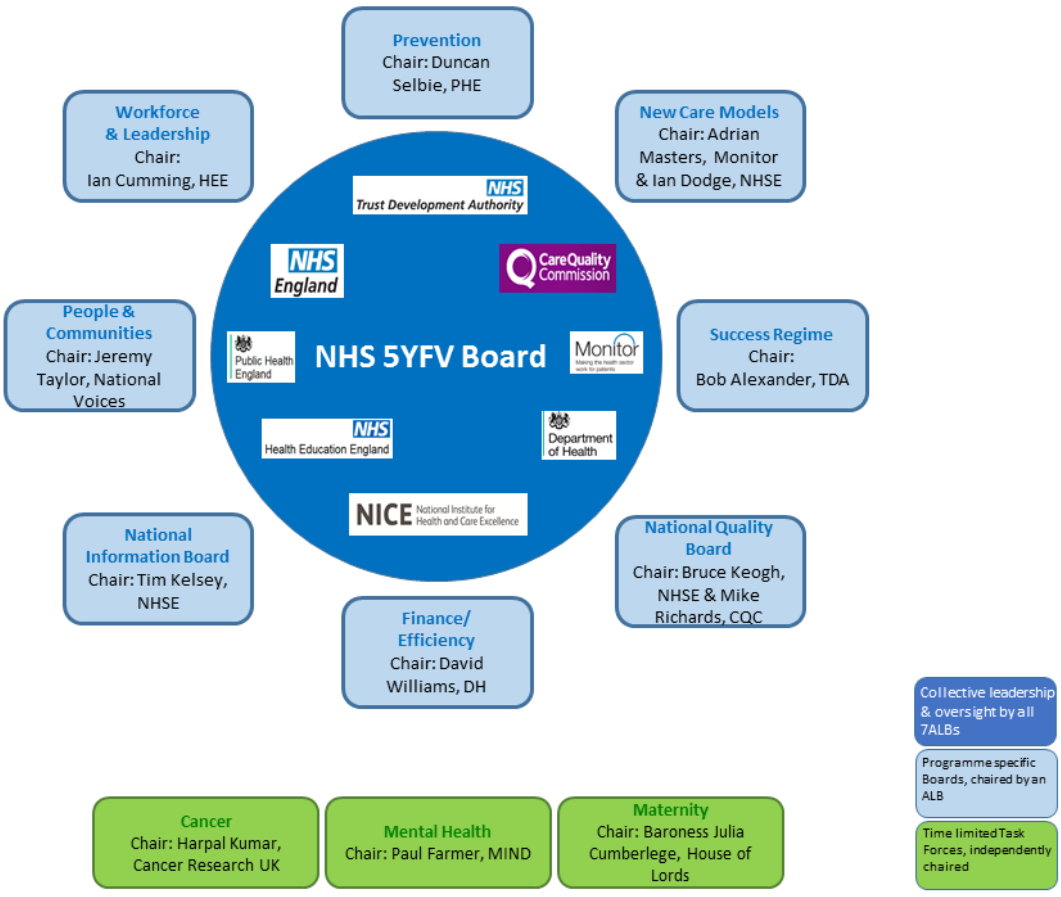
2.4 The Queen's speech set out the aspiration for delivering the Five Year Forward View:

> *"In England, my Government will secure the future of the NHS by implementing NHS's own Five Year Forward View, by increasing the health budget, integrating health care and social care and ensuring the NHS works on a seven day basis. Measures will be taken to increase access to General Practitioners and to Mental Health care."*

2.5 A new approach to struggling systems was announced called the 'Success Regime'. This new approach will:

- Work across whole health and care economies as opposed to just individual organisations.
- Be overseen jointly by NHS England, Monitor and the NHS Trust Development Authority at both a national and regional level, so that the efforts of the various statutory bodies and regulators are aligned.
- Provide the necessary support and challenge to health and care economies by diagnosing the problems, identifying the changes required and implementing them.
- Strengthen local leadership capacity and capability, with a particular focus on radical change and developing collaborative system leadership.

2.6 A new national Board has been established to oversee and drive forward the ambitions in the Five Year Forward View and the new system improvements, set out below:



2.7 The CQC has published its report on the experience of people receiving help, care and support during a mental health crisis. The report, can be found here - http://www.cqc.org.uk/sites/default/files/20150611_righthere_mhcrisiscare_full.pdf provides an overview of national progress and areas for further improvement. CQC identified that:

- significant variation exists in the quality, availability and accessibility of crisis care;
- a person's experience of care varies significantly depending on local area and the part of the system they come into contact with;
- accessibility and quality of services available after 5pm is poor and needs improved commissioning;
- liaison psychiatry services in acute settings - while rapidly improving – offer "unreliable quality or outcome";
- service users' experiences of compassion and care were significantly lower when given in A&E services and mental health specialist providers, compared with ambulance, police and voluntary services;
- providers should ensure the role and function of crisis resolution home treatment teams is well defined and can meet core functions, with skills to support people at specific risk of suicide;
- service users need greater involvement in community mental health care planning;
- there are local areas that are using the momentum generated by sign-up to local Crisis Care Concordat arrangements to drive innovation and more joined-up delivery resulting in improved services and personal experiences of care, with better outcomes;
- providers should work with local partners to develop improved data quality that can both better inform understanding of local services requirements, but also build a national evidence base.

2.8 Monitor and the NHS Trust Development Authority (TDA) will become more aligned under the leadership of one chief executive.

2.9 The Department of Health has published an interim report (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/434202/carter-interim-report.pdf) outlining the work that has been carried out by Lord Carter of Coles to review the productivity of NHS hospitals, working with a group of 22 NHS providers. The report providers interim recommendations and next steps, with a full report expected in the autumn.

Local Context

2.10 Services continue to experience high demand, but the requirement to meet twice weekly to manage staffing shortfalls and to ensure that services are maintained at safe levels has reduced.

2.11 The Spotlight on Leadership event was held in the Trust on 3rd June with over 140 leaders from across the Trust meeting together to discuss the current leadership challenges and opportunities we face including – quality of care, financial austerity and the culture of the organisation including the feedback from the staff survey and the cultural health check.

2.12 On 12th June service receivers, colleagues from the Trust and I attended the national BME Network Annual Conference where we presented the work undertaken in Derby City Reverse (Values Based) Commissioning. The conference also explored issues in the NHS including racism, leadership and the under representation of senior roles in Trusts and on NHS Boards filled by colleagues from BME backgrounds.

3. Key issues before the Board today

I ask that our Board challenge each other on all aspects relating to the issues before it today in order to gain necessary assurance on items pertaining to our Trust and improvements underway (particularly our response to the staff health check), safety (health and safety), effectiveness (managing demand and revalidation of doctors), and responsiveness and management of the Trusts key risks (through the BAF).

I also ask that our Board robustly challenge and assure themselves of the Trusts financial performance and the management actions being taken to mitigate the position.

Legal Issues

There are no legal issues arising from this Board report at this time.

Equality Delivery System

None specifically.

Consultation

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

Recommendation

The Board of Directors are requested:

1) To note and discuss the paper and challenge me on any item.
2) To approve the refreshed Strategy (at Appendix D2),
3) To discuss and note the communication from the South Derbyshire Unit of Planning (at Appendices D3-D7).

Report Prepared by: **Steve Trenchard**
Chief Executive

Derbyshire Healthcare NHS
NHS Foundation Trust

Enc D

Improving lives, Strengthening communities, Shaping a better future together

Our refreshed strategy for 2015 - 2016

Better together

Contents

Foreword from the Chair and Chief Executive

Professor Steve Trenchard
Chief Executive

Mark Todd
Chairman

Thousands of people across Derbyshire rely on our children's, mental health, learning disability and substance misuse services every day. As a Trust we provide care across the whole life spectrum; from our perinatal beds and support within the community, through to dementia care and support in our services for older people.

As Trust we have one vital purpose - to consistently provide excellent, personalised health care to each and every individual who uses our services. In so doing we aim to become known as a leading provider of safe, high quality health and wellbeing services. We want people to experience care that is always positive and based on compassionate relationships that support individuals and families to meet health and wellbeing needs.

The Health and Social Care Act 2012 heralded the way for NHS services in England to develop a more competitive market approach to the supply of health care services. This process began with the development of internal markets in the 1990s and was extended with the introduction of patient choice, foundation trusts, payment by results and similar initiatives over subsequent decades. The result of this move has been that NHS provider organisations were required to change their approach to strategic planning, from one of complying with and implementing central directives, to one of responding to and anticipating market developments.

In any market there is, and always will be uncertainty, which makes strategic planning a far more difficult process; but market variations do not, in any way, diminish the need for an organisation to have a clear direction. In fact, in many ways, the uncertainties of the market increases the need for clarity of purpose, a focus for future thinking and a methodology of approach to every change, opportunity and threat that the local health and care economy may produce.

Our current strategy, 'Improving lives, strengthening communities, getting better together' was adopted in April 2013, and was set against the backdrop of the day, focusing on quality of service delivery. Given the changing environment and today's agenda of integrated services and collaborative partnerships, we have refreshed this strategy for its final year. Titled 'Improving lives, strengthening communities, shaping a better future together', this update provides a reflection on current key issues, whilst continuing the vision outlined in our 2013-16 strategy.

We are already working in partnership with others, and beginning to develop integrated services, and plan to focus more on this area in the forthcoming year. Our ambition is to become acknowledged leaders, building on our achievements to date and developing our thinking from our growing experience.

In this strategy we restate our intention that all our services will be delivered by compassionate and caring, well-trained, motivated and engaged staff working in highly performing teams. Our staff will be committed to excellence in all they do and to providing patient centred care of the highest quality. They will be proud to work for our Trust and will understand their contribution to the delivery of safe, caring, well led, responsive and effective care. We will recruit, develop and retain staff of the highest calibre to meet the needs of our local communities.

Introduction

Our three year strategy ‘Improving lives, strengthening communities, getting better together’ comes to an end in April 2016.

Since this document was produced, there have been a number of significant changes within our local and national environment. For example, there are a number of key strategy documents that have been released by NHS England, there are marked developments in the way the Trust is working with partners across the local healthcare economy, and inwardly the Trust has made significant steps towards transforming our services and developing a new, neighbourhood based approach to service delivery.

We continue to face uncertainty and changes in the external environment in which we operate, including a changing commissioning landscape, move to Conservative government, and potential procurement opportunities that could change the nature of our service provision,

Given this level of change it may be pertinent to ask how it is possible to plan with any certainty into the future. However, a clear strategic direction is vital for the organisation, to guide our decision making as we continue to move forward within this complex environment.

As an organisation we need our refreshed strategy to:

- Enable us to focus and have a clear direction
- Provide a framework within which we can both “be ahead of the curve” and react to events
- Give the people in our organisation a framework within which to work and clear objectives around which our divisions and service lines can plan
- Provide stakeholders, service users, carers, governors and the public with a clear understanding of what our organisation’s ambition and focus is and where it is heading in the future.

There are some things which we can predict with a high level of certainty. For example, we know that public finances are likely to be stretched for some time to come, we know that demand is rising and we know that there is a direction of travel from all commissioners towards primary care, out of hospital services and towards the integration of mental and physical health and social care pathways.

There are also some things which we can always be in control of; for example our organisational culture, our approach to people using our services, ensuring financial efficiency and good governance.

Our revised strategy needs to be broad enough to cope with changing events, but detailed enough to provide overall direction and to aid planning and decision making. It needs to contain strategic principles and objectives which can be shared with, understood and owned by everyone across the organisation.

The current competitive market in health and social care means that we are often not in control of events and, in particular, of procurement timetables or decisions. A clear strategy, and ways of working, will therefore enable us to proactively identify opportunities within our service portfolio.

Establishing good relationships with our partners and collaborating with others who have a similar vision and commitment to ourselves, will provide a consistent and proactive approach, rather than being reactive to market forces and commissioner intentions. Whilst doing this, it is also vital to maintain and further develop our reputation for delivering high quality, innovative care

centred around families and their neighbourhoods, to affirm the quality outcomes of the approach we take.

The context, within which we operate, and the expectations for health and social care moving forward have changed significantly since our previous strategy, and this refreshed plan sets out our ambition to remain at the foreground of excellent care delivery.

Our refreshed strategy sets out our plans for 2015-2016 and has at its heart the people who use our services, their families and carers. People have told us that they want us to view them as whole people with strengths, ambitions and goals to have a life worth living beyond their illness, and to remember their physical and mental health needs are combined. People want safe, health and wellbeing and where appropriate recovery focused services that support inclusion in the communities of their choice.

Above all, people want to be at the centre of decisions made about their lives. They want to be fully and actively involved in their care and to have positive experiences of the care they receive. They also want the organisations that support them to work closely together, so that pathways of care feel seamless and easy to follow.

Our strategy sets out our commitment to providing excellent quality services – with people at the centre of them. We are doing this against a backdrop of an increasing and changing population, including a growing number of older people across the county, an expanding child and youth population in Derby city and southern Derbyshire and greater ethnic diversity in the city. There are ongoing financial challenges locally in Derbyshire and nationally in the NHS. We aim to be responsive and flexible to these changing needs and to work closely and in partnership with commissioners and other health and care provider organisations to provide the best joined up care.

Our communities

There are a number of significant changes affecting the population of Derby and Derbyshire, as the area becomes increasingly vibrant and diverse.

We know our community profile is constantly changing, with new and growing communities representing people from Eastern Europe, Poland, Bosnia, Africa, Kosovo, Iraq, Turkey and the Roma community.

As an organisation we embrace and support the richness of our cultural heritage. However, this growing cultural diversity places different requirements on our services to ensure we are offering equal access to and experience of our services. Over the duration of this strategy we will make service adjustments to meet the needs of our population. This will also include adapting our service offers to meet the religious and spiritual needs of our communities.

Of specific note:

In Derbyshire…	In Derby…
• Dementia rates in are higher than average • We have more adults with learning difficulties • There is a higher diagnosis of adults suffering from depression • 19.2% of year 6 children are classified as obese • We have alcohol specific hospital stays among under 18s • Breast feeding initiation and smoking in pregnancy rates are worse than the England average. • There is a high level of adult obesity • 24,000 children live in poverty • There is a large and active Deaf community • There is a growing mortality gap between the general population and those with mental health problems • There is a growth in new migrant communities.	• There is an ever increasing population • Almost ¼ of the communities in Derby are non-white British • 13.9% of the total population was born outside of the United Kingdom • Derby has the second largest Deaf community outside of London • There are higher rates of self harm • It is estimated that there are over 180 nationalities represented in Derby and around 71 languages spoken.

Our Trust during 2014/15

Number of staff

2,356

99,746 service users seen

Income circa

£131m

311 beds

Population of almost

1 million

Values

Our vision, values and strategic outcomes

Our vision is aspirational, yet realistic, and is based on a thorough understanding of our strengths and weaknesses as an organisation.

Our vision as an organisation is:
To improve the health and wellbeing of all the communities we serve.

This vision is supported by our strategic outcomes, which outline the experience we want our patients and their families to have. These are that:

- People receive the best quality care
- People receive care that is joined up and easy to access
- The public have confidence in our healthcare and developments
- Care is delivered by empowered and compassionate teams.

Our aim:
We aim for the Trust to become the provider of choice within Derbyshire and beyond, for the delivery of high quality services that improve the health and wellbeing of the people we serve.

The Trust's vision is underpinned by four key values, which were developed in partnership with our patients, carers, staff and wider partners. They are:

- We put our patients at the centre of everything we do
- We focus on our people
- We involve our people in making decisions
- We deliver excellence.

Our services

The local health and care environment for our services will continue to be challenging as a result of ongoing financial austerity, the high expectations to perform against new regulatory standards and a desire by commissioners to develop integrated care pathways and innovative models of care.

In all of our services we will ensure that physical and mental health is given equal priority. We will work tirelessly to address the prejudice and stigma associated with the services we provide by joining with local and national campaigns to portray positive and optimistic stories of wellbeing, recovery and social inclusion of our individual and families.

Over the past few years the NHS has changed shape, with competition becoming increasingly prevalent in our environment. We have experienced this in the areas of substance misuse, alcohol services and children's services and the uncertainty arising from this will continue. We therefore need to ensure that our services are the services that our patients want to use and our commissioners want to buy.

We have been a successful Foundation Trust since 2011 and during this time have maintained a healthy financial position and retained a very positive rating of green for our quality.

Our core values provide the foundation from which we continue to build on our strong track record of delivering the following services:

Hospital and community based mental health and wellbeing services

We are the largest provider of all age mental health services across Derbyshire. We will continue to improve and grow these services, ensuring that the pathways provided to patients are easily accessible, have minimum transitions and are close to home. If we grow our services in this area and offer more of the clinical pathway to our patients, we believe there becomes more opportunity for transformation and innovation, to deliver high quality services to meet the needs of current and future patients.

Community learning disabilities services

We provide multidisciplinary community learning disability teams serving Derby City and Southern Derbyshire alongside 24 hour non bed-based assessment and treatment services, also serving Derby City and South Derbyshire, working with clients in their own homes. We are responding to the recommendations of the Winterbourne Review to support people with a learning disability to lead, design and receive care and support 'in a place I call home', and to access mainstream services. We also work closely with GPs and other health and social service providers through our health facilitation programme.

Substance misuse services

Our county services are delivered with independent sector partners, providing high and low intensity drug treatment services. In the city of Derby we deliver an integrated high and low intensity drug and alcohol service. Clinical leadership is offered throughout our service provision for those people with a dual diagnosis. We also support our colleagues in the local acute hospitals by providing specialist alcohol and drug services as part of the acute hospital liaison team in both Derby and Chesterfield.

Services for children and young people

Through our collaborative partnership work with colleagues across the local health economy, we have agreed with commissioners in the city and South Derbyshire to be the lead provider of services to children and their families. We will actively promote an approach that supports early detection and early intervention across all health conditions and all age groups.

Many people who come into contact with our universal and child services have early identifiable health needs. Helping our children and families in the early years to achieve and thrive is now part of our core business and the continued integration of our children's care offer in health, wellbeing and psychological mindfulness is one of the unique capabilities in our Trust.

In our mental health services we often see individuals as a result of distressing or traumatic life experiences in their childhood. Approximately 75% of people coming to adult mental health services are known to services by the age of 18 years, with 40% of this group being known by 14 years.

We believe that having these services in our portfolio strengthens our ability to build healthier communities for Derbyshire in the future and to support children and their families at an early stage and reduce the future need for acute care and adult mental health services through effective early work.

By adopting a public health model with young people and their families at an early stage we aim to tackle the known contributors to mental distress and mental illness that may show in later years. The Trust has well established Child and Adolescent Mental Health Services (CAMHS) in Southern Derbyshire and our priority is to ensure that young people receive local care and, when needed, have a positive transition to adult services.

For all of our core services we will look for continual quality improvement and opportunities to increase our market share of these services. Following this strategy refresh, we will be developing an ambitious commercial development strategy in response to the Dalton Review for Providers of NHS Care, being proactive in seeking new opportunities for healthcare development and growth in areas that complement our core service portfolio. We will continue to defend, develop and invest in our core services.

The national and local picture for our refreshed strategy

The Government's mental health strategy, 'No health without mental health', published in 2011, made a commitment to 'parity of esteem between mental and physical health services'. It outlines a clear objective to improve the physical health of those with mental health conditions, as well to ensure that those with physical health problems have access to the right psychological care.

The strategy is still current and sets out six objectives:

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a positive experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination.

'Closing the gap: Priorities for essential change in mental health' was published by the Department of Health in February 2014, and focused upon increasing access to mental health services, the integration of physical and mental health care at every level, the promotion of mental wellbeing and improving quality of life for people with mental health problems.

The NHS Mandate now recognises that there is a strong association between mental and physical ill health. People who have a long term physical health condition are more than twice as likely to have a mental health problem as the general population and are more likely to die early. Similarly, the physical health of people with mental health problems is significantly worse than the general population. We also know that even though mental health related conditions cause 23% of the national burden of illness, they receive only 11% of the allocated resource, and this allocation of resource is reflected differently locally.

Local commissioner responses to national strategy have tended to focus upon IAPT (Improving Access to Psychological Therapies) services and the integration agenda. Across the two Health and Wellbeing Boards (Derby City and Derby County Councils) there is general agreement, in line with what has become known as the 'Derbyshire health and care wedge', that:

- Children and families should get the best start in life
- People should enjoy good health and wellbeing
- People have aspirations and achieve their ambitions through education, training and lifelong-learning
- People in Derbyshire live in safe and sustainable communities and are protected from harm
- Sustainable economic growth for all our communities and businesses
- People can live independently and exercise control over their lives
- The resource and activity supporting acute care needs to focus equally on prevention, early detection and keeping people in their communities avoiding hospital admission wherever possible.

Specifically with regard to mental health services, the four Derbyshire CCGs (Clinical Commissioning Groups) are committed to:

- A reduction in the number of people in residential care, spend on registered care, and also on supporting more people to live in their own homes

- A greater emphasis on community based care to avoid the use of institutional care
- A drive towards more personalised recovery focused services, where people have greater choice and control over the support they receive
- Engagement of service users in the co-design of services
- Improved support for carers, alongside a new statutory duty to provide more support to carers, as a result of the Care Act
- To address financial hardship and unemployment as contributors to ill health and early death in people with mental health issues
- Address health choices made by people with mental health problems, especially smoking
- Support strong parenting as key to a child's future mental wellbeing throughout its life
- Better support and management for people with dementia, their families and carers.

The strategic direction set out by the four CCGs which account for 90% of our income, share an overall approach of providing more care closer to people in their homes and, as far as possible in an integrated and joined up approach with other providers. All four CCGs are working in the context of considerable financial challenges, with particular pressure in Derby City caused by the financial performance of Derby Hospitals NHS Foundation Trust.

Changes across the local health care economy

In Derbyshire two strategic systems leadership groups have evolved to address the system level financial pressures facing the health and care system as a whole. As a Trust we span both these groups. In the north, the 21st Century (21c) Board comprises North Derbyshire and Hardwick CCGs (plus local authority and providers) and in the south the System Transformation and Reconfiguration (STaR) Board has Southern Derbyshire and Erewash CCGs (plus local authority and providers).

All four CCGs have committed themselves to maintaining sustainable mental health services and to prioritising the physical health of people with mental health needs, and all four of our CCGs see integration as a key driver in their planning. They are fully supportive of the approach taken by the Trust to develop neighbourhood and geographical focused services.

There are therefore a range of threats and opportunities identified within commissioners' plans which may develop over the course of the next five years. At the present time these include:

- The move to cost and volume for mental health care clusters 1-8
- Implementation of the patient choice agenda in mental health services, and the future sustainability of IAPT services in the Any Qualified Provider competitive environment
- CCGs looking toward integration of mental and physical healthcare
- Competitive tendering of services that sit within the Trust's core business (e.g. substance misuse services, children's and CAMHS)
- Opportunities to win new business from tenders
- Our new strategy takes account of this new context and our commissioners' plans, and puts us in a position to thrive within the new health and social care landscape.

In addition to the programmes established by the north and south of the county, and in response to the 'Five Year Forward View', we will also be working with Erewash Clinical Commissioning Group (CCG), after NHS England chose the Erewash area to be a vanguard site for integrated health services.

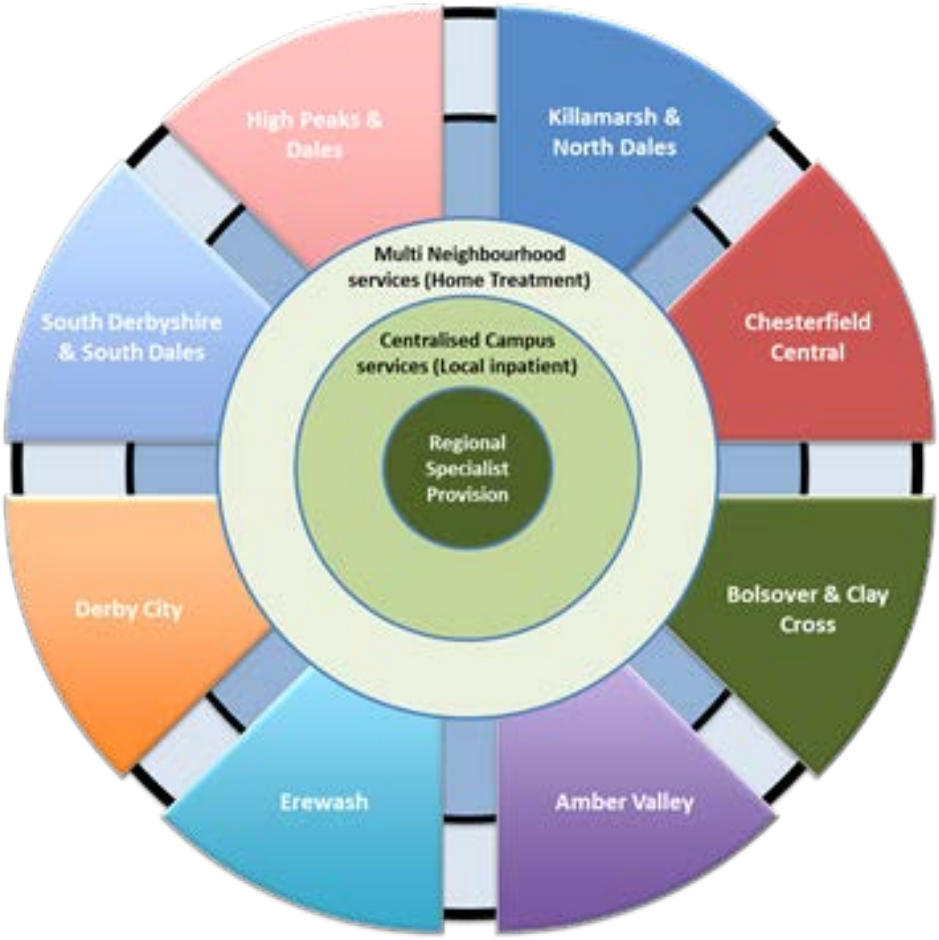
Erewash was one of 29 sites across the country selected by NHS England to receive additional support as part of its national New Care Models programme. The aim is to develop an Erewash prevention team made up of health and care professionals including GPs, advanced nurse practitioners, mental health nurses, extended care support and therapy support. It will deliver services to people who do not require hospital services and can be treated for their conditions in a community setting.

Shaping a better future

Following continued engagement with all stakeholders, the Trust has recently developed a neighbourhood and campus model of care which will transform our community and inpatient services in coming years.

The neighbourhood model has been developed to reflect the need to ensure that care is in line with the national definition of integrated care: *"I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me."*

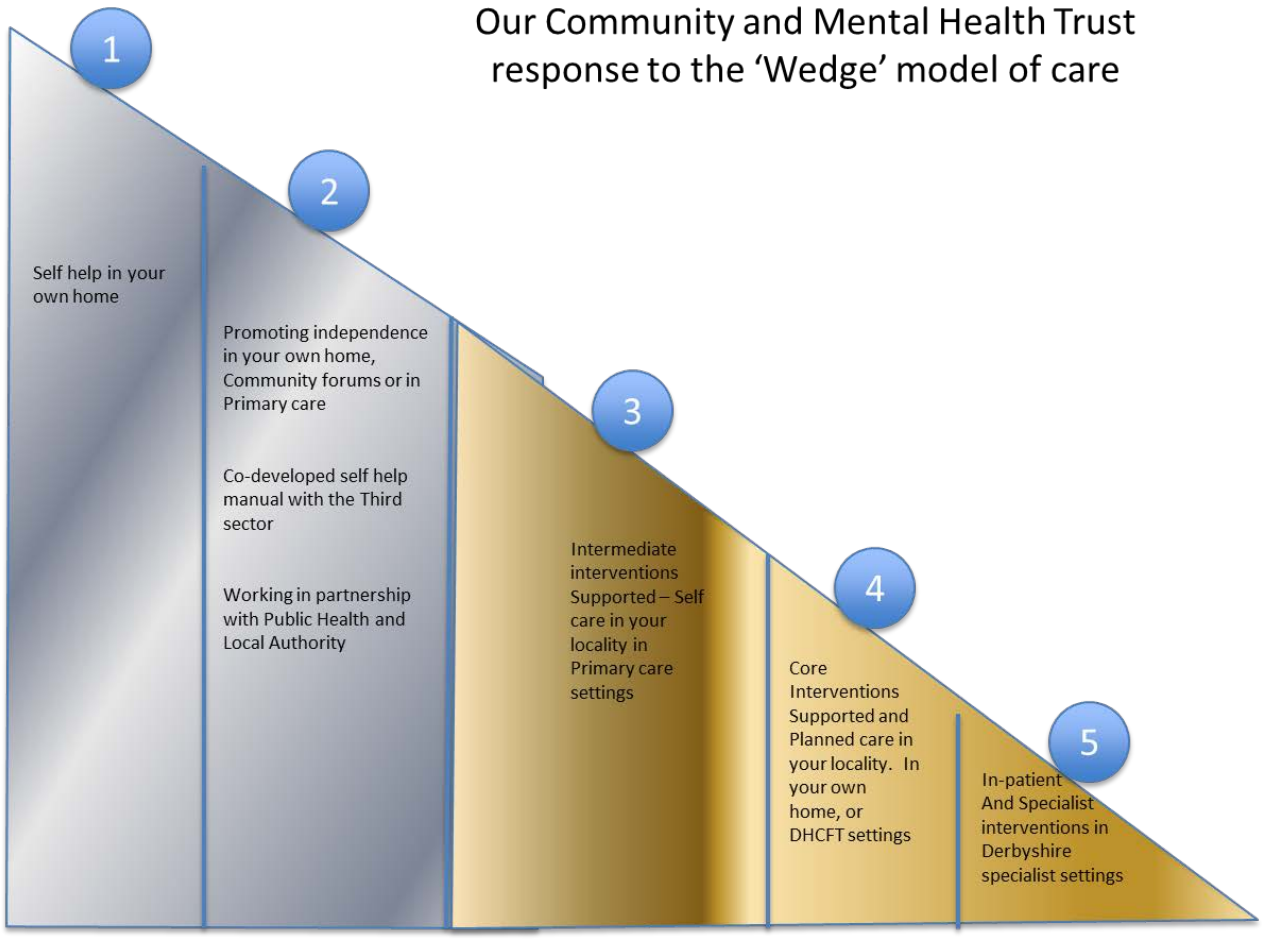
By delivering care within and around identified geographical communities we believe we have a better chance of improving lives, strengthening communities working in partnership with others, and building resilience and sustainability across all age groups. We will ensure that the new community and campus models of care reflect the on-going needs of our local communities and the best evidence available to ensure they remain recovery focused and promote hope, personal control, choice and opportunities for living a meaningful life.



Neighbourhood and campus model of care

Working with our partners and through our involvement in the wider county's transformation plans, we have identified a series of neighbourhoods through which our services can be structured. This will increase our teams' integration with local communities, building social capital and resilience to help people remain living independently within their own homes. This is in line with what our patients and carers tell us they want – people only want to be in hospital when it is clinically necessary and to live independently, with support, when it is safe to do so.

This focus on increasing the level of support we offer to people within the community will, in turn, reduce our reliance on offering care through inpatient beds. This is a traditional model of care which we know does not offer the best patient experience or integration into the communities of choice for those recovering their mental health and wellbeing. Over time we intend to move our provision of care away from hospital and into the community, supporting people within their homes and their neighbourhoods. This is in line with the wider vision of the local Derbyshire health economy, and the views of our patients, carers and wider stakeholder groups.



The 'Derbyshire Health and Care Wedge' model outlined above, shows the movement from supporting a high number of people in the community, with the number of people receiving higher interventions of care decreasing, as the wedge moves down to inpatient and specialist services.

How we manage our finances

Since 2011 we have consistently achieved our statutory requirements for Monitor, which demonstrates our financial viability. Each year we continue to invest in our capital funds which allow us to improve our estates and facilities as well as being able to support the introduction of new technology in our clinical services.

We work in partnership with our commissioners and have made progress in moving towards a more cost sensitive commissioning approach, such as required through the National Tariff Payment System (NTPS). NTPS may introduce a different way in which we will be funded by our commissioners in the future, with more focus on defined outcome measures.

Having now implemented financial systems such as service line reporting, we have a much better understanding of the financial performance of individual business service lines which help to make us more responsive.

Over the three year horizon, the ultimate aim is to be successful in retaining all community services via joint integrated service offerings with other providers, in line with local health economy commissioning intentions. Specialist services will also be enhanced and retained, in addition to growth by providing specialist and community services in other geographical areas. As an existing provider of integrated community based secondary care we are ideally placed to work with others to improve planned and urgent care pathways.

Our ambition for people who receive our services

What will our success look like?

By achieving this vision, our services will be able to demonstrate the following:

- A compassionate approach to care and each other
- Strong leadership in every part of our services
- High standards
- Continued improvement.

None of the above can happen unless the whole system moves forward together, with a single purpose. We need to continue to develop a culture which will help us to succeed.

To deliver our strategy, we need all our 2,300 people to commit to embracing the values we are proud of for the long term. That means adopting a business ethos alongside our delivery of outstanding and compassionate care. It means shouting much louder about who we are, what we do and how good we are, drawing comparison against national benchmarks. It also means working harder to develop the business partnerships that will sustain for the long term.

It means being clear about the standards we expect from each other. It means growing in a sensible and measured way so that we are still here tomorrow and into the future, sharing our expertise and compassion on a wider scale and building a better future for our most vulnerable citizens, and the people who rely on us the most.

In order to make change happen it's vital that we have a sense of who we are, what we stand for and the right sort of culture at our Trust; a culture that will help us live up to our core purpose and achieve our strategic aims. We cannot impose a culture, but we can certainly help shape it through setting mutual expectations, standards and leading by example in everything that we do.

Success will be reflected in the safety of our services, the clinical and personal outcomes our service users achieve and the feedback we receive from them and our other stakeholders on their experiences of our care. Success will be reflected in our ability to continually improve our existing services as well as develop new services. Success will be demonstrated by maintaining financial viability as a consequence of our continual improvements.

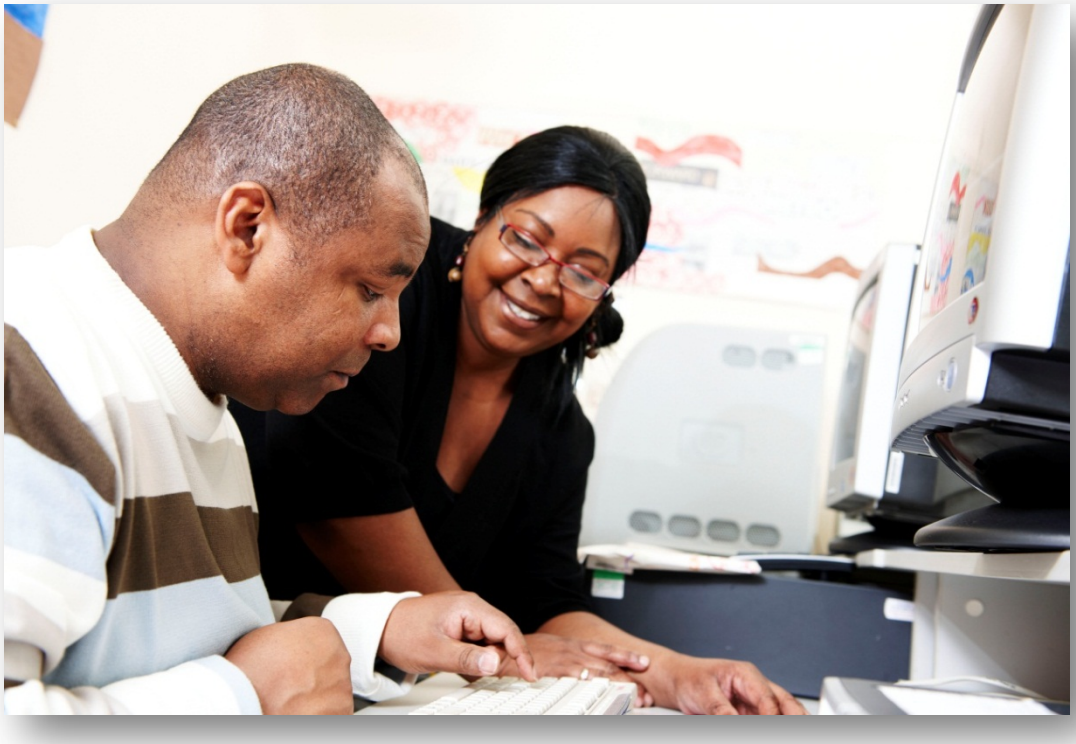
Locally we will be recognised as a flexible, responsive and influential provider and opinion leader. Our expertise will be recognised in our position as a lead provider for integrated pathways of care, and as a responsive and proactive partner. Our services will use all the resources available to them as efficiently and effectively as possible. We will deliver value for money to our commissioners whilst delivering care that results in excellent outcomes for our patients at the best value.

We will work to the principle of there being one 'Derbyshire Pound' and one set of Derbyshire citizens, for whom we provide care for in partnership with others, collaborating wherever possible.

We will be known regionally and nationally as an exemplar organisation for our highly engaged, competent workforce, contemporary leadership and people development practices and use of technology to enhance service delivery. We will continue to build on our reputation in regionally

recognised services such as eating disorder services, perinatal services, and services for women.

In our position as a leading Foundation Trust we will be known nationally and internationally for our quality of care and our contribution to research and development. We will influence national policy in areas such as NTPS (National Tariff Payment System), compassion and recovery.



This refreshed strategy has been developed by listening to the people who use our services, to their families and carers, and to our workforce, governors and commissioners. Working in partnerships we aim to achieve our vision which is:

“To improve the health and wellbeing of all the communities we serve.”

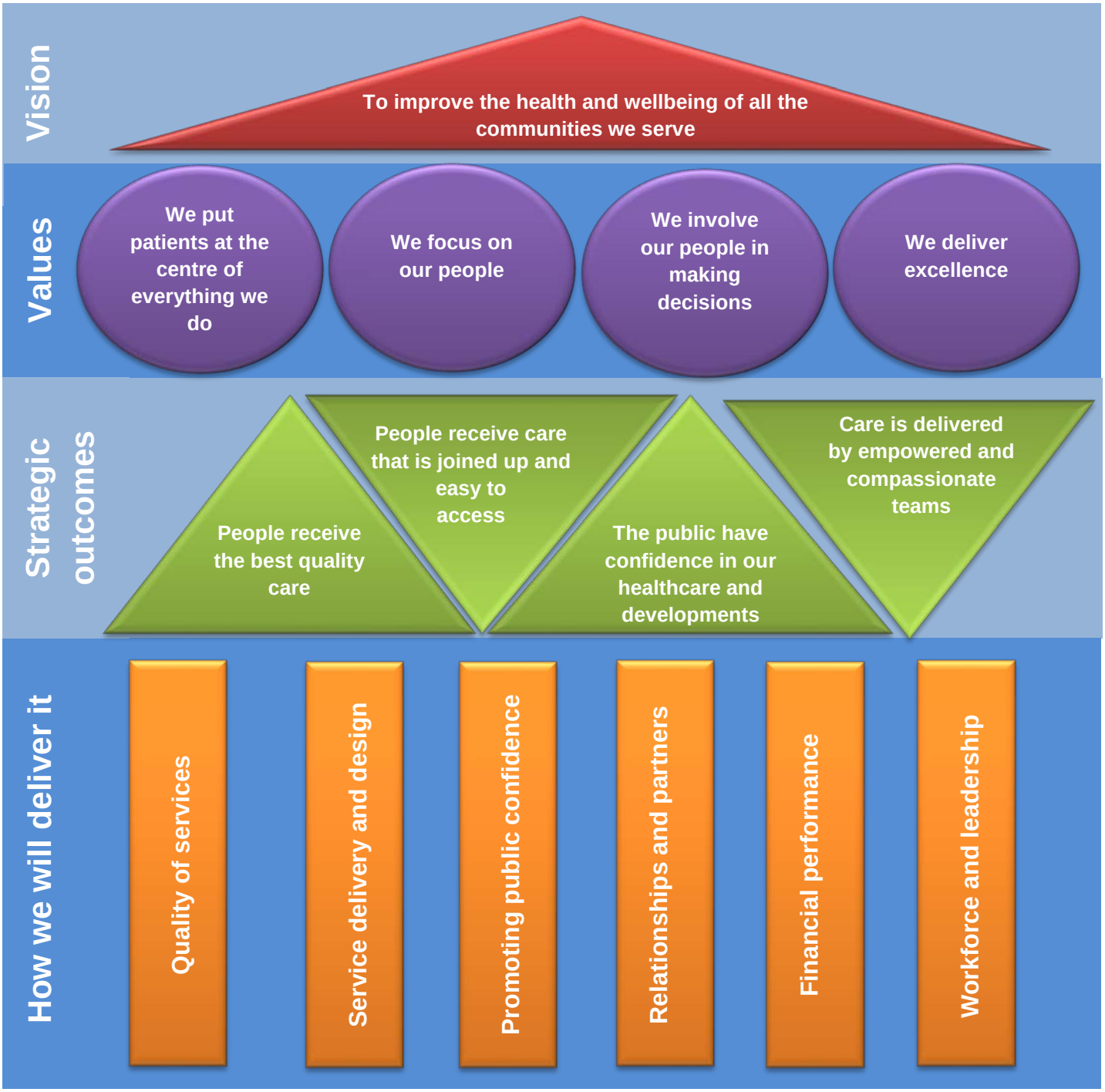
We have thought about what this will mean to the people who receive our services and have developed four strategic outcomes that are focused on the nature of care that people who use our services should experience. These strategic outcomes have guided the work of the service transformation and will continue to guide our direction of travel and the things we must do to achieve our ambitions. They will help us to improve across all service areas and differentiate Derbyshire Healthcare from other providers. As a result, the strategic outcomes are all about the people who receive our services.

Strategic objectives

Sitting below these outcomes are a set of enabling strategies or work programmes that have specific objectives and resources (people, money, time) allocated to them. We have called these our pillars of improvement and they will guide the work of senior managers and the Board of Directors.

