Derbyshire Healthcare NHS
NHS Foundation Trust

Meeting of the Board of Directors

29 July 2015

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

NOTICE OF BOARD MEETING
WEDNESDAY 29 JULY 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	**-**	Mark Todd
2.	1:05	Service User Feedback "Your Service Your Say"	**A**	
3.	1:30	Apologies for Absence Declarations of Interest		Mark Todd
4.	1:35	Minutes of Board of Directors meeting, held on 24 June 2015	**B**	Mark Todd
5.	1:45	Matters arising – Actions Matrix	**C**	Mark Todd
6.	1:55	Chairman's Report	**D**	Mark Todd
7.	2:05	Acting Chief Executive's Report	**E**	Ifti Majid
FINANCE, STRATEGY AND GOVERNANCE				
8.	2:25	Committee Summary Reports: - Audit Committee (VERBAL) - Quality Committee	 **-** **F**	Committee Chairs
9.	2:35	Annual Audit Letter	**G**	Claire Wright
10.	2:45	Governance Framework	**H** to follow	Jenna Davies
11.	3:00	Verbal Workforce Strategy Update	**-**	Jayne Storey
B R E A K 3:15				
12.	3:30	Annual Members Meeting	**I**	Anna Shaw
PATIENTS, QUALITY AND SAFETY				
13.	3:35	Medicine Management - Deep Dive	**J**	Sangeeta Bassi
14.	3:55	Position Statement on Quality and Quality Dashboard	**K**	Carolyn Green
OPERATIONAL PERFORMANCE REVIEW				
15.	4:10	Finance Director's Report Month 3	**L**	Claire Wright
16.	4:20	Integrated Performance and Activity Report	**M**	Ifti Majid
FOR INFORMATION				
17.	4:30	I. Board Forward Plan II. Monitor Regulatory Letter III. Identification of any issues arising from the meeting for inclusion or updating of the Board Assurance Framework IV. Discussion on future deep dives V. Comments from observers on Board performance and content of meeting	**N** **O**	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.

There will be no meeting in August.
The next meeting is to be held on 30 September 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. `

Examples of feedback

Below are some examples of how your feedback has helped us to improve our services.

You said: “The hub needs new table tennis equipment.”

We did: New bats, net and balls was purchased.

You said: “There is nowhere for drink to be put down in the courtyard.”

We did: Purchased and fitted benches and tables.

You said: “I would like to use the gym more often.”

We did: Opened the gym for all service users to access.

Your Service, Your Say

Service user feedback

Your chance to have your say

Your Service, Your Say is an opportunity to support and enable service users to have their say and give us feedback about the treatment and care they receive at the Hartington Unit.

All comments, suggestions, complaints and compliments are welcomed as we pride ourselves on providing the highest quality of care to all our service users.

Your Service, Your Say is run by a Trust volunteer who will link in with the wards, and Recreation and Occupational Therapy Services to support you to receive the best possible service whilst you're an inpatient at the Hartington unit.

How we support you

After you have spoken with us we will anonymously pass on all your feedback to the relevant manager for their response. Our aim is for you to receive feedback from us within one week, this will be given to you either face to face or displayed anonymously on the **Your Service, Your Say** notice board, located at the rear of The Hub.

Please feel free to ask your service user representative or a member of the Recreation Team if you have not received any feedback within one week.

At all times feedback is kept completely confidential, please speak to your representative if you have any worries on how we will use your feedback.

Where can you find us?

The service user representative will be available in The Hub every Thursday afternoon from 1.30pm.

A word from your representative

"Hello, my name is Hilary and I am your service user representative. You can recognise me as I wear a royal blue polo shirt and carry a clip board. As a service user myself, I bring to this role a wealth of experience of both inpatient and community care.

"My role is to provide a listening ear for you to have **YOUR SAY** about any issues you may have about your inpatient experience. This can take place in The Hub or quiet room over a cup of tea or coffee. I do approach service users asking them if they would like a chat, however if you want to chat, but feel uncomfortable to approach me yourself, just ask one of The Hub team (recreational staff) and they'll let me know.

"A 'chat' can last any length of time, from five minutes to one hour; there are no time limits. Any issues that arise whilst we are talking, I shall try and deal with there and then or, if that's not possible, I will pass it on to the appropriate person to deal with. You will receive feedback on these issues within one week. If you feel able, do make use of this service as it's a golden opportunity for you to have **YOUR SAY**."

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, 24 June 2015

MEETING HELD IN PUBLIC

Commenced: 1:00 pm Closed: 5:10 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
	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
	Mark Powell	Director of Business Development and Marketing
	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
	Peter Charlton	General Manager IM&T
	Sue Turner	Executive Administrator and Minute Taker
For item DHCFT 2015/102	Mandy Meyrick	Staff Side Secretary
For item DHCFT 2015/102	Sara Bains	Recovery Lead
For item DHCFT 2015/102	Helen Brockbank	OT, Amber Valley Community Older Adult Team
For item DHCFT 2015/102	Sue Phillip	Qualified Nurse
For item DHCFT 2015/102	Annie Cole	Nursing Assistant
For item DHCFT 2015/102	Zara Worthy	Staff Nurse
For item DHCFT 2015/102	Stephen Jones	Domestic Supervisor
For item DHCFT 2015/102	Pete Matkin	Charge Hand Porter
VISITORS:	Carole Riley	Derbyshire Voice Representative
	John Morrissey	Council of Governors
	Moira Kerr	Council of Governors
	Michael Walsh	Council of Governors
APOLOGIES:	Graham Gillham	Director of Corporate and Legal Affairs
	Tony Smith	Non-Executive Director

DHCFT 2015/090	**CHAIRMAN'S OPENING REMARKS, APOLOGIES, DECLARATIONS OF INTEREST** The Chairman opened the meeting by welcoming all present. No declarations of interest were noted.
DHCFT 2015/091	**VOLUNTEERING FOR TRAINING AND RESOURCE** Robert introduced himself and explained some of his life history. He had travelled around the world as an ex-serviceman and returned to the area to care for his parents when they became ill and he supported them both to the end. Robert told the story about his wife who had been diagnosed with a brain tumour two and half years ago. Nothing could be done for her and he cared for her in their home for a period of 12 months. Robert found this hard as he had very little help until the final stage when a nursing team helped him to care for his wife. Although the nurses were there to help he and his wife found it difficult as they had many different nurses caring for her from the District Nursing team (non-Trust service). When Robert's wife died Robert spent seven weeks in a day care centre. He thought the mental health team carried out some tremendous work with him and helped build his confidence but this help stopped when he was discharged and he felt very isolated after he was sent home. The social network available to him outside of the Trust following a bereavement was non-existent. Eventually Robert was put in touch with the Community Psychiatric Nurse (CPN) who suggested he did volunteer work. Robert felt this was the best thing he could have done as it gave him a reason to go out and meet new people and it made him feel valued. Robert's volunteer work consists of helping to organise room bookings in the Research & Development Centre and because of his background in IT he carries out computer support work and he also volunteers in a centre in Ilkeston. Carolyn Green felt Robert's story was very positive and gave the Board the opportunity to learn about volunteering and she felt it would be a good idea if Robert could help the Trust improve its services. Robert replied immediately that consistency and compassion were the most important things that could improve the services he received while caring for his wife. Having the same nurse in the community team would have helped enormously. He had the same CPN while he was being treated and this enabled him to build a relationship with the CPN who recommended he carried out volunteer work. Volunteering also gave Robert the opportunity to sign up to e-learning and this has provided him with additional qualifications. Carolyn Green thanked Robert for his comments. She acknowledged that the Board had listened to his story and would bear in mind the points he made and will strive to help people who are bereaved, especially as bereavement is a leading cause of depression and for people coming into the Trust's service to gain help. The Chairman added that he could see that volunteering was a very important part of Robert's life and it was good for the Trust to have people like him with real life experience providing such vital support. The Chairman thanked Robert for sharing his story and for his commitment and support as a volunteer within the Trust's service that is sincerely valued and appreciated.