The pillars of our strategy will enable us to deliver the Trust's vision and provide consistent care in the right way, at the right time and in the right place. Details of the Trust's annual work plan that demonstrates how we will deliver the actions related to our pillars of improvement are outlined in the appendix to this strategy on an annual basis.

The following diagram illustrates our vision, the outcomes we want to achieve and how we will deliver the detail of this strategy. It is a plan on a page of our direction over the next three years to deliver integrated services and be part of a Trust that we continue to be proud of.



Strategic outcomes

The Trust's vision is supported by our strategic outcomes, which outline the experience we want our patients and their families to have. These are that:

- People receive the best quality care
- People receive care that is joined up and easy to access
- The public have confidence in our healthcare and developments
- Care is delivered by empowered and compassionate teams.

Outcome 1: People receive the best quality care
We put our patients first, not only in the quality of services that we deliver, but in the way we assess the quality of our services. We strive to give every patient, service user and carer who comes into contact with us the safest, most effective care and the best experience possible.

We do this by ensuring that we listen and learn directly from our patients and carers. By listening to our patients and carers' experiences we can continually improve and provide care that is experienced as positive and safe. Therefore, we will continue to use a range of interventions to ensure we are systematically obtaining and acting on the feedback from our patients and carers in real time.

For many years we have had in place a robust process whereby concerns can be raised to the highest level - we call this 'whistleblowing'. We will ensure that we fulfil our 'duty of candour' which means we are open and transparent in the way the trust is managed and services are delivered. We have undertaken a review of the whistleblowing process and how it has been accessed and utilised. We are committed to implementing improvements to patient safety and to support organisational learning.

We have put in place the foundations from which to build our quality culture such as the publication of our Clinical and Quality Strategy, Integrated Quality Governance arrangements and the development of the Quality Framework. The Quality Framework articulates how we will sustain and improve the quality of care we provide from the perspective of each and every person. We are proud of the external recognition from Monitor and the Care Quality Commission for our quality systems and processes. However, we will not be complacent and will use the outcomes from external reports (such as the Francis report published on 6 February 2013) and new emerging research and evidence on what works in driving forward a responsive, listening, learning organisation which is making continual improvements.

Core to our approach to quality is setting and maintaining professional standards. In our Trust we are championing the strength of professional contributions, with each profession group expressing their own identity and professional contribution to the Trust's quality priorities.

Historically professional leadership took a homogenous approach to clinical leadership; this approach has been refined to be proud of professional difference, unique talents, embracing difference, scope of practice and strengths and readjust the professional view to a mosaic of difference contributing to the whole. The defining characteristics of all professional leadership will be our Trust values and creating a compassionate caring culture.

One of the cornerstones in striving for continual improvement and quality is our Centre for Research and Development. Research and Development will enable us to inform our practice to ensure we are providing the most innovative, contemporary research informed services to our patients. Our people, patients, families and carers will play a key role in shaping our thinking in the areas of research and development and already actively support it.

To improve the quality of services we want them to feel personalised, in line with the principles of 'no decision about me without me'. We want to develop models of individual, family and carer informed decision making and clinical and personal goal outcome-focused services to be delivered to the best evidence and highest standards.

This is what we will do to deliver this outcome:

- We will see an increasing number of patients reporting that they are involved in (and actively designing where possible) their Care Plan and that it reflects their needs, strengths and aspirations. We will measure this through the Community Survey and In-patient Survey and other national benchmarking, which provides the baseline for this indicator. We aim to see annual improvements in this goal, to continue to receive baseline scores that are above the national average.
- We will embed the Friends and Family test across all our services and look for annual improvements in our results. We will look to identify any learning through the results of this data through proactively looking for recurring issues and themes.
- We have established a Research and Development Centre and we will gradually increase our reputation for driving research into practice to enhance quality, improve patient outcomes and the experience of those who use our services. We will continue to build the research experience of this centre, and develop research bids based upon our organisational and quality priorities.
- We will support our teams to develop expertise to support the physical health of our patients, embedding the holistic person approach.
- We will continue to deliver good standards of cleanliness for hospital wards and rooms. This will be measured through the annual inpatient survey and PLACE.

Outcome 2: People receive care that is joined up and easy to access
As is the case with all NHS organisations, we are facing some significant challenges over the next few years both financially and from the changing demography of our population. Therefore, it is important that we work with other providers to support closer working and better integration of services to meet these challenges. We want to be at the forefront of influencing and setting the pace around the integration agenda. Our approach to integration is one that is wrapped around the patient and the patient pathway to support early detection, easy access and effective treatment.

Our first step on this journey is to provide clear needs led pathways of care internally, and to ensure that people who may choose to use our services have the information and mechanisms to do so. As part of the implementation of our neighbourhood and campus model we have reviewed our pathways to optimise clinical synergies between services and have identified clinical standards and outcome measures. Our aim is to ensure that all our pathways are easy to navigate and accessible locally, that they avoid duplication and unnecessary delays and provide the best patient outcomes.

The second stage of this approach will be to work proactively with our commissioners and partner organisations in Derbyshire to ensure there are clear synergies between our models of care and the emerging community support teams and community hubs. This will require us to have an increased focus on partnerships, including the private and voluntary sector, ensuring that the most appropriate evidence-based care is followed in line with NICE guidelines or recommended practices. This will also include identifying any commissioning gaps, which are based upon historical patterns rather than patient needs; we will then and share these risks proactively with our commissioners, so we can jointly plan to meet the needs of our population

The third strand to this strategic aim is information integration. We have implemented a new electronic patient record system called PARIS and we now need to make sure we can use it to its full potential to support our staff to deliver responsive care, aligned to pathways and support through agile working offers. Information will be the glue that binds the pathways both internally and externally and will allow our patients to move effectively between services. Therefore, we must develop information services that not only interface amongst our internal services but also allow information to be shared safely and securely, linking care providers.

To ensure that care is joined up and that we have streamlined clinical care pathways we will support our teams to work more efficiently through working closely with external partners to ensure flexible and responsive care is delivered as close to home as possible.

To deliver this outcome we will:

- Implement our neighbourhood and campus model
- Actively contribute to the design and implementation of community hubs and integrated community support teams. We will support the development of the Erewash Multi-Speciality Community Provider Vanguard project, ensuring all opportunities for embedding our core services in easy to access joined up care provision are adopted.
- Optimise the benefits of PARIS (electronic patient record), including developing and implementing a mobile working offer for our staff
- Lead the development of an innovative integrated service model for children, young people and their families in Southern Derbyshire.

Outcome 3: The public have confidence in our business and developments
It is everyone's responsibility within the Trust to foster public confidence in the services that we deliver. Therefore, it is important that all our people, no matter where they work, understand and are able to articulate their contribution to providing high quality care. It will be all our business to promote the excellent care and work we undertake.

We want our brand and reputation to be one of delivering safe, effective and compassionate care that is responsive to our patients' and carers' needs. We want to be recognised nationally for our work on quality, organisational development and patient experience. We want to be acknowledged regionally for being a leader of effective and innovative care pathways and locally as a provider who delivers high quality care and good patient outcomes at best value. All of this equates to a well governed, individually focused health care 'business' that people in our local communities choose to use, and will recommend to their friends and family.

Whilst we expect all of our people to be Trust ambassadors we recognise that they will need be supported to enable them to undertake this role. This is why we are strengthening the infrastructure around our communication and market-promoting capabilities. Communication is a vital component in this strategy. Engagement with our patients, staff, partners and other stakeholders is vital.

It is now more important than ever to maintain public confidence in our services. The experience of consistent good quality of our care will be the cornerstone of what we are recognised for. We will be known for compassion, patient centred, clinical effectiveness in symptom and social recovery and our highly skilled staff working better together to deliver good outcomes for Derbyshire.

We will be exploring new and innovative partnerships with the voluntary and community sectors to ensure services are accessible, not stigmatising and open and transparent. We will continue to publish information on our services and abide by the high standards and expectations for the governance of a public service.

To achieve this we will:

- Retain and improving our services for children, including core services such as child and adolescent mental health
- Rebalance our service portfolio through partnerships, transfers and mergers – within the Local Health Economy (LHE), we wish to work closely in integrated service delivery to provide joined-up care with our local NHS colleagues and also the independent sector providers
- Make productivity improvements in current services - we need to focus on improving efficiency and financial return in those services that currently perform the least well in Service Line Reporting (SLR), and the need to make more efficient use of our PFI estate and deliver our wider estate strategy.
- Utilise the models set out in the Dalton Review to grow business in a number of new markets such as integrated prison health care.
- Strengthen the infrastructure around our communication with our communities, stakeholder engagement, listening events and market-promoting capabilities

Outcome 4: Care is delivered by empowered and compassionate teams
The relationship between people working in well-led teams, who are engaged and empowered to work autonomously within clearly accountable systems and positive patient care outcomes is well known. We will continue with our approach to leadership and management development based on our Trust's values to encourage compassionate relationships, compassionate teams and a compassionate culture of care. We will continue to strengthen the organisational performance framework to strengthen service line management leading to further de-centralisation, bringing decision making closer to teams and patient care.

Over the next three years the Trust will be shaping processes that will ensure that the organisation has the right level of capacity, reduces bureaucracy, has the right people, with the right skills, values, attitudes and behaviours that are in tune with those of the Trust. We will recognise success amongst our staff and embed our new staff recognition scheme DEED (Delivering Excellence Every Day) which celebrates good practice and compassion across all staffing groups.

As a result of our creation of neighbourhoods, the structure of the organisation will be transformed in a way that enables decision making to be made closer to direct patient care. The organisation's design and culture will facilitate explicit clinical leadership that is linked into senior operational management and will be clearly involved in decision making at a service level. Clinical operational managers and clinical leaders will have the freedom to make service improvements and determine resources in line with best practice service line management.

This system of delegated authority will move teams to become more empowered and have greater authority in a model of earned autonomy. We would envisage that this would result in operational managers and clinicians becoming more empowered to lead at the point of service delivery and in executives becoming more strategic in horizon scanning, influencing the local and national agenda and rebalancing work to increasing the executive presence to be more externally facing whilst retaining the safety net function to the Trust to ensure that our services are effective and well led.

We will create leaders at every level of our organisation who are able to continually improve the quality of care provided and enhance our patients' experience by driving forward innovation, transformation and modernisation of our services. We will introduce a leadership offer aimed at preparing our leaders for the transition needed and challenges ahead.

Coaching competencies and development will form a significant facet in our leadership approach by developing a culture where coaching is the preferred leadership and management style. Fostering this preferred approach, we will be continually equipping our leaders with the skills and competencies to develop a compassionate culture.

We will achieve this through:

- Quality improvement objectives as outlined in our quality strategy , as well as addressing any service areas displaying symptoms of what we call "distress" (early warning signs of potential or actual service failure) or any actions from feedback from CQC inspections.
- Continuing with our approach to leadership and management development based on our Trust's values to encourage compassionate relationships, compassionate teams and a compassionate culture of care
- We will continue to strengthen the organisational performance framework to strengthen service line management leading to further de-centralisation, bringing decision making closer to teams and patient care following our key transformational changes.

- As a result of our creation of neighbourhoods, the structure of the organisation will be transformed in a way that enables decision making to be made closer to direct patient care so that operational managers and clinical leaders will have the freedom to make service improvements and determine resources in line with service line management best practice, and executives become more strategic in horizon scanning, influencing the local and national agenda.
- We will create leaders at every level of our organisation who are able to continually improve the quality of care provided and enhance our patients' experience by driving forward innovation, transformation and modernisation of our services. We will introduce a leadership offer aimed at preparing our leaders for the transition needed and challenges ahead.
- Coaching competencies and development will form a significant facet in our leadership approach by developing a culture where coaching is the preferred leadership and management style. Fostering this preferred approach, we will be continually equipping our leaders with the skills and competencies to develop a compassionate culture.

Assurance of our strategy

The key sources of assurance and oversight on the delivery of our strategy will be:

- The Trust's Integrated Service Delivery Programme, which will monitor and drive delivery of new care models
- The Trust's Chief Executive, who will provide regular updates on the delivery of our Trust strategy
- Our Trust Governors provide a key assurance role within the Trust and our strategy has been developed having had regard to the views of the Council of Governors
- The Programme Assurance Office, which will provide assurance that planned savings are delivered and that quality impact assessments and actions are taken
- Service line reporting, which will provide assurance on the new services' operating costs and the levels of income and therefore profitability
- Our contractual performance meetings with commissioners, to assure them that we are delivering our commissioned services as required
- The risks within our board assurance framework, which will be refreshed and monitored at Audit Committee to ensure the risks are adequately understood and managed.
- Our workforce planning, which will take into account our people requirements as well as their learning and development and any cultural and EIA (equality) impacts
- Our communication and engagement strategy, which will ensure that all stakeholders are informed of our progress and wherever possible we will express that communication in the patient or carer's voice.

Being open, honest and accountable as we go forward

This strategy document has set out our vision, values and the outcomes we hope to achieve for the people who receive our services. We have set a clear path to do this. We will report back to our communities, partners and commissioners on our progress. We have at the heart of our plans the people who receive our services, their families and carers.

We have been clear about how we will measure our progress, including the areas that need measures to be developed where they don't yet exist. We are clear that we cannot improve lives and make the communities we serve stronger by working in isolation. We are better together. We are dependent on our partners to work with us on our shared purpose of improving the health and wellbeing of residents living in Derbyshire.

We will review our strategy each year and report progress through our Annual Report and Quality Accounts as well as though updates to the Board which are available to the public.

We will adopt a regular reporting process whereby we constantly compare our various core services and healthcare support functions to the national leaders, thereby continually striving to improve our services and provide the best quality care that we can.

Working in partnership with local communities through our Council of Governors and key stakeholders we will ensure full accountability to meeting the identified needs of those we serve.

Derbyshire Healthcare NHS Foundation Trust

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Joined Up Care – The South Derbyshire Vision

We are working together to improve health and care services for people in the city of Derby and county of Derbyshire. We are committed to working together to develop vibrant and resilient communities in which our citizens can flourish, supported by seamless health, social care and voluntary sector services.

We have summarised what we have heard local people say they want for their care and their family's care into our vision for local services:

"I can plan my care with people who work together to understand me and my carer(s), allowing me control and bringing together services to achieve the outcomes important to me".

Our vision will help us to meet the desires of local people. These desires include statements such as:

- There will be more help for me in the community where I live and this will link up with my specialist doctors at hospital.
- I will have the main responsibility for making sure I stay fit and well, but if I'm ill then services will be there to help
- If I need rehabilitation for either my physical or mental health I will feel supported and I will receive help at home if possible.
- If I am a carer I will be supported to be fully involved and I will be able to get a break if needed.
- My GP practice will be central to my care and know everything about me. I will make one call and my care will be delivered by the most appropriate person.
- The team supporting me will work together so I only tell my story once. I will know where to go and who to talk to.
- Hospitals will be there when I need specialist care.
- If I have a mental and physical illness I will only deal with one team.
- I will have access to information and a greater support network to help me manage my condition better and remain independent for as long as possible.
- My local community will be supported to help each other
- If I am over 85 I will have a personal plan to help me stay well through the winter.
- I will get an early assessment if I might have dementia
- My care will be the same whether I am ill during the day, at night or at the weekend.

Our vision is only achievable by working in partnership as organisations and with local people. We must transform local services in the face of significant demographic and financial challenge but recognise that together we are stronger and more resilient than we are when working alone.

JoinedUpCare in the South of Derbyshire

Enc D

A Derby and Derbyshire approach to all health and care service organisations working as one

All health and care service organisations in south Derbyshire want to ensure people stay healthy and independent for as long as possible. We are committed to preventing ill-health and dependency, through self-help, community resilience and a range of inclusive universal services.

When people do want to access our specific health and care services, the way in which they wish to do so is changing. People want to receive support within their own homes for as long as possible, community services to be more accessible, staying overnight in hospital only when absolutely necessary. This is true across all health conditions and for all ages.

People want their health and care to be delivered flexibly and be available during evenings and the weekend.

We know this because the people of Derby City and Derbyshire have shared this with us. Our challenge is to make this happen, to meet the changing health and care needs and to provide more opportunities to help people take more control of their own care.

We have been working together to address the challenges we all face. We are confident that the best way to improve and develop services across Derby City and Derbyshire is to do it together, in a consistent and joined up way.

This approach is shared by us all, and reflects our commitment to work together to meet the needs and expectations of people living in Derby City and Derbyshire.

To do this, we are committed to:

- working with patients, carers, young people and families to enable them to take more control of their own health and care needs.
- working as one big team, across organisations and within communities, to achieve the best outcomes for the people of Derby City and Derbyshire. We will establish a set of shared values, and work together in a consistent and collaborative way.
- people telling their story once. Where possible and appropriate, we will share information and knowledge between us, reduce transfers between services, enhancing people's experience of our services.
- providing care at or close to home where possible. We will work together in an innovative way to develop new models of care, that best meet the needs of the people of Derby City and Derbyshire.
- delivering accessible local services which are of high quality and are able to demonstrate they provide taxpayers with value for money.

This is how we will improve health and care services for people in Derby City and Derbyshire. We are committed to working together to develop healthy, independent and resilient communities in which people can flourish.

Derby City Council

DERBYSHIRE County Council
Improving life for local people

NHS

What will this mean for me in 2020?

Our Vision:

"I can plan my care with people who work together to understand me and my carer(s), allowing me control and bringing together services to achieve the outcomes important to me".

There will be more help for me in the community where I live and this will link up with my specialist doctor at hospital

The team supporting me will work together so I only tell my story once. I will know where to go and who to talk to

I will know where to go and who to talk to. Services will be joined up and I will feel all professionals are working together to make it easier for me

If I need rehabilitation for either my physical or mental health I will feel supported and I will receive help at home if possible

If I am a carer I will be supported to be fully involved and I will be able to get a break if needed

My care will be the same whether I am ill during the day, at night or at the weekend

If I have a mental and physical illness I will still deal with the one team.

My GP practice will be central to my care and know everything about me. I will make one call and my care will be delivered by the most appropriate person

If I am over 85 I will have a personal plan to help me stay well through winter

Hospitals will be there when I need specialist care

I will have access to information and a greater support network to help me manage my condition better - I will remain independent for as long as possible

My local community will be supported to help each other

I will get an early assessment if I might have dementia

Joined Up Care - South Derbyshire

Working in partnership, all NHS and care organisations in the South Derbyshire Unit of Planning – the area covered by Southern Derbyshire and Erewash CCGs – are planning changes to the way in which local services are provided to make them fit for the future.

The overall vision is to ensure patients can plan their care with health, social care and other services which work together to understand their needs and the needs of their carer and achieve the outcomes important to them.

This evolution towards our vision of Joined Up Care is only achievable through organisations working in partnership with each other and with local people. We must transform local services in the face of significant demographic and financial challenge but recognise that together we are stronger and more resilient than we are when working alone.

Background

The UK is regarded as having one of the most envied welfare systems in the world, where the whole population funds health and social care for everyone, with support from voluntary and other sectors in delivering services. But the current system of services is under strain due to a number of factors, including:

- An increasingly elderly population - people are living longer and have more complex health and care needs
- The changing needs and desires of the population - demand for quick access for increasing complex care and for care 'close to home'
- Skills shortages and recruitment challenges among some staff groups
- Services being provided from some buildings which are old and undesirable for the provision of modern day health and care
- An unprecedented financial challenge

So the health and care community in south Derbyshire will look to change the way services are delivered and work together in the future, meaning people have better access to services when they need them, have a better experience of the service when it is being used and have a better outcome from the care they receive.

The challenge is simple: if things stay as they are, access to quality services will continue to become more difficult, the quality of services could suffer and by 2019 there will be £150million deficit per year between the cost of local health services and the money available. This figure does not include deficits in funding for social care and the voluntary sector. It is both an important and exciting time for local health and care services to rise to the challenge.

What will change?

Our strategy already shows that we need to move more care from specialist, hospital-based services to a model where more care is provided in the community and patients are empowered to take greater care of themselves. Our Joined Up

Care approach will support this evolution and over the last few months has identified four transformation areas where local services feel changes must be made to meet the challenge:

- Redesigning community services to support more people outside of hospital
- Transforming general practice to ensure it can manage growing demand
- Improving care and support for people - and their families and carers – at the end of their life
- Ensure services work better together to make sure people only spend time in hospital when that is necessary and that people can more easily move between services without duplication

To ensure progress is made in making these changes, health and care professionals have formed 'delivery groups' dedicated to making the outcomes of each priority area happen. Chaired and sponsored by a local clinician and Chief Officer/Executive, the groups are in the process of forming their work plans for the coming year and it is expected that these will be in place shortly. The delivery groups are:

Delivery Group	**Delivery Group Board Sponsor**	**Delivery Group Clinical Chair**
Urgent Care	Andy Layzell, Chief Officer, Southern Derbyshire CCG	Dr Paul Wood, GP Locality Lead, SDCCG
Elective Care	Sue James, Chief Executive, Derby Hospitals Teaching Foundation Trust	Arthur Stephen, Consultant Orthopaedic Surgeon/Divisional Medical Director, Derby Teaching Hospitals Foundation Trust
Community Support (Southern Derbyshire)	Tracy Allen, Chief Executive, Derbyshire Community Health Services Foundation Trust	Dr Ian Lawrence, GP Locality Lead, Southern Derbyshire CCG
Out of Hospital Care (Erewash)	Rakesh Marwaha, Chief Officer, Erewash CCG	Dr Duncan Gooch, GP, Erewash CCG
Children's Services	Steve Trenchard, Chief Executive, Derbyshire Healthcare Foundation Trust	Dr Andrew Mott, GP Locality Lead, Southern Derbyshire CCG
Mental Health	Steve Trenchard, Chief Executive, Derbyshire Healthcare Foundation Trust	Steve Trenchard, Chief Executive, Derbyshire Healthcare Foundation Trust

The Delivery Groups are in the process of outlining the work programmes for the coming year and we already know that proposals will be developed in co-creation with service users and staff and we will start this engagement work shortly.

Meanwhile, work will commence to begin to help local stakeholders understand the challenge facing local services and to outline the way in which health and care organisations are coming together to meet these challenges.

We will continue to keep you updated as the programme progresses and it will be critical to seek your involvement and support as the delivery groups get into their work programmes.

JOINED UP CARE

JoinedUpCare in the South of Derbyshire

Our Vision:

"I can plan my care with people who work together to understand me and my carer(s), allowing me control and bringing together services to achieve the outcomes important to me".

Why?

- Increased focus on quality
- Demographic changes
- National policy drivers
- Financial pressures

- Case for Change _ Access, Quality and Affordability
- Programmes of work defined

How?

The priorities

- Primary Care Transformation
- Enhance Flow
- Redesign Community Services
- Improve End of Life Care

Delivery Groups

- Urgent Care
- Elective Care
- Community Support (Southern Derbyshire CCG)
- Out of Hospital (Erewash CCG)
- Mental Health
- Children

Derbyshire Healthcare NHS
NHS Foundation Trust

Enc E

Audit Committee

Annual Report

May 2015

Better together

AUDIT COMMITTEE
Annual Report 2014/15

1. Introduction

The purpose of the report is to formally report to the Board of Directors on the work of the Audit Committee during 2014/15.

2. The Committee

The Audit Committee is responsible for ensuring the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities in support of the organisation's objectives. It achieves this by:

- Ensuring that there is an effective internal audit function providing appropriate independent assurance to the Audit Committee, Chief Executive and Board
- Reviewing the work and findings of the external auditor
- Reviewing the findings of other significant assurance functions, both internal and external to the organisation
- Reviewing the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work
- Requesting and reviewing reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control
- Reviewing the Annual Report and financial statements (as a delegated responsibility of the Board) and ensuring that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

2.1 Membership of Audit Committee

Our Audit Committee comprises:

Non-Executive Directors

- Caroline Maley – Non-Executive Director (Chair)
- Phil Harris – Non-Executive Director (from 3 November 2014)
- Tony Smith – Non-Executive Director
- Maura Teager – Non-Executive Director (until 3 November 2014).

Non-Executive Directors' attendance at the Audit Committee during the year was as follows:

	Possible attendances	**Actual**
Caroline Maley	7	7
Phil Harris (from 3 November 2014)	2	2
Tony Smith	7	5
Maura Teager (until 3 November 2014)	5	5

3. Internal Audit

Much of the Committee's work is supported by the programme of work for the internal audit service, which is provided by PWC. The service is provided within an agreed work-plan, prepared in consultation with the Executive team and approved by the Committee, which over a three-year cycle seeks to ensure that all areas of risk that could have significant impacts are subject to reviews, both for the design of controls and their effective implementation in practice.

Each review report by Internal Audit, together with the responses and action plan from Trust management, are laid before the Committee. During the year, the Committee has considered seven audit reports, including one advisory and one following up previous recommendations; three reports received a medium classification which are detailed below;

- **Serious Incidents Requiring Investigation,** this report reviewed the Trust's treatment of Serious Incidents Requiring Investigation (SIRIs) which relates to two of our principle risks within the Board Assurance Framework, these are;
    - Failure to learn from SIRIs, complaints, and incidents in that action plans are not fully embedded and therefore practice isn't changed, resulting in a negative impact on patient experience.
    - Risk that the organisation does not create the right environment for staff to be able to deliver compassionate care which could undermine the quality of care for patients

It noted that there was some Inconsistency/ambiguity in relation to the grading of catastrophic incidents within the organisation. The Committee received assurance from senior managers that the recommendations within the report have been completed.

- **Clinical Audit,** This report considered the key controls for clinical audit and how the results of audits are used by the Trust. The audit identified that there are two low risk differences between current practice and those which are formally documented, these differences are as follows;
    - The Research and Development Governance Group has replaced and undertakes the duties of the Quality Governance Committee;
    - Direct reporting to the Trust Board as part of the Research and Development Governance report has replaced the Integrated Governance Report.

This report identified 5 Medium findings and 3 advisory findings. The Committee received assurance from senior managers that the recommendations within the report have been addressed within an action plan which will be continually monitored by the Audit Committee throughout 15/16.

- **Transformation**, this report considered key themes and findings which directly link to the strategic objective "People receive the best quality care" and "care is delivered by empowered and compassionate teams. The audit identified two medium risk and two low risk findings.
    - There is a risk that if a significant number of projects are not delivered on time, to budget or to quality standards this may compromise the delivery of the whole transformation programme.
    - The use of one set of data to model changes is inherently risky, and the Trust should consider whether there are alternative datasets available which could be used to model the change programme and compare outcomes.

We are pleased to be able to report that the Head of Internal Audit opinion has stated the view that there is substantial assurance around the control systems in place within the Trust; and this view then supports the statements made in the Annual Governance Statement by the Accounting Officer.

The Head of Internal audit opinion is as follows:

> Our work identified low and medium rated findings. Based on the work we have completed, we believe that there is some risk that management's objectives may not be fully achieved. Improvements are required in those areas to enhance the adequacy and / or effectiveness of governance, risk management and control.

An independent review was undertaken by PwC of the effectiveness its service to the Trust, and suggestions for improvement. The review was largely positive with some areas noted for improvement.

The internal audit contract has been extended for a further two years, and will now run to November 2016. The Committee would like to thank PwC for their approach to internal audit work through the year, and also the support that they have provided to the Committee.

4. External Audit

Grant Thornton continued to serve as the external Auditors for the year.

The Committee has continued to be supported in its work by the external Auditors, who attend all scheduled meetings of the Committee and have unrestricted access to the Committee's Chairman. Although the outcomes of the external auditor's work are published with the Annual Accounts, work is undertaken throughout the year to support their final opinions and to ensure that the audit process is effective. As usual, the Committee will be reporting to Council regarding the conduct of the Audit; however, we can report to the Board that no significant areas of concern regarding the work undertaken are currently apparent to the Committee.

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

The external audit firm, Grant Thornton, was appointed on 1 November 2012 following an open tender process in the summer of 2012. The contract awarded was for an initial term of three years. The total value of the three year contract was £116,560 + VAT.

In adherence with all requirements, including approval by the Council of Governors, this contract was extended for a further two years. The value of the 2014/15 accounts work is £39,850 + VAT. Grant Thornton also provided non-audit services (employment taxes review) for a fee of £4,000 plus VAT.

5. Local Counter-Fraud Service

The Trust's counter fraud service is provided by an external organisation named 360 Assurance. They provide our Local Counter Fraud Specialist (LCFS), who works with us to devise an Operational Counter Fraud Work Plan for the year, which is agreed by our Audit Committee. The plan is designed to provide counter-fraud, bribery and corruption work

across generic areas of activity in compliance with NHS Protect guidance and Provider Standards.

The Trust has agreed to take all necessary steps to counter fraud affecting NHS-funded services and will maintain appropriate and adequate arrangements and policies to detect and prevent fraud and corruption. We have a Counter Fraud, Bribery and Corruption Policy and a Raising Concerns at work (Whistleblowing) policy and procedures in place which are communicated to staff – for example, through Trust information systems, newsletters and training.

During 2014/15 the Trust planned for and used 65 days of counter fraud activity, across the following areas:

Strategic governance – 19 days
Inform and involve – 19 days
Prevent and deter – 24 days
Hold to account – 3 days
Total – 65 days

The Trust's Audit Committee receives regular updates from the Local Counter Fraud Specialist in order to gain appropriate assurance around our counter fraud work programme.

The Local Counter Fraud annual report concluded that the Audit Committee could be assured that the Trust's counter fraud, bribery and corruption arrangements are embedded, that there is a strong anti-fraud, bribery and corruption culture within the Trust and that the Counter Fraud service delivered by 360 Assurance is efficient and effective.

The Local Counter Fraud contract has been extended for a further two years, and will now run to November 2016. The Committee would like to thank 360 Assurance for their approach to their work through the year, and also the support that they have provided to the Committee.

6. Other sources of assurance

The Committee adopted a proves of "Deep Dive" review of the BAF risks, which proved invaluable in providing assurance over controls and gaps in assurance with a focus on action plans to improve, This approach has informed and supported our overall review of the BAF prior to submission to Board,

The Annual Governance Statement has been subject to scrutiny and challenge by the Audit Committee to ensure that it meets the requirements as set out for this report. The Committee is assured that the report is balanced and fair.

Finally, the Committee also received assurance from the Shared Business Services over the controls that are in place and any weaknesses identified in their systems and processes.

7. Review of our effectiveness and impact

We have considered the overall impact and effectiveness of the Committee's work, as is recommended in the *Audit Committee Handbook*. Overall, we consider that the Committee is effective, in that it has maintained good oversight of the systems and controls in place for the Trust. As part of the outcome of the audit committee effectiveness process members were concerned as to our impact and the awareness of our role and requirements especially relating to the Council of Governors. In addition Members also noted the importance of

gaining assurance used by third parties the organisation uses to manage / operate key functions.

8. Objectives of the Committee

For 2014/15 the Committee had set as its objectives:

- To promote good governance by ensuring greater clarity and cohesion between board committees
- To apply rigorous challenge to the Board Assurance Framework through a "deep dive" approach and through close collaboration with other board committees
- To continue to engage more deeply with the clinical audit programme to improve integration of its activities
- To apply a patient-centred approach to audit plans, with data quality as a constant element.
- To consider the implications of the planned advisory review on corporate governance and advise accordingly on the briefing to Monitor.
- To scrutinise the Safer Staffing bulletins, in collaboration with the Finance and Performance Committee.

During the self-assessment of the Committee's effectiveness, the Committee reviewed these objectives and concluded that they had been largely met, but in particular noting the improvement in the engagement with clinical audit, and the BAF deep dive approach which was used during the year to gain assurance on the controls and gaps in assurance relating to each of the strategic risks.

For 2015/16, the Committee has set the following objectives:

- To promote good governance by ensuring greater clarity and cohesion between board committees
- To continue to engage more deeply with the clinical audit programme to improve integration of its activities
- To apply rigorous challenge to the Board Assurance Framework through a "deep dive" approach and through close collaboration with other board committees
- To clarify the role of the Committee and the Council of Governors, and improve relations with the Council of Governors
- To keep a focus on and be assured on the quality of data.

9. Conclusion

Having considered the other documents that are being presented to the Board in connection with the Annual Report and Accounts, the Audit Committee is of the opinion that this report is consistent with them. Having made reasonable enquiry, we report to the Board that:

- The Board can have reasonable assurance regarding the contents of the Annual Report, Financial Statements, and Quality Report for the year ended 31st March 2015;
- The Annual Governance Statement appears to be consistent with the internal controls environment that existed in the Trust during the year
- There is reasonable assurance that the statements made by the Board in the Letter of Representation to the Auditors are appropriate

The Annual Report and Accounts have been signed on 22 May 2015 and have been adopted on behalf of the board. The letter of representation has also been signed by the Chair of the Audit Committee.

MINUTES OF THE AUDIT COMMITTEE HELD ON WEDNESDAY, 22 MAY, 2015 AT 2.00 PM HELD IN THE BOARD ROOM, TRUST HEAD QUARTERS, BRAMBLE HOUSE, KINGSWAY SITE, DERBY DE22 3LZ

PRESENT:	Caroline Maley	Chair/Senior Independent Director
	Phil Harris	Non-Executive Director
	Tony Smith	Non-Executive Director
IN ATTENDANCE:	Mark Todd	Trust Chair
	Steve Trenchard	Chief Executive
	Claire Wright	Executive Director of Finance
	Carolyn Green	Executive Director of Nursing
	Jenna Davies	Interim Director Corporate and Legal Affairs
	Rachel Kempster	Risk & Assurance Manager
	Rachel Leyland	Deputy Director of Finance
	Stacey Forbes	Financial Controller
	Mark Stocks	Engagement Lead Grant Thornton
	Joan Barnett	Engagement Manager Grant Thornton
	Clare Grainger	Head of Quality
	Richard Eaton	Communications Manager
	Sue Turner	Executive Administrator and Minute Taker
APOLOGIES:	Graham Gillham	Director Corporate and Legal Affairs
	Anna Shaw	Deputy Director of Communications & Involvement
	Ifti Majid	Chief Operating Officer/Deputy Chief Executive
NOT REQUIRED:	Dr John Sykes	Executive Medical Director
	Alison Breadon	PricewaterhouseCoopers
	Reena Bajaj	PricewaterhouseCoopers
	Rubina Reza	Research & Clinical Audit Manager

WELCOME AND APOLOGIES

The Chair, Caroline Maley opened the meeting and welcomed everyone present and carried out a short mindfulness exercise to help the Committee to focus on decision making and enhance performance.

The apologies were noted above.

AUD 2015/055	**MINUTES OF THE AUDIT COMMITTEE MEETING DATED 28 APRIL 2015** The Minutes of the Audit Committee dated 28 April 2015 were agreed as an accurate record.
AUD 2014/056	**ACTION MATRIX** Updates provided by members of the committee were noted directly to the matrix.
AUD 2014/057	**BOARD ASSURANCE FRAMEWORK** Rachel Kempster presented the 205/16 Board Assurance Framework (BAF) to the Audit Committee, explaining that 8 principal risks had been identified by the Executive Leadership

	Team (ELT). The BAF was scrutinised and discussed by members of the committee and suggestions and amendments were noted directly to the BAF by Rachel Kempster. It was agreed that the committee would only focus on risks rated high or catastrophic and these will be included on agenda during 2015/16. Mark Todd, the Trust Chair, questioned whether the outcome of recent legal cases and lessons learnt from those cases would be added to the BAF in relation to governance issues. In response Jenna Davies noted that these were more operational risks and therefore would be managed through the internal risk process; she also noted that any risks relating to compliance would be added to the BAF. It was agreed that Jenna Davies would meet with Rachael Kempster to discuss the issues raised. **ACTION: Jenna Davies to meet with Rachael Kempster to discuss the possible risks relating to the outcome of recent legal cases.** It was agreed that risk 2a - transformational change will be the subject of the deep dive for the next meeting of the committee in July. **ACTION: Deep Dive of Risk 2a on Transformational Change to be an agenda item for the July meeting.** **ACTION: Rachel Kempster will attend a future Board Development session to cover the BAF.** **ACTION: Timing of the BAF coming to the Audit Committee will be looked at for next year and included in the forward plan.** **RESOLVED: The Audit Committee:** **1) Agreed the new Board Assurance Framework for 2015/16** **2) Agreed for the Audit Committee and Board to continue to receive a formal update on the BAF three times a year during 2015/16** **3) Supported the 'deep dive' review and challenge by the Audit Committee of only risks graded high, with lower graded risks being reviewed by the relevant named responsible committee.**
AUD 2015/058	**<u>REVIEW OF SUMMARY REPORTS OF OTHER BOARD COMMITTEES FOR ASSURANCE</u>** **Finance & Performance Committee Summary Report:** The committee considered the summary report which showed clear actions and assurance. Tony Smith asked for more information on the Sim:pathy/Spectrum project so he could understand and be assured of its effectiveness and it was agreed that this document would be circulated outside of the meeting. **ACTION: Claire Wright will hold discussions with Ifti Majid and Jayne Storey prior to circulating the Sim:pathy/Spectrum documents.** **Quality Committee Summary Report and Year-End Report:** The committee considered the detail in the summary report and noted that the year-end report contained a work plan for 2016/17 to its remit.

	Tony Smith questioned whether there was enough emphasis on clinical audit contained within the report; Clare Grainger agreed this would be enhanced to cover the performance management framework. The report would also be reviewed in conjunction with the committee's Terms of Reference. The Audit Committee agreed that for next year the report should highlight key gaps and be earlier to the Committee to enable the production of the Audit Committee Annual Report. **Safeguarding Committee:** The Audit Committee considered the inaugural meeting of the Safeguarding Committee to have been very constructive and acknowledged its very complex agenda. **RESOLVED: The Audit Committee obtained assurance from the work of the Finance & Performance, Quality and Safeguarding Committees contained in their reports and escalations.**
AUD 2015/059	**SUMMARY OF KEY CHANGES FROM DRAFT TO AUDITED ANNUAL REPORT AND ACCOUNTS 2014/15** Rachel Leyland ran through the summary of key changes to the final audited accounts, Annual Report, Quality Report and Annual Governance Statement and explained that amendments had been identified and signed off by the auditors. It was confirmed by Claire Wright that the drafts had been circulated to the full Board and no comments were received. **RESOLVED: The Audit Committee accepted that the Audited Annual Report and Accounts for 2014/15, Quality Report and Annual Governance Statement were in a satisfactory state to be signed today by the Trust Chair and Chief Executive Officer.**
AUD 2015/060	**REVIEW OF AUDITED ANNUAL REPORT AND ACCOUNTS 2014/15 (INCLUDING QUALITY REPORT AND ANNUAL GOVERNANCE STATEMENT)** Clarification of amendments to the Annual Report and Accounts 2014/15, Quality Report and Annual Governance Statement were reported to the Committee. Clare Grainger confirmed that Quarter 4 performance report has now been added to the Quality Report. The committee noted all the corrections and the committee accepted the Audited Annual Report and Accounts 2014/15 including the Annual Governance Statement and Quality Report 2014/15. The Trust Chair, Mark Todd thanked Grant Thornton and the Audit Committee for the co-operation that enabled the Annual Report and Accounts report to be signed off. **RESOLVED: The Audit Committee accepted the Audited Annual Report and Accounts 2014/15 Quality Report and Annual Governance Statement 2014/15.**
AUD 2015/061	**LETTER OF REPRESENTATION** Mark Stocks pointed out a confidential clarification to the audit findings report relating to a provision for costs associated with the employment tribunal. Claire Wright also confirmed the relevant confidential information was contained in the letter of representation to be signed today.

	RESOLVED: **The letter of representation on Trust Headed Paper was agreed and signed at the meeting by the Audit Committee Chair and the Executive Director of Finance.**
AUD 2015/062	**PROPOSED OPINION ON THE ACCOUNTS** Mark Stocks confirmed that the audit resulted in an unqualified opinion. This report highlighted the audit findings arising from Grant Thornton's audit and concluded that there were no issues that needed to be brought to the committee's attention. It was agreed that a summary report of these findings will be produced for the Annual Members Meeting. The Chair thanked everyone for their input. **AUDIT FINDINGS REPORT** Mark Stocks ran through the slight changes to the accounts and reports and confirmed that Grant Thornton considered these to be a good set of accounts. It was agreed that Joan Barnett would send Sue Turner this amended version to complete the version held on file and be a true record of what the committee has considered today. He also wished to thank the Trust's finance team for their co-operation in producing the report. Grant Thornton confirmed the accounts and working papers presented for audit were of a good quality and that there were no major audit findings to report. Reference was made to the recent employment tribunal and the committee confirmed it was content that these matters had been communicated correctly to Mark Stocks. It was also the opinion of Grant Thornton that the Trust is correctly accounting as a going concern. Grant Thornton considered the audit of this year's accounts worked exceptionally well and was an exemplary process. **QUALITY ACCOUNT OPINION** Grant Thornton were satisfied that the Trust has adequate arrangements to secure value for money in its use of resources. No issues arose from their review of the Trust's Quality Report. The Chair gave thanks to Carolyn Green and the team for producing the report. Steve Trenchard wished thanks to also be made to the quality and communications team who worked together extremely well and these thanks were endorsed by the committee. It was agreed that the Trust Chair and Chief Executive Officer would sign the accounts and the signed documents would be submitted to Monitor by 29 May. A summary of the Auditors Report will be made to the Governors at the Annual members Meeting on 23 September.
AUD 2015/063	**ANNUAL REPORT FROM THE AUDIT COMMITTEE TO THE BOARD** This report accompanied the signing of the Annual Accounts and was presented to assure the Trust Board and Governors of the work of the Audit Committee during 2014/15. The Trust Chair and Chief Executive Officer confirmed that the Audit Committee Annual Report

	and all the documents presented today provided them with the assurance to enable them to sign the Annual Report and Accounts 2014/15. **RESOLVED: The Audit Committee, having considered the other documents presented to the Board in connection with the Annual Report and Accounts, is of the opinion that this report is consistent with them and reported to the Board that:** **1) The Board can have reasonable assurance regarding the contents of the Annual Report, Financial Statements, and Quality Report for the year ended 31st March 2015;** **2) The Annual Governance Statement appears to be consistent with the internal controls environment that existed in the Trust during the year** **3) There is reasonable assurance that the statements made by the Board in the Letter of Representation to the Auditors are appropriate** **The Annual Report and Accounts were signed on 22 May 2015 and have been adopted on behalf of the Board in line with their delegated authority. The letter of representation has also been signed by the Chair of the Audit Committee and Executive Director of Finance.**
AUD 2015/064	**PWC GOVERNANCE AUDIT MANAGEMENT RESPONSE** The committee recognised that the response to the PWC Governance Audit commenced in in October last year. The Chair explained that Jenna Davies was leading this exercise now and asked that any comments or concerns be addressed to her outside of the meeting. **RESOLVED: The Audit Committee noted that the response to the PWC Governance Audit Management would be brought to the July meeting of the committee and that a final version would be available for the July meeting of the Board.**
AUD 2015/065	**MEETING EFFECTIVENESS** The committee agreed the meeting was well chaired, ran ahead of the agenda and that the good work carried out was due to team effort. The committee once again confirmed it was happy to adopt the Annual Report and Accounts, Quality Report and Annual Governance Statement 2014/15.
AUD 2015/066	**CLOSURE OF THE MEETING** The Chair thanked all those present for their attention and attendance and closed the meeting at 4pm. **Date of next meeting:** Wednesday, 21 July at 2pm Venue: Trust HQ – Board Room – Bramble House, Kingsway, Derby DE22 3LZ.