	RESOLVED: The Board expressed thanks to Robert for sharing his story and for the ideas he had proposed.
DHCFT 2015/092	**<u>MINUTES OF DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST BOARD MEETING, HELD ON 27 MAY 2015</u>** The minutes of the Derbyshire Healthcare NHS Foundation Trust Board meeting, held on 27 May were accepted and approved.
DHCFT 2015/093	**<u>MATTERS ARISING</u>** **DHCFT 2015/068: County CAMHS Staff Levels and Capacity -** Jayne Storey and Maura Teager provided a verbal report of their visit to the County CAMHS team. Good two way conversations addressed concerns regarding staff levels, capacity and recruitment. The team's skill mix is being reviewed, together with the risks to retention and this is being looked at in the workforce profile. There are still concerns with waiting times but this is being met. All impacts of the Cost Improvement Programme (CIP) are seen as challenging and the team is looking at how they can deliver the service going forward. They also feel anxious about the effects of transformation. Maura Teager thought the combination of the Non-Executive Director and Executive was a good pairing and this became clear in their conversational approach to the visit and they took assurance from the systems they saw the team working with. It was evident that any gaps would be covered within the committee structure and working through business as usual. Jayne Storey and Maura Teager will provide a further update to the Board after their next visit to the team in September. Ifti Majid and Steve Trenchard proposed that members of the CAMHS team who attended last month's deep dive be asked to present their concerns further and the Chairman asked for this to be co-ordinated. The recruitment of CAMHS consultants was discussed and it was agreed that a Non-Executive Director would be invited to sit on the interview panel if the Chairman or Chief Executive were unavailable. **ACTION: Further discussion to be arranged with the CAMHS team and the Board.** **ACTION: Substitute arrangements be implemented should either the Chair or Chief Exective be unavailable for consultant interviews.** **<u>Actions Matrix</u>:** All green completed items to be removed and all other updates were noted directly on the matrix.
DHCFT 2015/094	**<u>CHAIRMAN'S REPORT</u>** The Board noted the Chairman's report which summarised his meetings and visits during the month. The Chairman was particularly impressed during his quality visit to the CAMHS team in the City who had been facing difficulties with managing the number of individuals and families within resources but had scored well on safety issues. He felt this was due to the very clear leadership of the team and the strong integration of all team members including nurses and consultants.

	RESOLVED: The Board received and noted the Chairman's report.
DHCF 2015/095	**<u>CHIEF EXECUTIVE REPORT</u>** Steve Trenchard presented his regular monthly report which contained a number of papers that were included for information and also included a communication around plans for the Joined Up Care South Derbyshire vision that was included for the Board to note. He drew attention to the new approach of the Success Regime that had been brought in to work across the whole health and care system that would join leadership together to ascertain financial stability and autonomy. This will mean there will be a challenge between local CCGs and Derby Hospital's five year plan to show strengthening local leadership capacity and capability, with a particular focus on radical change and developing collaborative system leadership. The Chairman and Steve Trenchard referred to the report that the CQC (Care Quality Commission) had published that provided an overview of the experience of people receiving help, care and support during a mental health crisis. The main theme of the report looked at attitudes of staff especially around the Section 136 use in police cells. It had been suggested that the Trust built a specific 136 Section area for young people. Better access of the services after 5 o'clock and at weekends was seen as an issue and would be explored. The Chairman pointed out there were significant challenges to commissioners contained in the CQC's paper but he took assurance from the systems and the achievements the Trust has in place. The Board discussed who would champion the voice of mental health and whether the new ministers will carry on this work now that Norman Lamb is no longer a minister. It was hoped that the focus and drive towards parity will not start to wane and Steve Trenchard said he would share this thought with Simon Stevens as this is a real national cry for a continued focus on mental health. The Trust's refreshed strategy was attached to the Chief Executive's report and the Quarter 1 report to the Board will show measures that have been developed. The Board would receive a new strategy in June next year that would be produced in co-ordination with Monitor's business planning timetable. This prompted Caroline Maley to suggest that Jayne Storey produced an updated Board Development Schedule for discussion at the next Board meeting. **ACTION: Jayne Storey to produce an updated version of the 2015/16 Board Development Schedule for the next Board meeting in July.** **RESOLVED: The Board of Directors received and noted the Chief Executive's Report.**
DHCFT 2015/096	**<u>AUDIT COMMITTEE ANNUAL REPORT</u>** 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. This report explained the work of the Audit Committee during 2014/15 and was noted by the Board.

	RESOLVED: The Board of Directors received and noted the Audit Committee Annual Report.
DHCFT 2015/097	**<u>COMMITTEE SUMMARY REPORTS</u>** **I. <u>Audit Committee</u>:** The draft minutes of the meeting of the Audit Committee held on 22 May were noted by the Board. **II. <u>Quality Committee</u>:** • The Board noted that the limited assurance on overdue actions of the Serious Incident Annual Report will be improved once a further report is submitted to the Quality Committee at its next meeting in July. • A report on the impact of legal highs on the Trust's services will be brought to the committee by Carolyn Green and will address some of the key service improvements that are needed to meet this changing patient need and profile • The Duty of Candour Policy was adopted by the Board on the recommendation of the Quality Committee. **III. <u>Mental Health Act Committee</u>:** • John Sykes confirmed he had written to individual consultants setting out the approved and lawful process for recording capacity to consent. He also provided a brief update on actions taken for patients detained under Section 3 of the Mental Health Act and explained that further audits and spot checks have been planned. • The Board noted that a process to provide appropriate support to the Mental Health Act Committee had been discussed by the Chairman and Jenna Davies. • Feedback on gaps in assurance will be reported to the next meeting of the Board under matters arising by Tony Smith. **ACTION: Tony Smith to be advised on his return from holiday that he is to provide an update in gaps in assurance at the next Board meeting in July.** **RESOLVED: The Board of Directors noted the contents of the Committee Summary Reports.**
DHCFT 2015/098	**<u>MONITOR CORPORATE GOVERNANCE STATEMENTS</u>** This paper supported the requirement for the Board to submit Governance Statements four, five and six to Monitor by 30 June 2015 (statements one, two and three having been previously submitted in April and May). Caroline Maley was of the opinion Statement 4 was "too light" and asked for a further response to be made. It was agreed that Jenna Davies and the relevant executives will add further detail to all the points itemised in statement 4 to provide assurance that the Trust effectively implements the appropriate systems and / or processes and to confirm the mitigations for each statement.

	ACTION: Jenna Davies to work with the executives and provide further detail to Statement 4. **RESOLVED: The Board of Directors:** **1) Confirmed the following governance statements:** **Statement 4: For the Corporate Governance Statement that it is appropriate to select confirmed for each statement and that the risks and mitigations for each statement are correct** **Statement 5: This statement is not applicable because we are neither:** **• part of a major Joint Venture or Academic Health Science Centre (AHSC); or** **• considering entering into either a major Joint Venture or an AHSC.** **Statement 6: The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.** **2) Noted that the statements will need to be appropriately published in accordance with general condition G6, paragraph 4: "The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to Monitor in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it."**
DHCFT 2015/099	**<u>REVALIDATION OF DOCTORS</u>** Revalidation is a process by which doctors in the UK have their licence to practise reviewed. Unless there is an acceptable reason every doctor must have an annual appraisal within the specified time window. The Trust Board oversees compliance and is required to submit a statement of compliance to NHS England by 30 September 2015. Maura Teager asked if there were learning opportunities that can be transferred to the revalidation of nurses. John Sykes replied that he and Ed Komocki were working with Carolyn Green to share good practice. The Chairman questioned to what extent issues were reviewed throughout the year and how these were fed into the appraisal process. In response John Sykes explained that legal issues regarding compliance with the Mental Health Act were built into the appraisal system and comments arising from the patient survey will also be incorporated into the appraisal process in the future. Claire Wright noted the high number of locums and requested that "high-cost off-payroll" HMRC requirements be considered as part of the recruitment and appraisal process for appropriate medical staff. John Sykes agreed and it was noted that this would form part of an internal audit for the current year. Steve Trenchard queried the quality scores as he thought they were low. He asked if training was going to take place to improve on this process as he could

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	not see if there is enough reflective practice to help doctors improve. John Sykes explained that he considered that reflective practice was weak and this would be developed over the next 12 months and the Board recognised that more work was required. It was acknowledged that appraisals are about personal development and the personal development plan is at the heart of the Trust's well led framework. John Sykes will discuss the issues raised by the Board with the appraisal lead, Ed Komocki and will update the Quality Committee on the number and ratio of appraisers and doctors. John Sykes would also feedback discussions into TMAC (Trust Medical Advisory Committee). It was agreed that in future the report will not contain quite so much example material, it is key performance detail that is required. The Board approved the statement of compliance that confirmed the Trust as a Designated Body in compliance with the regulation and this was duly signed by the Chairman. A**CTION: John Sykes to provide a further report to the Quality Committee.** **RESOLVED: The Board of Directors:** **1) Accepted this report noting it will be shared alongside the Annual Organisational Statement of Compliance with the higher level responsible officer at NHS England.** **2) Noted that an appraisal lead has been appointed following consideration of resource issues and last year's annual report.** **3) Approved the statement of compliance confirming that the Trust as a Designated Body is in compliance with the regulations.**
DHCFT 2015/100	**<u>POSITION STATEMENT ON QUALITY</u>** The Position Statement on Quality provided the Trust Board of Directors with an update on continuing work to improve the quality of services the organisation provides in line with the Trust Strategy, Quality Strategy and Framework and its strategic objectives. Carolyn Green drew the Board's attention to the key findings in suicide and self-harm in the specific REGARDS group in particular those people who are lesbian, gay and bisexual men and the potential higher risk to self-harm and suicide of those significant groups and the research being carried out that will be used in the design of DHCFT education. The safer staffing indicators and response to the NHS England letter was also highlighted by Carolyn Green and the Board noted that the actions required were being monitored by the Quality Committee and the Trust's approach to an in-patient service skill mix review. The Board noted the Care Quality Intelligent Monitoring Report had a sustained rating of Level 4 which is the lowest risk rating by the CQC and that this was scrutinised by the Quality Committee. **RESOLVED: The Board of Directors:**

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	1) Noted the quality position statement including the intelligent monitoring report, and the annual report on complaints, concerns and compliments. **2) Scrutinised the current position and work plan.**
DHCFT 2015/101	**<u>RESEARCH & DEVELOPMENT CENTRE UPDATE</u>** The purpose of the report was to provide the Board of Directors with an update on the activity of the Trust's Research & Development (R&D) Centre. This report highlighted 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 included updates on the other aspects of the R&D centre: the Library and Knowledge Service and Clinical Audit. The Board noted that the Trust's performance in delivering national clinical research continued to be strong. The Board had received some assurance that the R&D Centre is providing a quality impact on services. However, in order to compare the Trust with comparable organisations, more benchmarking data is needed. Carolyn Green was heartened to see so many research opportunities developing and was impressed with the research profile and stressed that this needed to be linked back to the Quality Leadership Teams to improve service level. It was noted that the next report would focus more on benchmarking and links to education detail and training. The contribution of R&D to deliver the Trust's Strategy would be emphasised. **RESOLVED: The Board of Directors** **1) Noted the content of the report.** **2) Received assurance from the activity report that research and development is making a positive impact on the quality of the Trust's services.**
DHCFT 2015/102	**<u>STAFF HEALTH CHECK</u>** In response to the Trust's Staff Health Check the Trust received a community, clinical and ward response as well as a response from the domestic function and porters. Representatives from these areas were invited to attend the Board meeting and gave an overview of working across the whole organisation. Staff highlighted to the Board some of the day to day issues they were facing: • Management of wards - one manager running three teams including the day centre. • There is no stability of staff, there is always a rapid changeover and patients cannot build up a relationship with bank nurses.

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	• Domestic staff can only carry out their work well if the ward is led and managed well and this depends on particular staff being present on the wards. • Nurses want to learn from a positive role model but don't feel there is anyone on the ward who can do this. Newly qualified nurses are working together instead due to lower numbers of experienced staff and some experienced staff had entrenched styles of nursing that younger nurses do not want to learn from. • A few, more experienced nursing / support staff have a very pessimistic attitude to making a difference to patients' recovery. This discourages the young new staff who want to make a difference. • There is a primary fear of what is going to happen in the transformation programme. There is a significant amount of fear about losing jobs. • Staff have issues with stress and sickness and they are fearful that vacancies will not be replaced. • Pressure in community teams is high, they are starting work early and working through lunch breaks and staying late and working at weekends. • Staffing levels are not keeping up with the demands of expanding GP areas. • Staff bullying attributed to the pressures of carrying out the job because people feel threatened within their role and because they are finding it hard to pay their bills. • So many cuts have been made staff cannot manage any more. • Band 6 staff are expected to carry out leadership roles. Staff feel they are fire-fighting and do not have time to carry out their job properly. Carolyn Green thanked the teams for their valuable work and for coming to the meeting to discuss their issues. She explained that a new way of working using skill mixing would be put in place. She was keen to stress that some of the practices described today have no part to play in the Trust and this would be changed. She urged teams to seek out any bureaucratic issues that are stopping staff from working well. Ifti Majid was keen to state that there would be no reduction in band 7 managers in the neighbourhood. The plan would be to skill mix and expand social recovery and ensure people have the skill sets that are required. Leadership problems would be tackled and the Board would work with staff to make improvements. Members of the Board took the issues raised very seriously and pledged to work with staff and put new and improved ways of working in place. The Chairman thanked the teams for setting out the importance of nursing and their expectation that it should be carried out to the highest possible standard and he asked the executive leads to provide a report to the Board that would address specific actions to address the issues that were raised.

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	ACTION: Executive Leads to provide a report to the Board detailing specific actions to address staff issues. **RESOLVED: The Board of Directors acknowledged the issues raised by members of staff relating to the Trust's Staff Health Check.**
DHCFT 2015/103	**<u>FINANCE DIRECTORS REPORT MONTH 2</u>** This paper provided the Trust Board with an update on the current financial performance against the Trust's operational financial plan as at the end of May 2015. Claire Wright informed the Board that although the Trust was in a satisfactory year to date position the draft forecast position had deteriorated and actions had been taken to mitigate the deterioration. She also clarified that she was waiting to be notified of the outcome of proposed key changes to the Risk Assessment Framework by Monitor that would impact on risk ratings, as noted in the paper. The Board considered this to be a very thorough report and it was noted that the Executive Leadership Team had separately discussed and agreed management action to address these pressures and that the reported forecast assumes the success of these actions in order to continue to safely deliver the Trust's services. **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 2015/104	**<u>IM&T STRATEGY UPDATE</u>** This report provided the Board with a view of the updated Information Management, Technology and Records Strategy 2015-2020. The document reviewed the strategic drivers and defined the themes that need to be addressed to underpin the Trust's Strategy. Peter Charlton presented this report and acknowledged that as technology moves at such a rapid pace it would be naïve to put a strategy in place for five years without an agreement to review the strategy annually. He strived to give the Board an understanding of the current position, the national and system imperatives linked to IT development and how the IM&T strategy would support delivery of both the Trust and health community strategy. Jim Dixon asked as Chair of the Finance & Performance Committee if he could spend time with Peter Charlton in order to understand some of these issues. The Chairman pointed out he would like to receive more detail of the longer term view on how the Trust intends to deliver care using technology in the future and asked that a more "visioned" perspective in the IMT Strategy update be brought to the Board every six months. **ACTION: Forward Plan to be amended to reflect six monthly reporting of the IM&T Strategy Update** **RESOLVED: The Board of Directors:**

	1) Acknowledged the Information Management, Technology and Records Strategy 2015-20 **2) Clarified that updates be provided to the Board at six monthly intervals.**
DHCFT 2015/105	**<u>INTEGRATED PERFORMANCE AND ACTIVITY REPORT AND SAFER STAFFING</u>** This report defined 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. Ifti Majid noted that this report was almost identical to last month's but there had been a higher percentage of overdue patient letters. This had been reviewed at PCOG (Performance and Contract Operational Group) and it transpired that although letters had been prepared in time, they had not been signed off. A specific training process is now taking place to address this to train staff to be more comfortable using the electronic sign off process and delegation process within it. Ifti Majid brought to the Board's attention that the Kedleston Unit were currently the highest safer staffing risk area and he was astonished that over a three month period they had maintained safer staffing levels. Steve Trenchard wished to highlight this as an example of good practice within the unit. **RESOLVED: The Board of Directors is requested to:** **1) Acknowledged the current performance of the Trust** **2) Noted the actions in place to ensure sustained performance**

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DHCFT 2015/106	**FOR INFORMATION** **I. Board Forward Plan** • IMT Strategy will be scheduled 6 monthly • R&D Strategy will be scheduled 6 monthly • Safeguarding Children and Adults report will be submitted to and signed off by the Safeguarding Committee in August **II. Board Assurance Framework:** Risks and actions resulting from the Staff Health Check have already been added to the BAF **IV. Discussion on future deep dives:** It was noted that the Audit Committee regularly conducted deep dives on high rated risks and a deep dive of the Transformation risk would be conducted at its next meeting on 21 July. Other Board committees would be encouraged to conduct their own deep dives. It was agreed that the Sangeeta Bassi would be invited to the next meeting of the Board to conduct a deep dive in Medicine Management. Maura Teager suggested that a pairing of a Non-Executive Director and Executive be made to follow up the front line issues discussed in today's Staff Health Check and this could be followed up by a deep dive at the Finance & Performance Committee. **ACTION: Detailed list of Deep Dives will be produced by the executive team**
DHCFT 2015/107	**ANY OTHER BUSINESS** Jenna Davies informed the Board that prior to today's meeting, a meeting of the Remunerations Committee took place to consider the committee's terms of reference and provide justification of salary paid to very senior managers in the Trust. The Board noted that the minutes of the Remunerations Committee meeting would not reported to the Board of Directors in public session. **RESOLVED: The Board of Directors noted the subjects discussed at the Remunerations Committee.**
DHCFT 2015/108	**COMMENTS FROM OBSERVERS ON BOARD PERFORMANCE AND CONTENT OF MEETING** The Chairman invited the governors, John Morrissey, Michael Walsh and Moira Kerr to comment on their observation of proceedings: John Morrissey informed the Board that governors had been surprised that no reference had been made to a recent employment tribunal (ET) during today's meeting and that this matter had not been mentioned or recorded in the minutes of previous meetings of the Board. He complained that as the Council of Governors was supposed to hold the Board to account, it had not been able to do so in respect of the ET because the matter had not been discussed in public by the Board. Governors also asked to receive a copy of the judgement of the ET. In response the Chairman informed the governors that the Trust had received