Quality Committee - feedback summary
Meeting held 11 June 2015 (Length of meeting 2:15pm – 4:20pm)

Key issues linked to Strategy and Governance requirements:

Strategy or Quality governance requirement	**Issue**	**Actions and assurance**
Minutes and action matrix from meeting held on 15 May 2015.		Agreed
Serious incident report	A matter arising The effect of legal highs (NPS) having an impact on cases of seclusion was raised by Maura Teager New (or novel) psychoactive substances (NPS), often inappropriately called 'legal highs' or 'research chemicals' constitute a significant public health risk and clinical risk in the Trust. Carolyn Green informed the committee of events that were taking place with the Nursing Leadership Event on this area of clinical practice and en event in Derbyshire with the Police Commissioner and proposed that this paper be based on learning gathered from these proceedings. The committee also agreed that the clinical practice protocol for working with individuals of New (or novel) psychoactive substances (NPS). Mrs Henson presented the Serious Incidents (SIs) year-end report and the main themes of the report were highlighted.	A paper will be brought to the committee in order to understand the impact of legal highs on the Trust's client group. The Intoxication Recognition, Assessment and Management of Suspected and confirmed Intoxication with alcohol and or opiates policy is being re-written in line with new and emerging clinical practices in practices in substance misuse and seclusion. The Quality Committee: Evaluated the report Noted themes from the report and work in progress. 1) Received limited assurance on the number of actions outstanding. 2) Was made aware of the emergent and current issues under a monitoring brief by the SIRI Review Group
Draft Untoward Incident Policy	Wendy Henson presented the updated policy which had been updated to reflect the current requirements of serious incidents framework and changes to Patient safety guidance on never events.	The policy was agreed in principle subject to action points with a professional opinion review from the Human Resources team on the changes to the policy. Specifically with regard to clinical accountability, duty of candour and suspension as a neutral act in cases to protect individuals from further patient safety events.

Strategy or Quality governance requirement	**Issue**	**Actions and assurance**
The Staff Friends and Family Test (Staff FFT)	The Staff Friends and Family Test (Staff FFT) was introduced in April 2014 to allow staff feedback on NHS Services based on recent experience and Liam Carrier's report informed the committee of the results of this scheme. The committee noted that the timing of the Staff FFT held in Quarter 4 last year when staff were under extreme pressure. The collective view was although the committee would want to understand in detail why our FFT and Staff survey is demonstrating concerns in our workforce and our staff are reporting these results. A full sensitive analysis may not be available. The committee agreed a solution focused approach to effective re-engagement; listening and an effective work plan would be the best form of assurance that could be gained at this time.	Jayne Storey will ensure that a paper is brought to the July meeting of the committee from the People Forum. This paper will show an analysis of hot spots within the Trust and will compare this with the national picture and also include an action plan. The committee noted that the Staff Health Check will take place in the Public Board meeting in June and will provide evidence of how the Trust is observing the impact of staff engagement and morale on the quality of care across our organisation.
Waiting list new National guidance and associated work plan with regard to Psychosis and referral to treatment waiting times	The committee received the progress report on the work plan and requested that a further update report be brought to the committee in October. The inter relationships between the Finance and Performance committee (operational management of access, waiting time and performance and the Quality committee (the quality of the interventions and the clinical risks associated with waiting time) on this standard were noted. Clear discussion cross committee support on managing this item was confirmed, this would be led by executive members.	The Quality Committee noted the new guidance relating to Mental Health Patient Access. Noted themes from the report and work in progress, confirmed date for additional briefing and up-date on work plan.
Improving Mental Health of BME People through a Reverse Commissioning Pilot	This report provided an update on Improving Mental Health of BME People through a Reverse Commissioning Pilot. The committee noted the project was advancing as planned and that meetings with general managers, clinical and training leads would develop aspirations into an actionable plan for delivery.	The Quality Committee noted: 1) Project progress, key themes, and the establishment of improving mental health of BME people through Reverse Commissioning Group (special interest group as a source of reference and engagement) 2) Key findings of service utilisation data and disproportion. 3) Approval to share data analysis and project at the National BME Conference on 12 June 2015 4) Agreed to receive an update report against the action plan in the autumn.

Strategy or Quality governance requirement	**Issue**	**Actions and assurance**
Annual Complaints and compliments report	The Quality Committee was asked to consider the contents of this annual report on complaints, concerns and compliments. The report set out the performance against the Trust's Policy and Procedure for Handling Patient Feedback: Comments, Concerns, Complaints, and Compliments, themes from analysis of data from the financial year 2014/15, lessons learnt and recommendations to be implemented in the financial year 2015/16. Carolyn Green that the key issue of complaint and concerns remains unchanged, when compared to committee previous report in the Patient experience quarterly reports, that it is not the quality of service or staff attitude that is the highest concern. It is access and waiting time to the service including access to therapies. Discussion points included benchmarking data, review of the complaints policy, monitoring and improving performance of areas with little feedback, communicating the difference between complaints and compliments and embedding learning.	Noted themes from the report and work in progress, confirmed date for additional briefing and up-date on work plan. Carolyn Green would provide this report to the commissioners via the Quality Assurance Group to seek advice on solutions and the shared risk register and to agree joint plans to mitigate these risks to patient experience and to patient care
NICE guidelines, development and redesign of the monitoring system	Rachel Kempster, Peter Charlton and Emma Sharratt presented the populated NICE Guidelines SharePoint site to the committee and highlighted the system's processes for improving the monitoring and effectiveness of the implementation of NICE guidance and advice. Rachel Kempster informed the Committee that she and the team were working with the Quality Leadership Teams to ensure guidelines relevant to the Trust are followed, are re-allocated, that clinical performance on completing NICE guidelines occurs in a timely manner. She and the team would also assist Carolyn Green and John Sykes to ensure there was the necessary focus on prioritised areas and the implementation of this system to provide a performance dashboard to understand our performance of monitoring and compliance of current NICE compliance levels, in an open and transparent way. In addition this system would provide both the routine access to NICE guidelines to promote their use and the access to Patient and Family information on the system which could be issued to Service receivers to help inform their	The Quality Committee noted the systems contained within SharePoint for monitoring the clinical effectiveness and clinical performance of the implementation of NICE guidance and advice The committee noted that the system would be populated further and developed to enter Phase 2 and a progress report will be provided to the committee later in the year. Report received and reviewed and the progress was noted Presentation of the populated NICE Guidelines SharePoint site to be made to the next meeting of the committee. Action Following full project implementation the committee will receive routine reports form the Head of quality through the QLT reports on current clinical team performance, through a paper outfling the dashboard information

	decision making on choices.	

Strategy or Quality governance requirement	**Issue**	**Actions and assurance**
Risk register report	Rachel Kempster's report provided the Quality Committee with evidence and assurance that the processes and procedures outlined in the Risk Assessment Procedure are in place throughout the Trust and are effective.	The Quality Committee scrutinised the report and accepted the report and noted the progress made so far.
Board Assurance Framework (BAF)	Rachel Kempster's report outlined the roles and requirements for the 'named responsible committees' review of the Board Assurance Framework (BAF) during 2015/16 to ensure recommendations made by internal audit are met.	The Quality Committee scrutinised the report and accepted the report and noted the progress made so far and agreed its recommendations.
Quality Committee Forward Plan	Agreed	
Any Other Business	No other business	Agreed and noted

Escalation issues
There were no issues to be escalated to the Board.
Cross committee and other governance group's actions to be noted.
Collaboration and cross committee feedback on waiting times changes to the Finance and performance committee

The Trust Board are requested to receive this report and guide the Quality committee on its current work and work plan

Chair of the Quality committee

Derbyshire Healthcare NHS
NHS Foundation Trust

Bettertogether

Policy and Procedure for 'Duty of Candour and Being Open'

Communicating openly with patients and their carers.

See also:	Located in the following Policy folder on the Trust Intranet
Untoward Incident Reporting and Investigation Policy and Procedure	Corporate and Risk Management Policies and Procedures
Handling Patient Feedback Policy and Procedures	Corporate and Risk Management Policies and Procedures
Claims Handling Policy	Corporate and Risk Management Policies and Procedures
Disciplinary Policy & Procedure	Human Resources Policies and Procedures
Raising Concerns at Work ("Whistleblowing") Policy and Procedures	Corporate and Risk Management Policies and Procedures

Service Area				Issue Date	Issue No.	Review Date	
Adult	Older Adult	LD	CAMHS	May 15		May 17	
Author(s)		**Ratified by**		**Date**	**Responsibility for review:**		
Wendy Henson / Amy Johnson		Quality Committee		May 2015	Medical Director		

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

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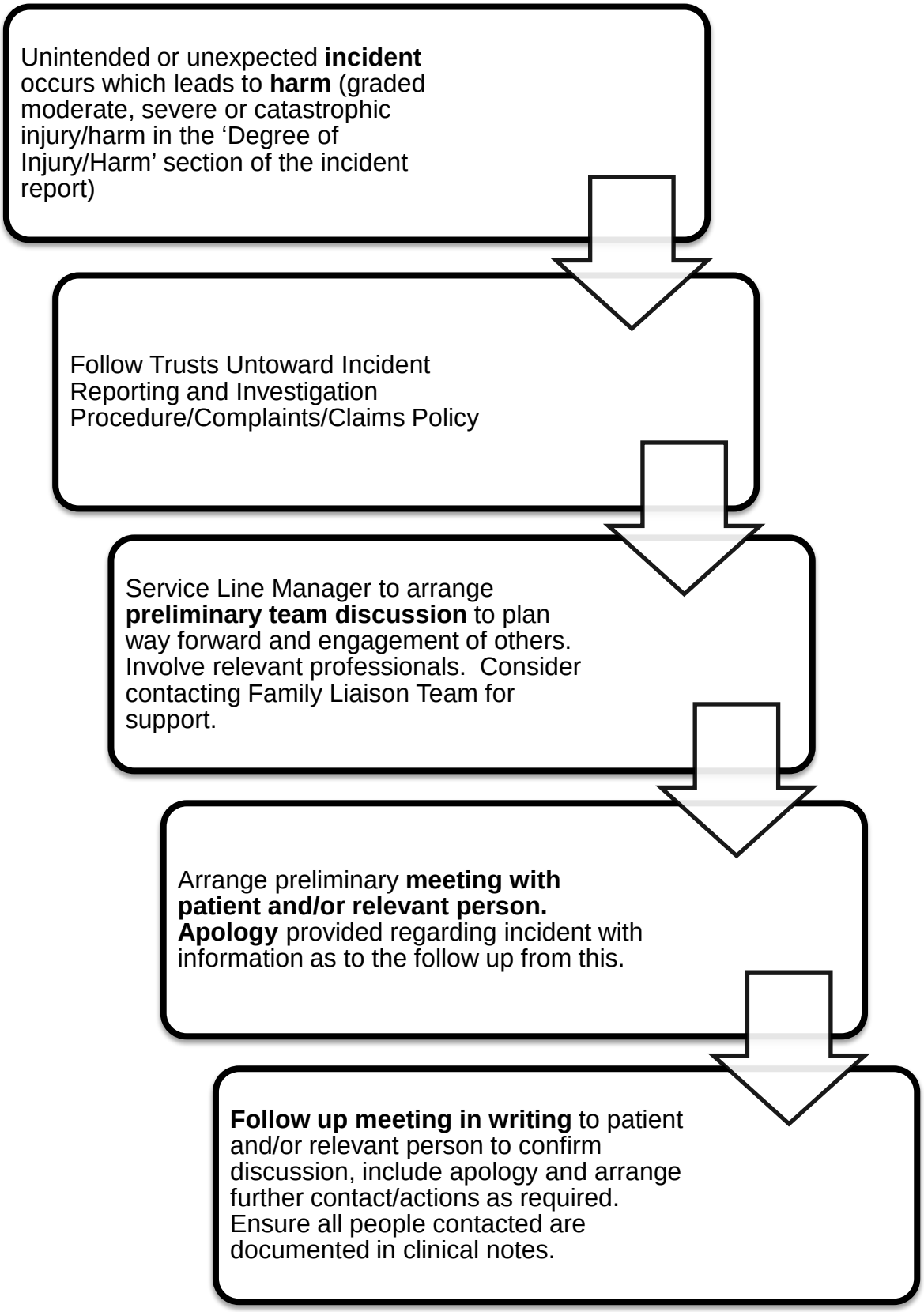
Checklist for 'Duty of Candour and Being Open Policy and Procedure.

Name / Title	'Duty of Candour and Being Open' Policy and Procedure. Communicating openly with patients and their carers.	Working name/title of the policy/procedure
Summary	Communicating effectively with service receivers and/or carers is a vital part of the process of dealing with errors or problems in their treatment. In doing so the Trust can mitigate the trauma suffered by service receivers and potentially reduce complaints.	Brief summary of main themes
Sponsor	John Sykes, Medical Director	Name and job title of person taking through approval and signing off
Author(s)	Wendy Henson, Head of Patient Safety Amy Johnson, Family Liaison and Investigation Facilitator	Job titles of those involved in producing the document

Reason for document production:	To improve communication with service receivers and the families / carers of service receivers who could have been or were harmed during their care and/or treatment in the NHS. For incidents relating to homicide this will include the families of the victims and perpetrators. Policy reviewed following the introduction of Care Quality Commission Regulation 20 regarding Duty of Candour. http://www.cqc.org.uk/content/regulation-20-duty-candour The National Patient Safety Agency recommend that all NHS Trusts implement a local policy on 'Being Open' linked to their Safer Practice Notice no 10. Available at: http://www.nrls.npsa.nhs.uk/resources/patientsafetytopics/consentcommunicationconfidentiality
Commissioning Individual or Group:	Quality Committee

Individuals or Groups who have been consulted:	**Date:**	**Response**
Quality Committee	May 2015	

Overview of Process



Policy and Procedure for 'Duty of Candour and Being Open

Communicating openly with patients and their carers.

Contents Page

Policy and Procedure for 'Duty of Candour and Being Open'

Communicating openly with patients and their carers.

1. Introduction

1.1. The aim of this policy is to promote a culture that encourages candour, openness and honesty at all levels.

1.2. The National Patient Safety Agency's (NPSA) ''Being Open'' Safer Practice Notice 101 and associated Policy states that it is central to the NPSA strategy to improve patient/service receiver safety through a commitment to improving communication between healthcare organisations and patients/service receivers and/or carers, when a patient/service receiver is moderately harmed, severely harmed or has died as a result of a patient (service receiver) safety incident.

A patient safety incident is defined as: any unintended or unexpected incident that could have or did lead to harm for one of more patients receiving NHS funded health care.

This is the preferred term of the National Patients Safety Agency and is synonymous with Derbyshire Healthcare Foundation Trust Untoward Incident Reporting and Investigation Procedure. One notable difference is that 'incidents' referred to in the Procedure include incidents involving staff, equipment, confidentiality breaches as well as patients. Although the 'Being Open' policy focuses specifically on patient safety incidents the general principles can be extracted to other types of incidents where a timely apology and an honest and open communication of the facts surrounding an incident are required. Throughout this document we use the terms patient safety incident and notifiable incident interchangeably.

1.3. The terms 'patient' and 'service receiver' are used interchangeably throughout this policy.

1.4. Effective communication with patients begins at the start of their care and should continue throughout their time with the healthcare organisation. There should be no difference when a patient safety incident occurs. Openness about what happened and discussing incidents promptly, fully and compassionately can help patients cope better with the after-effects. Patient safety incidents also incur extra costs through litigation and further treatment; openness and honesty can help prevent such events becoming formal complaints and litigation claims. Openness when things go wrong is fundamental to the partnership between patients and those who provide their care.

1.5. 'Being Open' means, apologising and explaining what has happened to service receivers and/or their relatives/carers involved in an incident. It ensures communication is open and honest and occurs as soon as possible following an incident.

1.6. The 'Duty of Candour' requirements reinforce the 'Being Open' principles by placing more emphasis on organisational responsibility. While the Duty applies to organisations, not individuals, it is clear that individual NHS staff must cooperate with it to ensure the Duty is met.

1.7. Breaches of Duty of Candour may incur financial consequences to the trust.

1.8. Action will be taken to tackle bullying, harassment and undermining in relation to staff fulfilling their duty of candour. Instances where a member of staff may have obstructed another will be investigated.

1.9. **It is important to remember that saying sorry is not an admission of liability and it is the right thing to do.** Furthermore the importance of being open is emphasised by the NHSLA Scheme, and the General Medical Council's **Good Medical Practice**

1.10. Although this policy relates predominantly to the management of incidents, the same principles of openness and honesty should be used when dealing with complaints or claims.

2. Scope

2.1. This policy is relevant to all care delivered by any of the clinical services to patients and their families.
2.2. Although the Trust promotes openness in all cases where appropriate, it is not a requirement of this policy that 'near misses', no harm and low harm incidents follow 'Duty of Candour' or 'Being Open' practices and procedures.
2.3. It is advised that the Policy only be applied to patient/service receiver safety incidents which result in or could have resulted in **moderate harm, severe harm or death**.
2.4. Research has shown that applying such practices to **no harm or low harm** incidents can lead to added stress to the patient/service receiver, compromised confidence in standards of care, can have negative effects on staff confidence and morale, and decreased public confidence in the NHS. It is therefore advised that in these cases an apology and explanation is given by the staff providing care locally.
2.5. In the event of a homicide this policy will apply to the families and carers of both the victim and the perpetrator.

3. Key Benefits of 'Duty of Candour and Being Open'

3.1 For healthcare organisations and teams, 'Duty of Candour and Being Open' involves:

- acknowledging, apologising and explaining when things go wrong;
- conducting a thorough investigation into the incident and reassuring patients and/or their carers that lessons learned will help prevent the incident recurring;
- providing support to patients (service receivers) and their carers to cope with the physical and psychological consequences of what happened.

3.2 For healthcare staff, 'Duty of Candour and Being Open' has several benefits including:

- satisfaction that communication with patients and/or their carers following a patient safety incident has been handled in the most appropriate way;
- improving the understanding of incidents from the perspective of the patient and/or their carers;
- Knowledge that lessons learned from incidents will help prevent them happening again; having a good professional reputation for handling a difficult situation well and earning respect among peers and colleagues.

4. Definitions

4.1 Duty of Candour

Candour is defined in The Francis report:

"The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made."

4.2 Being Open

As defined by 'Being Open, Saying Sorry when things go wrong'

Being open involves acknowledging, apologising and explaining when things go wrong; conducting a thorough investigation into the incident and reassuring patients, their families and carers that lessons learned will help prevent the incident recurring; providing support for those involved to cope with the physical and psychological consequences of what happened.

5. Procedure

5.1 A patient/service receiver safety incident can be identified by:

- A member of staff at the time of the incident.
- A member of staff retrospectively when an unexpected outcome is detected.
- A patient/service receiver and/or their carers who expresses concern or dissatisfaction with the patient's/service receiver's healthcare either at the time of the incident or retrospectively.
- Incident detection systems such as incident reporting or medical records review.
- Other sources such as detection by other patients/service receivers, visitors or non-clinical staff.

5.2 As soon as a patient safety incident is identified, the top priority is prompt and appropriate clinical care and prevention of further harm. Where additional treatment is required this should occur whenever reasonably practicable after discussion with the patient and with appropriate consent. The Trusts Untoward Incident Reporting and Investigation Procedure Policy must be implemented and an untoward incident /accident form completed on Datix.

5.2 All **media** issues/enquiries must be referred to the Trusts Communications Department immediately – no unauthorised statements should be given to the Press.

5.3 If it is likely that a **complaint** or **claim** may be made against the Trust as a result of the incident, please inform the Complaints Manager/Director of Corporate & Legal Affairs respectively.

6. Duty of Candour

Unlike the existing professional and ethical duty which applies to all circumstances where a patient is harmed when something goes wrong, the statutory Duty of Candour only applies to incidents where a patient suffered (or could have suffered) unintended harm resulting in moderate or severe harm or death or prolonged psychological harm.

6.1 The requirements of the Duty of Candour as set out by Care Quality Commission Regulation 20 are as follows:

- As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must—
- (a) notify the relevant person that the incident has occurred
- (b) provide reasonable support to the relevant person in relation to the incident, including when giving such notification.

- The notification to be given must:
- (a) be given in person by one or more representatives of the health service body,
- (b) provide an account, which to the best of the health service body's knowledge is true, of all the facts the health service body knows about the incident as at the date of the notification,
- (c) advise the relevant person what further enquiries into the incident the health service body believes are appropriate,
- (d) include an apology, and
- (e) be recorded in a written record which is kept securely by the health service body.

- This notification must be followed up in writing containing a summary of the information provided, details of any enquiries to be undertaken, the results of further enquiries and an apology.

- If the relevant person cannot be contacted in person or declines to speak to the representative from the health service body sections 2 and 3 are not to apply however a written record should be kept of all attempts to contact or speak to the relevant person.

6.2 The notification must be as soon as practicable however this needs to be within 10 working days of the incident being reported, sooner where possible.

6.3 Moderate **harm** is defined as 'harm that requires a moderate increase in treatment (i.e. a prolonged episode of care or transfer to another treatment area such as the acute trust), the shortening of the life expectancy of the service receiver, or requires treatment by a healthcare professional in order to prevent the death of a service receiver, or any injury which left untreated would lead to the aforementioned outcomes.

6.4 Severe **harm** means a permanent lessoning of bodily, sensory, motor, physiologic or intellectual functions.

6.5 Prolonged **psychological harm** means psychological harm which a service receiver has experienced, or is likely to experience, for a continuous period of 28 days or more.

6.6 Apology means 'an expression of sorrow or regret' in respect of a notifiable safety incident.

6.7 **Relevant person** means the service receiver or in the following circumstances someone acting on their behalf:

a) the death of a service receiver
b) where the service receiver is under 16 and is not competent to make a decision in relation to their care or treatment
c) where the service receiver is over 16 and lacks capacity (as determined in accordance with sections 2 and 3 of the 2005 act)

6.8 The level of harm must be attributable to the notifiable safety incident and not related to natural cause of the service receivers illness or underlying condition.

6.9 Incidents that result in no harm or low harm are not covered by the Duty of Candour. Patients should still be informed of such events in line with being open, but the emphasis for the Duty of Candour is on incidents that could or have resulted in moderate harm, severe harm or death.

Examples of application of duty of candour

Appendix 1 outlines examples of where duty of candour may be applicable.

7. Standards for Duty of Candour and Being Open

1. There will be a multi-disciplinary discussion following the incident, complaint or claim where an appropriate individual is identified to liaise with the service receiver/carer/family/relevant person and it is established what other organisations/individuals need to be engaged in the process and receive communication. Consideration should be given as to when to involve Family Liaison Team.

2. The incident/complaint/claim will be reported using the relevant Trust Procedure for the management of untoward incidents, complaints or claims.

3. Duty of Candour information will be included in the incident report, Internal Service Management Review, Serious Untoward Incident Report.

4. Service receivers/carers/family/relevant person will receive a face to face acknowledgement, apology and explanation following the patient safety incident/complaint or claim. This should take place within 10 working days.

5. The discussions will be followed in writing to confirm.

6. Service receivers/carers/family/relevant person will receive communication that is truthful, timely and clear.

7. Service receivers/carers/family/relevant person will be offered additional support as appropriate to their needs.

8. There will be a record made of all communication with the service receivers/carers/family/relevant person.

8. Monitoring Compliance

Minimum requirement to be monitored/audited	Monitoring method e.g. audit
Open, transparent and candid communication between healthcare organisations, healthcare teams, staff, patients their relatives, carers or relevant person	Inclusion in incident reporting on Datix Internal Service Management Review Serious Untoward Incident Reports Documented contact with relevant people
Regular assurance offered regarding Duty of Candour being undertaken.	Report available on Datix Monthly Duty of Candour Report to Commissioners Duty of Candour included in monthly SIRI report to Quality Committee Monthly report for board
Being Open	Six monthly review to be included in complaints report to Patient Experience Committee.
Responsibility for reports	Family Liaison and Investigation Facilitator

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Health and Social Care Act 2008, Regulations 2014

Regulation 20: Duty of Candour. Guidance for NHS bodies. November 2014.

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Robert Francis QC. February 2013.

Serious Incident Framework 2015 - https://www.england.nhs.uk/ourwork/patientsafety/serious-incident/

'Being Open'**: Communicating Patient Safety Incidents with Patients and their Carers**. National Patient Safety Agency. 2005.

National Health Service Litigation Authority (2002). Litigation Circular:02/02. **Apologies and explanations**. Issued 11 February 2002. Available at www.nhsla.com

Welsh Risk Pool (2001). Technical Note 23**. Apologies and Explanations**. Approved 26 July 2001.

NHSLA Risk Management Standards Mental Health and Learning Disability Trusts. May 2007. Criteria 1.5.10.

General Medical Council (2001). Good Medical Practice. Available at www.gmc-uk.org

Department of Health (2003) **Making Amends**. London: The Stationary Office.

National Patient Safety Incident Decision Tree. Available at: http://www.npsa.nhs.uk/patientsafety/improvingpatientsafety/incidentdecisiontree/

National Patient Safety Alert. NPSA/2009/PSA003. 19 November 2009

Appendix 1 – Duty of Candour Application

It is important that this is used alongside the definitions of relevant person, levels of harm and is based upon sound clinical judgement.

Death of child (current or past. This would be dependent on circumstances – refer to matrix above

*If natural causes this would revert to Being Open

**Maladministration, wrongful detention etc.

Appendix 2 – Ten Principles of Being Open

Acknowledgement	• Acknowledge & Report incident as soon as identified. Take patient and/or carer reports of incidents seriously immediately. Be compassionate and understanding.
Truthfulness, Timeliness, Clarity of Communication	• Give information to patients and/or carers in a truthful and open manner; use an appropriately nominated person to do this. Give a step-by-step explanation considering individual needs. Be timely in delivery of information. **State the facts only**. Explain that new information may come to light during the investigation, and keep patients and/or carers up to date. Give clear, unambiguous information and identify single point of contact for queries. Avoid jargon.
Apology	• Give a sincere expression of sorrow or regret to patients and/or carers, appropriately worded in an apology, as soon as possible. Give written and verbal apology. Verbal apology must not be delayed by any factors including fear, apprehension, lack of staff etc. Delays will increase patient anxiety, anger and frustration. Identify most appropriate staff member to give apology (consider seniority, relationship to patient, experience and expertise). • The communication needs of the recipient should be considered and addressed.
Recognising Patient and Carer Expectations	• Patients and/or their carers can reasonably expect to be informed of an incident and the issues surrounding it in a face-to-face meeting with representatives from the Trust, and should be treated with sympathy, respect and consideration. Maintain confidentiality at all times. Provide information on the Trusts Complaints, Claims and Incident Procedures. Provide support appropriate to individual needs including use of an advocate or translator. Give information re: support agencies i.e. Family Liaison Team/Patient Experience Team
Staff Support	• Staff should feel supported throughout the investigation process and should not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or threat to registration. Use NPSA Incident Decision Tree[7] to ensure consistent decision-making. If action is necessary against staff member, the Trust must preserve its position and advise staff member immediately to allow them to seek advice and/or representation. Encourage staff to seek support from professional bodies.
Risk Management and Systems Improvement	• Use Root Cause Analysis (RCA), or similar techniques to uncover underlying causes of the incident. Focus on improved systems of care, to be reviewed for effectiveness. Use 'Being Open' practices in conjunction with Trust incident reporting and risk management processes.
Multidisciplinary Responsibility	• 'Being Open' applies to all Trust staff, particularly those in key roles regarding patient care. To ensure MDT approach, identify clinical, nursing and managerial opinion leaders as champions. Senior Managers and Senior Clinicians, as local opinion leaders, must participate in incident investigations and clinical risk management.
Clinical Governance	• 'Being Open' requires support of patient safety and quality improvement process through clinical governance frameworks to ensure lessons are learned. Accountability through the Chief Executive to the Trust Board ensures implementation of changes and effectiveness reviews. Findings should be disseminated to staff to facilitate learning. Establish practice-based systems, continuous learning programmes and audits to monitor implementation and effects of change
Confidentiality	• Give full consideration to patient confidentiality and staff privacy. Incident information should be considered confidential at all times. Consent from the individual must be sought prior to any disclosure. Where this is not possible, consent is still legal and justifiable if it is in the public interest or if those investigating the incident have statutory powers for obtaining information. Communication outside of the clinical team should be on a strictly need to know basis and records should be, where possible, anonymous. Inform the patient and/or carer who will be involved in the investigation before it takes place.
Continuity of Care	• Patients are entitled to expect they will continue to receive all usual treatment, and to be treated with respect and compassion. If the patient expresses a desire to be treated by a different team, arrangements should be made.

Equality Impact Risk Assessment (EIRA) Form for 'Duty of Candour and Being Open'

Communicating patient safety incidents with patients and their carers.

	Yes/No	Comments
1. Does the policy/guidance affect one group less or more favourably than another on the basis of:	No	
• Race		
• Ethnic origins (including gypsies and travellers)		
• Nationality		
• Gender		
• Culture		
• Religion or belief		
• Sexual orientation including lesbian, gay and bisexual people		
• Age		
• Disability - learning disabilities, physical disability, sensory impairment and mental health problems		
2. Is there any evidence that some groups are affected differently?	No	
3. If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	No	
4. Is the impact of the policy/guidance likely to be negative?	No	Impact is positive
5. If so can the impact be avoided?		
6. What alternatives are there to achieving the policy/guidance without the impact?	NA	
7. Can we reduce the impact by taking different action?	NA	

Action to be taken following EIRA assessment:	

EIRA completed by:	**Amy Johnson Family Liaison and Investigation Facilitator**	**Date completed:**	29/04/2015

Mental Health Act Committee - feedback summary
Meeting held 29 May 2015 (Length of meeting 10pm – 1pm)

Key issues linked to Strategy and Governance requirements:

Agenda item	Issue and actions	Assurance
Re-Audit - Consent To Treatment – Section 58	Ed Komocki attended the meeting to provide members with an update on the Re audit of section 58. He outlined a number of recommendations and members received a number of actions • John Sykes to write to all consultants setting out the approved and lawful process for recording Capacity of Consent. • Action Plan to be extended to include spot checks on clinicians and progress of these actions reported to the next meeting of the committee by John Sykes.	John Sykes will ensure actions are included in regular reports to the Quality Committee for monitoring. Agreed that the audit will be repeated annually to ensure compliance
Mental Health Act Committee Report	Christine Henson provided the committee with her quarterly report covering the period 1 January to 31 March 2015 and highlighted the key themes. The report showed that during the last quarter the number of formal admissions had increased, particularly the number of females admitted on Section 2 which had doubled and it was noted there was no substantial reason for this increase. The Chair was concerned about the overall lack of assurance contained in the CQC reports. It was noted there was an action plan in place and Chris Wheway felt it was the remit of the QLTs and the clinical director to provide the committee with this assurance	Tracey Holtom and Clare Grainger to Prepare a quarterly integrated governance report to pick up thematic issues that are outside the ambit of the Mental Health Act Committee for escalation to Quality Committee
Mental Health Act Committee Annual Report	The Chair wished to take the opportunity to thank Christine Henson for the production of the first draft of the committee's annual report and asked for thanks to be passed on to Kelly Sims for the graphs contained in the report.	Annual report to be submitted to Audit Committee

Availability Of Section 12 Doctors	A breach in Section 12 recommendations was previously reported to the Mental Health Act Committee at its meeting in January. John Sykes asked that this matter be raised at a Crisis Concordat meeting and Chris Wheway agreed to raise this at the meeting.	Rachel Kempster informed the committee that she had provided a report to the SIRI Group clarifying Section 12 breaches and ran through the main actions taken
Section 136 - Joint Policy For Ratification	The Joint Policy for Derbyshire on the Operation of 136 of the Mental Health Act 1983 was presented to the committee, together with the amended S136 Implementation Group Terms of Reference. Christine Henson highlighted the amendments to the Terms of Reference, consultation took place and the committee agreed it was satisfied they were complete and approved the policy.	The Mental Health Act Committee ratified the Section 136 Joint Policy
Community Treatment Order Policy And Procedure For Ratification	The Community Treatment Order Policy and procedure was presented to the committee for approval.	The Mental Health Act Committee ratified the Community Treatment Order Policy and Procedure.
Meeting Effectiveness	• Meeting efficiently chaired. Intense discussions took place but strayed too much into operational issues. Meeting finished on time (with comfort break). Committee felt reasonably satisfied with issues raised, discussions.	

Issues to be escalated to Board, Audit Committee or other Board Committees
• Escalate to the Board the matter of disproportion within the county wide triage team • Section 58 Consent to Treatment risks and recording issues escalated to the Board, the BAF and CQC • 132 Rights function resource issues to be clarified and escalated to the Board as an area of concern
Confirmation of any updates to the Mental Health Act Committee BAF risks

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 24th June 2015

POSITION STATEMENT ON QUALITY (including Patient Experience annual report on complaints, concerns and compliments).

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 Care Quality Commission Intelligent Monitoring Report

On the 11th June 2015 the Care Quality Commission published our end of financial year intelligent monitoring report. The Care Quality commission use 59 'indicators' to help them decide when, where and what to inspect. The change since the October report is that the Care Quality Commission have aligned the indicators to CQC's key questions (safe, effective, caring, responsive and well -led) in each trust's report. Any risks identified for our trust are now also grouped by these key questions on the Trust Summary page.

In October we were banded at level 4 which is the highest performing, this end of year report confirms our banding remains the same. It is attached for information.

We continue to work on our work plan on Patient Safety planning and suicide prevention.

Our new lead professional for Patient Safety planning Nicola Fletcher is leading a service improvement project to redesign our based education offer through eLearning and drawing upon the clinical research, NICE guideline and best practice available to promote our services as safe and effective.

In this work and in the suicide prevention work, we were struck by the significant impact of the The RaRE Study research project 2010 – 2015 is a 5-year collaboration between PACE, the LGBT+ mental health charity and an academic panel drawn from three UK universities. The study looked at risk and resilience factors for three mental health issues that affect LGBT+ people disproportionally:

1. Suicide attempts and self-harm for young LGBT+ people under 26
2. Alcohol misuse in lesbian and bisexual women
3. Body image issues for gay and bisexual men

Data was collected between 2011 and 2014, through two sets of interviews with 58 people in total and a national survey of 2078 people in England.

Key Findings – Suicide and Self-harm for Young LGB&T People

*Young LGB and Trans*1 people under 26 are more likely to attempt suicide and to self-harm than their heterosexual and cisgender2 peers.*

What Risk Factors did RaRE find?

People who attempted suicide while young reported factors that appear to correlate closely with suicidal thoughts or attempts. These were: negative experiences of coming out; homophobic and transphobic bullying; and struggles about being LGB or Trans* within the family, at school and in peer groups.

In addition, participants reported that a lack of awareness and training means responses from medical or professional staff can feel inadequate. Inclusive resources, which reflect the lives and issues of young LGB&T people, are sparse outside of LGBT+ specialist services.

We will be factoring these research findings into our work plan for Patient Safety planning and learning for our Suicide prevention group.

1.2 Safe Staffing

Safer Staffing Indicators and response to NHS England Letter

NHS organisations need to demonstrate they are delivering safe and effective care. National actions taken so far to support include:

- The publication of actual versus planned staffing levels
- Publication of staffing levels through NHS choices
- NICE Guidance for safer staffing (paused)

Actions required for NHS organisations are:

- The publication of actual versus planned staffing levels (monthly).
- In depth review and report to board of nursing staff requirements using Evidence Based tools and to include contact time (6 Monthly).
- Publication of staffing indicators from spring 2015.
- RAG rating of Staffing indicators.
- Temperature checks of contact time to be undertaken using a consistent methodology to assess any changes (ie Change in care model or skill mix, or introduction new technology)

The Nursing team are working in partnership witht the information team to report on these key indicators.

Staffing Indicators
Staffing indicators that will be used and published are as follows:

- Staff sickness rates
- Completion of Mandatory training completed
- Completion of PADRs in last 12 months
- Staff views on staffing from national staff survey measure
- Patient views on staffing form national patient survey measure

It is proposed ESR will be used as vehicle to collect indicators therefore we need to review information currently held and identify any gaps in data and mitigate any risks

It is likely that the following areas of mandatory training will be considered as training priorities for mandatory training indicators:

- Health and Safety
- Equality and Diversity
- Prevention and or handling Violence and aggression
- Infection Control
- Handling confidential information
- Delivering good patient/service receiver experience

Trusts will be scored on RAG rating using outlier methodology which is consistent with the approach adopted by CQC for its intelligence monitoring.

One indicator being red would result in an overall red rating for the Trust. It is thought that further developments on indicators and their analysis will include indicators on the following:

- Use of Turnover.
- Meaningful data on agency use.
- Looking at how we get more timely data of the annual data collections.

Care Contact Time and Quality outcome measures

In addition to the safe staffing indicators, there is a strong focus on care contact time and the use of evidence based tools in how we measure care contact time, It will also be necessary to measure how we use our Nurse sensitive information on looking at the quality of intervention as well as just numbers of nurses on a ward. Value in determining contact time and how contact time is being used will be key to ensuring the effective deployment of staff. It is recognised that there will need to be a strong focus on ward leadership going forward.

Care contact time measures will need to focus on the following:

- Proportion of nursing time spent in direct care, indirect care, associated work and unproductive time.
- The relationship between patient dependency and acuity and how much nursing time is in direct care, indirect care, associated work and unproductive time.
- The relationship between overall nursing staff available per bed and how much nursing time is in direct care, indirect care, associated work and unproductive time.
- A breakdown of care contact time by grade.

It is recommended that evidence based tools such as Safer Nursing Care Tool

(SNCT), and Productive Ward are used to measure skill mix and establishment requirements.
It is also recommended that Nurse Sensitive data should be used as quality indicators in order to link nurse staffing issues (ie Leadership, skill mix, training and development etc).

These would include:

- Complaints
- Drug errors (Actual errors where nursing primary cause)
- Infection
- Pressure ulcers
- Nutrition
- Protected meal times implementation

What actions are required for Derbyshire Healthcare NHS Foundation Trust?
Derbyshire Health Care NHS Foundation Trust has already progressed on safer staffing having published data actual against planned staffing data. Ward managers, Clinicians, and Senior Managers are already engaged in safe staffing and are integral to safe staffing reporting.
ESR is already used as a vehicle for collection of most staffing indicators and therefore an existing platform is in place. However assurance will be required that this will be functional for all data collection requirements therefore a benchmarking exercise needs to be undertaken regards ESR. A gap analysis review of ESR and the information currently held on ESR needs to be undertaken in order and identify any gaps in data.
We will need to consider building a performance dashboard so we can systematically and consistently monitor performance against indicators

Care Contact time requirements need to be further explored regards how we systematically review care contact time and utilise this data in relation to understanding required skill mix and establishment. The trust already has skilled clinicians trained in productive ward capabilities able to lead on implement care contact time measures.
We will need to conduct a skills mix review using tools to support implantation such as productive or SNCT.
It would seem there will be some prescription regards what elements of mandatory training will be monitored through the indicators. Given this consideration to be given to these areas by Training Board.

Health Education England (HEE) has established a work group to design and develop a bespoke education training pack on safe staffing. This will be aimed at three levels:

- Frontline staff
- Heads/Matrons
- Directors of Nursing

Key to delivering implementation will be:

Preparation: Staff will need to be prepared and trained to undertake acuity and

dependency scoring.

Communication: It will be essential that all staff at all levels are aware of and understand the principles for safer staffing.
It is proposed that meetings are set up with ward/service managers to explain process and reasons indicators and the measuring of acuity and dependency.

The Executive Board will need a brief in the form of a board paper on developments. Clinical Directors, Divisional Directors and General Managers will need to be engaged and it is proposed engagement should be through SMT's and QLT's.

Data Management and Input: Data management will be essential to effective monitoring and management of the staffing indicators, therefore IMT and Performance heads will need briefing and will need to support with nominated leads.

Designing a new safer skill mix review matrix tool: this will assess through quantative and qualitative analysis a new safer staff level and skill mix based on clinical team interventions and needs.

Jayne Cummings, Chief Nursing Officer, NHS England has written to all organisations to update them on the next steps on the shared work programme to improve the safety and quality of NHS staffing. The letter confirms that

"The Mental Health Taskforce has agreed to lead the work on establishing what is the right balance of staff in the many settings treating those with mental illness. They will report back by the end of the year and take into account the mental health staffing guidance that has recently been developed with colleagues from the Mental Health Directors of Nursing Network and commissioned through the Compassion in Practice Strategy." (taken directly from the letter).