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	the draft judgement only the day before. This judgement still remained subject to legal process and exchange between the Trust's representatives and the claimant's representatives. The Chairman further informed governors that the Board had already agreed to consider the judgement received and an action plan will be produced to address the issues that the ET has raised. Individuals affected by this ET have issues of their own which the Board needs to address in private and there will not be a public process relating to anything associated with individuals named in this employment tribunal judgement. The Trust has a duty to keep this process in confidence and this had been the guiding principle in this matter especially once legal process was underway. John Morrissey reminded the Board that throughout the ET process governors should have been holding the Non-Executive Directors to account. With the Chairman's support a governor led committee was being formed that would ask for confidential documents to show how executives had been held to account by the Board. Moira Kerr asked that the draft judgement that the Trust received the day before be circulated to the governors. Jenna Davies explained that as soon as the judgment becomes a public document it will be shared with governors. She further informed governors that the draft judgement received by the Trust was an operational document and not an approved public document. She and Jayne Storey were the only members of the Board who had seen the judgement at this point in time. The Chairman confirmed he had not yet read the document. Moira Kerr read from the legislative process she had in front of her and reiterated that she wanted all governors to receive a copy of the judgement that the Trust received yesterday so they could establish if any pleas had been made, what was in the document originally, what the evidence base was, and any action that the Board might take and whether this would be in the best interests of the Trust in order to hold the Trust to account. She felt that she and the other governors present at the meeting should be told what was in the document. Steve Trenchard declared his conflict of interest and agreed that this matter sat within the realm of the Trust's Board and he left the meeting to attend a prior engagement. The Chairman confirmed that the final judgement document would be the document shared with governors. Governors would also be informed of any changes the Board proposed to make, depending on the matter. Governors would also be informed if the Trust chooses to appeal. The Chairman concluded that a process for the governors to consider this matter further had now been established. He hoped that it would both consider past actions taken and learning for the future. **RESOLVED: The Board of Directors noted the observations made by the governors.**
DHCFT 2015/109	**CLOSE OF THE MEETING** The Chairman thanked all of those present for their attention and comments and

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	closed the public meeting at 5:10 pm.

DATE OF NEXT MEETING

The next meeting of the Board in public session is scheduled take place on Wednesday, 29 July 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 - JULY 2015						
Date	**Minute Ref**	**Action**	**Lead**	**Status of Action**	**Current Position**	**Enc C**
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.	The Well Led Framework Review has been brought forward and we will review on the outcome of this.	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	24.6.2015 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. 29.6.2015 This is paused until we receive our HEEM allocation of funds, Carolyn Green will report request to People forum	Amber
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 to be supplied within the Board report ongoing. ACTION COMPLETE	Green
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 and **24.6.2015**	DHCFT 2015/068 and DHCFT 2015/093	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	A further visit will be scheduled and reported back as appropriate. Further discusion to be arranged with the CAMHS team and the Board.	Yellow
29.4.2015 and **24.6.2015**	DHCFT 2015/068 and DHCFT 2015/093	County CAMHS Staff Levels and Capacity	Jayne Storey	Recruitment of CAMHS consultants - substitute arrangements to be implemented should either the Chair or Chief Executive be unavailable for consultant interviews.	Medical recruitment informed of NED/Exec Directors to be invited to sit on the panel when diaries do not allow the Chair/CEO to be available.	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	To be rescheduled on Board Development forward plan and presented to the Board in September.	Yellow
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. This will also be reported through Finance & Performance Committee.	Yellow
24.6.2015	DHCFT 2015/095	Chief Executive's Report	Jayne Storey	Jayne Storey to produce an updated version of the 2015/16 Board Development Schedule for the next Board meeting in July	Revised Board Development Programme will be issued at September Board meeting	Yellow
24.6.2015	DHCFT 2015/098	Monitor Corporate Governance Statements	Jenna Davies	Jenna Davies to work with the executives and provide further detail to Statement 4	ACTION COMPLETE	Green

24.6.2015	DHCFT 2015/098	Revalidation of Doctors	John Sykes	John Sykes to provide a further report to the Quality Committee	Agenda item for August Quality Committee	Yellow
24.6.2015	DHCFT 2015/099	Staff Health Check	Jayne Storey	Jayne Storey to lead the Cultural Change Programme	In progress. Update will be given at September Board.	Yellow
24.6.2015	DHCFT 2015/104	IM&T Strategy Update	Sue Turner	Forward Plan to be amended to reflect six monthly reporting of the IM&T Strategy Update	Forward Plan now reflects six monthly reporting of the IM&T Strategy Update. ACTION COMPLETE	Green
24.6.2015	DHCFT 2015/106	Forward Plan	Ifti Majid	Detailed list of Deep Dives will be produced by the Executive Team		Amber

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 – 29 July 2015

Chairman's Report

Background

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

Meetings attended

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

Attended the Governors Induction Day on 29 June
Attended a Quality Visit to Estates & Facilities on 1 July
Met with Jonathan Lloyd of the South Derbyshire Citizens Advice Bureau on 3 July
Attended the NEDs' Quarterly meeting on 7 July
Attended a Quality Visit at Amber Valley Older Adult CMHT and Erewash Older Adult CMHT on 7 July
Attended the Monitor Networking and Knowledge Sharing Day in London on 8 July
Attended the Finance & Performance meeting on 14 July
Met with the Acute Care Commission who visited the Trust on 17 July
Attended a County Council Health and Wellbeing Workshop 2 on 20 July
Attended a Quality Visit at the Day Hospital Services in Ilkeston on 20 July
Met with Helen Phillips, Chair of Chesterfield Royal Hospital at the Hartington Unit in Chesterfield on 21 July
Attended a Quality Visit at Derby and South County CRHT on 22 July

I also met with 4 Governors for one-to-ones within the agreed programme of review.

Points arising

1. I was delighted to be involved in four quality visits this month across a wide range of our services. I continue to be impressed with the professionalism and commitment our staff are displaying in often straitened and challenging circumstances.

2. As you will be aware, the Trust received the outcome of the recent employment tribunal on 26 June. The Trust has produced a high level action plan to address some of the immediate actions and lessons learnt and we have started an internal but independent panel investigation which has been commissioned by the Senior Independent Director to address some concerns identified within the employment tribunal judgement and matters raised subsequently. Monitor has recently advised us that they will conduct an investigation into our governance, prompted by the matters raised in the judgement and other third party concerns and attached is a copy of the letter that we have received. Our governors have also been engaged in their own examination of matters within their responsibility and an extraordinary meeting of governors has been scheduled for 5 August to consider this work to date.

3. The Monitor briefing demonstrated the sector-wide financial challenges that trusts face this year and the increasing recognition that it was not possible to triangulate access requirements, finance and quality across the system in predicted financial circumstances. It appeared that the Department of Health remained and would remain active – the arms-length national commissioning and regulator architecture was pretty notional. While a tool had been developed to assist with the political initiative on agency spend there was some scepticism. There was also recognition that broad CIP (Cost Improvement Programme) targets were increasingly inappropriate. The meeting also allowed some networking. I will circulate slides to Board members when I have them.

4. The Health and Wellbeing workshop I attended considered child and adolescent mental health and self-harm prevention. It was encouraging to see county-wide (excluding the city) engagement in this and wide support for early intervention and prevention support.

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. However elements of the learning from the tribunal outcome are likely to require the Trust to reflect on aspects of employment practice and oversight of behaviour.

Consultation

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

Recommendation

The Board of Directors are requested to note the paper and challenge me on any item.

Report Prepared by: **Mark Todd**
Chairman

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23 July 2015

Dear Mark

Derbyshire Healthcare NHS Foundation Trust ("the Trust'): Notification of Decision to Open a Formal Investigation into the Trust's Compliance with its Licence

1. I am writing to inform you of Monitor's decision to open a formal investigation into the Trust's compliance with its licence. This investigation has been opened due to governance concerns identified from the judgement of the Employment Tribunal dated 18 June 2015 in which the Tribunal found that Mrs Helen Marks, former HR Director at the Trust, had been unfairly dismissed and subjected to direct sex discrimination, harassment and victimisation. Monitor also has concerns following related complaints raised by other parties including individuals who have approached Monitor in line with its whistleblowing policy.

2. The purpose of this letter is to:

   2.1 Set out Monitor's concerns in relation to the Trust; and

   2.2 Confirm the process that Monitor will adopt in assessing the extent of these concerns, whether they amount to a breach of the Trust's licence and any regulatory action that may be appropriate as a consequence.

3. I would be grateful if you would ensure that this letter is shared with your Board of Directors and Council of Governors.

4. **<u>Monitor's Concerns</u>**

   4.1 The Employment Tribunal judgement and related complaints indicate concerns in relation to the Trust's application of standards of good

corporate governance. In particular, the Tribunal found that the Trust had failed to follow its HR procedures in relation to Helen Marks' case and raised serious concerns in relation to the Trust's investigation of this matter.

5. Monitor's Process to Determine what, if any, Regulatory Action is Appropriate

5.1 Monitor considers all relevant factors in assessing what, if any, regulatory action is appropriate in relation to its concerns, including:

- Information gathered from the Trust and relevant third parties;
- Any Trust Board assurance that the Trust is able to continue to meet the requirements of its licence;
- Monitor's published guidance relating to the requirements of the licence; and
- The factors set out in Monitor's Enforcement Guidance.

5.2 We may also seek further information from the Trust and will consider any relevant information from third parties, such as the Care Quality Commission and the Trust's commissioners.

6. Investigation Process

6.1 As per the Trust's letter dated 7 July 2015, I understand that the Trust is commissioning a Well Led review, and an investigation of the concerns raised by the Employment Tribunal and subsequent complaints.

6.2 It is imperative that the Trust commissioned investigation has appropriate oversight from Monitor and is, and is seen to be, independent, and to an appropriate scope. Monitor also expects to have appropriate oversight of the Well Led review. We will liaise with your Senior Independent Director in relation to the above, and also to agree timescales.

6.3 We will arrange a meeting at Monitor's offices at a date to be agreed with the Trust. We currently envisage this meeting being after we have sight of the findings of the Well Led review, and the Trust commissioned investigation. This will provide an opportunity for the Trust Board to explain and provide evidence as to the nature and strength of its governance arrangements and its consideration of the concerns set out in section 4 of this letter.

6.4 Any meetings with members of the Trust Board that take place will form part of the evidence Monitor will take into account in determining what, if any, regulatory action is appropriate. They will also form part of the

evidence for any formal enforcement action that may be considered appropriate, in line with our Enforcement Guidance.

6.5 Meetings will be chaired by Monitor and attended by members of our investigations project team for the Trust; a representative from Monitor's legal team will also attend, as required.

6.6 Should formal enforcement action be considered as a result of our investigation, the Trust will be afforded an opportunity for further engagement, in line with our Enforcement Guidance.

7. Next Steps

7.1 The Trust's governance rating will be replaced until further notice with a description of the issues and the steps we are taking to address it. The revised governance rating, which will be published on the Monitor external website, will be "Under Review - Monitor is investigating governance concerns at the trust triggered by the findings of a third party report". Further guidance on how Monitor assigns a governance rating to trusts is set out in paragraph 4.3 of the Risk Assessment Framework.

7.2 Monitor will be issuing a press release on Friday 24 July announcing that we have opened a formal investigation into the Trust's compliance with its licence.

8. If you have any questions in relation to the matters set out in this letter, please contact Alex Coull (Deputy Regional Director), on 020 3747 0053 or by email at Alexandra.Coull@monitor.gov.uk.

Yours sincerely

Naresh Chenani
Deputy Regional Director

cc: Ifti Majid – Acting Chief Executive Officer
Caroline Maley – Senior Independent Director
Victoria Cassidy – Lead Public Governor

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 29 July 2015

Chief Executive's Report

1. Introduction

This report provides the Board of Directors with some of the key national policy changes or announcements over the last month that we should consider and use to inform strategic discussions within the Board meeting. The report also provides an update on work within the Derbyshire Health and Social Care Community as well as covering key issues internal to the Trust.

2. National Context

2.1 Monitor has announced it has set up a team of experts to help Trusts reduce the amount of money being spent on agency staff. The Team are commencing three month pilots with three FT's. The NHS spend on agency staff at the end of last financial year was £1.77bn, more than double the planned figure and a significant increase on the previous year's £1.37bn. Lessons from the 3 pilots will be disseminated and we need to assimilate those into our planning processes.

2.2 NHS England has published it new Safe Staffing Framework for Mental Health Wards. The model was commissioned as part of NHS England's 'Compassion in Practice' programme and developed by an independent group of Directors of Nursing. It is an interactive model and so best viewed at:

http://www.networks.nhs.uk/networks/news/new-nhs-safe-staffing-framework-for-mental-health-wards

2.3 The Law Commission's consultation paper, *Mental Capacity and Deprivation of Liberty* published on 7th July. The paper can be accessed on http://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/#related.

The consultation paper reviews the Deprivation of Liberty Safeguards (DoLS) in England and Wales. The goal is to replace the DoLS with a straightforward and accessible legal framework which provides appropriate safeguards for people who lack capacity where their care or treatment is becoming restrictive.

The provisional proposals in the consultation paper represent the Law Commission's initial view about how the law should be reformed. The consultation period will run from 7 July until 2 November 2015. The proposals will then be reviewed on the basis of all of the responses received during the consultation period and a Final Report published accompanied by a draft bill by the end of 2016

2.4 The Nursing and Midwifery Council along with the General Medical Council have issued joint guidance around the professional duty of candour called *Openness and honesty when things go wrong: the professional duty of candour*. This guidance applies to all staff registered under the two professional bodies including those staff that are not in direct clinical practice but are in a management position.

2.5 The 8th July saw the new government's first budget delivered to the House. The most notable direct NHS impact is the commitment to fully fund the Five Year Forward View with a further £8Million investment confirmed before 2020. Other key impacts that could have an impact on our Trust include:

- Public sector pay capped at 1% for the next 4 years
- A new national living wage of £9 per hour by 2020
- 3 million more apprenticeships created with a possible impact for the NHS of an apprenticeship levy being placed on large firms
- Pensions allowance tapered to £10,000
- Further powers announced that support devolution
- Free childcare up to 30 hours a week for 3 and 4 year olds

2.6 The Kingsfund have released a new report 'Better value in the NHS' which is a call to clinicians and managers to deliver better outcomes at lower cost. The document nicely bridges the strategic imperative with specific examples and evidence of best practice. The report can be downloaded from the link below and may be a useful addition to a Board development discussion:

http://www.kingsfund.org.uk/publications/better-value-nhs/summary

Derbyshire Health and Social Care Community

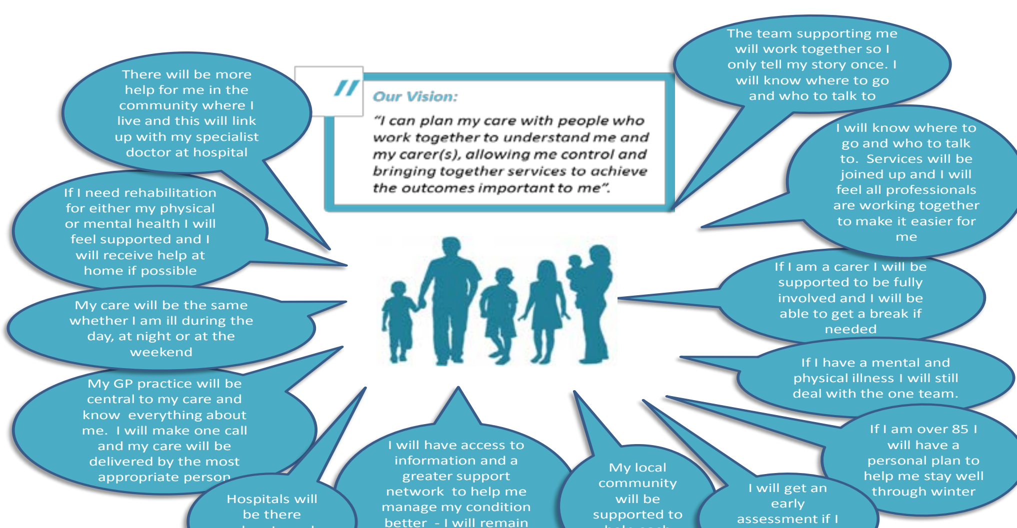
2.7 The Southern Derbyshire Unit of Planning Joined up Care Programme continues to be developed through the 6 workstreams and associated task groups. The transformational efficiency requirement for the programme is at significant risk and at the latest meeting of the Joined up Care Board measures were put in place to speed up the delivery of some of the key workstream areas. The mental health workstream is currently developing its initiation documentation and will meet for the first time during the coming month.