The letter also sets out 6 reasons why we need to adapt our approach, they are:

1. The need to take into account all multi professionals working in a team not just nursing staff. Our Allied Health professional workforce will be key to this.

2. To consider how services span organizational boundaries.

3. To emphasize that it is not just about numbers of staff but the actual time spent with patients.

4. The current NICE guidance for acute settings will not be changed but its implications for different care settings has to be taken into account.

5. There is a need for career progression for non-registered staff, nurse retention and flexible working.

6. To commission new research and learning from national and international best practice to inform what safe staffing looks like in other care settings.

Our Trust is recommencing its six monthly review of skill mix, as an organization in

line with the steer from the Chief Nurse, which is supported by the Trust, this will be a service in-reach approach supporting our senior Nurses to review their own skill mix and support their own analysis of their team requirements based upon a critique and review of the year, this will be led by the Assistant Director of Clinical professional practice and will report initially to clinical reference groups and Quality Leadership teams with a full completion date prior to September 2015.

2. CARING SERVICES

See attached annual report on complaints, concerns and compliments 2014/15. Please note the additional actions in paragraph 8.2 agreed at the Quality Committee on June 11th 2015 with comments and amendments based upon the committee's member's viewpoints. Due to the timing of this report we were unable to include other trusts performance in this area, the nursing and patient experience team will include benchmarking form other trusts in subsequent patient experience reports to the Quality committee as other key trusts are not publishing annual report until June/ July 2015. Overall when comparing our trust performance to other trusts annual reports historically our complaints and compliments levels are favourable. This re-enforces previous analysis and feedback from our Healthwatch Derby City report. We continue to have the leading cause of complaint being not the quality of the service but access to and availability of service. This annual report is in line with quarterly report and this them has been shared with our commissioners and this annual report will also be shared with the commissioners in July 2015, Quality assurance meeting to explore further shared solutions and plans to mitigate these patient experience concerns.

3. EFFECTIVE SERVICES

3.1 Standards for Prison Mental Health Services

The Quality Network for Prison Mental Health Services has published these standards in June 2015. The standards address areas that are key to prison mental health care and provide a framework for benchmarking and improving quality. Our organisation is reviewing these key standards through service line management and quality leadership teams to inform our care offers in our prison service. The Director of Nursing as an outreach visit to Foston Hall to visit our service and champion the use of these standards in our care teams.

Development of the Implementation Plan – CQUIN Improving Physical Healthcare to reduce Premature Mortality in People with Severe Mental Illness 1015/16

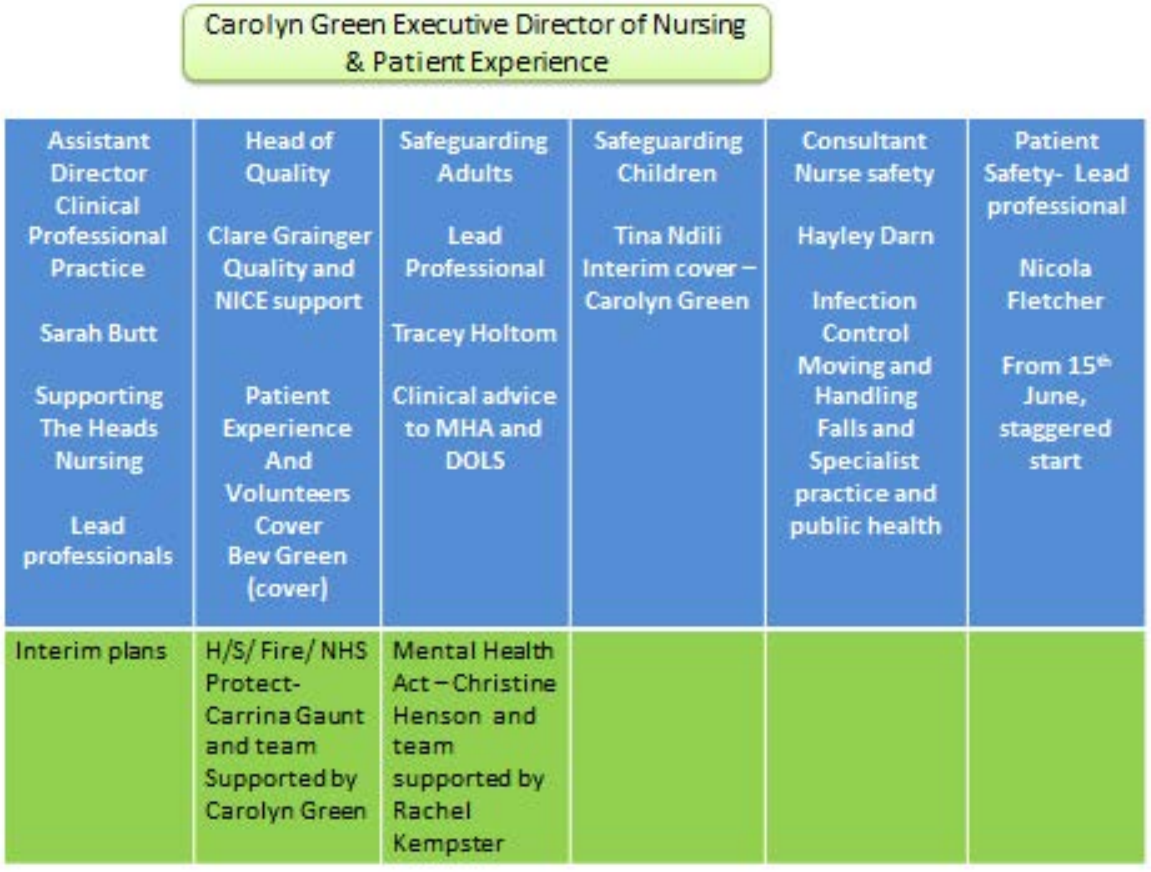
This National CQUIN initiative aims to fully embed the framework covering the acknowledged risk factors into clinical practice in key areas where risks are felt to be highest. This is based on the Lester Cardiometabolic Parameters, developed by the Royal College of Psychiatrists. For 2015/16, and in line with NICE guidance on Schizophrenia, this will centre on inpatients with psychoses, and also community patients under the care of the Early Interventions teams. The CQUIN work will be

led by Hayley Darn, Nurse Consultant and Dr Mahendra Kumar, Chair of the Physical Care Committee.
An element of staff training will be required, along with ongoing developmental work on the Electronic Patient Record system. National and local audit requirements are detailed as part of the CQUIN requirements, and as yet we as an organisation have not been notified of the upcoming national audit requirements, scheduled to take place in Quarter 2.

The Board of Directors are asked to support the ongoing development which relates to one of our Quality Priorities.

3.2 Nursing and Patient Experience Directorate

An interim structure for the Directorate has been put in place to respond to staff vacancies as set out below:



4. RESPONSIVE SERVICES

4.1 Service Receiver & Carer Reference Group (SRCRG), Listening events and service design.

This group was established in February 2015 with a wide membership of service receivers and carers. It meets monthly at venues across the City and County. The aim of the forum is to provide a space for service receivers and carers to talk and be listened to, focusing on the transformational change to community and inpatient services. This is learning from our feedback from transformational change, our patient survey and from our Healthwatch survey on engaging our population in redesigning our services. The group are contributing to a number of events to be held over the summer to receive feedback on what our services will look like in the future by coproduction and codesign of a set of mutual expectations of care offers. To build upon our core care standards and existing work in the triangle of care.

The events will cover 3 areas:

1) Firstly all **In-patient services**, including acute care through to recovery. These are referred to as the "Campus" services, that is services provided in the main at the in-patient areas in Derby and Chesterfield. This includes the new "Hope & Resilience" Hub at the Radbourne Unit at Derby Royal.

2) Secondly, the **"Neighbourhood"** services. These are currently being planned for introduction soon. Eight Neighbourhood Teams are planned across Derbyshire and Derby City. They will provide local response and support for people in the community with mental health needs.

3) Lastly, **"Family Inclusive Practice";** that is how services can support family, friends and other carers who have loved ones going through mental health issues and treatment, and their after-care. This is an area that is vitally important to the support and recovery of people with mental health problems.

These events will be co-chaired and co-developed by NHS staff, service receivers and carers. This will include sharing as many ideas and suggestions as possible. We are aiming to complete the work by the end of August 2015. Outcomes will achieve the following:

- A common understanding of what good **"outcomes"** should be for anyone recovering from a mental health problem.
- A common understanding of what good **engagement** with service receivers and their loved ones should look like.
- A **"Charter" or "Covenant"** which will be agreed by everyone and incorporated into any future service design.

This will be presented to the Integrated service delivery group for sign off and to be incorporated into our Transformation plans. We believe that using the service improvement methodology and setting shared expectations, the design of these mutual expectations will both ensure that we are listening to service receivers, carers and family members and our staff to lead the redesign of our shared solutions to our mutual expectations of each other.

4.2 NICE guidance on violence and aggression

New guidance has been issued to replace the previous guidance. New recommendations have been added to cover a broader range of setting and to also cover children and young people aged under 16, family members and carers. We are currently mapping the new guidance against the old with a particular focus on its impact on training, seclusion and positive and safe work plans to ensure we understand our current clinical performance and put in place service improvement work plans to adjust our clinical policies and operating procedures to meet this standard.

Strategic considerations

- The continuation of all our quality improvement work to maintain our positive risk based bandings with our regulator the Care Quality Commission.
- NICE guidance implementation plan for violence and aggression.
- A briefing on safer staffing and how this contributes to our teams providing safe care and our work plan.
- Several national reports have influenced our work on complaints, including the public inquiry led by Sir Robert Francis QC, and the complaints review by the Rt Hon Ann Clwyd MP and Professor Patricia Hart. In December 2014 the Care Quality Commission published a report 'Complaints matter'. This report sets out how its new inspection regime will focus on complaints and how it proposes to embed complaints and concerns in the new regulatory model.

(Board) Assurances

Quality Position statement

- Assurance on the overall high quality of care we provide as reported in our intelligent monitoring report and our current banding with the Care Quality Commission.
- Assurance on our focus upon our quality priorities and CQUIN of Patient safety planning including our wider focus on considering new research and how this impacts upon on our clinical strategic planning
- Assurance on our safer staffing, taking into consideration the key messages.
- Assurance on our engagement with service receivers and carers and how they can influence what our services look like in the future.

Annual Complaints, concerns and compliments report

- Our annual report on complaints, concerns and compliments provides assurances against the National Guidance for Complaints Handling.

- As the Health Service Ombudsman has taken no further action in regard to 6 out of the 8 complaints they independently reviewed during the year assurance can be provided that complaints are handling and reported on in accordance with the National Guidance for Complaints Handling.
- Information is being collected and acted on to ensure learning informs changes in practice.
- The trust is promoting an open culture where complaints and concerns are welcomed and learnt from.
- Compliments tell us what we are doing well and how we can put positive experiences at the heart of all we do as well as highlighting teams that flourish to enable other teams to be signposted to them or model their practices.

Consultation

The annual complaints, concerns and compliments report was presented at Quality committee on 11th June 2015. Some additional actions have been added following discussions in paragraph 8.2.

Governance or Legal issues

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

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 16 sets out the requirement for providers to make sure that people can make a complaint about their care and treatment. To meet this regulation we have to have an effective and accessible system for identifying, receiving, handling and responding to complaints from people using the service, people acting on their behalf or other stakeholders. We have to ensure all complaints are investigated thoroughly and any necessary action taken where failures have been identified.

Equality Delivery System

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

To be briefed in the risk and resilience factors for three mental health issues that affect LGBT+ people disproportionally.

The gender and ethnic of patients in complaints are routinely logged on DATIX risk management system. The information is used (anonymously) for routine internal and external monitoring.

Recommendations

The Board of Directors is requested to:

1. Note the quality position statement including the intelligent monitoring report, and the annual report on complaints, concerns and compliments.
2. 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

Intelligent Monitoring Report

Report on

Derbyshire Healthcare NHS Foundation Trust

To view the most recent inspection report please visit the link below.

http://www.cqc.org.uk/Provider/RXM

June 2015

Intelligent Monitoring: Report on 11 June 2015

CQC has developed a new model for monitoring a range of key indicators about Trusts that provide Mental Health services. These indicators relate to the five key questions we will ask of all services – are they safe, effective, caring, responsive and well-led? The indicators will be used to raise questions about the quality of care. They will not be used on their own to make judgements. **Our judgements will always be based on the result of an inspection, which will take into account our Intelligent Monitoring analysis alongside local information from the public, the trust and other organisations.**

To view the most recent inspection report please visit the link below.
http://www.cqc.org.uk/Provider/RXM

What does this report contain?

This report presents CQC's analysis of the key indicators (which we call 'tier one indicators') for Derbyshire Healthcare NHS Foundation Trust. We have analysed each indicator to identify two possible levels of risk.

We have used a number of statistical tests to determine where the thresholds of "risk" and "elevated risk" sit for each indicator, based on our judgement of which statistical tests are most appropriate. These tests include Poisson and z scoring techniques. Where an indicator has 'no evidence of risk' this refers to where our statistical analysis has not deemed there to be a risk or elevated risk. For some data sources we have applied a set of rules to the data as the basis for these thresholds - for example concerns raised by staff to CQC (and validated by CQC) are always flagged in the model.

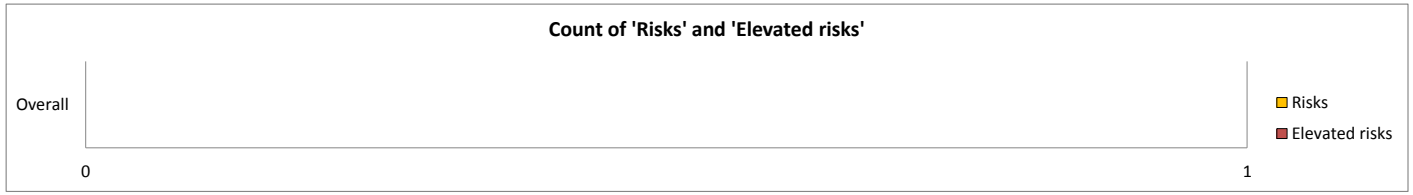
Further details of the analysis applied are explained in the accompanying guidance document.

What guidance is available?

We have published a document setting out the definition and full methodology for each indicator. If you have any queries or need more information, please email enquiries@cqc.org.uk or use the contact details at www.cqc.org.uk/contact-us

Derbyshire Healthcare NHS Foundation Trust

Trust Summary



Band	4
Number of 'Risks'	0
Number of 'Elevated risks'	0
Overall Risk Score	0
Number without "Evidence of risk"	64
Number of Applicable Indicators	64
Proportional Score	0.00%
Maximum Possible Risk Score	127

Derbyshire Healthcare NHS Foundation Trust

Tier One Indicators

Domain	ID	Indicators - Source	From	To	Observed	Expected	Risk?
Safe	MHSAF07C	Potential under-reporting of patient safety incidents - **NRLS/MHLDDS-HES Bridged**	01/12/2013	30/11/2014	0.08	0.10	No evidence of risk
	MHSAFE06	Proportion of reported patient safety incidents that are harmful - **NRLS**	01/12/2013	30/11/2014	0.39	0.40	No evidence of risk
	MHSAFE63	Patients that die following injury or self-harm within 3 days of being admitted to acute hospital beds - **MHLDDS-HES Bridged**	01/10/2013	30/09/2014	0.00	n/a	No evidence of risk
	MHSAFE64	People that take their own lives within 3 days of discharge from hospital - **MHLDDS-HES Bridged**	01/12/2013	30/11/2014	0.00	0.08	No evidence of risk
	COM_MORT01	Composite indicator showing trusts flagging for risk in relation to the number of deaths of patients detained under the Mental Health Act - **MHLDDS/MHAdb**	01/01/2014	31/12/2014	n/a	n/a	No evidence of risk
	MHMORT01	*Trusts flagging for risk in the number of suicides of patients detained under the Mental Health Act (all ages) - **MHLDDS/MHAdb***	*01/01/2014*	*31/12/2014*	*0.00*	*n/a*	*No evidence of risk*
	MHMORT03	*Trusts flagging for risk in relation to the number of deaths due to natural causes of patients detained under the Mental Health Act (people aged under 75) - **MHAdb/HSCIC KP90***	*01/01/2014*	*31/12/2014*	*0.00*	*n/a*	*No evidence of risk*
	NHSSTAFF11	Fairness and effectiveness of incident reporting procedures - **NHS Staff Survey**	01/09/2014	31/12/2014	0.64	0.63	No evidence of risk
	NRLSL08	Consistency of reporting to the National Reporting and Learning System - **NRLS**	01/04/2014	30/09/2014	6 months of reporting	n/a	No evidence of risk
	COM_CASMH	Composite of Central Alerting System (CAS): Dealing with (CAS) safety alerts in a timely way - **CAS**	01/04/2004	31/01/2015	n/a	n/a	No evidence of risk
	CASMH01A	*The number of alerts which CAS stipulated should have been closed by trusts during the preceding 12 months, but which were still open on the date CQC extracted data from the CAS system - **CAS***	*01/02/2014*	*31/01/2015*	*0 alerts still open*	*n/a*	*No evidence of risk*
	CASMH01B	*The number of alerts which CAS stipulated should have been closed by trusts more than 12 months before, but which were still open on the date CQC extracted data from the CAS system - **CAS***	*01/04/2004*	*31/01/2014*	*0 alerts still open*	*n/a*	*No evidence of risk*
	CASMH01C	*Percentage of CAS alerts with closing dates during the preceding 12 months which the trust has closed late - **CAS***	*01/02/2014*	*31/01/2015*	*< 25% of alerts closed late*	*n/a*	*No evidence of risk*
	MHRES20	Proportion of discharges from hospital followed up within 7 days - **MHLDDS**	01/12/2013	30/11/2014	0.90	0.72	No evidence of risk
	NHSSTAFF07	Proportion of staff receiving health and safety training in last 12 months - **NHS Staff Survey**	01/09/2014	31/12/2014	0.88	0.73	No evidence of risk
	PLACE01	PLACE (patient-led assessments of the care environment) score for cleanliness of environment - **PLACE**	29/01/2014	17/06/2014	0.98	0.98	No evidence of risk
	SAFEGUAR01	CQC's National Customer Service Centre (NCSC) safeguarding concerns - **CQC**	25/02/2014	24/02/2015	10.00	24.56	No evidence of risk
	MHWEL129	Proportion of registered nursing staff - **ESR**	31/12/2014	31/12/2014	0.59	0.52	No evidence of risk
	MHWEL132	Ratio of occupied beds to all nursing staff - **ESR**	31/12/2014	31/12/2014	3.15	2.85	No evidence of risk
Effective	CMHSURA06	Being informed: for having been told who is in charge of organising their care and services - **CMH Survey**	01/09/2013	30/11/2013	8.01	n/a	No evidence of risk
	CMHSURA38	Help finding support for physical health needs: for those with physical health needs receiving help or advice with finding support for this, if they needed this - **CMH Survey**	01/09/2013	30/11/2013	5.80	n/a	No evidence of risk
	MHCAR201	Proportion of patients who have been in hospital less than a year who received a physical health check on admission - **MHA Database**	01/12/2013	30/11/2014	1.00	0.97	No evidence of risk
	MHCAR202	Proportion of wards where there were difficulties in arranging GP services - **MHA Database**	01/12/2013	30/11/2014	0.00	0.13	No evidence of risk
	MHEFF107	Proportion of records checked that show evidence of discharge planning - **MHA Database**	01/12/2013	30/11/2014	0.58	0.72	No evidence of risk
	NAS_PH02	Service users who had five individual cardiometabolic health risk factors monitored in the past 12 months - **NAS2**	01/08/2013	30/11/2013	0.20	0.33	No evidence of risk
	NAS_PH03	Monitoring of alcohol intake in the past 12 months - **NAS2**	01/08/2013	30/11/2013	0.67	0.71	No evidence of risk
	NAS_PT01	Has cognitive behavioural therapy ever been offered to the service user? - **NAS2**	01/08/2013	30/11/2013	0.40	0.41	No evidence of risk
	NAS_PT02	Has family intervention ever been offered to the service user? - **NAS2**	01/08/2013	30/11/2013	0.23	0.20	No evidence of risk
	PLACE02	PLACE (patient-led assessments of the care environment) score for food - **PLACE**	29/01/2014	17/06/2014	0.90	0.90	No evidence of risk
	NHSSTAFF04	Proportion of staff appraised in last 12 months - **NHS Staff Survey**	01/09/2014	31/12/2014	0.91	0.87	No evidence of risk
	NHSSTAFF05	Proportion of staff having well-structured appraisals in last 12 months - **NHS Staff Survey**	01/09/2014	31/12/2014	0.37	0.41	No evidence of risk
	NHSSTAFF06	Proportion of staff receiving support from immediate managers - **NHS Staff Survey**	01/09/2014	31/12/2014	0.69	0.70	No evidence of risk
	MHSAFE51	The proportion of times that the Responsible Clinician has recorded their assessment of a patients' capacity to consent at first treatment - **MHA Database**	01/12/2013	30/11/2014	0.53	0.65	No evidence of risk
	MHCAR19	Is there a current independent Mental Health Advocate (IMHA) service? - **MHA Database**	01/12/2013	30/11/2014	1.00	0.99	No evidence of risk
	MHCAR20	Do detained patients have direct access to the Independent Mental Health Advocate (IMHA) service? - **MHA Database**	01/12/2013	30/11/2014	1.00	0.94	No evidence of risk
	MHEFF106	Proportion of Approved Mental Health Practitioner (AMHP) reports available - **MHA Database**	01/12/2013	30/11/2014	0.73	0.77	No evidence of risk
	MHSAFE52	Proportion of patients who have their rights on detention explained to them - **MHA Database**	01/12/2013	30/11/2014	0.83	0.90	No evidence of risk

Domain	ID	Indicators - Source	From	To	Observed	Expected	Risk?
Caring	CMHSURA18	Respect and dignity: for feeling that they were treated with respect and dignity by NHS mental health services - **CMH Survey**	01/09/2013	30/11/2013	8.66	n/a	No evidence of risk
	CMHSURA31	Time: for being given enough time to discuss their needs and treatment - **CMH Survey**	01/09/2013	30/11/2013	7.91	n/a	No evidence of risk
	PLACE03	PLACE (patient-led assessments of the care environment) score for privacy, dignity and well being - **PLACE**	29/01/2014	17/06/2014	0.89	0.89	No evidence of risk
	CMHSURA10	Involvement in planning care: for those who have agreed what care and services they will receive, being involved as much as they would like in agreeing this - **CMH Survey**	01/09/2013	30/11/2013	7.54	n/a	No evidence of risk
	CMHSURA12	Involvement in care review: for those who had had a formal meeting to discuss how their care is working, being involved as much as they wanted to be in this discussion - **CMH Survey**	01/09/2013	30/11/2013	7.45	n/a	No evidence of risk
	CMHSURA35	Involvement in decisions: for those receiving medicines, being involved as much as they wanted in decisions about medicines received - **CMH Survey**	01/09/2013	30/11/2013	7.14	n/a	No evidence of risk
	CMHSURA42	Involving family or friends: for NHS mental health services involving family or someone else close to them as much as they would like - **CMH Survey**	01/09/2013	30/11/2013	6.72	n/a	No evidence of risk
	NAS_SD01	Was the patient provided with written information (or an appropriate alternative) about the most recent antipsychotic prescribed? - **NAS2**	01/08/2013	30/11/2013	0.25	0.36	No evidence of risk
	CMHSURA16	Support: for the people seen through NHS mental health services helping them achieve what is important to them - **CMH Survey**	01/09/2013	30/11/2013	6.58	n/a	No evidence of risk
Responsive	COM_BEDS	Composite indicator to assess bed occupancy - **MHA Database/NHS England**	01/12/2013	31/12/2014	n/a	n/a	No evidence of risk
	MHSAF65a	*Occupancy ratio, looking at the number of patients allocated to a location, compared with the number of available beds - **MHA Database***	*01/12/2013*	*30/11/2014*	*0.98*	*n/a*	*No evidence of risk*
	MHSAF65c	*Occupancy ratio, looking at the average daily number of available and occupied beds open overnight - **NHS England***	*01/01/2014*	*31/12/2014*	*0.98*	*n/a*	*Risk*
	PLACE04	PLACE (patient-led Assessments of the care environment) score for facilities - **PLACE**	29/01/2014	17/06/2014	0.95	0.92	No evidence of risk
	CMHSURA23	Contact: for knowing who to contact out of office hours if they have a crisis - **CMH Survey**	01/09/2013	30/11/2013	6.70	n/a	No evidence of risk
	DTC46	The ratio of the number of patients whose transfer of care is delayed to the average daily number of occupied beds open overnight in the quarter, where the delay is attributable to the NHS or both the NHS and social care - **NHS England**	01/10/2014	31/12/2014	0.00	0.03	No evidence of risk
	MHRES12	Proportion of IAPT referrals with first assessment in the reporting period where people have waited more than 28 days - **IAPT**	01/07/2014	30/09/2014	0.31	0.28	No evidence of risk
	MHRES13	Proportion of IAPT referrals with first treatment in the reporting period where people have waited more than 28 days - **IAPT**	01/07/2014	30/09/2014	0.31	0.36	No evidence of risk
	CQC_COM01	Concerns and complaints received by CQC - **CQC**	25/02/2014	24/02/2015	23.00	30.35	No evidence of risk
	PHSOMH01	Fully and partially upheld investigations into complaints - **PHSO**	01/04/2013	31/03/2014	Less than 3	n/a	No evidence of risk
	PROV_COM01	NHS written complaints - **HSCIC**	01/04/2013	31/03/2014	127.00	221.80	No evidence of risk
Well-led	MONITOR01	Monitor: risk rating for governance - **Monitor**	02/03/2015	02/03/2015	Monitor risk rating: No evident concerns	n/a	No evidence of risk
	TDA03	NHS Trust Development Authority escalation score - **TDA**	Not included	Not included	Not included	Not included	Not included
	FLUVACMH01	Proportion of Health Care Workers with direct patient care that have been vaccinated against seasonal influenza - **Department of Health**	01/09/2013	31/01/2014	0.28	0.41	No evidence of risk
	MHWEL137	Proportion of days sick in the last 12 months for medical and dental staff - **ESR**	01/01/2014	31/12/2014	0.03	0.02	No evidence of risk
	MHWEL138	Proportion of days sick in the last 12 months for nursing and midwifery staff - **ESR**	01/01/2014	31/12/2014	0.05	0.05	No evidence of risk
	MHWEL139	Proportion of days sick in the last 12 months for other clinical staff - **ESR**	01/01/2014	31/12/2014	0.05	0.05	No evidence of risk
	MHWEL140	Proportion of days sick in the last 12 months for non-clinical staff - **ESR**	01/01/2014	31/12/2014	0.04	0.04	No evidence of risk
	NHSSTAFF16	Proportion of staff reporting good communication between senior management and staff - **NHS Staff Survey**	01/09/2014	31/12/2014	0.30	0.31	No evidence of risk
	NHSSTAFF20	Proportion of staff feeling pressure to attend work when feeling unwell in the last 3 months - **NHS Staff Survey**	01/09/2014	31/12/2014	0.19	0.21	No evidence of risk
	GMC_MH01	General Medical Council enhanced monitoring - **GMC**	31/03/2015	31/03/2015	No concerns	n/a	No evidence of risk
	NTS12	General Medical Council national training survey – trainee's overall satisfaction - **GMC**	26/03/2014	08/05/2014	Within the middle quartile (Q2/IQR)	n/a	No evidence of risk
	STASURBG01	Proportion of staff who would recommend the trust as a place to work or receive treatment - **NHS Staff Survey**	01/09/2014	31/12/2014	0.65	0.63	No evidence of risk
	MHRES17	Proportion of wards that have community meetings - **MHA Database**	01/12/2013	30/11/2014	0.90	0.92	No evidence of risk
	WBLOW_MH01	Snapshot of whistleblowing alerts received by CQC - **CQC**	04/03/2015	04/03/2015	0.00	n/a	No evidence of risk
	MONITOR02	Monitor: continuity of service rating - **Monitor**	02/03/2015	02/03/2015	4: no evident concerns	n/a	No evidence of risk

Suppression: We apply a strict statistical disclosure control in accordance with the HES protocol to all published data. This requires that small numbers are supressed to prevent individuals being identified and to ensure that patient confidentiality is maintained. An asterisk (*) in the observed column indicates a suppressed value between 1 and 5.

Not applicable or N/A Values: "n/a" is used to mean either that an expected value is not relevant to a specific indicator because the indicator is rules based or the indicator does not have an observed value.

Derbyshire Healthcare NHS
NHS Foundation Trust

PATIENT EXPERIENCE REPORT – ANNUAL REPORT ON COMPLAINTS, CONCERNS AND COMPLIMENTS JUNE 2015

1. STRATEGIC CONTEXT

Complaints and concerns are welcomed by us as a means of learning from the feedback from people who use our services. Compliments help us to understand what we have done well and how we share this with other parts of our services. Our annual report sets out some of the improvements we have made as a result of complaints etc.

National Policy dictates that it is essential where complaints arise within the NHS that they are dealt with sensitively and effectively.

The National Health Service (Complaints) Regulations 2004, as amended in 2006, were revoked in March 2009. Plans to reform NHS and adult social care complaints were formally consulted on between June and October 2007. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 came into force on 1st April 2009 and introduced a single complaints system for all health and local authority social services in England. This is a new approach to resolving complaints more effectively by responding more personally and positively to individuals who are unhappy and ensure opportunities for services to learn and improve are not lost. The new complaints regulations have replaced the previous three-stage process with a two stage process: Stage 1 is resolution by Trusts; Stage 2 is the Parliamentary and Health Service Commissioner (Ombudsman).

Several national reports have influenced our work on complaints, including the public inquiry led by Sir Robert Francis QC, and the complaints review by the Rt Hon Ann Clwyd MP and Professor Patricia Hart. In December 2014 the Care Quality Commission published a report 'Complaints matter'. This report sets out how its new inspection regime will focus on complaints and how it proposes to embed complaints and concerns in the new regulatory model.

The Care Quality Commission focus on complaints as part of their regular monitoring of trusts, including when they carry out their inspections.

1.1 REQUIREMENTS

The Trust is required to have in place arrangements for the handling and consideration of concerns and complaints which ensure that they are dealt with efficiently and investigated properly. Complainants should be treated with respect, dignity and courtesy. Complainants should be assisted in enabling them to understand the procedure and provided with advice on where to obtain independent assistance. Complainant should receive appropriate and proportionate responses within an agreed timeframe. They should be told the outcome of the investigation and any actions taken.

2. OUR COMPLAINTS PROCESS AND STRUCTURE

The Patient Experience team is the central point of contact for people to provide feedback and raise concerns about the services provided by the Trust. The team is located within the Nursing and Patient Experience directorate and is based at the Trust Headquarters. Staff have direct contact with the Chief Executive and Executive Directors and liaise regularly with Senior Managers. Our aim is to provide a swift response to concerns or queries that are raised and to ensure a thorough investigation takes place when required, with complainants receiving comprehensive written responses that describe any actions taken.

Face to face meetings are routinely offered when people express concerns, at the start and/or end of the formal investigation process. If we are unable to resolve complaints satisfactorily people are advised of their right to contact the Health Service Ombudsman who can investigate complaints on their behalf.

Learning from the feedback we receive is essential. This is shared with staff through the Trust 'Practice Matters' publication. During the year we have included advice on the transfer of patients using police vehicles and the need to formally respond to families when investigations have been concluded. A Pod cast has also been used to promote learning from investigations and it is envisaged that this will become routine practice in the coming year.

Two new roles have been created: Family Liaison Co-ordinator and Family Liaison Facilitator - specifically to work across serious incidents and complaints in order to ensure families concerns are heard and they are fully supported during the process. During the year complaints and concerns have been themed so reports are now more meaningful. Recommendations will also follow this process and be themed at source. This will allow for an overarching action plan to be put in place to address any recurring themes.

As planned we introduced the Datix web based system so staff can now log and review concerns and compliments at source.

The Friends and Family test was introduced and the results are to be reported alongside concerns, compliments and complaints.

We have also changed our visual monitoring system within the office to ensure that we can easily see due dates for responses

2.1 How we have and will continue to monitor and report

- Reporting of concerns, complaints and compliments will continue to be by 'main subject' and then by 'theme'. All responses to complaints are reviewed and signed off by the Chief Executive.
- Weekly reports will be produced highlighting the length of time cases are open.
- Quarterly reports are provided for General Managers, highlighting key issues, with the expectation that the information will be disseminated across their service lines.

- A thematic review which includes the learning from complaints is undertaken quarterly by the Divisional Nurses and is reported on in the Improving Patient Experience team report. Quarterly reports are provided for the Patient Experience Committee, Quality Committee and Trust Board.

3. SUMMARY OF OUR PERFORMANCE FINANCIAL YEAR 2014/15

3.1 Number of contacts

- At the time of writing this report 1219 cases have been logged. So far 746 compliments have been recorded. 215 concerns and 130 complaints have also been logged.

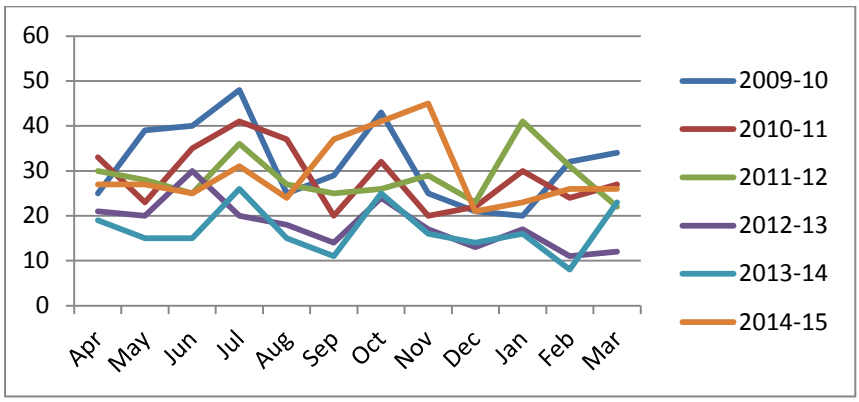
- From the completed investigations 114 individual actions have been identified and, to date, 88 actions have been completed.

3.2 Trends for concerns and complaints 2009-15

- The trend for concerns and complaints over the last 6 years appears to follow the same pattern with 3 peaks during the year, specifically July and October and to a lesser degree January.

- In 2009-10 the overall numbers of concerns and complaints received was 384 this dropped steadily year on year until 2013-14 when it was 202. However, in 2014-15 the number rose significantly to 357. Whilst the number of formally investigated complaints has not changed significantly the logging of concerns has increased resulting in the overall increase in numbers.

- 130 formally investigated complaints were received during the year. This is not significantly higher than last year (127). The reporting of concerns, however, has increased from 70 - 202. The number of compliments reported during the year has decreased slightly from 833 to 746.



3.3 % of complaints and compliments against activity

- The % of complaints reported against activity for 2014-15 is below 0.1%. This is felt to be an acceptable level and is not anticipated to change significantly over the coming year.

- For compliments it is 0.2%.

3.4 Staff members

- A number of staff have been named twice in complaints during the year but only 1 member of staff has been named in 3 complaints during the year, this information has been highlighted as part of the medical appraisal system.

3.5 REGARDS information

Age groups for concerns and complaints

- Most complaints and concerns (91) were raised in respect of patients between 26 and 50. 57 from people aged between 51 and 75. 56 related to people under 25 and 56 had not stated their age. 6 were in respect of people aged over 76.

Gender

- 131 complaints and concerns were about women, 79 male and 56 gender was not stated.

Ethnicity

- 173 complaints and concerns were from white British, 56 ethnicity was not stated and 15 not known.

4. SUMMARY OF OUR PERFORMANCE AGAINST OUR COMPLAINTS PROCESS

4.1 Accessible complaints procedure

- Complaints are received in a variety of ways, letter, e-mail, telephone and in person. They can come via staff, or advocacy services, Members of Parliament, directly from the service user and also from carers or family members acting on behalf of a service user. Complaints can also be received from Healthwatch (Derby and Derbyshire), NHS Choices, Patient Opinion, Clinical Commissioning Groups and other organisations.

- Translation services are used if required.

4.2 Measure of level of response

Measure	Grade	Description	Sign off
Concern - an issue that can be resolved	Yellow	Potential to impact on service provision/delivery. Legitimate consumer concern but not causing lasting detriment. Low risk of litigation.	Local Manager
Complaint - an issue that requires investigation	Orange	Significant issues of standards, quality of care, or denial of rights. Complaints with clear quality assurance or risk management implications or issues causing lasting detriment that require investigation. Possibility of litigation.	Chief Executive
Complaint - an issue that requires investigation	Red	Issues regarding serious adverse events, long term damage, grossly substandard care, professional misconduct or death that require investigation. Serious patient safety issues. High probability of litigation.	Chief Executive

4.3 Complaints investigation outcomes

- Of the 99 completed complaints, 68 have been graded as well founded or well founded in part. This grading is based on whether actions to improve the care or service have been taken as a direct result of the complaint being made. Reports for senior managers are now being produced weekly to highlight the number of days cases are open for. This is initially to raise awareness and then reduce the time taken to complete investigations.

4.4 Complaints handling

Complaints response times

- Of the 130 formally investigated complaints 91 were acknowledged within 3 working days. Action is being taken to improve the number of complaints acknowledged within the 3 working day target. Protected time is now allocated to this task three times per week. 59 responses have been completed within an agreed target, 40 were responded to over the agreed target and 31 are still ongoing. Response times are set by the Investigating Officer in discussion with the complainant and Patient Experience Team.

4.5 Complaints to the Ombudsman

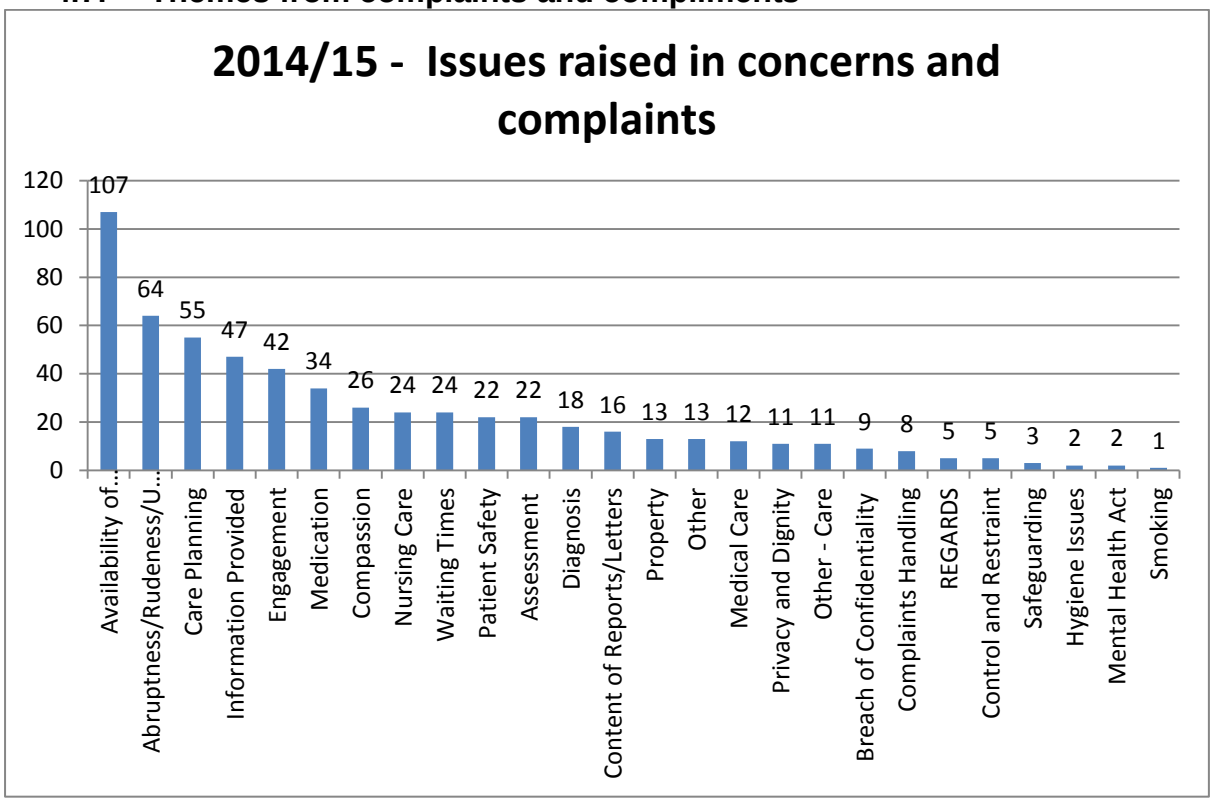
- 8 Ombudsman assessments have been requested during the year, 6 required no further action. 2 cases resulted in actions, one an explanation and apology was given and one resulted in a payment of £1,000 for a breach of confidentiality.

- As the Health Service Ombudsman has taken no further action in regard to 6 out of the 8 complaints they independently reviewed during the year assurance can be provided that complaints are handling and reported on in accordance with the National Guidance for Complaints Handling.