2.8 The Erewash Vanguard continues to develop supported by NHS England. Following a range of stakeholder events the vision has been identified as

Our vision is for thriving communities within Erewash, where you feel confident and supported to choose a healthier lifestyle, stay well, and know how to get help and support when you need it.

Our mission is to develop **Thriving, Capable, and Healthier Communities**

Residents of Erewash will be able to say:



A Vanguard value proposition is being developed that will be shared with this Board in due course. In order to turn the vision into a reality for the people of Erewash 4 themes have been identified that will be used to develop and deliver concrete actions, these themes are:

- Building community resilience
- Making self-care and shared decision making a reality
- Integrated community service provision
- Responsive and accessible Primary Care

2.10 The 21st Century programme in North Derbyshire continues to focus on the development of the 8 Geographical Communities (GCs), understanding demographics, demand and through stakeholder engagement the needs of local people in the geographical communities to develop individualised blueprints for the design of local services. The current exercises are around local GCs mapping of voluntary and self-help sector activity to ensure this is integrated within a community offer

Inside Our Trust

2.11 Our Community and in-patient services remain under pressure associated with capacity and demand though local actions have reduced the number of people needing to receive in-patient treatment from outside Derbyshire. Operational monitoring continues on a two weekly basis.

2.12 I am delighted that the Trust through the leadership of Dr Rais Ahmed and Dr Subodh Dave is going to be involved in a pilot for the 'patient knows best' platform which is a technological innovation that enables and supports interactions/communication between clinicians and patients both in a written form and via skype.

2.13 On Friday the 17th July Lord Nigel Crisp, Chair of the Acute Adult Psychiatric Care Commission, visited the Trust in particular spending time with staff within our acute services, before holding the routine acute commission meeting within the Ashbourne Centre. His visit came two days after the Commission released its interim report. Three key findings from this report are:

- The so-called bed crisis in adult mental health is very significantly a problem of discharges and alternatives to admission that can only be addressed through changes in services and management of the whole system.

- A Commission survey of acute adult psychiatric wards found that 92% of wards surveyed are treating patients who could have been treated by other services if they had been available. In practice, this applies to approximately three patients per ward (16%).

- The survey also found that approximately three patients per ward (16%) are clinically well enough to be discharged from inpatient care, but cannot be because of other factors

Monitoring Progress against the Trust Strategy

2.14 At the June Board of Directors the revised Trust strategy was presented and approved with the agreement that the metrics that will form the basis of the quarterly reports would be available in July. The metrics can be seen in appendix 1and any comments from the Board can be added prior to first report that will cover quarters 1 & 2

Legal Issues

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

Equality Delivery System

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

Consultation

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

Recommendation

The Board of Directors are requested:

1) To note and discuss the paper using its content to inform strategic discussion.
2) To approve the refreshed Strategy metrics(at Appendix 1),
3)

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

Delivery of Strategic Outcomes

Goal	How we will measure this	Baseline (achieved)2014/15	Target for 2015/16	Director Lead	Progress against Target - Quarter 1
Outcome 1 - People receive the best quality care					
Pillar 1 - Quality of Services					
Patients will report that they are involved in their care plan and that it reflects their needs, strengths and aspirations.	We will use the Community and In-patient Survey results and other national benchmarking. We will aim to see an annual improvement and receive baseline scores 'better' against similar trusts	Section score from **community survey** was 7.3. This was in 'about the same' range when benchmarked against 'similar' trusts. **Inpatient survey results** 'were you involved as much as you wanted to be in decisions about your care and treatment?' ; Yes definitely 36%	Annual improvement and score 'better' when benchmarked against 'similar' trusts	**CG**	
We will embed the Friends and Family test across all our services.	We will aim for annual improvements in our results and look to identify any learning through the results of this data through proactively looking for recurring issues and themes	n/a new target	Quarterly submission of evidence of identification of learning based upon recurring issues and themes such as 'You said - We did'	**CG**	

Goal	How we will measure this	Baseline (achieved)2014/15	Target for 2015/16	Director Lead	Progress against Target - Quarter 1
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	n/a new target	Evidence that the research bids submitted are developed in line with our organisational and quality priorities	**JSy**	
We will support our teams to develop expertise to support the physical health of our patients, embedding the holistic person approach.	We will expect to see opportunities within teams being developed to support staff training needs in this area. We will use the results from the patients survey to indicate that teams are developing expertise in this area through an improvement in the annual results	**Community patient survey** results 5.8 for physical healthcare. **Inpatient survey** 56% said 'yes definitely' enough care was taken about physical health	Evidence each quarter that teams are being provided with opportunities to develop expertise in this area. Annual patient survey results to show improvement against baseline	**CG**	

Goal	How we will measure this	Baseline (achieved)2014/15	Target for 2015/16	Director Lead	Progress against Target - Quarter 1
We will continue to deliver good standards of cleanliness for hospital wards and rooms.	We will use the results from the annual inpatient survey and PLACE.	**PLACE**: Cleanliness 98.75%**In-patient survey**: How clean was the hospital room or ward; Very clean 64%. How clean was the toilets or bathroom; Very clean 49%	Maintain current good standards of cleanliness as measured by PLACE. Improvement shown in annual in-patient survey results against baseline	**CG**	
Outcome 2 - People receive care that is joined up and easy to access					
Pillar 2 - Service Delivery and Design					
Implement our Neighbourhood and Campus model	Neighbourhood Model in place for November 2015. There will be a revised dementia pathway in place linked to the development of DRRT by March 2015.	Neighbourhood approach to service delivery progressing towards implementation November 2015.	Submission of Quarterly evidence that provides assurance that we are progressing towards implementation November 2015 of the Neighbourhood model and report against campus planned timeline	**IM**	

Goal	How we will measure this	Baseline (achieved)2014/15	Target for 2015/16	Director Lead	Progress against Target - Quarter 1
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 and 21C community hubs project ensuring all opportunities for delivering our core services in an integrated way to ensure easy to access joined up care provision.	n/a new target	Provide quarterly evidence of how we have supported developments within the wider health and social care community	**IM**	
Optimise the benefits of PARIS (electronic patient record), including developing and implementing a mobile working offer for our staff	We will see an overall increase in the number of teams that have an implemented agile working offer in place to support optimization of the PARIS system	no (0) teams were fully operational in agile working end of Q4 14/15	Quarterly increase of the number of identified teams who have access to this offer	**IM**	
Lead the development of an innovative integrated service model for children, young people and their families in Southern Derbyshire.	We will demonstrate leadership in the development of an integrated service model for this group	n/a new target	Submission of Quarterly evidence that provides assurance that we are leading this development with progress update	**IM**	

Goal	How we will measure this	Baseline (achieved)2014/15	Target for 2015/16	Director Lead	Progress against Target - Quarter 1
Outcome 3 - The public have confidence in our business and developments					
Pillar 3 - Promoting Public Confidence					
Retain and improve our services for children, including core services such as child and adolescent mental health	We will have retained these services throughout the year and utilisation of service receiver and parental feedback (Friends and Family test) to demonstrate improvement in service provision	Friends and Family test: 89% of people who responded said that they were likely or extremely likely to recommend services to Family and Friends	Retention of Children's Services. Year end improvement against baseline.	**MP**	
Utilise the models set out in the Dalton Review to grow business in a number of new markets such as integrated prison health care.	We will have a clear business development plan in place that is linked to core service portfolio to grow business in existing and new markets.	n/a new target	Evidence by Q4 that we have a clear business development plan in place, linked to core service portfolio to grow business in existing and new markets. Evidence will be submitted each quarter that demonstrates that the Trust is considering, and where possible, using new vehicles for delivery.	**MP**	

Goal	How we will measure this	Baseline (achieved)2014/15	Target for 2015/16	Director Lead	Progress against Target - Quarter 1
Pillar 4 - Relationships & Partners					
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	We will review the Trusts Core Service portfolio and demonstrate the implementation of the outcome of the review	n/a new target	We will provide quarterly evidence of the implementation of the outcome of the review of the Trusts Core Service portfolio (the provision of papers/evidence in respect of any shift in core service provision would align to the content of this objective).	**MP**	
Strengthen the infrastructure around our communication with our communities, stakeholder engagement, listening events and market-promoting capabilities	We will have a programme of engagement via 4Es that encompasses each Neighbourhood over the year. We will demonstrate through 4Es that engagement is seen as key to influencing decisions and helping to shape services.	n/a new target	Programme of 4Es across each Neighbourhood. Evidence of 4Es influencing decision making to support shaping of services	**MP**	

Goal	How we will measure this	Baseline (achieved)2014/15	Target for 2015/16	Director Lead	Progress against Target - Quarter 1
Pillar 5 - Financial Performance					
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.	We will measure efficiency and financial return using Service Line Reporting and other relevant KPIs as reported to Finance and Performance Committee and other meetings. Delivery against our estate strategy will be reported twice yearly to Trust Board	n/a new target	Provide quarterly evidence of how services have performed financially Report estate strategy delivery to Trust Board twice yearly	**CW**	
Achieve Continuity of Service Risk Rating (COSRR) of at least 3 each quarter	We will report each quarter on the risk rating reported	3	maintain risk rating of 3	**CW**	

Goal	How we will measure this	Baseline (achieved)2014/15	Target for 2015/16	Director Lead	Progress against Target - Quarter 1
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.	We will report each quarter on progress of our teams in care planning (performance form in-pt and comm survey) number of in-pts team having personalised care planning and documentation of capacity errors as a concerns in 2015, from 1 April a narrative on development of accountability and development of our QLT's	Narrative and number of teams.	Improved performance than 2014 for care planning and capacity/consent documentation and narrative on QLTs - feedback from team and team defined outcomes	**CG**	

Goal	How we will measure this	Baseline (achieved)2014/15	Target for 2015/16	Director Lead	Progress against Target - Quarter 1
Outcome 4 - Care is delivered by empowered and compassionate teams					
Pillar 6 - Workforce and Leadership					
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 report each quarter on the approach utilised to develop leaders within the organisation	n/a new target	To have a programme of leadership development in place based upon Trust values that encourages compassionate relationships, compassionate teams and a compassionate culture of care. We will measure the impact of this through use pre & post impact evaluation assessment. Narrative on QLT development	**JSt**	
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	We will use the Annual staff survey as an indicator of Effective Team Working. We will also monitor our compliance with regulatory performance requirements	3.84% Base line is green for all Monitor targets	Improvement against baseline for staff survey and maintaince of the regulatory baseline.	**IM**	

Goal	**How we will measure this**	**Baseline (achieved)2014/15**	**Target for 2015/16**	**Director Lead**	**Progress against Target - Quarter 1**
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 use the annual staff survey through staff pledge 4 - *To engage staff in the decisions that affect them, the services they provide and empower them to put forward ways that deliver better and safer services*. Using the % of staff reporting good communication between senior management and staff as a baseline by which to measure against	29.00%	Improvement against baseline	**JSt**	

Board summary - Quality Committee - 11 July 2015

Key issues linked to Strategy and governance requirements

Strategy or Quality governance requirement	Issue	Actions and assurance
Minutes and action matrix from meeting held in May 2015		Agreed
Serious Incident Report	The report provided the Quality Committee with information relating to all Serious Incidents (SIs) occurring during June 2015. The committee was pleased to note there had been a decrease in the number of major and catastrophic incidents that occurred in June compared to May. Reviewed some specific SIRI's with quality of practice concerns and scrutinised those actions and recommendations with regard to substandard practice. The main area of concern continues to be the number of overdue actions. Since the end of June work had been undertaken with specific individuals with a responsibility for a high number of outstanding actions. It was thought many of these may be due to IT capability as some staff are unclear how to close incidents on DATIX. It was agreed that the team would work with individuals who were struggling to navigate the electronic system as well as potential capacity issues. The effect of legal highs (NPS) having an impact on individuals New (or novel) psychoactive substances (NPS).	The Quality Committee: Evaluated the report. Noted themes from the report and work in progress. Received limited assurance on the number of actions outstanding Was made aware of the emergent and current issues under a monitoring brief by the SIRI Review Group A paper will be brought by Carolyn Green to the committee in August to more fully understand the impact of legal highs on the Trust's client group.
Quality Leadership Team (QLT) quarterly report	Wendy Brown provided the Urgent and Planned Care report for the committee to consider the work plan and work completed since the last quarterly report in May. The report contained an update on priorities and the work plan for 2015/16. Wendy Brown informed the committee that the QLT had looked at the Trust's priorities and CQUINS and it will develop the work plan around each of these pieces of work to establish which NICE Guidance is relevant to the division, she proposed carrying out a review to identify leads to prioritise these pieces of work. A priority for the QLT was to ensure involvement of staff and to reinforce the	The QLT's work plan has identified key areas of priority: • Engagement of staff in the Clinical Reference Groups and reporting structures • Individualised Care Planning • Physical Healthcare

Strategy or Quality governance requirement	Issue	Actions and assurance
	relevance of these meetings in governance terms to attendees. However, members of the QLT currently felt that the CRG for urgent care had poor attendance and a plan was being discussed at QLT to address this. Maura Teager suggested that this matter be escalated to ELT if improvements were not achieved with the plan proposed The challenges of QLTs forming and understanding their role and workload. There is a pressure felt within teams to deliver at a pace and pressure of delivery. These issues were discussed as well as capacity to deliver on NICE guideline mapping.	The committee agreed this matter would be highlighted to the Trust Board as part of the governance process. Noted themes from the report and work in progress, confirmed date for additional briefing and update on work plan.
Triangle of Care, working with carers	Wendy Slater's update report enabled the committee to consider the feedback from the assessment of the first year of implementation of the Triangle of Care, as part of the national membership scheme. The result was a star awarded to the Trust's Triangle of Care membership logo with certain provisos that were by the Triangle of Care lead. Proposed actions in response this feedback. Carolyn Green informed the committee that family inclusive practice and carer work will be shared with the North Derbyshire Statutory Planning Group as part of their redesign and development of mutual expectations. Mutual expectations is a set of both community members and staff expectations of agreed clinical practice which is developed collaboratively, (similar to a charter of expectations of behaviours or rights) redesigned in line with future Neighbourhood / Campus and Family inclusive services The committee noted that paper copies of the survey will be brought to the Carer's Forum.	Actions to occur: • Presentation to relevant groups including operational management, carers groups, 4E's group etc. • Identify senior management and operational support and commitment for the Triangle of Care • Identify local carer involvement in inpatient self-assessments • Revisit the self-assessments with acute services and re-submit these to the national lead in October for quality assurance. • Defer the roll-out the Triangle of Care to community services until next year • Regular updates on progress to the Quality Committee ACTION: Forward Plan to be amended to reflect 6 monthly reporting to Quality Committee. Noted the award of a star to the membership logo. Support the plan to continue development of the Triangle of Care: Carers Included in the Trust, giving full backing to this as an important tool to support carers, and receiving regular progress reports.
CPA Policy	The CPA Policy was presented for ratification. Wendy Slater's report outlined the need for changes to the Core Care Standards and CPA Policy and Procedures. Ifti Majid reminded the committee that delivery of this policy is a priority for the	The policy was ratified for 12 months and communication of this significant policy change and proactive communication on care planning will be required and managed through the Nursing and governance team. The Quality Committee approved the

Strategy or Quality governance requirement	Issue	Actions and assurance
	Trust and there were still areas of current performance in personalised care planning that could be improved. This was discussed as this is a key outcome of our Quality strategy and we need to focus upon its delivery. In response, Wendy Slater suggested imposing a year's review period on the policy to allow time to work with organisations such as Derbyshire Voice and the Carers Forum to further develop and maximise new ways of working and ensure personalised care is and becomes routine not an option or choice of practice. Care planning expectations to move from Care plan, to My plan and my strengths and wishes based upon a new rebalanced of ownership of decision making and care demonstrated through mutual expectations will be redesigned worked on with Derbyshire Voice for stage 2 of the policy.	policy and procedures with the proviso that the policy would undergo a further review in July next year to further the cultural change required to maximise person centred care.
Physical Care Committee End of Year Report	Dr Mahendra Kumar's Physical Care Committee End of Year Report provided the committee with assurance about the Physical Care Committee (PCC) activities over the last financial year. The committee was informed there has been increasing visibility of physical health issues that affected our patient group over the last few years nationally and locally. There has been a concentrated effort to address this with the launch of the Physical Health Monitoring CQUIN last year, with special emphasis on the inpatient and this was gradually phased to the community setting this year starting with Early Intervention Services The recruitment of dietitians has also given a boost to the physical health agenda for our patients based upon the work of this committee and its work on NICE guidelines by mapping and identifying the needs for individuals with obesity and need for bariatric care in our inpatient group.	Dr Kumar raised a concern that due to sickness of the resuscitation trainer compliance with Resuscitation training was now falling. Carolyn Green agreed to escalate this matter to the Training Board Lead Director. ACTION: Resuscitation training to be agenda item for the next meeting of the committee and will be led by Tracy Shaw. ACTION: Carolyn Green will refer issues to Jane Storey and for solutions or options identified for resource management and or additional investment for training to ELT and then to the Finance & Performance Committee for consideration. RESOLVED: The Quality Committee noted the contents of the Physical Care Committee End of Year Report 2014/15.
Safety Planning	This report provided feedback from Dr Bethan Davies on the progress of the Safety Planning Group. The new Terms of Reference for the Safety Planning group were presented to the committee for approval. Dr John Sykes highlighted the work carried out to date on safety planning. Dr Bethan Davies informed the committee that a suicide prevention learning package has been delivered to senior staff within the Drug and Alcohol Service as a pilot.	ACTION: Mortality data and scorecard and papers referred to above to be an agenda item for discussion at the August meeting with a written paper from Dr Sykes on his final analysis of information and reconciliation of both data sets. The Terms of Reference for the Safety Plan Group will also go to the August meeting for ratification by the committee. RESOLVED: The Quality Committee: 1) Noted the progress of the safety planning group and considered what