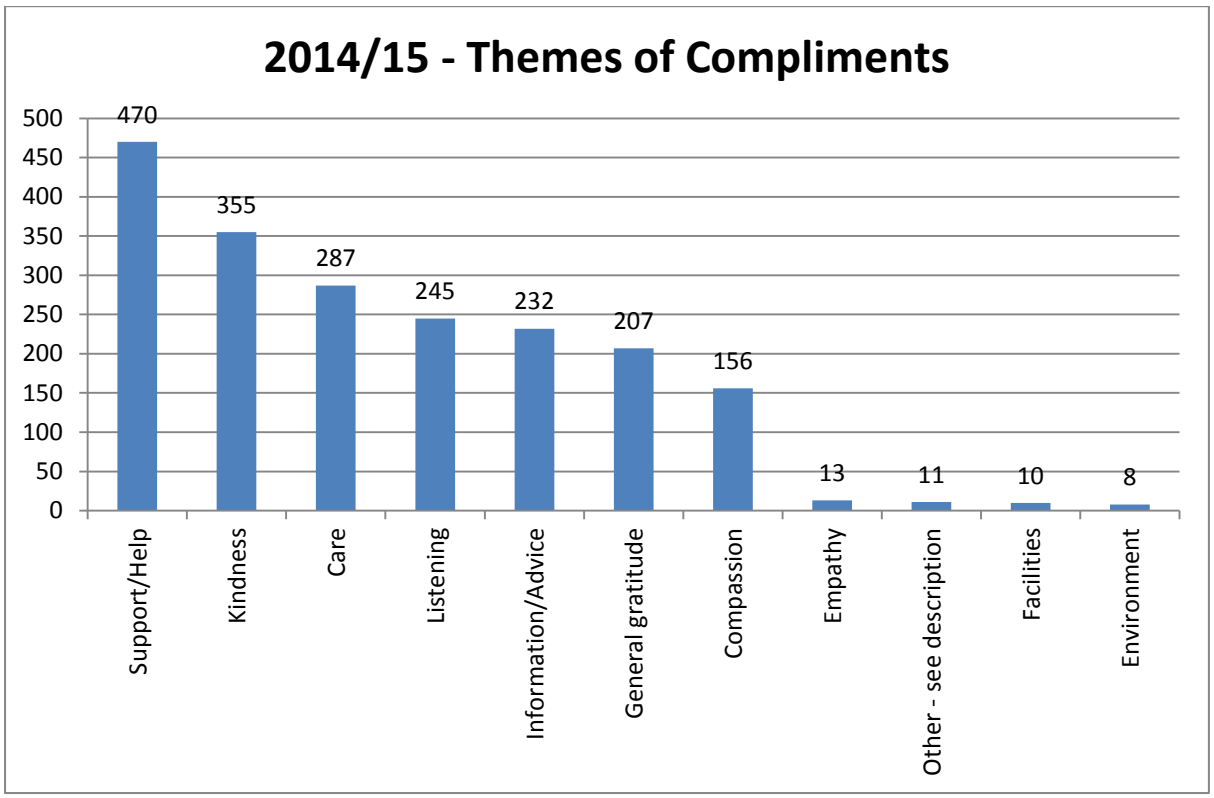
4.6 Training

- Root Cause Analysis Investigation Training is provided for staff on at least two occasions throughout the year. Complaints training is provided when requested by teams.

4.7. Themes from complaints and compliments



- Most (107) of the issues raised from concerns and complaints related to the availability of service/therapies/activities. Issues related to staff attitude were second with 64 issues being raised and care planning third with 55 issues.

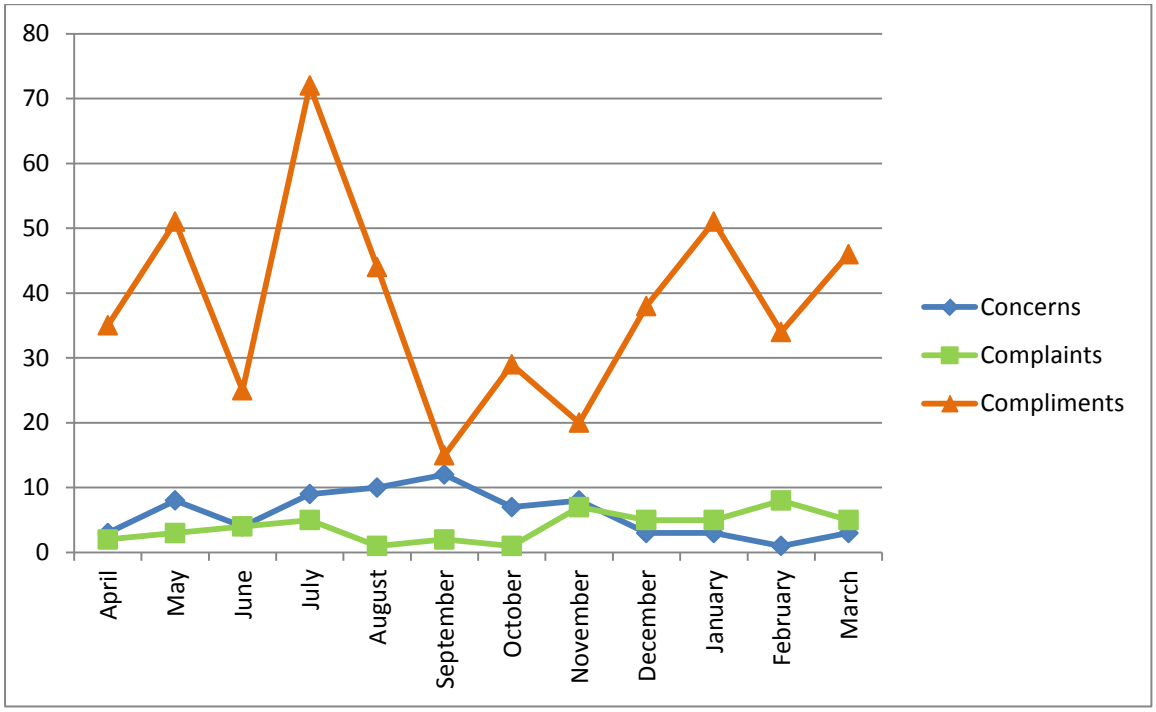


Most compliments referred to the support/help given by staff (470), 355 for the kindness shown by staff and 287 for the care given.

This information is shared with staff through the operational lines. Discussions are, however, underway looking at how we can use the feedback more effectively.

5. CONCERNS, COMPLAINTS AND COMPLIMENTS REPORTING AT A LOCAL LEVEL

5.1 Urgent Care Division



5.2 Complaints by teams and themes

- Most were recorded by the **Crisis Resolution & Home Treatment Team City & County South (7).**
- Availability of services/activities/therapies (3), abruptness/rudeness/unprofessionalism (2), waiting times (2), care planning (1), privacy and dignity (1) and complaints handling (1).

Ward 33 (5).
Information provided (1), assessment (1), medication (1), availability of services/activities/therapies (1) and breach of confidentiality (1).

Enhanced Care Ward (5)
Availability of services/activities/therapies (2), care planning (2), abruptness/rudeness/unprofessionalism (1), privacy and dignity (1), medical care (1), nursing care (1), patient safety (1), compassion (1), property (1), control and restraint (1) and information provided (1)

Ward 34 (5)
Information provided (2), availability of services/activities/therapies (2), care planning (2), diagnosis (2), patient safety (1), medication (1), safeguarding (1), engagement (1) and hygiene (1).

5.3 Learning from complaints at a local level

1 To provide clarity for staff patients and carers on the process for escorting patients to hospital for admission following assessment to ensure professional standards are met.

Completed: Team Meeting held on 28th January 2015. Feedback from complaint given and staff informed of findings by Clinical Lead. Staff also informed of Best Practice.

2 The Trust shuld ensure a timelier responsive referral system from physicians. This agreement should ensure a minimum arrangement of weekly ward visits from physicians in person.

Completed: The Service Level Agreement was obtained to confirm the expected number of vists and referrals are now made by telephone to physcians if needed.

3 The Trust should ensure that all ward staff are aware of the process of making a referral to Tissue Viability. Also that ward staff are fully familiar with nursing documentation relating to wound care.

Completed: Training session took place on 20/11/14 with regard to wound care. It was discussed at the ward meeting and evidenced in the minutes. The ward has two tissue viability link nurses who link into sessions conducted by the Physical Healthcare Lead looking at best practice/products and advice. Physical Health Care Lead and Link Nurses are looking into a care plan that will be standardised in terms of using Non touch aseptic technique though will be individualised with treatment plan etc. Tissue viability referral is usually done following consultation with Physical Health Care Lead.

5.4 Concerns by teams and themes

Morton Ward (17)
Property 3, engagement 3, abruptness/rudeness/unprofessionalism 2, compassion 2, information provided 2, assessment 1, care planning 1, medication 1, nursing care 1, privacy and dignity 1.

Ward 33 (11)
Abruptness/Rudeness/Unprofessionalism 2, engagement 2, availability of services/activities/therapies 1, breach of confidentiality 1, compassion 1, information provided 1, medication 1, other care 1 and patient safety 1.

Ward 36 (9)
Diagnosis 2, availability of services/activities/therapies 1, information provided 1, medication 1, nursing care 1, property 1, REGARDS 1 and smoking 1.

Crisis Resolution & Home Treatment Team City & County South (9)
Availability of services/activities/therapies 4, waiting times 2, care planning 1, engagement 1 and assessment 1.

Crisis Resolution & Home Treatment Team Chesterfield (8)
Abruptness/rudeness/unprofessionalism 2, assessment 2, care planning 1, compassion 1, information provided 1 and patient safety 1.

Ward 34 (7)
Patient safety 2, availability of services/activities/therapies 1, care planning 1, diagnosis 1, information provided 1, other care 1,

Pleasley Ward (7)
Nursing care 3, diagnosis 1, information provided 1, medical care 1, privacy and dignity 1.

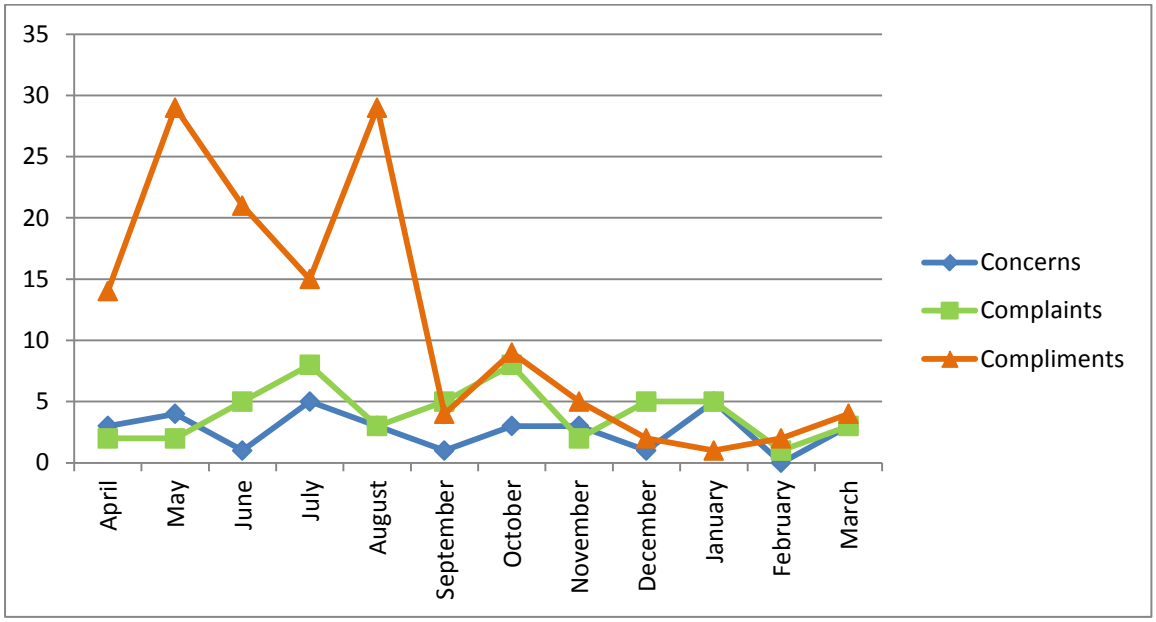
5.5 Compliments reported
Urgent care reported 460 compliments with over 1250 issues being raised. Most 280 related to the support and help provided, 235 for kindness, 188 care, 159 listening.

Most were reported by **Morton Ward (245)**
45 comments were in relation to the kindness shown by staff, 42 for support and help given, 36 gratitude, 36 care and 33 listening compassion 20.

Crisis Resolution & Home Treatment Team City & County South (230)
52 comments in relation to the support and help provided, 42 kindness shown, 33 listening, 32 advice given, care 29 and compassion 29.

Ward 33 (178)
41 support/ help provided, 33 kindness, care 29, listening 28, advice 25 and compassion14.

6. Planned Care Division



6.1 Complaints by teams and themes

Most were recorded by the: **Recovery & Pathfinder Team County South and Dales (7).**

Availability of services/activities/therapies (5), abruptness/rudeness/unprofessionalism (1), assessment (1), engagement (1) information provided (1), medication (1), waiting times (1), care planning (1) and compassion (1).

Recovery & Pathfinder Team Chesterfield Central Locality (6)

Engagement (4), diagnosis (3), information provided (3), availability of services/activities/therapies (2), waiting times (1), medication (1), assessment (1) and medical care (1).

Resource Centre Outpatient Department (6)

Engagement (1), REGARDS (1), other care (1), breach of confidentiality (1), availability of services/activities/therapies (1) and content of reports/letters (1).

6.2 Learning from complaints at a local level

1 Waiting lists should be effectively managed and lengths of wait communicated to service users.

Completed: Service Manager emailed all CBT staff to inform them of requirements

2 Ensure that literature pertaining to a dementia diagnosis is available and offered to all people attending memory assessment service.
Completed: All consultants advised that they should give literature pertaining to a diagnosis of dementia to a person they are giving a diagnosis to, the literature packs are available.

3 To improve the role of the Carers Champion.

Completed: Carers concerns now a standing agenda item at weekly team meeting, giving all staff members oppurtunity to raise any concerns.

6.3 Concerns by teams and themes

Recovery & Pathfinder Team County South and Dales (13)
Availability of Services/Activities/Therapies, 5, other 2, assessment 1, care planning 1, diagnosis 1, medication 1, other care,1 and safeguarding 1.

Recovery & Pathfinder Team Killamarsh and Chesterfield North Locality (13)
Availability of Services/Activities/Therapies 6, care planning 3, abruptness/rudeness/unprofessionalism, 1, content of reports/letters 2 and nursing care 1.

Recovery & Pathfinder Team Amber Valley (13)
Availability of services/activities/therapies 3, care planning 3, abruptness/rudeness/unprofessionalism 2, content of reports/letters 1, information provided 1, medical care 1, other 1 and waiting times 1.

Recovery & Pathfinder Team Chesterfield Central Locality (12)
Abruptness/rudeness/unprofessionalism 4, availability of services/activities/therapies 2, engagement 2, assessment 1, care planning 1, content of reports/letters 1 and information provided 1.

Recovery & Pathfinder Team Bolsover & Clay Cross Locality (10)
Availability of Services/Activities/Therapies4, assessment 1, care planning 1, content of reports/letters 1, information provided 1, nursing care 1 and waiting times 1.

Resource Centre Outpatient Department (10)
Abruptness/rudeness/unprofessionalism 1, care planning 1, content of reports/letters 1 and medication 1.

Talking Mental Health Derbyshire (9)
Availability of Services/Activities/Therapies 6, information provided 1, other 1, and waiting times 1.

Recovery & Pathfinder Team 1 (7)
Availability of services/activities/therapies 2, breach of confidentiality 1, care planning 2, engagement 1 and information provided 1.

Recovery & Pathfinder Team 2 (7)
Care planning 3, availability of services/activities/therapies 2, abruptness/rudeness/unprofessionalism 1 and content of reports/letters 1.

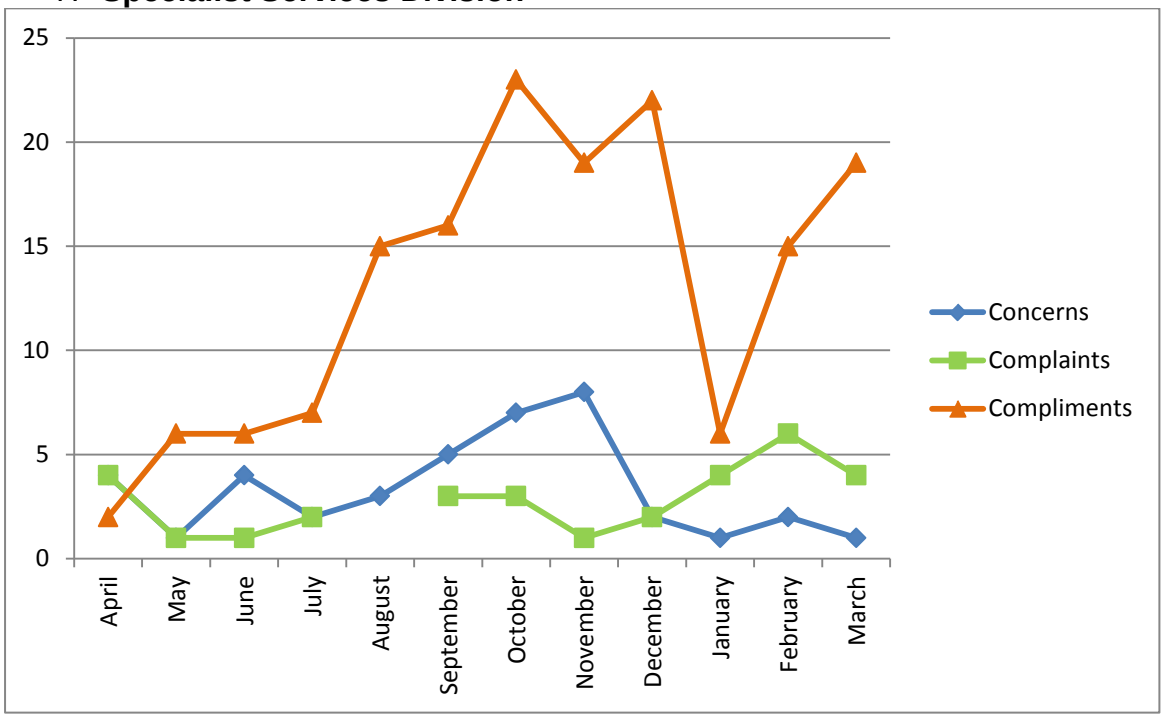
6.4 Compliments
Planned care reported 113 compliments with over 300 issues being raised. 78 for the support and help given, 58 for the kindness shown and 49 for the care provided.

Recovery & Pathfinder Team Amber Valley (69)
Kindness 17, Supporting/help 15, advice given 13, listening 13, care 8.

Recovery & Pathfinder Team High Peak and Dales (30)
Advice 7, support/help 7, kindness 4, listening 4, gratitude 3, compassion 2, care 2, and facilities 1.

Recovery & Pathfinder Team Erewash (29)
Care 8, support/help 6, listening 5, compassion 3, gratitude 3, kindness 3 and advice 1.

7. **Specialist Services Division**



7.1 Complaints by Teams and themes

CAMHS Derby City (4)

Availability of services/activities/therapies (3), information provided (1), compassion (1), medication (1), abruptness/rudeness/unprofessionalism (1) and care planning (1).

CAMHS County South Derbyshire (4)

Information provided (1), abruptness/rudeness/unprofessionalism (1), medication (1), availability of services/activities/therapies (1) and engagement (1).

7.2 Learning from complaints at a local level

1 Ensure wait times for neuro-developmental assessment are monitored for all internal referrals.

Completed: Pathway and protocol have been developed to ensure throughput and communications are auditable. Discussed monthly in medical staff meetings.

2 To strengthen the multi-disciplinary team (MDT) working in the Dales Locality.

Completed: Service is now integrated in to the Amber Valley team and is supported by a strong management & leadership team.

3 To ensure Psychology input is available for Melbourne House.

Completed: Substantive Psychologist 2 days per week has returned in to post. Further support provided from psychologist 1 day per week until March. 1 day per week psychologist employed to deliver Dialectic Behavioural Therapy has been recruited awaiting start date. 0.5 Band 5 Psychology assistant post created. Nurse attending Compassion Focused Therapy training course.

7.3 Concerns by teams and themes

CAMHS Derby City 9

Availability of services/ativities/therapies 2, waiting times 2, care planning 1, diagnosis 1 engagement 1, information provided 1 and medication 1.

Psychology Services Adults 5

Availability of services/activities/therapies 4, care planning 1.

Compliments

Specialist Services reported 156 compliments with over 400 issues being raised. 58 comments were for the kindness shown, 56 comments were in relation to general gratitude, 52 advice given and 49 for care given.

Audrey House (75)

Support/help 21, care 14, gratitude 14, kindness 7, advice 6, listening 5, compassion 3, facilities 3 and environment 2.

CAMHS Derby City (70)
Support/help 18, kindness 13, listening 11, advice 10, care 9, gratitude 6 and 3 compassion.

Melbourne House (36)
Support/help 12, kindness 7, advice 7, listening 4, gratitude 3, care 2 and compassion 1.

8. CONCLUSION

It is important to note that the Trust values feedback from people who use our services. Complaints and concerns are seen as positive opportunities to look into situations when people have not had good experiences. The Trust can learn from these situations and actions may be taken by the individual, the team or more widely across the Trust to improve services. It is important that all staff feel positive about receiving feedback, both positive and negative, about services as this will improve the relationship we have with service users and carers. During the year the Trust introduced the Datix Web module for complaints, concerns and compliments and staff are now logging compliments and concerns at source. As the Trust is a listening Trust, feedback should be encouraged within teams and actions taken should be highlighted using 'You said, We did' posters.

8.1 Key areas of focus in 2015/16

- We will work hard to significantly reduce the average time that it takes to handle complaints and to lessen the number of deadlines that are extended.
- We will ensure that complainants are kept up to date with the progress of their investigations.
- We will focus on the key elements of complaints handling and ensure that responses are provided in a timely manner.
- We will identify ways to use the feedback we receive more effectively.

8.2 Actions agreed following presentation at Quality Committee

- To include benchmarking information in future reports where available.
- To review and revise current policy on complaints, concerns and compliments to reflect new guidance and learning.
- To update Quality committee on those areas that do not receive many complaints for concerns such as Children's services, Learning Disabilities to improve their reporting.
- To request Quality Leadership Teams to develop mitigations to minimise impact and harm in those areas where there are a high number of complaints and concerns.
- To set up a process in the divisions that measures performance, using date of receipt of complaint to completion time.

Report prepared by: **Anne Reilly, Complaints Manager**

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

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 25th June 2014

Research & Development Centre Update

Purpose of Report
The purpose of the report is to provide the Board of Directors with an update on the activity of the Trust's Research & Development (R&D) Centre.

Executive Summary

- This report highlights the main areas of activity in research relating to National Research participation and local areas of focus in Compassion, Dementia and Self-harm and Suicide Prevention.

- The report also includes updates on the other aspects of the R&D centre: The Library and Knowledge Service and Clinical Audit.

- Our performance in delivering national clinical research continues to be strong but the new funding model implemented by the East Midlands Clinical Research Network means that we need to increase participation in interventional studies which attract more funding; although we remain committed to selecting studies for their clinical benefit rather than the design of the study.

- The work of all our three centres of excellence demonstrates good progress and significant activities with impact locally and wider reaching dissemination and learning.

- The Centre for Compassion is expected to change direction during the course of this year moving away from a research focus to more implementation and application of compassion models of care for service development.

- The Library and Knowledge Service impact survey provides important feedback and demonstrates the value of the service in its impact on patient care, research, learning and teaching.

- There is a positive culture of continuous quality improvement through the use of the Clinical Audit process within the organisation, and even where projects are delayed in completing, outcomes are positive as results are acted upon through improvement action plans.

- Progress has been made since approval of the revised Trust R&D Strategy but the reduced infrastructure continues to be a significant challenge that severely limits the scope of our work. A further allocated Cost Improvement

Programme has been delivered through the withdrawal of our annual subscription to the East Midlands Collaboration for Leadership in Applied Research programme (CLAHRC).

Strategic considerations

- Performance on research delivery and participation as required by the NHS constitution and reported in Quality Accounts.
- Delivery in line with Trust Strategy and Research & Development strategy and synergy with other Trust initiatives such as Transformation change.

Assurances

- This report provides assurance on activity being undertaken in the Trust as part of the Trust and R&D Strategy and contributes to the strategic outcome that people receive the best quality care.

Consultation

This report has been compiled through consultation and contributions from members of the R&D Centre only.

Governance or Legal issues

The R&D Governance Committee oversees the work the R&D Centre and reports to the Quality Committee on a reporting schedule

The Research Governance Framework covers the research activity reported in this document.

Some aspects of research e.g. relating to the National Portfolio research is delivered as part of a contract with the East Midlands Clinical Research Network as well as grant funded research such as the SHINE Health Foundation project.

Equality Delivery System

No negative impact on REGARDS groups.
Positive impact on REGARDS group can be demonstrated through the range of audit, research and related activities undertaken that impacts positively on the quality of care.

Recommendations

The Committee is requested to:

1) Note the content of the report.

2) Receive assurance from the activity reported that research and development is making a positive impact on the quality of our services.

Report presented by: **John Sykes, R&D/Medical Director**

Report prepared by: **Rubina Reza, Research & Clinical Audit Manager**

RESEARCH & DEVELOPMENT CENTRE UPDATE

The Research & Development Centre includes our three centres of excellence, Compassion, Dementia and Self-harm & Suicide Prevention; the Clinical Research Team responsible for our national portfolio of research; Library and Knowledge Services and Clinical Audit.

This update report provides an overview of activities from all aspects of the R&D Centre covering 2014-15 to date.

Compassion Centre

The mental health research unit has continued to operate such program as best it is able in regard to ensuring high quality publications and international / national research.

Publications

We have continued to maintain our publication rate. During the last year this has included 9 publications and a number of book chapters. Recent publications include:

- Gilbert. P. (2015). The evolution and social dynamics of compassion *Journal of Social & Personality Psychology Compass*. Advanced online publication
- Gilbert. P. (2015). An evolutionary approach to emotion in mental health with a focus on affiliative emotions. *Emotion Review* (special issues Normal and Abnormal Emotion. K Scherer, (ed.). DOI: 10.1177/1754073915576552.
- Gilbert, P., McEwan, K., Catarino, F & Baião, R. (2014). Fears of compassion in a depressed population: Implications for psychotherapy. *Journal of Depression and Anxiety* http://dx.doi.org/10.4172/2167-1044.S2-003.
- Gilbert, P., McEwan,K., Catarino, F & Baião, R. (2014). Fears of negative emotions in relation to fears of happiness, compassion, alexithymia and psychopathology in a depressed population: A preliminary study. *Journal of Depression and Anxiety* http://dx.doi.org/10.4172/2167-1044.S2-004
- Catarino, F., Gilbert, P., McEwan., K & Baião, R. (2014). Compassion motivations: Distinguishing submissive compassion from genuine compassion and its association with shame, submissive behaviour, depression, anxiety and stress *Journal of Social and Clinical Psychology*, 33, 399-412.

- Catarino, F., Sousa, J., Ceresatto,L., Moore, R & Gilbert P (in preparation) An exploration of different empathic competencies in submissive and genuine compassion
- Matos, M., Pinto-Gouveia, J., Gilbert, P., Duarte, C & Figueiredo, C. (2015). The Other As Shamer Scale – 2: Development and validation of a short version of a measure of external shame. *Personality and Individual Differences*, 74, 6–11. http://dx.doi.org/10.1016/j.paid.2014.09.037
- McEwan, K & Gilbert, P. (in press). A pilot feasibility study exploring the practising of compassionate imagery exercises in a nonclinical population. *Psychology and Psychotherapy*
- Ferreira, C., Palmeira, L., Trindade, I.A., Catarino, F. (2015). When thought suppression backfires: its moderator effect on eating psychopathology. Eating and Weight Disorders.Advance online publication. DOI10.1007/s40519-015-0180-5

Presentations

We have continued to disseminate our work widely and Prof Gilbert has provided a range of international keynote presentations in America and Europe over the past year. Other recent presentations include:

- Catarino, F. (2014). The Slimming World project: Compassionate mind training for people attempting to lose weight. Third International Compassion Focused Therapy conference, Birmingham. Link to a video of this presentation: http://www.compassionatemind.co.uk/resources/video37.htm

- Catarino, F. (2014). Bringing compassion to a common problem: Weight regulation. – British Psychological Society – Division of Clinical Psychology Annual Conference, 2014, Glasgow.

Research

Developing self-report measures of self and other-focused compassion and their relation with depression, anxiety, stress and wellbeing.
The aim of this study is to develop reliable and valid self-report scales for the assessment of compassion which are based in the model of Compassion developed by Paul Gilbert. 289 University students have taken part in this study. Colleagues in the US and Portugal have also collected data using the new scales. Data has been analysed and this study is currently in preparation for publication

Slimming World

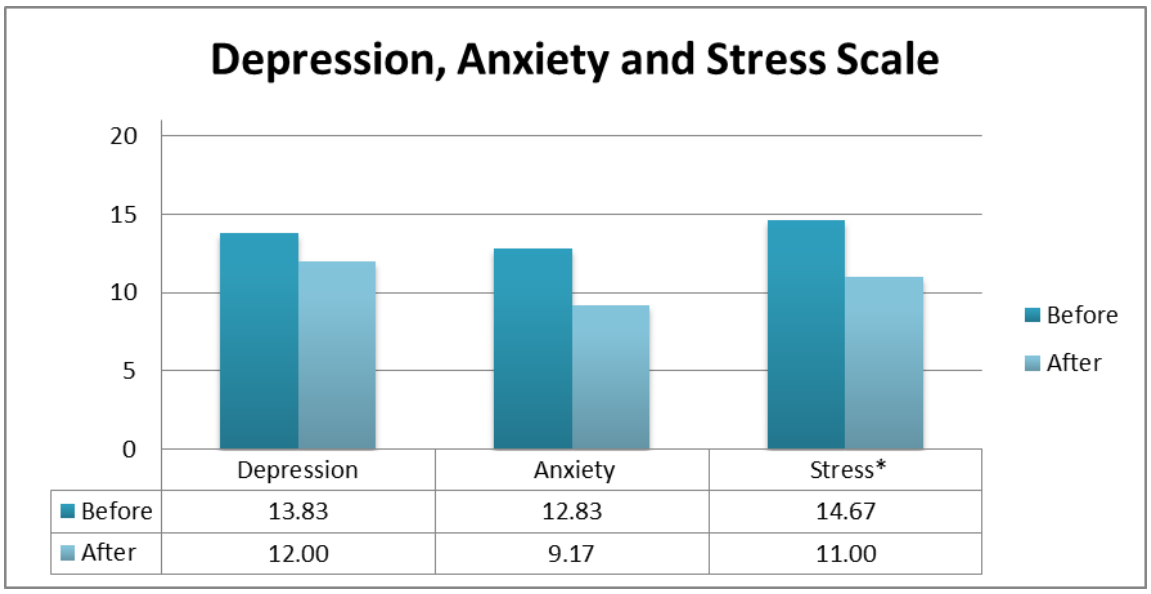
We will receive £45,467 from slimming world via the University of Derby for the work we have undertaken to develop an intervention for shame and self-criticism. This research is well progressed and we had 1202 Slimming World members (686 in the control group and 516 in the intervention group) who signed up to take part in the trial. Of these, we have received the following completed questionnaires at different time points throughout the study:

	Baseline	3 months	6 months	12 months (data collection is still ongoing)
Intervention	398	285	208	95
Control	539	349	299	79
Total	937	634	507	174

The data analysis phase has commenced. We anticipate that at least five main publications in high quality peer-review journals will result from this work.

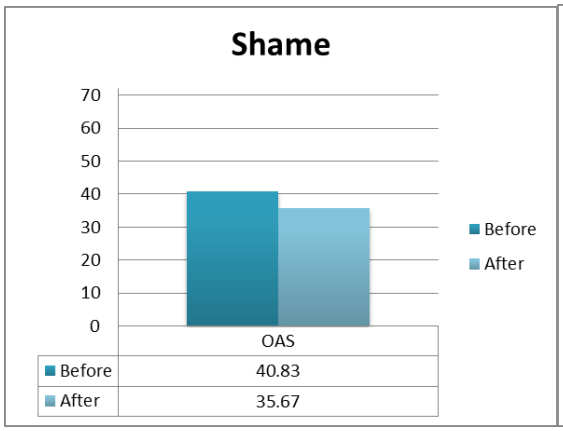
Melbourne house

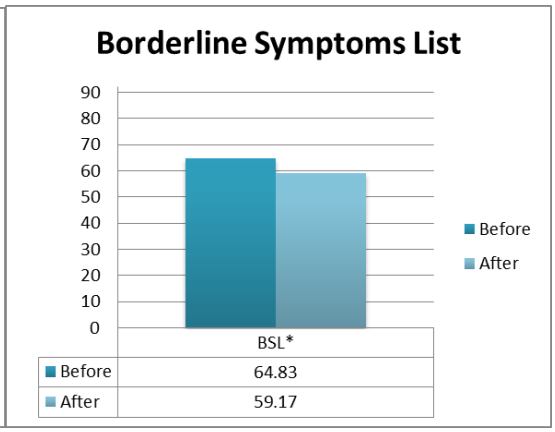
We developed a 20 week compassion focused group intervention for the clients of Melbourne house. Although the circumstances were not ideal, because the week we started, there were long-term sickness absence on the ward which was not replaced, and there were many staff shortages, nonetheless the group was well received and we have some helpful data. Below we present the histograms for all the variables in the study. On average, scores improved on most variables (with the exception of reassured self). However, given the numbers who agreed to take part in the study and also filled in their questionnaires (N= 6) these are mainly trends. Only Stress and Borderline symptoms showed statistically significant differences (these are marked with an * on the graphs below). It is also important to note that in this kind of study there are quite wide individual differences and so some people did much better than others.

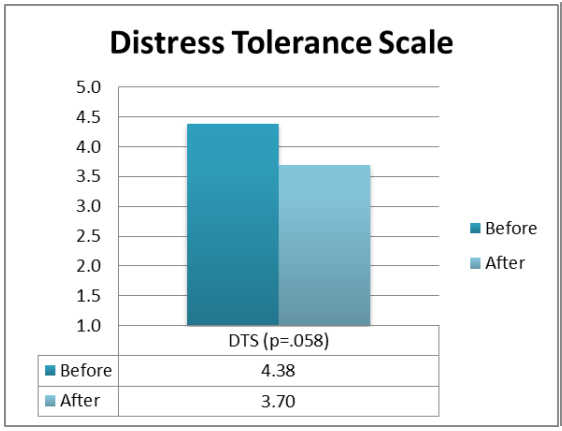


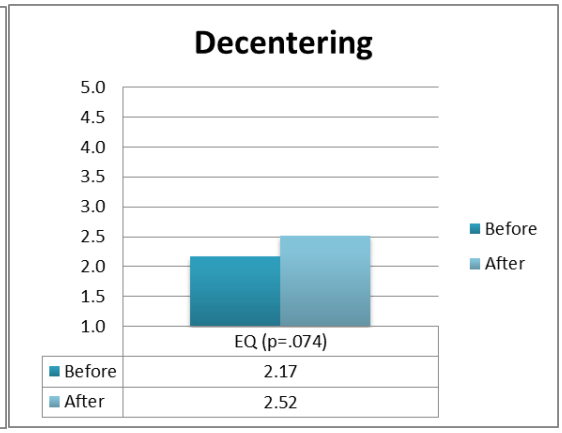
	Depression	Anxiety	Stress*
Before	13.83	12.83	14.67
After	12.00	9.17	11.00

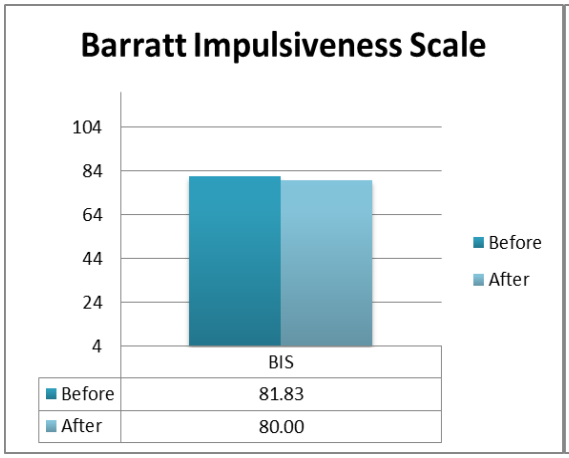

Forms of Self-Criticising and Self-Reassuring Scale
35
30
25
20
15
10
5
0
Before
After
Inadequate Self
Hated Self
Reassured Self
Before 30.67 15.67 11.00
After 26.83 14.83 9.83

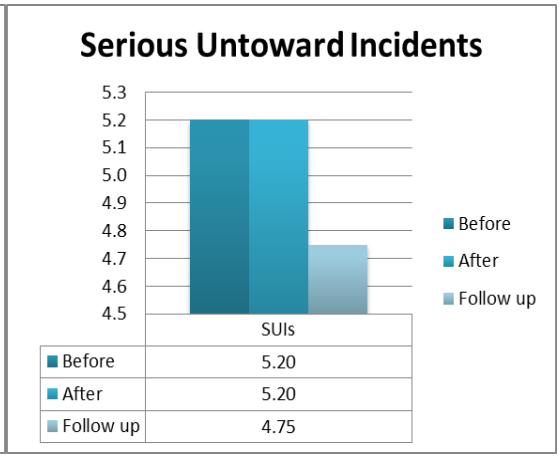

Shame
70
60
50
40
30
20
10
0
Before
After
OAS
Before 40.83
After 35.67


Borderline Symptoms List
90
80
70
60
50
40
30
20
10
0
Before
After
BSL*
Before 64.83
After 59.17


Distress Tolerance Scale
5.0
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
Before
After
DTS (p=.058)
Before 4.38
After 3.70


Decentering
5.0
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
Before
After
EQ (p=.074)
Before 2.17
After 2.52


Barratt Impulsiveness Scale
104
84
64
44
24
4
Before
After
BIS
Before 81.83
After 80.00


Serious Untoward Incidents
5.3
5.2
5.1
5.0
4.9
4.8
4.7
4.6
4.5
Before
After
Follow up
SUIs
Before 5.20
After 5.20
Follow up 4.75

It is important to recognise that these are people with quite complex difficulties and therefore the data are indeed encouraging. In a context where nurses were trained to be able to work with trauma memories (which they were not on Melbourne house) we would anticipate even better results.

The transcription of the qualitative data is currently being finalised and it will be analysed by Nottingham University

Compassionate Mind Skills Training Course for Health Visitors and School Nurses

We have now received data from 90 participants who attended 12 weeks of Compassionate Mind group training ran by Michelle Cree. Quantitative and qualitative results from this service evaluation project are being written up for publication in a peer reviewed journal and also internal dissemination within the Trust.

A Pilot Study Exploring the Effectiveness of Compassion Focused Therapy with Perinatal Mental Health Difficulties and Mother-Infant Bonding within a Routine Clinical Setting

We are expecting data from a sixth group of participants and once this is received, quantitative data analysis will be finalised and written up. Preparation for publication is currently underway.

Suicide study in liaison with the suicide management team

We have now submitted the data on our suicide study for publication. This study built on the entrapment and defeat model developed in the mental health research unit and also some of the measures. The abstract is presented below to provide insight into what was actually done and our findings:

> **Feelings of anger and escape in people presenting to an Emergency Department following an episode of self-harm**
>
> Clark, M., Gilbert, P., McEwan, K., Ness, J & Waters, K (submitted)
>
> Abstract
>
> *Objectives*: Self-harm behaviour has many sources and can include difficulties in elevated feelings of but difficulties in expressing anger (arrested anger) and feeling trapped with high flight/ escape motivation (arrested flight). This study developed measures of these constructs for the study of self-harm behaviour.
>
> *Methods*: Sixty individuals presenting to a Hospital's Emergency Department following an act of self-harm were recruited following a psychosocial assessment by a Mental Health Liaison Team clinician. Participants completed new questionnaires measures of arrested flight and arrested anger in regard to self-harm.

Results: The majority of participants presented after self-poisoning (93%). 95% reported experiencing high escape motivation that felt blocked (arrested flight) with (70%) reporting feeling angry with someone but unable to express it (arrested anger). Furthermore, for around half of all participants, strong desires to escape from current situations and/or express anger did not diminish immediately after the act.

Conclusions: Our findings suggest that aroused but arrested defences of fight and flight are common in self-harm and may continue after self-harm acts. Many participants revealed that talking about their experiences in these contexts was very helpful to them.

Practice points:

- Feelings of entrapment and arrested anger are common in people who self-harm
- Clinicians would benefit from increased awareness and measures of arrested flight and arrested anger.
- Discussing these experiences appear to be useful to people who self-harm
- Further research is needed on how best to help people with these experiences

Other

- Collaborations with University of Coimbra, University of Derby, Slimming World, Compassionate Mind Foundation
- New volunteer research assistant recruited: we hosted a guest researcher for 3 months who collaborated on the Slimming World study
- We continue to hold the data for Schwartz Rounds and provide support to the normal running of the Rounds
- University of Derby, College of Health & Social Care, Post Graduate Certificate Compassion Focused Therapy for which we received 15K for Prof Gilbert's contributions

Future directions and the ending of the mental health research unit

At a meeting with Prof Stephen Trenchard and Dr John Sykes it was decided to close the mental health research unit as an entity. Due to further funding not being secured the research assistant post will not be replaced when the current post holder leaves to take up a clinical psychology training position in August. Hence, we are now running down the research programme and will not be undertaking any new research projects unless specifically agreed and supporting infrastructure is available for further projects. As a result we will be unable to offer research placements at the Centre for Compassion. This will therefore be the last report under the name of the mental health research unit.

Future direction of the Compassion Centre is anticipated to be focused on clinical implementation and Prof Paul Gilbert will continue to be employed in an advisory and supportive capacity across relevant clinical pathways and service developments.

Report contributions by Prof Paul Gilbert & Francisca Catarino

Dementia Centre

Delirium Project

The focus continues on the implementation and raising awareness of the Stop Delirium programme of work. This work is concordant with the integrated care component of transformational change. In addition:

- Dr Thacker has been appointed Strategic Clinical Advisor to East Midlands Patient Safety Collaborative (1 session per week). The aim is to cohere work that is taking place across the East Midlands and use the profile of Liaison Psychiatry in its RAID (Rapid Assessment Interface Discharge) configuration to raise awareness of delirium (and its malign overlap with dementia) across the healthcare sector. This requires using our Trust's experience in developing ground-breaking psychiatric liaison services to create momentum for a greater reach of mental health expertise into physical healthcare across the East Midlands. Delirium is a "Trojan Horse" condition helps bridge the gulf between physical and mental health as mandated by the Parity of Esteem Agenda.

- Dr Thacker has also been appointed Public Engagement Officer for Trent Division of Royal College of Psychiatrists which will provide another opportunity for delirium/dementia awareness raising and feedback from the public and non-psychiatric professionals.

- The local Delirium group (Sallie Collis, Sue O'Dea, Tracie Collett, Sarah Wood and Simon Thacker) are preparing a presentation for the European Delirium Society Annual Meeting (London, September 2015) demonstrating our Trust's multi-dimensional, cross-organisational harmonisation of dementia and delirium care.

  Title: "Delirium: not just for physicians! -An organisation-wide Programme within a Mental Health Trust"

  Four key elements have been identified to the Delirium work being undertaken and these include:

Care Homes
The national drive to identify dementia in at least 2/3 of people with the disorder could potentially lead to the recruitment of less impaired people into services at the expense of those who are more vulnerable to delirium. We set out to identify PWD within care homes who had not previously been diagnosed and develop care plans in recognition of the dementia. Delirium Prevention was included in the care planning. We report on the barriers, facilitators, benefits and disadvantages of this approach.

Community Mental Health Team Erewash/Memory Assessment Service
Behavioural and psychological problems within dementia are evident at all stages of the illness. The overlaps between these and the manifestations of delirium can often be difficult to discern. Antibiotics are often prescribed for a putative infective delirium but the validity of this approach has been put into question unless there is convincing evidence of sepsis. Multi-component intervention to prevent delirium in hospital settings is underpinned by a robust evidence-base. We set out to promote the awareness of delirium, its extent, impact, treatment and prevention within a team serving People with Dementia living in the community. We then aimed to cascade knowledge of delirium throughout primary care and 3rd sector providers within our neighbourhoods. We report on the barriers, facilitators, benefits and disadvantages of this approach.

Liaison
The differential diagnosis of delirium is a major role of Liaison Psychiatry working in close collaboration with Geriatric Medicine. Yet the extent of delirium within the general hospital means that other specialities must “co-own” them. The RAID model of Liaison Psychiatry places on emphasis on proactive identification of psychiatric vulnerability, prompt response, multi-disciplinary working and staff training across the hospital. RAID is therefore well-placed to act as a hub of delirium knowledge and enthusiasm. We report on the barriers, facilitators, benefits and disadvantages of this approach.

Undergraduate Education
Parity of esteem for mental and physical health is the message but the reality is harder to achieve. The separate silos of Registered General Nurse (RGN) and Registered Mental Health Nurse (RMN) training need to cohere better. Delirium is a “bridging” disorder that merits a prominent place in both curricula. As both a cause and a consequence of Dementia, it also provides a bridge between acute and chronic care. We set out to use delirium education as an integrative paradigm within undergraduate nursing education. We report on the barriers, facilitators, benefits and disadvantages of this approach.

Other Dissemination Activity

In the last few months Dr Thacker has continued to collaborate and present widely on Delirium Prevention and Dementia care:

- Established links with the Age Anaesthesia Association regarding Post-Operative Cognitive Dysfunction which occurs in up to 25% of older surgical patients (sometimes but not necessarily associated with delirium) with opportunities for joint conferencing arising
- Presented on 'Pain, Dementia and Delirium' at the Chartered Physiotherapists in Mental Health Conference at Kingsway, 4th Feb 2015
- Did a Radio Broadcast (Radio Derby) on Dementia, Feb 2015
- Presented on 'End of Life Care in Dementia' at the Derby Royal College of Nursing (RCN) conference, 4th Dec 2014
- Presented at the National RAID Network conference in Birmingham with Keith Waters on the RAID model of Liaison Psychiatry entitled "Derby RAID- our 2-faced approach" - highlighting the uncomfortable, fascinating and essential position we maintain between physical and mental health services, 12th Dec 2014

Publications

- The joint Derby CQUIN Conference held at the Centre for R&D has been written up and published on Prof Alistair Burns NHS England blog: http://www.england.nhs.uk/wp-content/uploads/2015/05/cquin-derby-rep.pdf
- Psychiatry and the Geriatric Syndromes- creating constructive interfaces by S Thacker and M Skelton. Submitted to the Psychiatric Bulletin.
- Fast and Frugal Psychiatry by S Thacker submitted to Trent Division newsletter RCPsych
- Delirium – it ain't just for Physiciansby S Thacker submitted to Trent Division newsletter RCPsych
- Article on *Delirium Prevention in Psychiatry* published in the October Annals of Delirium

Dementia Challenge

The Dementia Centre and the Clinical Research Team continue to deliver on the national Dementia challenge to increase the number of national studies we open and therefore have to offer to our patients and carers to benefit from the latest interventions and treatments in Dementia as well as to contribute to latest discoveries through the sharing of their experiences of treatment, services and living with Dementia.

- New national portfolio studies we have opened include our first study in collaboration with our local care homes. This meets the aim to improve the

quality of life and quality of care for all care home residents especially people with dementia as part of a national initiative, Enabling Research in Care Homes (ENRICH):

The MARQUE Project
Managing Agitation and Raising QUality of LifE in dementia
Led by University College London, the MARQUE project is designed to increase knowledge and then improve the lives of people with moderate and severe dementia, including those near the end of life, and their families, by decreasing agitation and increasing quality of life. The current study is one part of the MARQUE programme. It will be the first naturalistic, longitudinal study to explore what determines quality of life in people with dementia living in care homes, with a sampling frame designed to be broadly representative of care homes in England. It will explore how agitation, quality of life, and care practices interact for people with dementia, and will inform development of an intervention to improve quality of life in this group.

- We have also been successful in our expression of interest to host the Centre for Dementia's second industry led clinical trial with Dr Thacker as the Principal Investigator for our site:

  ESKETINTRD3004: A Randomized, Double-blind, Multi-centre, Active-controlled Trial to Evaluate the Efficacy, Safety and Tolerability of Flexibly-dosed Intranasal Esketamine plus an Oral Antidepressant in Elderly patients with Treatment-Resistant Depression.

  The study is sponsored by Janssen and will be open to our patients 65 years or older with recurrent Major Depressive Disorder (MDD) which is a serious, recurrent, and disabling psychiatric illness. A substantial proportion of patients (up to 30%) are considered to be resistant to currently marketed monoaminergic antidepressants. In patients that respond to antidepressants, the time to onset of effect is typically 4 to 6 weeks, during which time patients continue to suffer from their symptoms and continue to be at risk of self-harm, as well as being impacted by the associated harm to their personal and professional lives. Therefore, there is a significant need to develop novel treatments based upon relevant pathophysiologic pathways underlying MDD for the rapid relief of symptoms of depression, especially in patients with treatment-resistant depression (TRD).

- Previously reported Dementia studies continue to do well with a total of 112 individuals consenting to take part in all dementia studies over 2014-15:

  Brains for Dementia: Brains for Dementia Research with 18 participants involving potential brain donors including longitudinal cognitive and memory assessments prior to donation (open to recruitment)

The MADE trial: 7 participants are enrolled on this Minocycline in Alzheimer's disease efficacy trial (open to recruitment)

LonDownS (The London Down Syndrome Consortium): an integrated study of cognition and risk for Alzheimer's Disease in Down Syndrome to which two participants have already consented to take part (open)

The IDEAL study: 70 participants have consented to this trial, improving the experience of dementia and enhancing active life: living well with Dementia (open to recruitment)

Fronto-Temporal Dementia: A Double-Blind, Placebo-Controlled, Randomized, Parallel Group, 12-Month Safety and Efficacy Trial of Leuco-methylthioninium bis(hydromethanesulfonate) in Subjects with Behavioral Variant Frontotemporal Dementia (bvFTD) sponsored by TauRx. Two patients were screened but did not meet eligibility criteria (closed to recruitment)

Memory Assessment Service (MAS) Evaluation: This National Evaluation of Memory Assessment Services aims to determine their impact on the Health Related Quality of Life of people with dementia and their carers and 7 participants were involved in this study (closed to recruitment)

Collaborating on research grants

- **Falls prevention in early dementia.** Dr Thacker has been working with colleagues at Nottingham University Hospitals on a proposed National Institute of Health Research Programme grant. People with dementia are at high risk of falls, which can have a severe impact on physical and mental health. The programme of work will develop and test a therapy programme which promotes activity and reduces the risk of falls, enabling people to live well with dementia for longer. The outcome of the grant is awaited.

- **Compassion Focused Therapy approaches with Inpatient Older Adults.** Dr Jenny Hartman has been undertaking this work involving initially the standardisation of usual care on older adult wards, after which Compassion Focused Therapy approaches will be implemented. With Multi-Disciplinary Team involvement the work has been progressing and a research grant funding application is being planned to support an evaluation of the implementation. Pre-application preparatory work is underway to ensure there is patient and public involvement in the proposed research and staff training is also due to commence.

Report contributions by Dr Simon Thacker

Self-harm & Suicide Prevention Centre

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

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

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

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

- **Mind the Gap: Group Facilitation for Frequent Repeaters of Self-harm.** [Health Foundation Award funded study, Led by Richard Morrow] which involved our peer support worker as an integral part of the local study team in the early stages of the study and its design. An initial group of four individuals consented to take part in the compassion focused group sessions but recruitment and retention in groups has proved challenging. The study is due to end in September 2015.

- **e-DaSH (Depression and Self-Harm) study**: A Randomised Controlled Trial (RCT) of the clinical and cost effectiveness of NICE recommended problem solving cognitive behaviour therapy (PS CBT) delivered remotely versus Treatment As Usual (TAU) in adolescents and young adults with depression who repeatedly self-harm. This East Midlands CLAHRC (Collaboration for Leadership in Applied Health Research and Care) study is open to recruitment in the North Liaison Team with Bob Gardner as the local Collaborator and has so far recruited 3 participants to the clinical trial.

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

- offering placements for Trust staff seeking experience in research and self-harm & suicide prevention as well as work experience placements for students;
- hosting a consultation open to all Trust staff to discuss what they would like from the Centre

- Supporting the initial exploration of ideas and project set ups such as the follow up study of patients retained on a Section 136 and Liaison team delivered suicide awareness training.
- The centre is further developing its External facing webpages within the Trust website to try to increase our visibility and availability to the public.

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

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

We continue to collaborate and work in partnership with others:

- Continuing collaboration with Oxford and Manchester University on the MCM study and other pieces of work
- Other organisations that we collaborate with on an ongoing basis include University of Leeds, University of Bristol, University of Nottingham, Harmless, Psychiatric accreditation network.
- Keith Waters has been appointed as:
    - ⇒ Clinical advisor to the Health Science Network
    - ⇒ Elected as a member of the National Suicide Prevention Alliance Steering group
    - ⇒ Critical friend by Sheffield CCG for the development of their Liaison Psychiatry services.
- We are working with Maria Michail and colleagues at the Institute of Mental Health to support the development of a training package for GPs.
- Further promote our East Midlands Self-harm & Suicide Prevention Research Network (EM-SRN):

- ⇒ Hosted regional East Midlands Self-harm and suicide prevention Research Network (EM-SRN) conference. We host these regional events bi-annually.
- ⇒ The network now has a webpage, discussion forum and bi-annual face to face meetings/conferences.
- ⇒ The membership is growing and is reaching out to and connecting a he variety of professions and organisations across the region.
- ⇒ The network has been made an organisational member of the National Suicide Prevention Alliance.
- ⇒ Traffic and knowledge sharing in the network discussion forum is increasing.

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

- ⇒ Securing funding from the Department of Health for the 2015/16 period of the multi-centre self-harm study,
- ⇒ Succeeding in our application for a SHINE award from the Health Foundation which has funded liaison team staff time and Richard Morrow's lead role in the study.
- ⇒ The South Liaison team also received funds from Manchester University for their participation in the national study on risk scales for repeat self-harm.
- ⇒ Conferences hosted by the Centre are also hosted on a cost recovery basis whenever appropriate.

Publications, conferences and training April 2014 to March 2015

Publications

1. **Bergen, H., Hawton, K., Webb, R., Cooper, J., Steeg, S., Haigh, M.,…& Kapur, N. (2014). Alcohol-related mortality following self-harm: a multicentre cohort study. Journal of the Royal Society of Medicine, (5)8. Doi: 2054270414533326**

   The aim of this paper, from the multicentre study of self-harm, was to assess alcohol-related premature death in people who self-harm compared to the general population - whilst taking socioeconomic deprivation into account. Causes of death for all the self-harm patients captured within the multicentre study within a 10 year period were analysed. More males died from an alcohol-related death

than females. Interestingly, alcohol related death was associated with unemployed or sick/disabled status, alcohol use at the time of the self-harm act and lack of psychosocial assessment following a self-harm act, as well as a referral to drug or alcohol service. Alcohol related premature death in people who self-harm was not associated with socio-economic deprivation (income, education, employment and housing).

Locally disseminated to: North and South Liaison teams; EM-SRN group.

Local clinical context and implications: The relationship found here between alcohol related death and unemployment, as well as registered sick/disabled status, is particularly important to note given the recent economic recession and changes in benefit allowances within England. The Both Derbyshire Healthcare's Liaison teams are in a position to identify, assess and signpost on anyone presenting to hospital with a combination of substance misuse and mental health or social care needs.

2. **Ness, J., Bergen,H., Waters, K., Hawton, K., Kapur, N., Cooper, J., Steeg,S., & Clarke, M (2015). Alcohol use and misuse, self-harm and subsequent mortality: an epidemiological and longitudinal study from the multicentre study of self-harm in England. Emergency Medicine Journal. doi 10.1136/emermed-2013-202753**

   Research has consistently shown alcohol use and misuse to be associated with self-harm and suicide but evidence from large-scale long term studies has been lacking. Alcohol misuse within the general UK population has increased in recent years but up until now it was not known whether this was also the case within the self-harm population. This longitudinal study of the MCM study's database between 2000 and 2009 showed alcohol use and misuse in self-harm patients to be more common than has been previously reported and alcohol misuse to have increased significantly in this population between 2000 and 2009, particularly in women. The findings highlight the need for clinicians to investigate alcohol use in self-harm patients and for ready availability of alcohol treatment specialists within hospitals to facilitate prevention of adverse alcohol-related outcomes.

   Locally disseminated to: North and South Liaison teams; EM-SRN group; Mortality group.

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

3. **Hawton, K., Bergen, H., Cooper, J., Turnbull, P., Waters, K., Ness, J., & Kapur, N. (2015). Suicide following self-harm: Findings from the Multicentre Study of self-harm in England, 2000-2012. Journal of Affective Disorders, (175)147-51. doi: 10.1016/j.jad.2014.12.062**

   An act of self-harm does not necessarily indicate a wish to die. Self-harm is a human behaviour resulting from extreme experiences of distress and despair. For some it may be an impulsive act or a coping mechanism. However, research has shown that people who self-harm are at higher risk of death from all causes, but particularly suicide, compared to the general population.

   In this study from the MCM project, over 40,000 patients who had attended one of the study hospitals with self-harm were followed up for mortality. Of the patients who died within the study period, 19% had suicide recorded as cause of death. However, this is likely to be an underestimate as a large percentage of deaths involving drug overdose were recorded by coroners as accidental.

   Locally disseminated to: North and South Liaison teams; EM-SRN group.

   Local clinical context and implications: The findings of this study indicate that people who have self-harmed are at increased risk of death from external causes (suicide, accidental, open verdicts). This study confirms the importance of taking every act of self-harm seriously regardless of apparent motive or means. The findings re-enforce the South Liaison team's aim to see, assess and develop a care plan with all patients that present to the Royal Derby hospital having/ who are thought to have self-harmed regardless of method or motive. Psychosocial assessments following a self-harm act have repeatedly been shown to have a protective influence, reducing the risk of repeat self-harm and suicide.

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

   Frequencies of self-poisoning and self-injury as methods of self-harm differ between hospital and community environments. This has often led to confusion around the concept of self-harm. Categorising a patient simply based upon the method they have used to harm themselves will be clinically misleading and it is thought that many people will switch between types of method.

   This study aimed to determine the frequency, pattern, causes and characteristics of switching methods by those repeatedly presenting to hospital with self-harm. The pattern of repeat self-harm was established for over 33,000 consecutive self-harm episodes captured as part of the MCM study. Of the 23% of patients who had more than one episode of self-harm (within an average of 30 months), one third switched methods. This was particularly true for young men and people with a history of self-harm behaviour.

   Disseminated to: Liaison teams, CAMHS Liaison teams, EM-SRN group.

   Local clinical context and implications: This study shows how changeable self-harm behaviours can be. Clinicians must avoid false assumptions about people's risks or needs based solely on the method used in one act of self-harm. Both the North and South liaison teams aim to offer every patient presenting with self-harm a full psychosocial assessment regardless of perceived intent or self-harm history.

Submitted:

5. Clarke, M., Gilbert, P., McEwan, K., Ness, J., & Waters, K (2014). Measuring feelings of arrested escape (entrapment) and arrested anger in people presenting to an Emergency Department following an episode of self-harm. Psychology and Psychotherapy: Theory, Research and Practice
6. Waters, K., Assessing risk of suicide and self-harm (2014). In P*sychiatric & Mental Health Nursing: the craft of caring.* Third Edition. CRC Press | Taylor & Francis Group.

Conferences hosted

1. 13th June 2014 – East Midlands self-harm, suicide prevention and suicide bereavement conference, Institute of Mental Health, Jubilee Campus, Nottingham University
2. 18th August 2014 – Visit by Hon John Dawkin's, Australian MP and Australian Suicide Prevention Lead, Research and Development Centre, Kingsway
3. 21st January 2015 - East Midlands Self-harm and Suicide Prevention Research Network Meeting, Jubilee Campus, University of Nottingham
4. 30th January 2015 – Suicide Prevention Awareness Conference, Research and Development Centre, Kingsway

Conferences presented/facilitated at

5. 26th June 2014 – Veteran Mental Health Conference, Chetwynd Barracks, Nottingham
6. 17th September 2014 – Keith Waters chaired NHS England Dementia CQUIN conference, Research and Development Centre, Kingsway
7. 8th October 2014 – Suicide Prevention Stakeholder Event
8. 24th October 2014 – Self-harm awareness – Myths, misconceptions and making a difference, the Psychiatric Accreditation annual conference
9. 27th November 2014 – Veteran Stakeholder Event, Chetwynd Barracks, Nottingham
10. 12th December 2014 – RAID Network Event, Birmingham

Training

11. June 2014 – Suicide Awareness Training to Street Triage Team
12. July 2014 - Suicide Awareness Training to the Derbyshire Fire service (support officers and managers)
13. August 2014 – Suicide Prevention Training to Post-graduate Health Science Students at Warwick University
14. October 2014 - Suicide Awareness Training to Social Care colleagues in North Derbyshire
15. October 2014 - Suicide Prevention Training to Police call handlers
16. December 2014 – Suicide Prevention Training to the Crown Prosecution Services (Leicester and Nottingham)
17. February 2015 - Suicide Prevention Training to East Midlands Occupational Health Staff
18. March 2015 – Suicide Awareness and Triage Training to the South CRISIS team

19. May 2015 - Suicide Prevention Training to an East Midlands Occupational Health Management Company

20. Ongoing (multiple sessions delivered throughout 2014/15):

21. Connecting With People training – so far delivered the full modules to over 80 Derbyshire Healthcare Trust colleagues.

22. STORM training – delivered multiple sessions to NHS Trusts in Coventry and Oxleas

23. Self-harm and Suicide Prevention Research Involvement presentations as Derbyshire Healthcare's Junior Dr training sessions

24. Suicide Awareness and Responses Training for Derby Teaching Hospitals Foundation Trust (Royal Derby Hospital colleagues)

25. Suicide Awareness and Prevention training (SAPT) throughout the East Midlands

Regular attendance/presence

Strategy Groups

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

Other Groups

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

Other Significant Meetings 2014/15

13. September 2014 – participated in CQC visits

14. January 2015 - Meeting with Geraldine Strathdee to discuss national suicide prevention training and approaches
15. January 2015 – Meeting at House of Commons regarding suicide prevention and mental health awareness

Serious untoward incidences/investigations

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

Report Contributions by Jenny Ness and Keith Waters

National Institute of Health Research (NIHR) Portfolio

East Midlands Clinical Research Network (EM CRN) has now confirmed final funding allocations of £263,398.00 for our 2015/16 delivery of NIHR Portfolio Research. We initially received a 7% budget reduction along with all other organisations receiving between 7.5% and 3% reduction in their budgets dependent on 40% of budgets varying according to recruitment activity. The savings made were passed on to Primary Care for research delivery in 2015-16. Subsequently the EM CRN itself received less funding than expected which when passed down to partner organisations equated to an 8% reduction for our Trust budget.

Funding allocations from 2015/16 has been based on a 1:2:15 ratio for recruitment into Band 1: Observational: Interventional study categories. Our MCM study is a Band 1 study because it requires less intensive observations or interventions.

We are increasing our participation in and recruitment from interventional studies. However, it is not possible to predict what study types will become available in year and studies are best selected on the basis of perceived clinical benefit rather than the study type.

The table below shows our recruitment activity for 2014-15:

DHCFT recruitment	Total 2014-15	Recruitment numbers by study type		
		Band 1	Observational	Interventional
Actual	1225	900	268	57
Weighted	2291	900	336	171

Research
In 2014-15 we had 26 NIHR studies open or in follow up. To date in 2015-16 we have approved a further 6 studies:

Enhancing the Quality Of User Involved Care Planning In Mental Health Services (EQUIP) – Manchester University/Nottingham University. The overall aim of the programme is to improve user and carer involvement in care planning in mental health services. A training programme to improve user and carer involvement in care planning has been co-produced and will be delivered in partnership with service users and carers. Four of our community teams and their service users and carers will be involved in this study - Chesterfield Recovery Team Derby City Recovery Team Erewash Recovery Team and South Derbyshire Dales Recovery Team

CODES - COgnitive behavioural therapy vs standardised medical care for adults with Dissociative non-Epileptic Seizures: A multicentre randomised controlled trial - King's College London. This is an interventional study and was brought to our Trust by Dr Mark Broadhurst who is the principal investigator. The study aims to evaluate the effectiveness and cost effectiveness of cognitive behavioural therapy to reduce seizure frequency and severity and improve psychological well-being in adults with dissociative seizures. The study is aiming for 10 participants at our site and 298 nationally.

SHARED study (The use of guided self-help in Anorexia Nervosa) – Kings College London/South London and Maudsley
Dr Joanna Miatt will be the local collaborator with a site target of 10 and is an interventional study. It is a feasibility study examining whether a guided self-help intervention developed for patients with eating disorders (SHARED) is a useful addition to standard treatment for people with Anorexia Nervosa with a primary objective of examining whether the intervention can reduce eating disorders symptoms and improve engagement in treatment as usual (TAU).

The 'listen-up!' project: understanding and helping looked-after young people who self-harm - University of Nottingham
This is a national portfolio research study which has under-recruited at its existing sites in Nottingham and Leicester and so is being opened up to other sites. We have been approached late and as a study with a short recruitment period is at high risk of not recruiting to target. However the study is felt to be of high patient benefit and clinicians are keen to participate. It is an observational study and Chris Kirk and Sarah Bramley are acting as local collaborators for this study.

Investigating the relationship between Schizophrenia, Attention and Theory of Mind – University of Nottingham.
This is a nationally funded basic science observational study involving Individuals with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder with

psychosis or psychotic depression aged 18 and above. DHCFT site target is 5 participants and our Principal Investigator is Dr Simon Taylor. This research aims to investigate psychological mechanisms of the symptoms of schizophrenia. Findings can be used to inform and develop effective interventions for individuals with schizophrenia.

National investigation into suicide in children and young people
The study is part of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). The study aims to describe the characteristics of young people in the general population who die by suicide and those of young people that die whilst in the care of mental health services; investigate the antecedents of suicide for these two groups and; establish the impact factors such as abuse, bullying, and social media have on young person suicide. A letter will be sent to the Medical Director, requesting copies of Serious Untoward Incident reports, if available, for any individual under the age of 20 who received a verdict of suicide or probable suicide at Coroners inquest.

Effective Home Support Dementia Care: Patterns of Current Provision v1 – University of Manchester
This is funded by NIHR Programme Grants for Applied Research. The study involves undertaking telephone interview with a suitable member of staff in order to ascertain which aspects of home support for dementia are currently provided by local authorities and/or NHS Trusts. Claire Biernacki has agreed to complete this questionnaire.

Performance Targets
All 12 new studies opened in 2014/15 have maintained 100% approval timescales within 15 days.

The requirement as a result of new contractual arrangements in 2014-15 is a central quarterly submission on performance relating to initiating studies classified as Clinical Trials and delivery to time and target for commercial Clinical Trials. This information must also be publishing on Trust websites.

The target measures whether the first participant recruited to a clinical trial is within 70 days from a valid research application. This is a reason why study approval times are monitored to be as short as possible, and no longer than 15 days to provide maximum time for recruitment of first participant to the study.

The 70 day benchmark is a difficult target to achieve as participants may be screened within timescales but may fail screening and hence not be randomised into the trial. There is opportunity to record reasons why a target is not achieved within required timescales.

Our second central submission was made by end of April covering Apr 2014 to Mar 2015.

Of the 12 studies we have opened in 2014-15, five are of the clinical trial design type. We achieved the 70 day benchmark for 3 out of the 5 (60%) clinical trials in Quarter 4, improving from 2 out of 4 (50%) in Quarter 3.

For the two studies which we did not achieve the benchmark, a contributory factor may have been the short recruitment period we had for both studies. These were opened at the late stages of the trial because these studies had not achieved their recruitment targets nationally and we may also have completed study feasibility less thoroughly in order to open the studies quickly and maximise on the remaining recruitment period.

Although we expected to avoid opening studies which have not met their recruitment numbers nationally and looking to extend recruitment from new sites during the last few months of the study, in practice we have not been able to take this approach as demonstrated by the new 'Listen Up' project which due to the perceived benefit of the study was opened with only 3 months remaining.

Thus expected clinical benefits of studies will outweigh the need to meet performance targets.

Appendix 1: Tables 1 and 2 shows the information that has been posted on our Trust website (R&D pages).

Outcomes of National Research we have supported:

Remote monitoring of Attention deficit hyperactivity disorder (ADHD) using mobile phone technology

Key Messages

- Using technologies, such as smartphones and tablet computers, offer ways to enhance how people with ADHD are treated and supported.
- Patients, their families and health professionals are supportive of using new technologies in the management of ADHD.
- An 'app' could include: (i) help to organise; (ii) reliable information; (ii) feedback and motivating messages; (iv) record and monitor symptoms and side effects over time.

Next steps include:

The MindTech team would like to collaborate with digital developers and patients/families to develop an app for ADHD that meets the needs we have discovered by doing this study. We hope this will be part of another research study

where we build and test an app and also find out what difference it makes to people living with ADHD.

The results from this study are intended to be published in an academic journal so that others can find out what people affected by ADHD think about using digital technology.

Inpatient suicide while under non-routine observation

Key Messages

- The current observation approach (especially intermittent observation) is not working safely enough. New models need to be developed and evaluated.
- The observation component of a care plan should not be stand-alone; time with a patient is an opportunity for engagement within a comprehensive risk management plan.
- Observation should be seen as an acute intervention - there should be a record of breaches and the transition to general observation should be planned.
- A balance of observation and active engagement should be agreed with the patient where possible.
- The observation component of a risk management plan should follow clear protocols, which should be adhered to, recorded, monitored, including actions to take if the patient absconds.
- As an acute intervention, observation is a skilled task for staff of appropriate seniority.
- Suicide under observation (intermittent or constant) should be considered an NHS ‘never event’ in England and Wales (or as a serious adverse event in Northern Ireland and Scotland) and should be subject to independent investigation.
- All serious breaches of protocol in the care of patients under constant observation (for example, leading to self-harm and absconding, not only where there is a fatal outcome) should be investigated under NHS incident procedures (SUI, CIR or SAI)

Other Activity

Supporting Student Nurses to become research aware

The Clinical Research Team has been hosting their first student nurse for a four week ‘Spoke’ placement as part of the University of Nottingham Graduate Entry Nursing programme.

Collaborating with our local University

We are actively working to discuss and agree joint areas of focus for research collaborations with University of Derby and in particular the College of Health and Social Care who have recently appointed two new professors in Primary Care and Public Health, and are launching their own Research Centre. We will be working together on local priorities.

Growing our research infrastructure

The clinical research team successfully recruited the minimum 500 participants to Clinical Research studies and received 20K Research Capability Funds from the Department of Health. The funding will be re-invested directly back into the team to appoint to a research support role which will further support the delivery of clinical research. Should similar funding be received in subsequent years, there is a potential to fund this post in future years.

H2020 grant application: European Union - Physical activity to improve outcome - an experimental study in old age psychiatry (EU-PATIO).

We have worked with Prof Reinhard Heun and a collaboration of 11 European countries to submit a grant proposal to the Horizon 2020 EU Framework Programme for Research and Innovation. The call was on promoting mental wellbeing in the ageing population. The aim of our proposed clinical trial includes testing the hypothesis that a sustained comprehensive intervention of physical activity and nutritional intervention has a positive impact and improves cardiorespiratory fitness and decreases negative symptoms, among older people with schizophrenia spectrum disorders. If successful the Trust would be awarded €515,750.00.

iGERAS: A public screening platform for early detection of geriatric depression and behavioural interventions

We have also worked with Prof Reinhard Heun on another collaboration of 9 European countries to submit a grant proposal to the saim Horizon 2020 Programme. While a diverse literature exists on how depression may manifest in the digital traces that we generate in everyday life, no previous work has brought together clinicians, psychiatrists, psychologists, computational linguists, and computer scientists and engineers to develop a comprehensive and validated method for early detection of geriatric depression. The vision is to develop an inexpensive and publicly available platform to enable widespread voluntary screening for geriatric depression, which will enable early detection and dramatically reduce healthcare costs. Our targeted breakthrough is to leverage mobile devices in combination with social media, digital sensing, and linguistic analysis for this purpose, and to bring together the growing literature on digital sensing of depression with a robust experimental methodology to obtain validated scientific evidence and develop effective behavioural interventions. If successful the Trust award would be for €350K.

Some challenges we are managing:

- Our Clinical Lead for Compassion & Dementia Centre (0.4 WTE) commenced a secondment in November 2014 and initially expected to return in Jan 2015. The secondment was extended to end of March 2015 and is now confirmed to continue till March 2016. We are now making longer term arrangements to review this role.

- The R&D Patient and Public Involvement lead who had committed to lead this plan of work has had other clinical commitments which have meant they have made little progress in this aspect of our plans. We are now reconsidering alternative approaches to delivering this work and have had positive discussions with our Derbyshire Voice representatives on our R&D Governance Committee to take forward new ideas for this important work.

- Due to the need to deliver a Cost Improvement Programme allocation to the R&D Centre a regrettable decision had to be made to discontinue the annual subscription fee for East Midlands CLAHRC. We have received a response on behalf of the Director of EM CLAHRC that they will remain fully committed to continue working in partnership with us on the projects we are currently involved in and on future opportunities that may arise.

Library and Knowledge Services

Annual report highlights May 2015

The Library – Space to think …. Knowledge to act

The goal of the library and knowledge service is to work hand in hand with our clinicians and managers to ensure that our staff have the skills and knowledge to provide the best possible care.

In addition to providing access to journal articles, books and electronic resources, we provide evidence to inform decision making; resources to support education and CPD; teach information literacy and evidence based practice and alert our members to key publications in their fields.

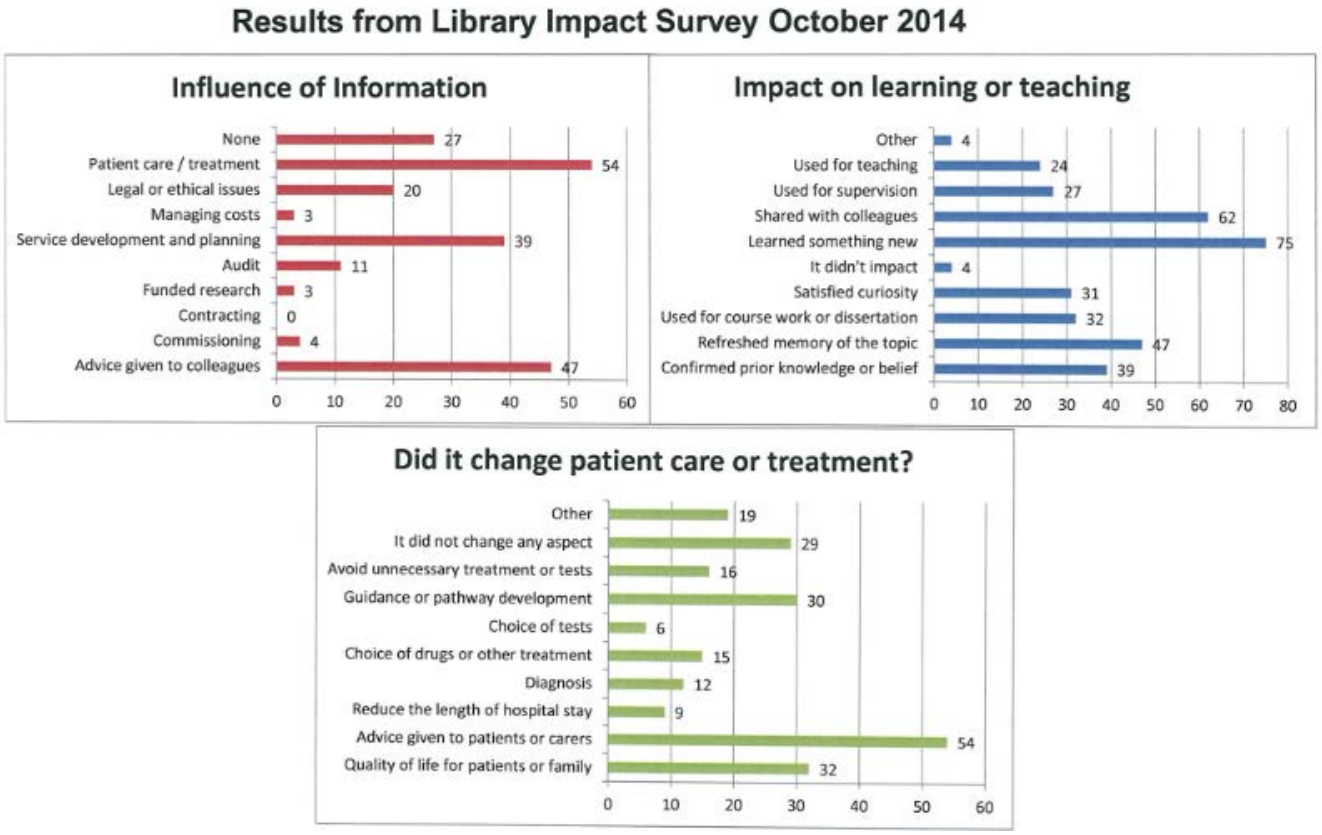
This year saw a continuing increase in usage across the service and increasing awareness of the facilities and resources available. We undertook an impact survey this year to show the impact library and knowledge services have on patient care.

Key results from the impact survey:

- 122 people completed our impact survey, which has given us a wealth of quantitative and qualitative data about why staff do and don't use the library, what

they do with the information they obtain and how it impacts on patient care, research, learning and teaching.

- 44% of responders of the impact survey said it influenced patient care
- 32% said it influenced service development and planning
- From the survey question "What did you do differently as a result of finding the information?"
  - ⇒ "Reduced ineffective treatments and influenced plan of care"
  - ⇒ "It helped me formulate my assessments…"
  - ⇒ "Challenged current policy"
  - ⇒ "More confident on my practice, supported by evidence in NICE"
  - ⇒ "To update the evidence base of the treatments we offer"
- 118 out of 122 respondents thought that the information impacted on their learning or teaching
- 30 responders from the impact survey said the information was for guidance or pathway development



Key points from our 2014/15 annual report:

- We extended our out of hours access at Kingsway, so staff can now access the library from 6.15am to 7.30pm 7 days a week.

- We increased the number of e-books available and usage has increased. We also purchased some e-readers for staff to borrow.
- We switched some journal subscriptions to electronic only, responded to demand for some new titles and again renewed our subscription to the Ebsco Psychology and Behavioural Sciences collection, which gives users access to over 500 full text journals.
- We undertook literature searches for a number of research bids, research projects and audits.
- We have participated in and promoted Reading Agency initiatives e.g. Mood Boosting Books, Books on Prescription and Six Read Challenge
- We achieved the required standards for the Library Quality Assurance Framework (LQAF). This is a self-assessment tool, used to measure the quality of library services and is an essential part of the Learning and Development Agreement with the Deaneries and Health Education East Midlands.

Key statistics:

- 1164 Registered Users
- 4975 Books Borrowed
- 982 Journal Articles Supplied
- 421 members of Trust staff with Athens accounts
- 3,963 Athens log-ins
- 190 e-book loans/downloads
- 1156 visits to the Library Connect Homepage
- 11 literature searches undertaken to support research or publication writing
- Research books were the 4th most borrowed subject
- Staff publications site or announcements were visited 373 times
- 84% of our registered users borrowed books
- 58% or our books were borrowed

Staff Publications

We encourage staff to publish their work and many do. Since the establishment of the R&D Centre the library has maintained a list of staff publications on the library webpage. The table below shows that there have been an encouraging number of staff publications over the past three years, and 2014 is likely to be an under-representation currently.

Year	2012	2013	2014
Total Impact Factor	143.419	121.663	131.916
No. of articles	40	31	35
Average Impact Factor	3.58548	3.92461	3.76903

The impact factor of journals (see appendix 2 for details) is frequently used as a proxy for the relative importance of a journal within its field, with journals with higher impact factors deemed to be more important than those with lower ones.

Report contributions by Marie Hickman

Clinical Audit

The 2014-15 Clinical Audit programme is now closed:

- There were 90 Clinical Audits registered on the Trust Clinical Audit Programme by the end of 2014-15
- 14 projects (16%) on the programme were categorised as 'Priority I' or external must do projects made up of 9 national projects and 5 commissioner contractual requirements
- 28 projects (31%) on the programme were categorised as 'Priority II' or internal must do projects arising from NICE guideline compliance, serious untoward incidence, safeguarding requirements etc
- We operate on a rolling programme of audits, approving new projects individually and adding to the programme throughout the year as needs are identified. This means not all projects are expected to be completed within a given financial year dependent on individual project timescales. Many audits will therefore have start and end dates which span the financial year
- In 2014-15, 29 projects were completed with evidence of compliance to standards or action plan developed to achieve compliance
- Completed clinical audit projects with action plans to improve the quality of healthcare provided included 5 national audits which were reported along with outcomes of other local audits in the Quality Account for 2014-15:

  National Audit of Schizophrenia
  This audit included an audit of practice as well as service user and carer survey. As a result of our participation in this second round of the National Audit and the review of the report, our practice is being further improved in monitoring of physical health risk factors and particularly monitoring of BMI, glucose control, lipids and blood pressure; Intervention for physical health problems for elevated BMI, blood pressure and alcohol consumption; and availability and uptake of psychological therapies. Actions that will be taken to achieve improvements in practice and therefore to improve the quality of care for patients will include gaining agreement across primary care with regard to shard care responsibility for monitoring the physical health needs of our patients; Improving the monitoring of patients physical health risk factors by

enabling teams to embed the LESTER tool for physical health monitoring which is an intervention framework for people experiencing psychosis and schizophrenia**;** ensuring access to basic equipment for monitoring physical health risk factors; improving access to psychological therapies; and providing training for staff to deliver psychological interventions through places on forthcoming CBT programme at Derby University.

Topic 4b: Prescribing anti-dementia drugs

As a result of our participation in this audit and review of the report we have identified the areas for action to improve the quality of care provided to our patients. The audit results suggested that there is a low Dementia presentation rate amongst ethnic minorities. This has led us to take action to increase Dementia awareness to GPs to be more pro-active in seeking out these patients as well as to Black and Minority Ethnic (BME) groups such as through faith leaders. We also held a Trust Bollywood Event using the medium of movies to generate discussions of the Dementia themes raised by screening of a Bollywood film night. Nationally there was marked variation in the prevalence of anti-dementia drug prescribing across the 54 participating mental health Trusts, so we are taking action locally to understand our decision process behind those cases where Anti-Alzheimer Drugs (AAD) were not prescribed to increase improvements in appropriate prescribing. We are investigating other actions in memory clinics to record discussion of patient/carer views around the prescribing of AADs and also recording of medication reviews taking place routinely in order to ensure that appropriate blood tests and BP/pulse/ECG are being performed in all cases before prescribing AAD aided by a locally developed checklist.

Topic 10c: Use of antipsychotic medication in children and adolescents

We have participated in this national POMH-UK quality improvement programme which is addressing the use of antipsychotic medication in children and adolescents. The audit standards for this programme relate to the assessment of the benefits and side effects of antipsychotic treatment which are relevant to all patients irrespective of diagnosis. As a result of our participation in this audit we are implementing actions to continually improve our practice. We will ensure that there is an explicit rationale for prescribing antipsychotic medication for children and adolescents. Pre-screening tests/measures will be documented before starting antipsychotic treatment: weight/BMI, blood pressure, pulse, blood glucose/HbA1c and blood lipids; and a review of therapeutic response and side-effects of antipsychotic medication will be documented at least once every 6 months - this review will include tests/measures of weight/BMI, blood pressure, glucose/HbA1c, lipids and assessment for the presence of extrapyramidal side effects. To maintain compliance to the required standards, the clinical teams are implementing refined processes supported by newly developed local guidelines to achieve improved outcomes through the recording of all antipsychotic prescribing and

reviews in children and adolescents which will ensure all our patients are treated safely and effectively.

Topic 14a: Prescribing for substance misuse: alcohol detoxification

The Topic 14a baseline report which has been reviewed presents data on prescribing practice for alcohol detoxification conducted in acute psychiatric inpatient settings. The audit included patients who had been admitted to an acute adult or intensive care psychiatric ward in the past year (prior to March 2014) and who had undergone alcohol detoxification whilst an inpatient. This national audit of the management of alcohol withdrawal for mental health inpatients examines all aspects of clinical assessment and management against NICE guidelines and quality standards with a view to implementing a nationally driven locally implemented quality improvement programme. Our clinical teams have reflected on their performance data and generated action plans to implement improvements in this important area of practice. The quality of care we provide will be improved through reinforcing the application of our detoxification protocol. Feedback on performance to clinicians and particularly junior doctors is an important action to increase awareness especially regarding completion of the Drug and alcohol section of clerking documentation. To sustain awareness in new intake of doctors, the junior doctor handbook and induction programmes are being updated. Other more specific actions are being taken to remind clinicians to undertake relevant blood tests, use of prophylaxis and monitoring for thee physical signs and symptoms of complications. As intended by POMH-UK, this first national audit of alcohol withdrawal will provide a benchmark against which a continuous quality improvement programme can be developed nationally.

Topic 12b: Prescribing for people with personality disorder

We have participated in this audit and our clinicians have reviewed the report and finalising the actions to be taken to change practice where needed and improve the quality of care provided. The audit reviewed against standards of reasons for prescribing antipsychotic medication be documented and a written crisis plan be in place which is accessible in the clinical records and which has been developed to incorporate the patient's views in the plan. Treatment targets audited included antipsychotic drugs not being prescribed for more than four consecutive weeks in the absence of a co-morbid psychotic illness; Z-hypnotics or Benzodiazepines not being prescribed for more than four consecutive weeks; and where medication is prescribed for more than four consecutive weeks, these being reviewed to take into account a) therapeutic response and b) possible adverse effects, and also c) be documented in the clinical records. Our final action plan will address the shortfalls identified so that improvements are demonstrated in subsequent audits.

- Clinical Audit action plans were monitored for completion and in total 127 improvement actions arising from 19 action plans were completed in 2014-15.
- In 2014-15 a PwC internal audit review assessed some aspects of the clinical audit process and identified 5 medium risk findings. All actions arising from this review has now been implemented.
- There is currently a vacancy in the Clinical Audit function and recruitment to the post has been delayed due to the post being held at the approval to appoint process for two months. This is likely to impact adversely on the Clinical Audit processes but all steps are being taken to manage the challenge.

APPENDIX 1

Performance information on the initiation and delivery of clinical research

The Department of Health requires, via the new National Institute for Health Research (NIHR) contracts with providers of NHS services, the publication on a quarterly basis of information regarding: the 70-day benchmark for clinical trial initiation; and the recruitment to time and target for commercial contract clinical trials.

Clinical Trials for which NHS Permission was given – End of Quarter 4, covering April 2014 to March 2015.

Table 1: Performance in Initiating all Clinical Trials:

REC Reference Number	Name of Trial	Date of Receipt of Valid Research Application	Date of NHS Permission	Date of First Patient Recruited	70-day Benchmark	Comments
12/LO/1514	Lamotrigine And Borderline Personality Disorder: Investigating Long-Term Effectiveness (LABILE)	15/04/2014	17/04/2014	15/05/2014	30	Benchmark Met
13/EE/0063	Minocycline in Alzheimer's Disease Efficacy (MADE) trial	28/04/2014	06/05/2014	23/05/2014	25	Benchmark Met
12/NW/0441	A Trial of LMTM in Patients with behavioural variant Fronto-Temporal Dementia (TRx-237-	12/09/2014	18/09/2014			Site opened in last 3 months of trial. 28 patients pre-screened and 2 patients consented but not randomised within the 70-day period. Closed early by sponsor on

REC Reference Number	Name of Trial	Date of Receipt of Valid Research Application	Date of NHS Permission	Date of First Patient Recruited	70-day Benchmark	Comments
	007)					12/12/2014 as global recruitment target achieved.
12/LO/1537	The E Sibling Project – exploratory randomised controlled trial of an online multi-component psychoeducational intervention for siblings of individuals with first episode psychosis	30/09/2014	08/10/2014	13/03/2015	164	Site opened in last 3 months of trial with recruitment due to end 31/12/2014. Trial then extended to 31/03/2015. All potential participants expressing interest within the70-day period have not met eligibility criteria being younger than 16 years, and one did not have access to internet.
14/EM/1084	Depression and Self-harm Study (e-DASH) V1.1	08/01/2015	16/01/2015	13/02/2015	36	Benchmark Met

Table 2: Performance in Delivering Commercial Contract Clinical Trials

REC Reference Number	Name of Trial	Target number of patients	Date Agreed to recruit target number of patients	Trial Status	Target met within the agreed time	Comments
12/NW/0441	A Trial of LMTM in Patients with behavioural variant Fronto-Temporal Dementia (TRx-237-007)	1	31/12/2014	Closed - In Follow Up	No	Site opened in last 3 months of trial. 28 patients pre-screened and 2 patients consented but not randomised. A 3rd potential participant identified but notification received from sponsor on 12/12/14 that global recruitment numbers achieved and no further participants could be enrolled.

APPENDIX 2

Staff Publications 2014

Notes on Impact Factor:

Definition: “It is a measure of the frequency with which the "average article" in a journal has been cited in a particular year or period. The annual *JCR* impact factor is a ratio between citations and recent citable items published. Thus, the impact factor of a journal is calculated by dividing the number of current year citations to the source items published in that journal during the previous two years.”
http://thomsonreuters.com/products_services/science/free/essays/impact_factor/

The top 50 psychiatry journals range from 16.833 to 3.968

The top 50 medical journals range from 53.298 to 1.848

Reference	Article Type	Impact Factor 2013	Full Text?
Bergen, H., Hawton, K., Webb, R., Cooper, J., Steeg, S., Haigh, M., Ness, J., Waters, K., & Kapur, N. 2014. Alcohol-related mortality following self-harm: a multicentre cohort study. *JRSM Open*, 5, (8)	Cohort Study	None	Yes
Chaplin, E., Partsenidis, I., Samuriwo, B., Underwood, L., & McCarthy, J. 2014. Does substance use predict contact with the criminal justice system for people with intellectual disabilities? *Journal of Intellectual Disabilities & Offending Behaviour*, 5, (3) 147-154	Research Article	None	No
Henderson, L., Gilbert, P., & Zimbardo, P. 2014. Shyness, social anxiety, and social phobia. In Hofmann, S. and DiBartolo, P. *Social anxiety: Clinical, developmental, and social perspectives* (3rd ed.). 95-118	Book Chapter	N/A	No
Lloyd JL, Coulson NS. 2014 The role of learning disability nurses in promoting cervical screening uptake in women with intellectual disabilities: A qualitative study. *Journal of Intellectual Disabilities.* 18(2) 129-45.	Research Article	None	Yes

Reference	Article Type	Impact Factor 2013	Full Text?
McEwan K, Gilbert P, Dandeneau S, Lipka S, Maratos F, Paterson KB, Baldwin M. 2014 Facial expressions depicting compassionate and critical emotions: The development and validation of a new emotional face stimulus set. *PloS one.* 9(2).	Research Article	None	Yes
News Item: Penfold J. 2014 Buddying up. *Mental Health Today.* January/February 2014 p10-12.	News	None	Yes
Prakash A, Thacker S. 2014 The audacity of hope: tyranny or liberation in dementia care. *GM: Midlife & Beyond.* 44(5) 27-31.	Article	None	Yes
Uppal G, Bonas S, Philpott H. 2014 Understanding and awareness of dementia in the Sikh community. *Mental Health, Religion & Culture.* 17(4) 400-415.	Research Article	None	Yes
Kenyon, E., Beail, N., & Jackson, T. 2014. Learning disability: experience of diagnosis. *British Journal of Learning Disabilities*, 42, (4) 257-264	Research Article	0.3	No
Veale D, Gilbert P. 2014 Body dysmorphic disorder: The functional and evolutionary context in phenomenology and a compassionate mind. *Journal of Obsessive-Compulsive and Related Disorders.* 3(2) 150-160.	Research Article	0.812	No
Rahman F, Maharaj V, Yates R, Beeley C, Moore I, Rose A, Counsell A. 2014. Addressing the inverse care law: the role of community paediatric services. *Perspectives in Public Health.* 134(2) 85-92	Audit	1.035	Yes
Crawford, P., Brown, B., Kvangarsnes, M., & Gilbert, P. 2014. The design of compassionate care. *Journal of Clinical Nursing*, 23, (23/24) 3589-3600	Narrative Literature Review	1.233	No
Catarino F, Gilbert P, McEwan K, Baiao R. 2014 Compassion Motivations: Distinguishing Submissive Compassion From Genuine Compassion and its Association With Shame, Submissive Behavior, Depression, Anxiety and Stress. *Journal of Social and Clinical Psychology.* 33(5) 399-412.	Research Article	1.411	Yes
Phillipson A, Akroyd M, Carley J. 2014 Audit of discharges from a regional service in the	Audit	1.744	Yes

Reference	Article Type	Impact Factor 2013	Full Text?
United Kingdom. *Early Intervention in Psychiatry.* 8(1) 91-97.			
Whale, R., Harris, M., Kavanagh, G., Wickramasinghe, V., Marwaha, S., Jethwa, K., Ayadura, N., Sardana, A., & Thompson, A. 2014. Effectiveness comparison of antipsychotics used in first-episode psychosis: A naturalistic cohort study. *Early Intervention in Psychiatry*, 8, Suppl 1 p. 149	Conference Abstract	1.744	Yes
Gale, C. & Schroder, T. 2014. Experiences of self-practice/self-reflection in cognitive behavioural therapy: a meta-synthesis of qualitative studies. *Psychology and psychotherapy,* 87, (4) 373	Meta-Synthesis	1.817	Yes
Holt, L. & Tickle, A. 2014. Exploring the experience of hearing voices from a first person perspective: a meta-ethnographic synthesis. *Psychology and Psychotherapy*, 87, (3) 278-297	Meta-Synthesis	1.817	Yes
Maharaj V, Rahman F, Adamson L. 2014 Tackling child health inequalities due to deprivation: Using health equity audit to improve and monitor access to a community paediatric service. *Child: Care, Health and Development.* 40(2) 223-30.	Audit	1.832	Yes
Brown, B., Crawford, P., Gilbert, P., Gilbert, J., & Gale, C. 2014. Practical compassions: repertoires of practice and compassion talk in acute mental healthcare. *Sociology of health & illness*, 36, (3) 383-399	Research Article	2.014	No
Elander, J., Duarte, J., Maratos, F.A., & Gilbert, P. 2014. Predictors of painkiller dependence among people with pain in the general population. *Pain Medicine (United States)*, 15, (4) 613-624	Research Article	2.243	No
Gilbert P. 2014 The origins and nature of compassion focused therapy. *The British journal of clinical psychology.* 53(1) 6-41.	Article	2.377	Yes
Gilbert P. 2014 Compassion-focused therapy: Preface and introduction for special section. *British Journal of Clinical Psychology.* 53(1) 1-6.	Editorial	2.377	Yes
Gilbert P, McEwan K, Catarino F, Baiao R, Palmeira L. 2014 Fears of happiness and	Research Article	2.377	Yes

Reference	Article Type	Impact Factor 2013	Full Text?
compassion in relationship with depression, alexithymia, and attachment security in a depressed sample. *British Journal of Clinical Psychology.* 53(2) 228-45.			
Gale, C., Gilbert, P., Read, N., & Goss, K. 2014. An evaluation of the impact of introducing compassion focused therapy to a standard treatment programme for people with eating disorders. *Clinical Psychology & Psychotherapy*, 21, (1) 1-12	Research Article	2.59	No
Cardi, V., Di, M., Gilbert, P., & Treasure, J. 2014. Rank perception and self-evaluation in eating disorders. *International Journal of Eating Disorders*, 47, (5) 543-553	Research Article	3.033	No
Gaebel W, Muijen M, Baumann AE, Bhugra D, Wasserman D, van RJ, Heun R, Zielasek J. 2014 EPA guidance on building trust in mental health services. *European Psychiatry.* 29(2) 83-100.	Review	3.21	Yes
Schoepf, D. & Heun, R. 2014. Anxiety disorders and physical comorbidity: increased prevalence but reduced relevance of specific risk factors for hospital.based mortality during a 12.5.year observation period in general hospital admissions. *European Archives of Psychiatry and Clinical Neuroscience,* e-pub	Retrospective Analysis	3.355	Yes
Schoepf D, Uppal H, Potluri R, Heun R. 2014 Physical comorbidity and its relevance on mortality in schizophrenia: a naturalistic 12-year follow-up in general hospital admissions. *European Archives of Psychiatry and Clinical Neuroscience.* 264(1) 3-28.	Retrospective Analysis	3.355	Yes
Schoepf, D. & Heun, R. 2014. Bipolar disorder and comorbidity: Increased prevalence and increased relevance of comorbidity for hospital-based mortality during a 12.5-year observation period in general hospital admissions. *Journal of Affective Disorders,* 169, 170-178	Retrospective Analysis	3.705	Yes
Schoepf D, Uppal H, Potluri R, Chandran S, Heun R. 2014 Comorbidity and its relevance on general hospital based mortality in major depressive disorder: A naturalistic 12-year follow-up in general hospital admissions. *Journal of Psychiatric Research.* 52(1) 28-35.	Retrospective Analysis	4.092	No
Medway, C., Combarros, O., Cortina-Borja, M., Heun, R., et al. 2014. The sex-specific associations of the aromatase gene with Alzheimer's disease and its interaction with IL10 in	Retrospective Analysis	4.225	No

Reference	Article Type	Impact Factor 2013	Full Text?
the Epistasis Project. *European Journal of Human Genetics*, 22, (2) 216-220			
Heun, R., Corral, R., Ahokas, A., Nicolini, H., Teixeira, J.M., Dehelean, P., Picarel-Blanchot, F., & De, C. 2014. Sustained efficacy and safety of agomelatine versus placebo over 24 weeks in elderly out-patients suffering from major depressive disorder. *European Neuropsychopharmacology*, 24, S403-S404	Conference Abstract	5.395	No
Velayudhan, L., Newhouse, S., Fogh, I., Heun, R., et al. 2014. Genetic Predisposition to Increased Blood Cholesterol and Triglyceride Lipid Levels and Risk of Alzheimer Disease: A Mendelian Randomization Analysis. *PLoS Medicine*, 11, (9)	Cohort Study	14	No
Ramirez, A., Heilmann, S., Drichel, D., Heun, R., et al. 2014. Role of PLD3 rare variants in european sporadic Alzheimer's disease patients. *Alzheimer's and Dementia*, 10, Suppl 4 P319-P320	Conference Abstract	17.472	Yes
Cruchaga, C., Karch, C.M., Jin, S.C., Heun, R., et al. 2014. Rare coding variants in the phospholipase D3 gene confer risk for Alzheimer's disease. *Nature*, 505, (7484) 550-554	Case Control	42.351 (top ranking science journal)	No

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 24th June 2015

Finance Director's Report Month 2

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 May 2015.

Recommendations

The Board of Directors is requested to:

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

Executive Summary

- There is a favourable performance in the first two months of the year; we are ahead of plan by £218k, the forecast is a slight overachievement of planned surplus by £52k. There are clear indications of both cost and income pressures within the financial forecast. The Executive Leadership have therefore agreed management action to address these pressures as far as possible and the reported forecast assumes the success of these actions.

- The forecast necessarily includes a set of assumptions based on knowledge and expectations at this point in time. There remains a large performance range from worst-case to best-case outturn which is primarily dependant on the successful mitigation of emerging risks. The range is shown in the chart in section 2.

- The risk rating is a 3 in the month and forecast to achieve a 3 at the end of the year which is worse than the plan of a 4. The risk rating is reported against current Monitor metrics. However Monitor has issued a consultation to increase the number of financial performance metrics that are measured. Analysis indicates that our risk rating will be adversely impacted if these rating changes are made. The key difference being that our headroom on clearance from a rating of 2 will be substantially reduced.

- The forecast assumes full achievement of all efficiencies and work is ongoing to ensure all savings that are assumed are sufficiently assured.

- Cash is currently above plan but is forecast to be lower than plan through the second half of the year and at year end

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

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

Board Assurances

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

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

Consultation

- The Executive Leadership Team has discussed and agreed 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 now 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.

- Asset Planning and Agile Working Board oversee the Capital Expenditure plan which is operationally managed by the Capital Action Team (CAT) on a monthly basis. (In the near future Asset Planning and CAT meetings plan to merge, to reduce meeting numbers, release staff time and improve efficiency without losing performance oversight)

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

Governance or Legal issues

The Trust Board should be aware that amendments to the Regulatory compliance framework called the Risk Assessment Framework are out for consultation and the impact of that change is discussed in a paper elsewhere in the Board meeting today

In the usual way, Monitor will ask for supporting explanation for any significant variances from elements of our operational plan.

There are no other governance or legal exceptions to note.

Equality Delivery System

This report has a neutral impact on REGARDS groups.

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

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

FINANCIAL OVERVIEW
MAY 2015

1. Overall Financial Performance

Income & Expenditure – key statistics

We have achieved an underlying surplus of £98k in the month which is £107k better than the plan as we had planned for a small deficit in the second month of the financial year. Operational profitability as measured by EBITDA[1] is better than plan by £123k in the month. This equates to 6.4% of income compared to a plan of 5.2%.

Year to date we are ahead of plan by £218k with EBITDA being ahead of plan by £214k. This equates to 6.5% of income compared to a plan of 5.4%.

The forecast position is an underlying surplus, excluding impairments, of £1.3m which is slightly ahead of plan by £52k. EBITDA is forecast to be slightly behind plan by £53k which is equal to the plan of 6.2%.

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

STATEMENT OF COMPREHENSIVE INCOME	MAY 2015								
	Current Month			Year to Date			Forecast		
	Plan	Actual	Variance Fav (+) / Adv (-)	Plan	Actual	Variance Fav (+) / Adv (-)	Plan	Actual	Variance Fav (+) / Adv (-)
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical Income	10,066	10,021	(45)	20,168	19,952	(216)	121,914	120,796	(1,118)
Non Clinical Income	819	752	(67)	1,673	1,543	(130)	10,248	9,442	(806)
Pay	(8,161)	(8,077)	84	(16,323)	(16,108)	215	(98,336)	(97,386)	950
Non Pay	(2,161)	(2,010)	151	(4,344)	(3,999)	345	(25,646)	(24,725)	921
EBITDA	**563**	**686**	**123**	**1,173**	**1,388**	**214**	**8,181**	**8,127**	**(53)**
Depreciation	(283)	(302)	(19)	(567)	(585)	(19)	(3,389)	(3,399)	(11)
Impairment	0	0	0	0	0	0	(300)	(300)	0
Profit (loss) on asset disposals	0	0	0	0	0	0	0	34	34
Interest/Financing	(181)	(178)	3	(411)	(388)	23	(2,221)	(2,140)	82
Dividend	(108)	(108)	0	(217)	(217)	0	(1,300)	(1,300)	0
Net Surplus / (Deficit)	**(10)**	**98**	**107**	**(21)**	**197**	**218**	**971**	**1,023**	**52**
Technical adj - Impairment	0	0	0	0	0	0	(300)	(300)	0
UnderlyingSurplus / (Deficit)	**(10)**	**98**	**107**	**(21)**	**197**	**218**	**1,271**	**1,323**	**52**

- Clinical income was behind plan in the month by £45k increasing the year to date under achievement to £216k due to two main drivers:

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

- cost per case income that is lower than planned activity levels due to lower occupancy levels
- service developments that were planned to start from the beginning of the year but are now forecast to start later on in the year, these have corresponding expenditure reductions.

With the assumed levels of activity and occupancy, along with the start dates of service developments, clinical income is forecast to remain behind plan by £1.1m at the end of the financial year. This is a small adverse movement in the forecast of £47k.

The key risks to clinical income are achieving forecast cost per case income in light of updated transformation planning requirements and staffing levels.

- Non-clinical income is behind plan in the month by £67k increasing the year to date position to £130k behind plan. The forecast has adversely moved by £124k and is now forecast to be £806k worse than the plan by the end of the financial year. £365k relates to Pharmacy recharges (with corresponding cost reduction) and £400k relates to an as-yet unachieved income target, which is the key risk to this element of performance.

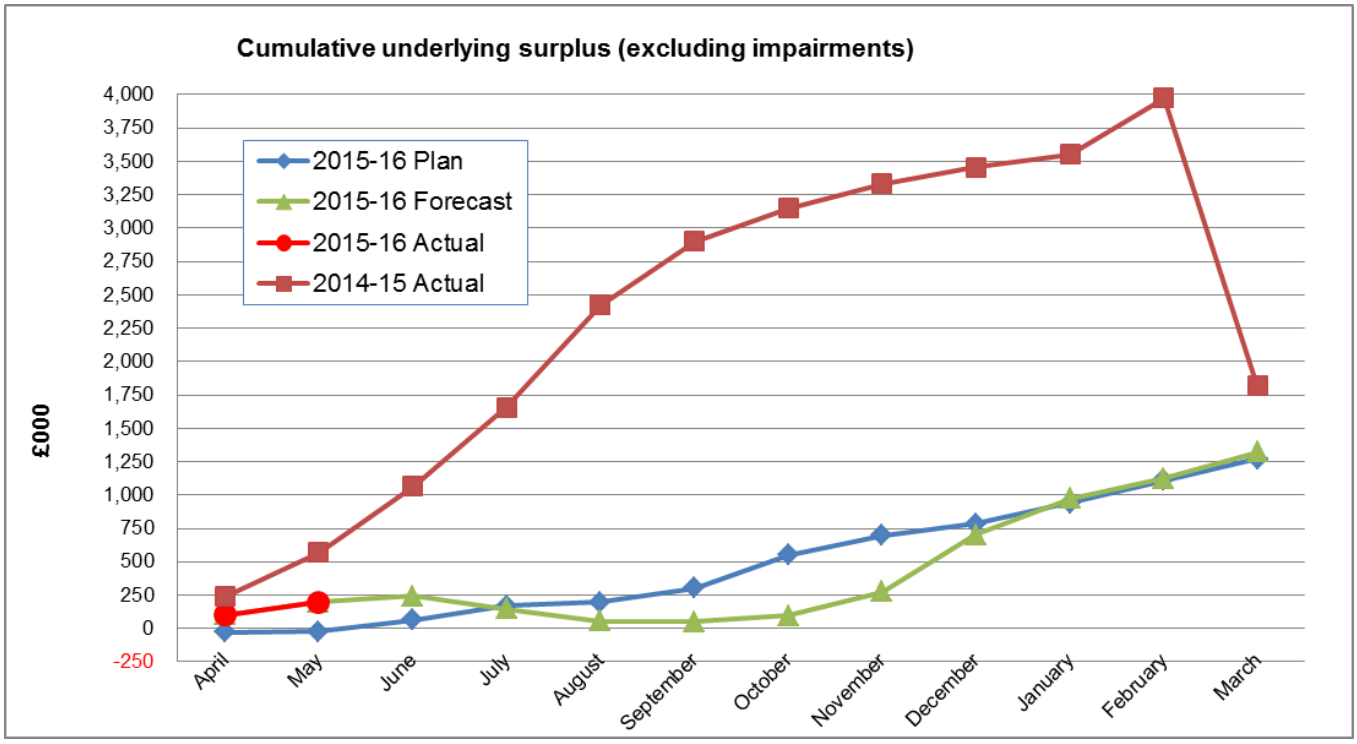
- Pay expenditure is underspent by £84k in the month which has increased the year to date underspend to £215k. The forecast has moved favourably by £166k and is forecast to be under budget by £950k at the end of the financial year. The main drivers within the forecast underspend are the later assumed start dates for service developments (less cost but also less income as above), the balance of the contingency reserves will now remain unspent in order to support the overall financial position. The balance of the budgeted pay-award funding will remain in reserves now that all awards have been actioned.

  The key risks to pay expenditure performance are successfully containing the cost of temporary (particularly agency) staffing and capping the use of contingency reserves.

- Non pay expenditure is underspent in the month by £151k increasing the year to date underspend to £345k. The forecast year end position is an underspend of £921k. The forecast underspend is driven by Pharmacy costs (which have a corresponding income reduction), start dates of service developments (with corresponding income reduction) and assumed-unspent contingency and reserves.

  The main non pay risks are CIP delivery for estate changes, PICU cost-pressure containment and capping the use of contingency reserves.

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



The forecast for the first quarter is slightly above plan which is mainly driven by cost per case income being higher than the plan (which then worsens from quarter two). The forecast for July is to be on plan with a slight downward movement in August. The forecast is remaining at those levels until November when there is a significant forecast increase in the surplus due to expected reductions in expenditure delivered by Cost Improvement Plan (CIP) schemes later in the year. The following months then remain on plan.

Forecast Range

Best Case	Likely Case	Worst Case
£1.34m favourable variance to plan	£0.05m favourable variance to plan	£3.26m adverse variance to plan

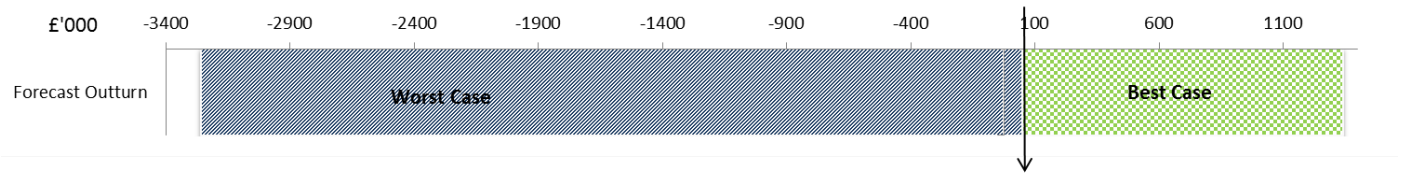
The best case of £1.34m better-than-plan assumes clinical income could improve by £359k from higher activity levels, staff cost savings could be reduced by different recruitment timings and current cost pressures improve sooner than in the likely case.

The worst case forecast includes an assumption that clinical income could worsen by £1.6m due to reductions in activity levels and delays in service developments, some efficiency savings not being realised, increases in PICU out of area placement cost pressures and further continuation of other cost pressures for which improvements are assumed in the likely case.

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

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

The key assumptions in the most likely scenarios in the draft forecast were discussed at length by Executive Leadership Team on 15th June in order to enable management action to be planned to address emerging risks.



NB: Position of arrow shows current likely case forecast outturn

2. Regulatory Risk Rating

This narrative describes performance against the current regulatory regime and rating metrics, which is out to consultation. When the outcome of the consultation is confirmed by Monitor, this section will be updated for future reporting.

The Board's attention is drawn to the fact that analysis of the impact of the proposed changes illustrate that our risk rating score will likely worsen and the headroom from a risk rating of 2 will be reduced. This is explored further in a financial strategy paper elsewhere in this Trust Board meeting.

Against the current metrics, using the Continuity of Services Risk Rating (CoSRR), our score is a 3 on each of the metrics and therefore a 3 overall year to date.

The forecast CoSRR is a 3 on each of the metrics and therefore a 3 overall, this is less than the plan of a 4 by the end of the year. This difference to the plan is driven by the liquidity metric which was planned to be a 4 at the end of the year but is now forecast to achieve a 3 due to lower cash levels.

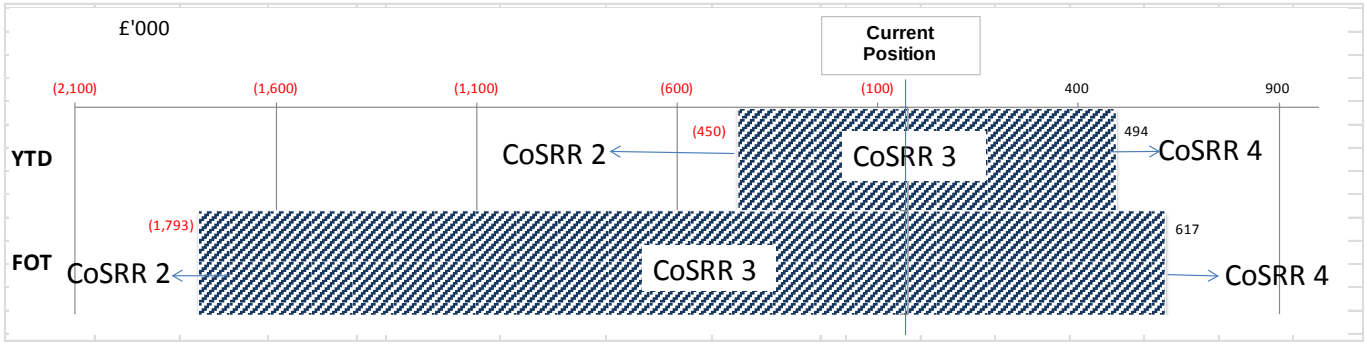
The liquidity ratio measures the Trust's ability to pay its bills from its liquid assets in terms of days and therefore the higher the number of days, the better. At the end of May the number of days is minus 1.5 and is forecast to be nearly minus 1.8 at the end of the financial year (which would still generate a rating of 3 for that metric). The Trust Board is reminded that benchmarking provided by external auditors illustrates that the peer average is nearer to +24 days, therefore our liquidity must remain a strategic priority for us to continue to improve.

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

Continuity of Service Risk Rating (CoSRR)	**YTD Actual**	**Forecast**
Capital Service Cover	3	3
Liquidity	3	3
Weighted Average	**3.0**	**3.0**
Overall CoSRR	**3**	**3**

The headroom in £'000s, from a CoSRR of 2 and 4 is shown in the chart below, both for year to date (YTD) and forecast outturn (FOT). This is for indicative use based on a set of assumptions. It serves to illustrate the impact of improving or worsening revenue and cash, but there would be other variables that could also have an impact. This chart will need to be revisited when the new risk rating metrics are published.

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

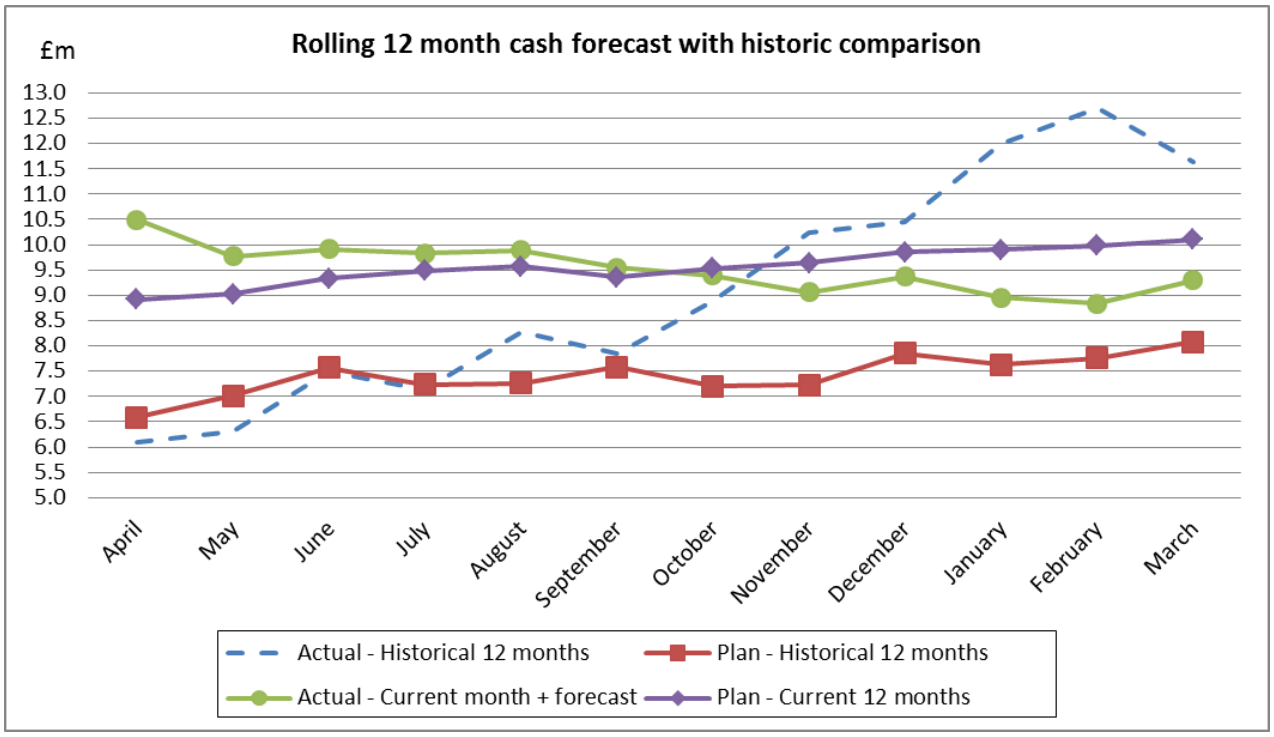


3. Efficiency / Cost Improvement Programme (CIP)

Year to date CIP is behind plan by £107k by the end of the first two months of the year. The forecast assumes that all risks to delivery of efficiency savings are mitigated and the target is fully achieved by the end of the financial year. Programme Assurance Board continues to performance-monitor CIP delivery which is reported to Finance and Performance Committee who have delegated authority from Trust Board for oversight of CIP delivery.

4. Cash Balances

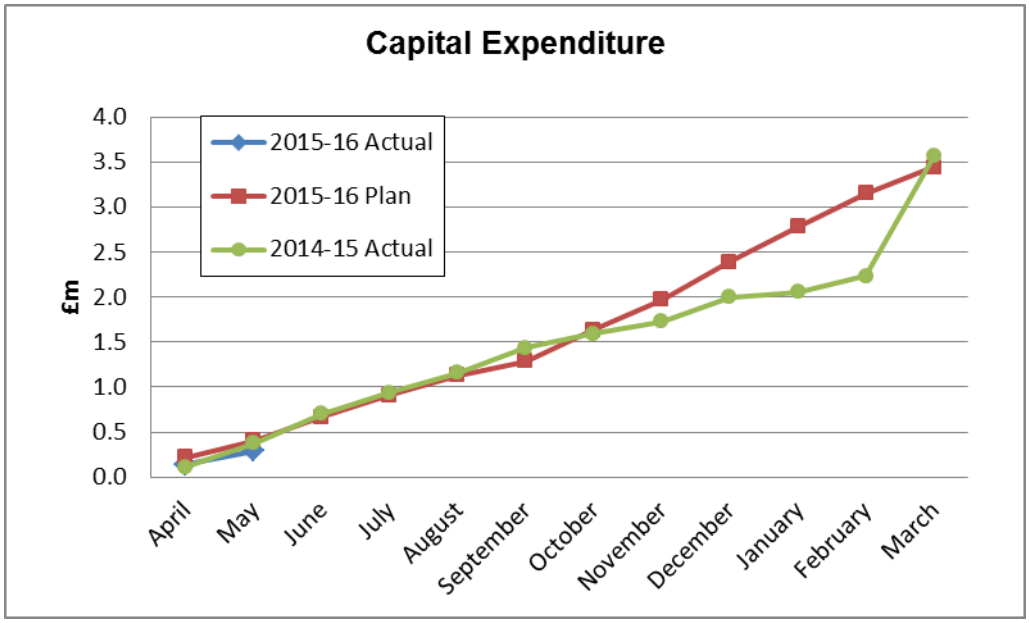
The cash balance at the end of May was £10.7m which is ahead of plan by £1.7m.
The levels of cash are forecast to reduce in June and July following the payment of some outstanding creditors. The forecast remains above plan until September when an additional cash outlay is expected. From October onwards cash remains below plan which is driven by the Income and Expenditure position and capital expenditure which is higher in the second half of the financial year.



At the end of month two our net current liabilities were £146k. We are forecasting to end the year with net current liabilities of £0.4m, which is an adverse change from the plan (which had generated net current assets).

5. Capital Expenditure

Capital Expenditure is £17k behind the plan at the end of May. However capital expenditure is forecast to spend to plan. This is tightly managed by Capital Action Team (CAT) and (Agile Working and) Asset Planning Board. The 2015/16 schemes have been reviewed by CAT. A reprioritisation to fund clinical priorities was approved by Asset Planning Board which is the reason for the change in expected capital expenditure profile compared to original plan.



6. Monthly Departmental Expenditure Limits Return

The Department of Health has mandated regular, monthly data reporting from Foundation Trusts to assist the Department of Health in controlling and forecasting expenditure against the two Departmental Expenditure Limits (DELs) for capital and revenue.

The return requires the following information in terms of year to date plan and actual along with the forecast position:

- surplus / deficit before impairments
- capital expenditure net of disposals

The return due for submission on 19th June, is not required to be signed by Trust Board members and the information contained in the return is readily available from and consistent with the Public Board report.

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 24th June 2015

Information, Technology and Records Strategy 2015-2020

Background
The purpose of this document is to provide the Board with a view of the updated Information Management, Technology and Records Strategy 2015-2020. The document reviews the strategic drivers and defines the themes that need to be addressed to underpin the Trust Strategy.

Executive Summary
- Significant progress has been made over the life of the previous strategy
- There are 5 essential themes to this strategy;
  - Access to Electronic Patient Information
  - Efficient Process Enablement
  - Agile Workforce
  - Business Intelligence
  - Underpinning technology and Service Delivery
- The Strategy also defines the processes and structures which will be required to ensure it is successfully delivered.

Strategic considerations
- This report supports the achievement of the following strategic outcomes :
  - People receive the best quality care
  - People receive care that is joined up and easy to access
  - The public have confidence in our healthcare and developments
  - Care is delivered by empowered and compassionate teams

(Board) Assurances
- This report provides assurance that a strategic approach is being undertaken regarding the deployment of systems and resources.

Consultation
- No other Group has been consulted prior to the submission of this document.

Governance or Legal issues
The document seeks to revise the governance structure supporting the successful delivery of Information Management, Technology and Records

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.

Recommendations
The Board of Directors is requested to:
1) To acknowledge the Information Management, Technology and Records Strategy 2015-20
2) Define the frequency with which updates to the Board will be required.

Report presented by: **Ifti Majid**
Chief Operating Officer/Deputy Chief Executive

Report prepared by: **Peter Charlton**
General Manager
Information Management, Technology and Records

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 24th June 2015

Trust Performance Report – Key Performance Indicators Compliance

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

Executive Summary

- The main Trust Dashboard has been updated this month to include a section of fixed indicators derived from our national submissions. These indicators relate to the proposed Commissioner financial penalties.
- The Trust continues to be compliant with all Monitor regulatory indicators
- The recording of Payment by Result Clusters and Health of the Nation Outcome Scores 12 month reviews continue to be challenging however there has been a small improvement this month.
- The rate of outpatients who did not attend is still causing concern though performance has improved
- Health Visitor performance remains strong and IAPT recovery rates remain above target
- The Trust continues to have qualified staffing vacancies that impact on staffing fill rates, Perinatal, Ward 34, Ward 35, Melbourne House and Tansley are most adversely effected

Strategic considerations

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

(Board) Assurances

- This report provides full assurance for;
    - Monitor Targets
    - Performance related elements of schedule 6
    - Health Visitor
    - IAPT Performance
- The report provides partial assurance for ;
    - Locally Agreed Targets
    - Performance related elements of schedule 4
    - Ward Staffing

Consultation

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

Governance or Legal issues

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

Equality Delivery System

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

Recommendations

The Board of Directors is requested to:

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

Report presented by: **Ifti Majid**
Chief Operating Officer/Deputy Chief Executive

Report prepared by: **Ifti Majid**
Chief Operating Officer/Deputy Chief Executive

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

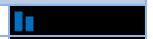
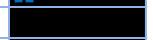
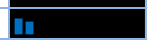
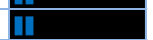
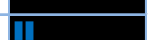
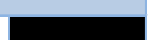
Introduction

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

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

1 Trust Performance Dashboard

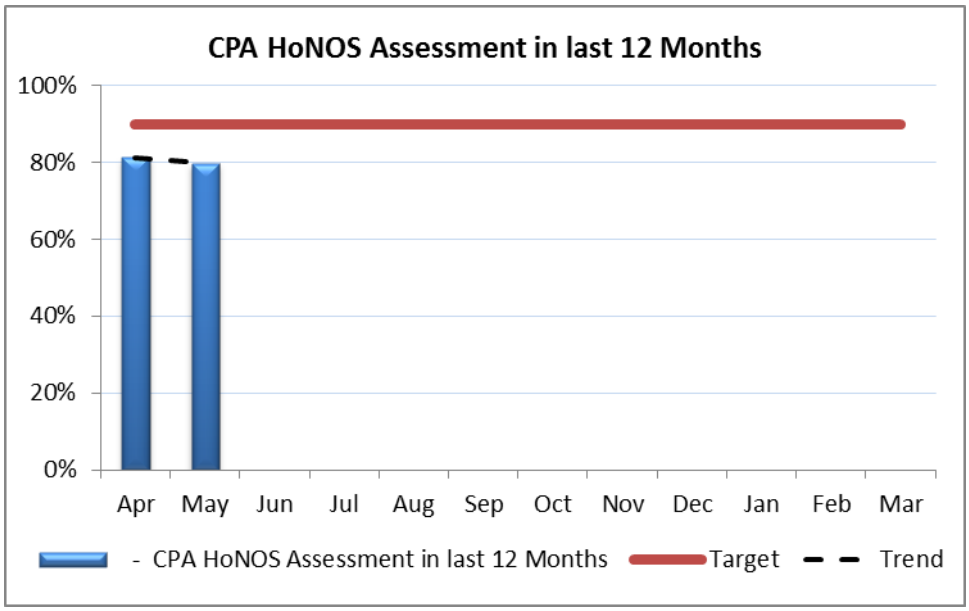
15-16 Performance Dashboard	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Trend
- Monitor Targets														
- CPA 7 Day Follow Up	95.00%	96.15%	97.67%											
- CPA Review in last 12 Months (on CPA > 12 Months)	95.00%	96.56%	95.95%											
- Delayed Transfers of Care	7.50%	0.41%	0.34%											
- Data Completeness: Identifiers	97.00%	99.20%	99.18%											
- Data Completeness: Outcomes	50.00%	93.94%	93.42%											
- Community Care Data - Activity Information Completeness	50.00%	90.19%	89.87%											
- Community Care Data - RTT Information Completeness	50.00%	92.31%	92.31%											
- Community Care Data - Referral Information Completeness	50.00%	71.03%	70.65%											
- 18 Week RTT Less Than 18 Weeks - Non-Admitted	95.00%	94.51%	96.40%											
- 18 Week RTT Less Than 18 Weeks - Incomplete	92.00%	95.10%	94.37%											
- Early Interventions New Caseloads	95.00%	163.60%	126.10%											
- Clostridium Difficile Incidents	7	0	0											
- Crisis GateKeeping	95.00%	100.00%	100.00%											
- Locally Agreed														
- CPA Settled Accommodation	90.00%	99.13%	98.97%											
- CPA Employment Status	90.00%	99.30%	99.23%											
- Data Completeness: Identifiers	99.00%	99.20%	99.18%											
- Data Completeness: Outcomes	90.00%	93.94%	93.42%											
- Patients Clustered not Breaching Today	99.00%	74.22%	74.41%											
- Patients Clustered Regardless of Review Dates	100.00%	91.25%	90.47%											
- CPA HoNOS Assessment in last 12 Months	90.00%	81.23%	79.76%											
- 7 Day Follow Up – All Inpatients	95.00%	95.90%	97.83%											
- Ethnicity Coding	90.00%	92.70%	93.06%											
- NHS Number	99.00%	99.96%	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%	4.12%	3.24%											
- Consultant Outpatient Appointments DNAs	15.00%	15.79%	15.70%											
- Under 18 Admissions To Adult Inpatient Facilities	0	0	0											
- Outpatient Letters Sent in 10 Working Days	90.00%	78.29%	69.94%											
- Outpatient Letters Sent in 15 Working Days	100.00%	88.57%	87.30%											
- Average Community Team Waiting Times (Weeks)	N/A	5.17	4.37											
- Inpatient 28 Day Readmissions	10.00%	11.81%	5.88%											
- MRSA - Blood Stream Infection	0	0	0											
- Mixed Sex Accommodation Breaches	0	0	0											
- 18 Week RTT Greater Than 52 weeks	0	0	0											
- Discharge Fax Sent in 2 Working Days	98.00%	98.45%	98.95%											
- Fixed Submitted Returns														
18 Week RTT Greater Than 52 weeks	0	0	0											
18 Week RTT Less Than 18 weeks - Incomplete	92.00%	93.70%	92.94%											
18 Week RTT Less Than 18 weeks - Non-Admitted	95.00%	95.20%	96.36%											
Mixed Sex Accommodation Breaches	0	0	0											
Completion of IAPT Data Outcomes	90.00%	98.32%	97.65%											
Ethnicity Coding	90.00%	93.60%	93.60%											
NHS Number	99.00%	100.00%	100.00%											

1.1 Exception Items and Specific Areas of Interest

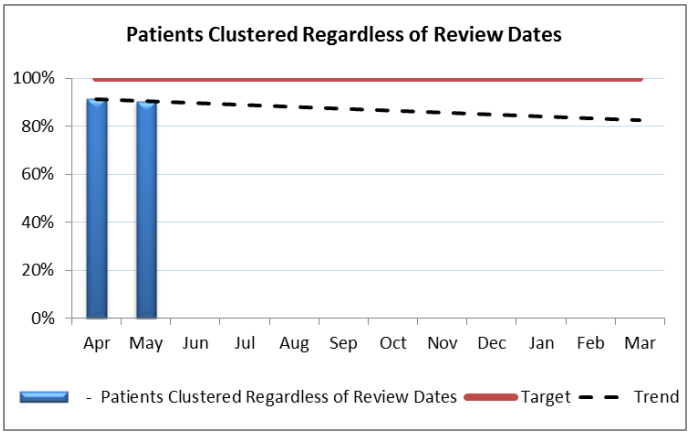
The following section reviews a number of indicators in more detail, identifying where actions are in place to address areas of performance.

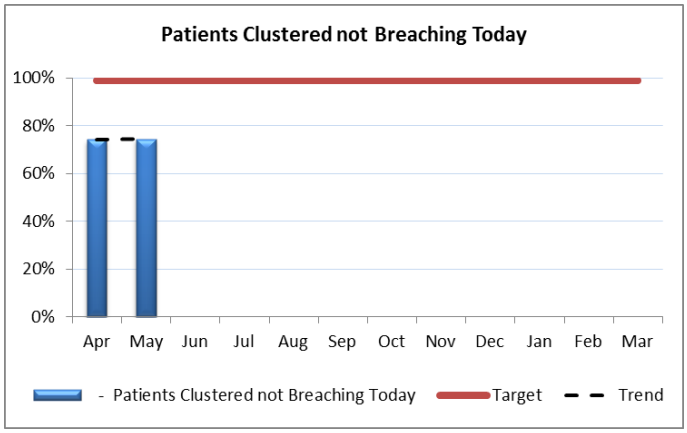
1.1.1 Locally Agreed – Care Programme Approach Health of the Nation Outcome Score Assessment in Last 12 Months



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 1.1.2

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





Ongoing analysis of this topic has highlighted a small number of issues related to the way PARIS organises data. Clinical practice also impacts on the problem.

Principally there are two main factors:

- Staff still getting familiar with PARIS

- Misunderstanding of some of the Care Clustering Principles which have been identified whilst analysing PARIS issues

The number of overdue reviews seems to have turned the corner – we are seeing a very slow but consistent reduction in exceptions week on week.

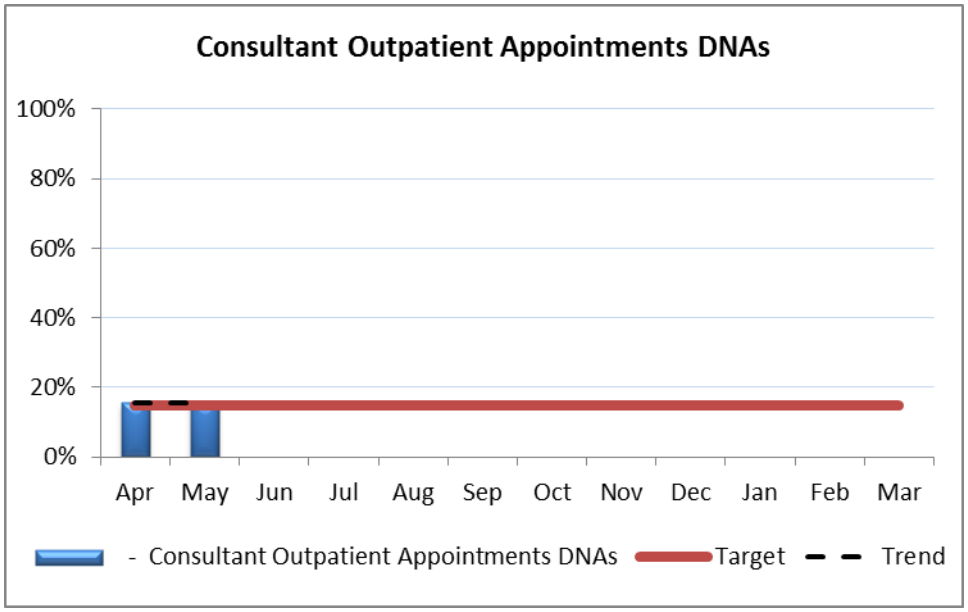
There has been a small but definite increase in requests for training and advice from teams and individuals.

Recently Information Management and Technology ran a new programme designed to address the problem of Health of the Nation Outcome Score / Payment by Result assessments not being fully completed ie ticking all the boxes in the right order. This has validated a number of assessments that were previously showing as exceptions. The result of this is that the number of not clustered exceptions has reduced by 294 (2.79%) and overdue reviews have reduced by 251 (2.03%). This programme will initially be run manually on a weekly basis to pick up any new errors, but will eventually become an automatic daily function.

Action planned: A range of solutions has been identified and are currently being deployed;

- PARIS workshops, Support from the Payment by Results Advisor.
- Additional professional group, team base and individual learning sessions have been arranged and are currently underway

1.1.3 Schedule 4 – Consultant Outpatient Did Not Attends



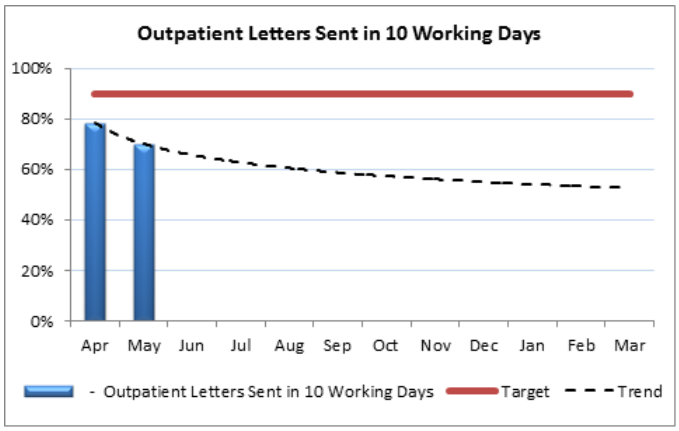
Recent study: http://qir.bmj.com/content/3/1/u202228.w1114.full

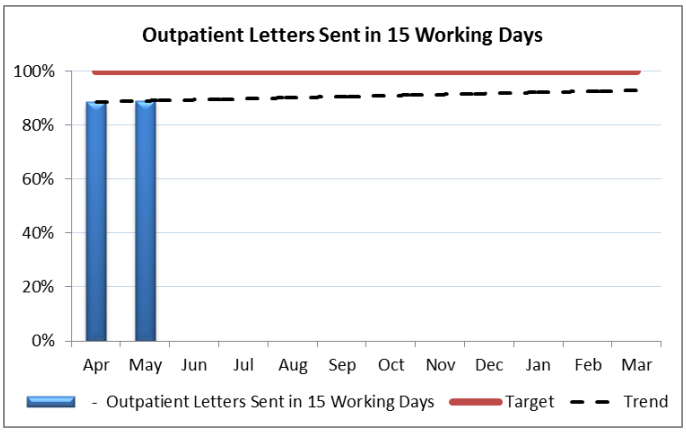
Research: http://ps.psychiatryonline.org/article.aspx?articleID=433008

Both suggest that text message reminders are effective in reducing did not attends.

Action planned: Information Management and Technology have set up text message reminder functionality on Paris. We now need to ensure that mobile numbers held are valid and that service users are willing to receive text reminders. A form has recently been approved for this purpose. This will be sent out over the coming months with all patient letters and, where staffing allows, completed with service users while they wait for their appointments

1.1.4 Schedule 4 –Outpatient Letters (Exceptions)





- Dictate IT Software – Awaiting rebuilt client for deployment. From receipt, Greater East Midland would need approx. 20 working days to action their part.
- Reports show gaps in event dates and patient IDs which are keyed by the medical secretary and vital to accurately populate Performance Dashboard and inform Commissioners. An audit is being undertaken to establish true status of jobs with missing information.
- As we approach summer holidays and increased leave requests additional flexible workers are being identified to cover typing during times of planned absence.
- Clinical Director finalising sign-up from Medics re. process for signing letters in their absence on leave. Proposing that we strive to type up to and including one week prior to planned leave date as a minimum.

Action planned

- Meeting set between Division and Information Management and Technology
- Divisions checking that staff are completing all the relevant fields required within the Dictate IT system

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	68.8										
Health Visitors in Post (Headcount)	N/A	82	81										
Number of Student Placements (Headcount)	N/A	9	9										
Number of Student Placements (FTE)	N/A	9	9										
Number of mothers receiving antenatal check	N/A	195	151										
% Births that receive NBV within 10-14 days	N/A	89.46%	83.79%										
% NBVs undertaken after 15 days	N/A	11.20%	5.80%										
% Children to received a 12 month review	N/A	97.10%	95.10%										
% Children who received a 12 month review at 15 months	N/A	97.30%	96.30%										
% Children who received a 2 to 2.5 year review	N/A	94.20%	91.70%										
% Staff who have received child protection training	N/A	63.40%	63.00%										
% 10-14 Day Breastfeeding coverage	95.00%	99.30%	98.10%										
% 6-8 Week Breastfeeding coverage	95.00%	100.00%	97.50%										
% Still Breastfeeding at 6-8 Weeks	65.00%	64.10%	68.90%										

2.1.1 Exception Comments

No exceptions

3 IAPT Services Dashboard

3.1 Dashboard

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)	981	917	0	0	0	0	0	0	0	0	0	0	1898
3b	The number of active referrals who have waited more than 28 days for treatment	2073	2000	0	0	0	0	0	0	0	0	0	0	
4	The number of people who have entered Psychological Therapies	564	401	0	0	0	0	0	0	0	0	0	0	965
5	The number of people who have completed treatment (for any reason)	533	502	0	0	0	0	0	0	0	0	0	0	1035
6	The number of people who are "moving to recovery"	273	251	0	0	0	0	0	0	0	0	0	0	524
6b	The number of people completing treatment who did not achieve caseness at the commencement of treatment	39	51	0	0	0	0	0	0	0	0	0	0	90
7	The number of people moving off sick pay and benefits	34	39	0	0	0	0	0	0	0	0	0	0	73

	Recovery Rates KPI 6 / (KPI 5 - KPI 6b)	**55.26%**	**55.65%**											**55.45%**

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%.

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	98.9%	100.0%	100.0%	100.0%	No	None Required
Child Bearing / Perinatal Inpatient	117.1%	171.2%	103.3%	190.0%	Yes	The fill rate tolerances for care staff (day and night) was broken due to the observation levels and care of baby when the mother is too unwell to do this or requires additional support.
CTC Residential Rehabilitation	102.2%	95.5%	100.0%	100.0%	No	None Required
Enhanced Care Ward	83.3%	116.6%	90.0%	122.8%	Yes	We are still carrying RG vacancies of 3 plus an adjustment we are making to our establishment. We have recruited into the 3 showing vacancies but new starters will not be with us until late September. We also had another RG in whom we were awaiting pre employment checks on since January. I have been speaking to recruitment and workforce today as I feel we should be looking at retracting provisional job offer due to concerns re this appointment. As usual I have been increasing unqualified numbers to ensure that minimum staffing levels are achieved. All Nurse in charge duties have been covered by out own staff with appropriate competencies.
Hartington Unit Morton Ward Adult	111.0%	93.8%	88.0%	116.3%	Yes	The ward is still carrying some Band 5 Registered nurse vacancies and we also have a Band 5 and a Band 6 nurse on maternity leave, it is therefore very difficult to staff night shifts with x 2 qualified for some of the time. Please do contact me again should you require any further information.
Hartington Unit Pleasley Ward Adult	92.3%	105.8%	103.2%	100.0%	No	None 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 (%)		
Hartington Unit Tansley Ward Adult	101.8%	71.6%	93.2%	85.2%	Yes	The ward continues to carry 8 vacant band 5 posts. There are new starters identified however none have started as this time. The ward is utilising agency RMNs (Blocked booked who work regular shifts on the ward and know the ward well as a temporary measure.)
Kedleston Unit - Curzon Ward	99.2%	97.7%	103.2%	100.0%	No	None Required
Kedleston Unit - Scarsdale Ward	96.9%	102.4%	100.0%	100.0%	No	None Required
KW Cubley Court Female	102.0%	93.9%	100.0%	109.4%	No	None Required
KW Cubley Court Male	100.0%	97.0%	96.4%	100.0%	No	None Required
KW Melbourne House	97.6%	88.0%	87.1%	104.4%	Yes	we did have a small staffing issue on the day shifts for unqualified staff due to short term sicknes which we had difficulty staffing with our own banks and flexible staffing as we had little response for covering this shift.The short term sickness has now come to an end and after a large recruitment drive we have recruited 4 band 2s in in august and 1 band 2 in july and 2 band 5s and have also developed a pool of DFCHT bank staff with a combination of these initives I hope to improve our tolerance levels.
KW Tissington Unit Older People	101.5%	94.2%	67.7%	115.9%	Yes	The red area for night qualified was broken due to sickness of staff.
LRCH Ward 1 OP	102.8%	103.1%	94.2%	161.5%	Yes	
LRCH Ward 2 OP	100.7%	96.4%	100.0%	98.3%	No	None Required
RDH Ward 33 Adult Acute Inpatient	100.0%	101.3%	95.8%	100.0%	No	None Required
RDH Ward 34 Adult Acute Inpatient	88.7%	134.8%	69.4%	164.2%	Yes	The ward continues to have a high number of RN vacancies which are being addressed through recruitment, also observations mean there are higher numbers of NA's
RDH Ward 35 Adult Acute Inpatient	91.8%	119.5%	83.0%	150.0%	Yes	the current levels reflect our unfilled vacancies
RDH Ward 36 Adult Acute Inpatient	99.5%	106.4%	91.4%	118.0%	No	None Required

People Strategy - update

June 2015

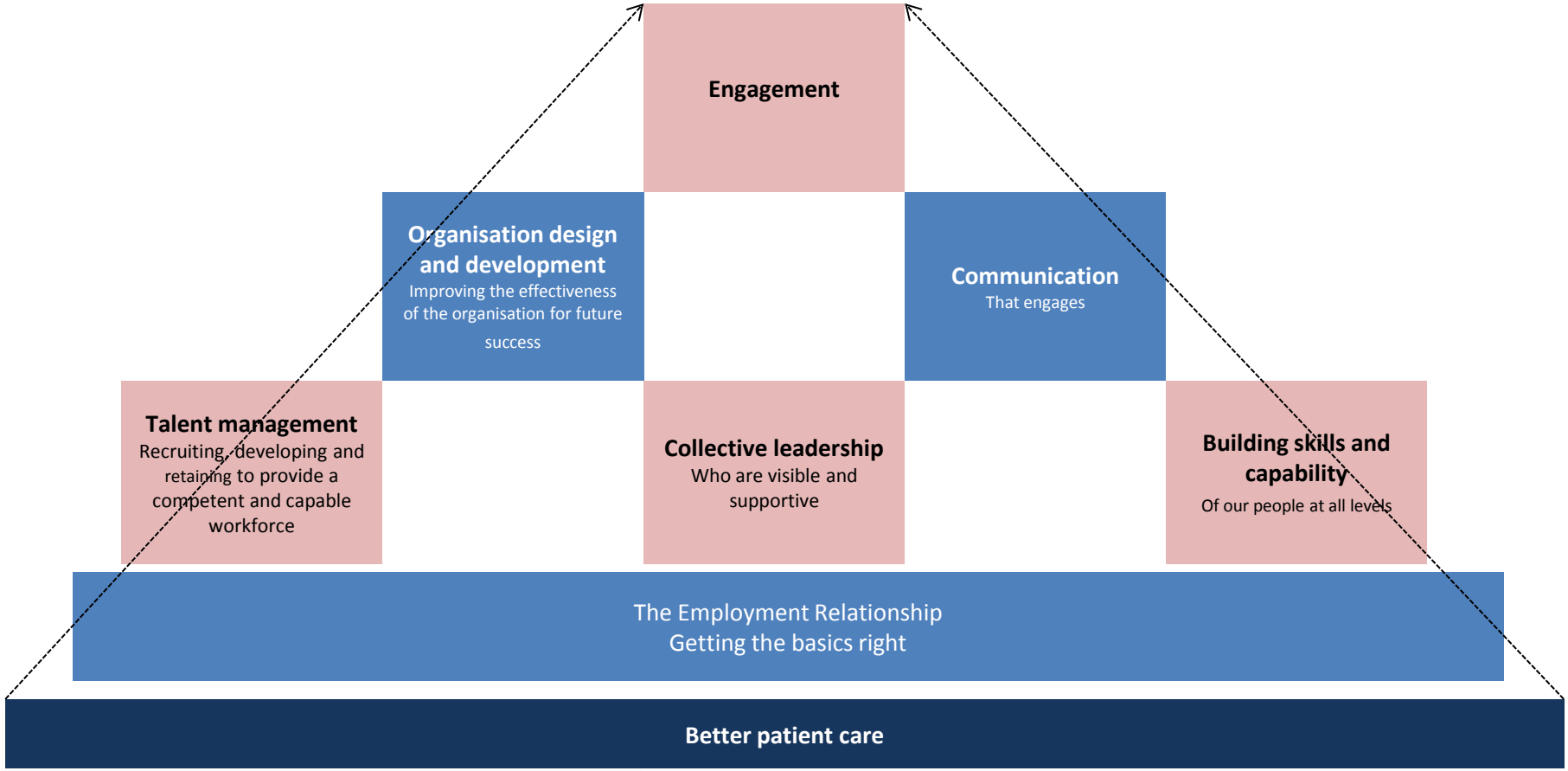
People Strategy Building Blocks

Derbyshire Healthcare NHS
NHS Foundation Trust

Enc L

The strategy consists of five primary aims:

- Engaging our people
- Educating and developing our people
- Maximising the potential of our people
- Our peoples' working environment
- Management of change.



Staff Survey Results

Derbyshire Healthcare NHS
NHS Foundation Trust

Enc L

Questionnaires were sent to all 2331 staff eligible to receive the survey which was only staff employed directly by the Trust. 1057 staff took part in the survey. This shows a response rate of 45% which is above average for mental health/learning disability trusts in England, and compares with a response rate of 41% in the 2013 survey.

The survey was structured around 4 of the seven pledges to staff in the NHS Constitution which was published in March 2013 plus two 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.

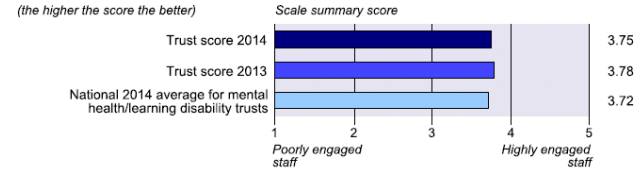
Staff Pledge 3: To provide support and opportunities for staff to maintain their health, well-being and safety.

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: Staff satisfaction, Equality & diversity and Patient experience measures

		Your Trust in 2014	Average (median) for mental health trusts	Your Trust in 2013
Q12a	"Care of patients / service users is my organisation's top priority"	68	65	71
Q12b	"My organisation acts on concerns raised by patients / service users"	74	71	78
Q12c	"I would recommend my organisation as a place to work"	54	54	58
Q12d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	60	60	67
KF24.	Staff recommendation of the trust as a place to work or receive treatment (Q12a, 12c-d)	3.60	3.57	3.68

OVERALL STAFF ENGAGEMENT



The Staff Survey Results

The survey covers 29 Key Findings (KFs). Compared against all Mental Health Trusts the survey breakdown for the Trust shows:

2 KFs in the top 20%
10 KFs above average
10 KFs average
6 KFs worse than average
1 KF in the worst 20%

	Change since 2013 survey	Ranking, compared with all mental health trusts
OVERALL STAFF ENGAGEMENT	• No change	✓ Above (better than) average
KF22. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	• No change	✓ Above (better than) average
KF24. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the Trust's top priority, would recommend their Trust to others as a place to work, and would be happy with the standard of care provided by the Trust if a friend or relative needed treatment.)*	• No change	• Average
KF25. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	• No change	✓ Above (better than) average

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Better together

Positive results

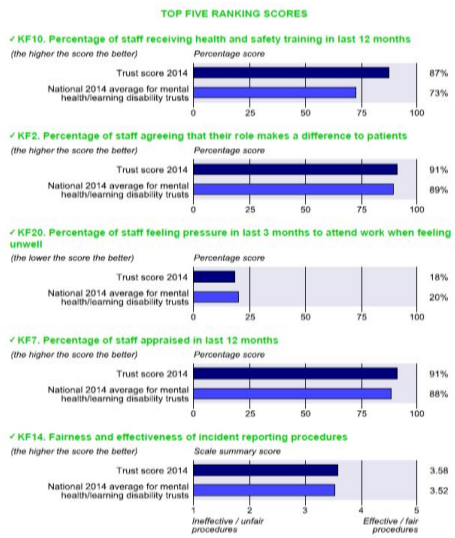
One of the areas in the top 20% was KF2. 91% of staff responding agreed "that their role makes a difference to patients". Whilst this is slightly lower than the 2013 score (92%) it is still an excellent score.

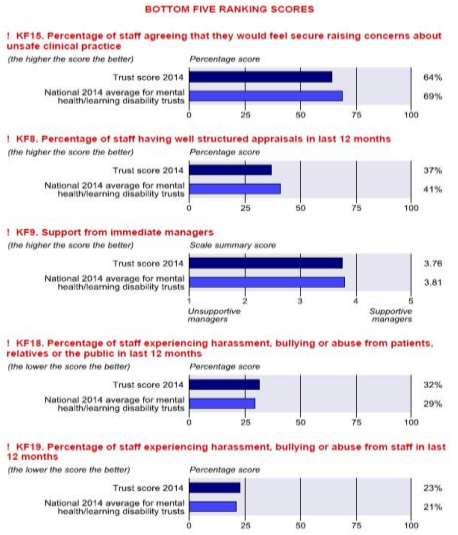
The other area scoring highly was the % of staff receiving Health & Safety training in the last 12 months (KF10) which whilst the same as last year (87%) was again in the top 20%.

A further area showing improvements on 2013 is KF20 which shows the % of staff feeling pressure in the last 3 months to attend work when feeling unwell. This has decreased to 18% from 19% which is better than average.

KF14 the fairness and effectiveness of incident reporting procedures has slightly decreased from 2013 but is still better than average against other Mental Health trusts.

The most improved score is the % of staff receiving an appraisal in the last 12 months. This has increased to 91% from 80% in 2013. However, this needs to be tempered by the fact that the % of staff having well-structured appraisals in the last 12 months has decreased to 37% from 39%. This is below average. A possible cause could be that the drive to complete appraisals and increase the number completed may have had a detrimental effect on the quality.





Results requiring more investigation

The area in the lowest 20% was KF15 where 64% of staff agreed they would "feel secure in raising concerns against unsafe clinical practice". This is very topical. The subject of whistleblowing has and still is the subject of media interest. The guidance coming from the 'centre' together with the Board's support could well see this element improving in the next 12 months. It should be noted that because of changes to the format of the survey questions this year, comparison with the 2013 survey is not possible.

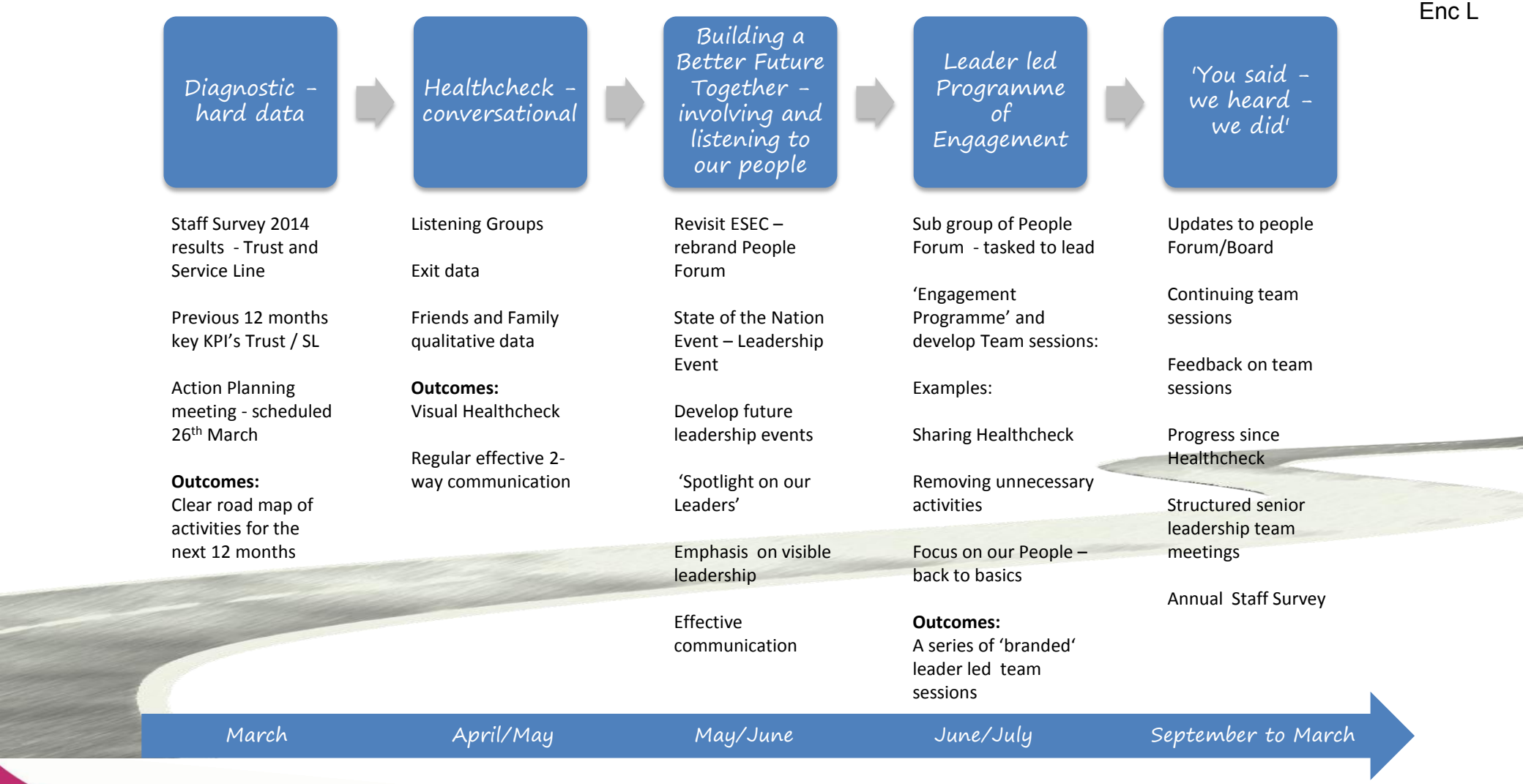
The Key Finding that has declined the most from 2013 is KF26 which is the % of staff receiving Equality & Diversity training in the last 12 months. This shows a 10% reduction (70% against 80% in 2013). Having said that the score is still showing as above average. A possible reason for the score is the fact that E & D training frequency is 3 yearly and therefore it maybe that the majority of staff completing the survey completed the training last year with only a few, plus new starters, completing this time around.

An area of concern is an area that the Trust Board is already aware of and which shows little change form 2013. This is around KF18 and KF19 which covers the % of staff experiencing harassment, bullying or abuse from patients, relatives or public in the last 12 months (32%; a slight increase) and the % of staff experiencing harassment, bullying or abuse from staff in the last 12 months (23%; a slight increase). Both scores are worse than average. In addition KF9 'Support from immediate managers' showed a slight deterioration from 2013 but is below the average for all Mental Health trusts.

Road Map

Derbyshire Healthcare NHS
NHS Foundation Trust

Enc L



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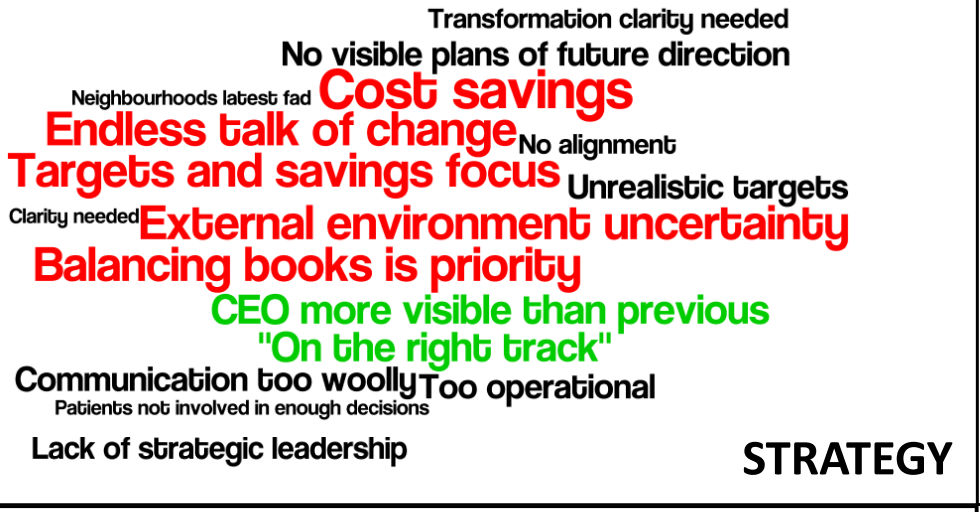
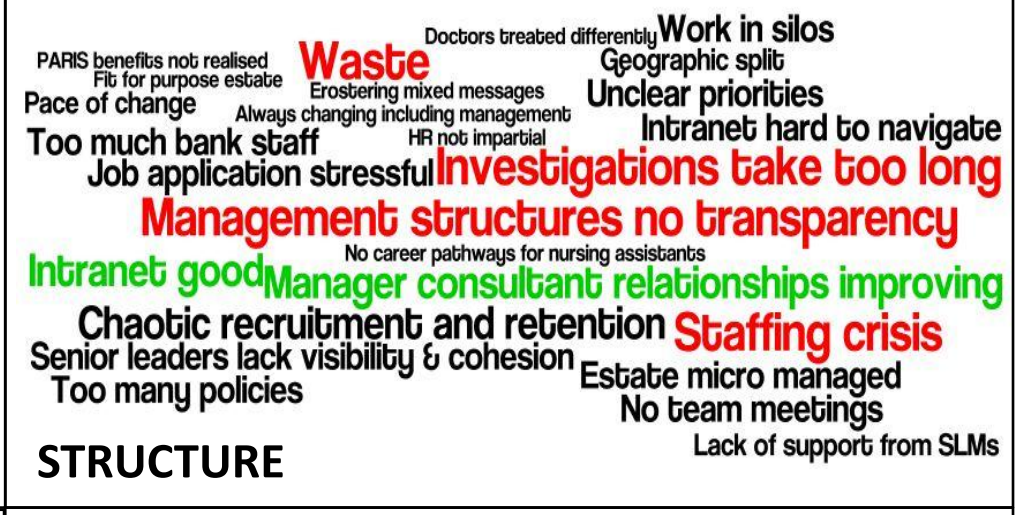
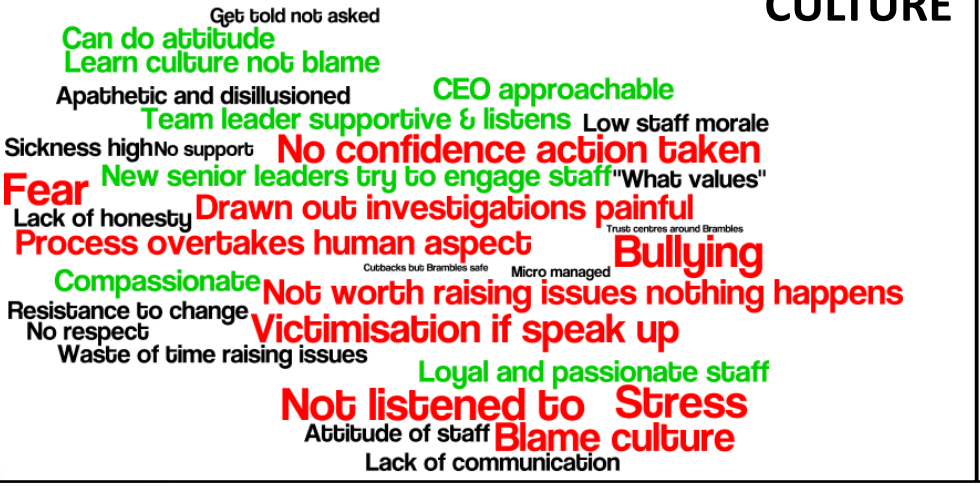
Better together


Transformation clarity needed
No visible plans of future direction
Neighbourhoods latest fad
Cost savings
Endless talk of change
No alignment
Targets and savings focus
Unrealistic targets
Clarity needed
External environment uncertainty
Balancing books is priority
CEO more visible than previous
"On the right track"
Communication too woolly
Too operational
Patients not involved in enough decisions
Lack of strategic leadership
STRATEGY


Doctors treated differently
Work in silos
PARIS benefits not realised
Waste
Geographic split
Fit for purpose estate
Erostering mixed messages
Unclear priorities
Pace of change
Always changing including management
Intranet hard to navigate
Too much bank staff
HR not impartial
Job application stressful
Investigations take too long
Management structures no transparency
No career pathways for nursing assistants
Intranet good
Manager consultant relationships improving
Chaotic recruitment and retention
Staffing crisis
Senior leaders lack visibility & cohesion
Estate micro managed
Too many policies
No team meetings
Lack of support from SLMs
STRUCTURE


CULTURE
Get told not asked
Can do attitude
Learn culture not blame
Apathetic and disillusioned
CEO approachable
Team leader supportive & listens
Low staff morale
Sickness high
No support
No confidence action taken
Fear
New senior leaders try to engage staff
"What values"
Lack of honesty
Drawn out investigations painful
Process overtakes human aspect
Trust centres around Brambles
Bullying
Cutbacks but Brambles safe
Micro managed
Compassionate
Not worth raising issues nothing happens
Resistance to change
No respect
Victimisation if speak up
Waste of time raising issues
Loyal and passionate staff
Not listened to
Stress
Attitude of staff
Blame culture
Lack of communication


ACHIEVING
Pressure
Bureaucratic
High workload
Capacity
Need to feel more recognised
Too many non - contracted hours worked
Too much waste
Case loads too big
Staff sickness high
High quality patient care
Communication not good
Disorganised
Lack of praise
Patient relationships hindered due to service changes
Doing best with limited resources
Good HR support
Ever increasing demand
Inconsistencies
Demand v support imbalanced
Staffing levels & recruitment
Resources stretched
Hot desking not workin
Too busy to attend training
Competing priorities
Too much admin
Library and resources
Frustrated

Key People Metrics

Derbyshire Healthcare NHS
NHS Foundation Trust

May 2014		Apr 2015	May 2015	Target	Benchmark
Annual Staff Turnover 9.34%	Regularly review hot spot areas	9.63%	9.70%	10%	NHS **9.12%** National MH&LD **12.50%** East Mids MH&LD **11.21%**
Compulsory Training 80.09%	Continued focus and improved access	83.41%	83.97%	95%	East Mids MH&LD **80%**
Appraisal Compliance 69.43%	Live Workforce Dashboard and ESR MSS	73.18%	72.65%	90%	NHS **83%** National MH&LD **88%** East Mids MH&LD **87%**
Sickness Absence 4.57% M 4.66% A	Leaders receive alerts and reports via FirstCare	5.46% M 4.98% A	4.83% M 5.04% A	3.9%	NHS **4.33%** A National MH&LD **4.85%** A East Mids MH&LD **4.90%** A
Active Recruitment 21 posts	Establishment Control Group	57 posts	36 posts		*Compulsory Training Dec 2014 Benchmark source:* ***East Mids Streamlining Prog***
Variance from Funded Establishment 13.66%	5% tolerance against target	14.97%	15.13%	90% staff in post	*Annual Staff Turnover Mar 2015 & Annual Sickness Absence Feb 2015 Benchmark source:* ***HSCIC NHS iView*** *Appraisal Compliance Oct 2014 Benchmark source:* ***NHS Staff Survey 2014***

Apr 2015 V May 2014

May 2015 V Apr 2015

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Within Trust Target Parameters

Outside Trust Target Parameters

WE FOCUS ON OUR PEOPLE

Better together

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**	**16-Oct**	**13-Nov**	**14-Jan**	**12-Feb**	**18-Mar**	**15-Apr**
SCT	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
ST	Chief Executive's report	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X	X
MP	APR Monitor Annual Plan submissions and governance statements, including financial planning (subject to change for Monitor deadlines each year) *Confidential*	FT Constitution/Monitor Risk Assurance Framework (RAF)	APR Progress update/ approval	APR Progress update/ approval						Self-assessm't if not covered in Bd Devpmt	APR Progress update	Approve start budgets. APR progress update/approval	APR Progress update/ approval
CW	Monitor Compliance Return *Confidential*	Monitor Risk Assurance Framework (RAF)	X			X		X		X			X
ST	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

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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
ST	Strategic review/quarterly progress to include Transformation Board update	Strategic Outcomes (all)		X					X			X	
IM	IM&T Strategy Updates that will include update on optimisation of EPR	Strategic Outcome 1 Strategic Outcome 2			X	Progress Report							X
IM	Information Governance Updates	Strategic Outcome 1 Strategic Outcome 3 Information Gov toolkit	X					X				X	
AS	Communications Strategy - Yearly Report	Strategic Outcome 3					X						Next one Sept 2016
JSt	Workforce 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					

2015-2016 Board Annual Forward Plan

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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
MT	Annual Members' Meeting - arrangements	FT Constitution				X							
OPERATIONAL PERFORMANCE													
IM	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	Quality Dashboard	CQC and Monitor				X						X	
CG	Position Statement on Quality (Incorporates Integrated Governance, Patient Experience and Patient Safety Reports)	Strategic Outcome 1		X	X	X	X	X	X	X	X	X	x
CG	Safeguarding Children	Children Act Mental Health Standard Contract				X				X			
CG	Safeguarding Adult	CQC Mental Health Standard Contract				X				X			
CG	Control of Infection Report	Health Act Hygiene Code		X									
CG	Integrated Clinical Governance Annual Report (inc MHA/Governance/Complaints and Compliments/SIRI's/Patient Safety/NHS Protect (LSMS) and Emergency Preparedness	CQC			X			X					

2015-2016 Board Annual Forward Plan

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CG	Integrated H & S Governance Annual Report (including H&S and Fire Compliance and Associated Training)	CQC and H&S Act				X		X					
CG	Annual Patient Survey	Clinical Practice CQC					X						
Jsy	Clinical Incidents Update *Confidential*	Monitor Risk Assurance Framework (RAF)	X	X	X	X	X	X	X	X	X	X	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								
CG	Health and Safety (Carrina Gaunt)	Health & Safety At Work Act					X						