Strategy or Quality governance requirement	Issue	Actions and assurance
	However, a project lead has yet to be identified and the PARIS system needs to be installed before the new approach can commence. The committee recognised that these matters need to be resolved before the policy can be taken forward. There are also challenges around rolling the training out in the community and acute care and this has stalled the programme for the time being. The Quality Committee supported the recommendation of establishing a project lead for the Patient safety planning group and discussions centred around how the project could be built into the neighbourhood model as part of the planned roll out. Director lead for this work and CQUIN is Dr John Sykes Dr Sykes referred to gaps in assurance regarding death rates that may relate to the suicide rate as identified at the Trust's Board meeting in May and the mortality data figures based on coroner inquests. He has been in liaison with the Suicide and Homicide inquiry and has the Trust benchmarked data. He also reported that the numbers from the Appleby study gave a high level of assurance up to 2014 and showed that the Trust did not have a higher than average suicide rate. The Quality committee discussed the two sets of information that are available from both the NRLS (National reporting and learning system data - reported by the Trust) and the Appleby study information based upon completed Coroners rulings with confirmation as death by suicide and narrative rulings. The Quality committee confirmed that both data sets are correct, however they are measuring two separate sets of information. The trust benchmark for the national inquiry is accurate and so is the NRLS data. The difference is explained that the NRLS data is reporting the death rate for a specific period and the Appleby study is reporting the suicide rate. It was also noted that the Derbyshire coroners have a delay in completing coroners' enquiries and further analysis and ongoing monitoring is required, with a review of our death rate and actual suicide rate over a three year rolling average.	further assurance was required. 2) Ratified the Terms of Reference of the Safety Planning Group and Suicide Prevention Group. 3) Noted the update regarding gaps in assurance relating to the death rate and potential rolling suicide rate of service receivers in our community. 4) Recommendation for project lead to be escalated to ELT for consideration. Not all the papers were available for this meeting and will be made available for the next meeting to enable further discussion to take place.
REGARDS. EIRA policy	The committee acknowledged that this policy was overdue for review. Discussions centred around making the policy less cumbersome which resulted in the committee agreeing to ratify the policy	ACTION: REGARDS EIRA Policy to be reviewed and refreshed in January 2016 and the Forward Plan will be updated to reflect this. RESOLVED: The Quality Committee

Strategy or Quality governance requirement	Issue	Actions and assurance
	with a further review carried out in six months' time.	approved the REGARDS EIRA Policy with the proviso that the policy would undergo a further review in six months' time by Harinder Dhaliwal.
Clinical audit programme	Rubina Reza's report provided the committee with an update on the Clinical Audit Programme for 2015-16. Of the 45 projects carried forward from 2014-15, 18 projects are being managed for completion as overdue audits i.e. 9 projects are over 18 months, and another 9 projects are over 12 months but less than 18 months. Priority II audits are expected to increase in year as new projects are identified through the QLTs following the synthesis of SIRI outputs, complaints, NICE guidance compliance review and other priorities and this is a standing recommendation. The ratio of completed and delayed audits was queried and Rubina Reza explained that some projects are classed as delayed because the sign off process is extended due to the reliance on the frequency of the relevant committee meetings. In terms of assurance the results that need to be implemented from audits are put through the Board Assurance Framework so the associated committees recognise the evidence of risk and subsequent action. The committee agreed to ratify the Clinical Audit Programme for 2015/16.	RESOLVED: The Quality Committee: 1) Noted the content of the report and the Clinical Audit Programme for 2015/16 2) Ratified the Clinical Audit Programme for 2015-16
Positive and Safe Strategy	Carolyn Green presented the Positive and Safe Strategy on behalf of Sarah Butt and explained the slight changes that had been put in place in the strategy in line with NG10 the NICE guideline for violence. The committee and Derbyshire Voice ratified the strategy and agreed that a further update of the strategy work plan implementation would be brought to the committee in six months' time.	ACTION: An updated Positive and Safe Strategy will be reviewed in January 2016 and the Forward Plan will be updated to reflect this RESOLVED: The Quality Committee ratified the Positive and Safe Strategy and looked forward to a further review of the strategy in six months' time.
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 training issues for resuscitation to be led by Jayne Storey

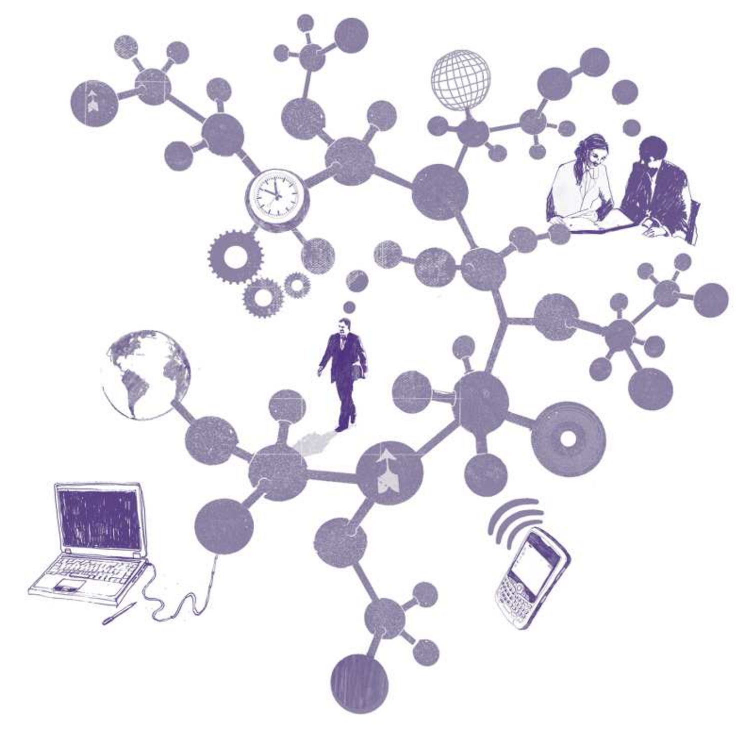
The Trust Board are requested to receive this report and guide the Quality Committee on its current work and work plan

Chair of the Quality committee

The Annual Audit Letter for Derbyshire Healthcare NHS Foundation Trust

Year ended 31 March 2015

July 2015



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Section 1: Executive summary

01. Executive summary

02. Audit of the accounts

03. Use of Resources

04. Quality Report

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Executive summary

Purpose of this Letter

Our Annual Audit Letter ('Letter') summarises the key findings arising from the following work that we have carried out at Derbyshire Healthcare NHS Foundation Trust ('the Trust') for the year ended 31 March 2015:

- auditing the 2014/15 accounts (Section two)
- assessing the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (Section three)
- reviewing the Trust's Quality Report (Section four).

The Letter is intended to communicate key messages to the Trust, its Governors, and external stakeholders, including members of the public.

We reported the detailed findings from our audit work to those charged with governance in the Audit Findings Report on 22 May 2015.

Responsibilities of the external auditors and the Trust

This Letter has been prepared in the context of the Audit Code issued by Monitor (www.monitor-nhsft.gov.uk). Monitor does not require an Annual Audit Letter for Foundation Trusts, however we have prepared this document at the Trust's request to consolidate the key messages from out work for 2014/15.

The Trust is responsible for preparing and publishing its financial statements, accompanied by an Annual Governance Statement. It is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources (Use of Resources).

Our annual work programme, which includes nationally prescribed and locally determined work, has been undertaken in accordance with the Audit Plan that we issued in January 2015 and was conducted in accordance with Monitor's Audit Code ('the Code'), International Standards on Auditing (UK and Ireland) and other guidance issued by Monitor.

Audit conclusions

The audit conclusions which we have provided in relation to 2014/15 are as follows:

- an unqualified opinion on the accounts which give a true and fair view of the Trust's financial position as at 31 March 2015 and its income and expenditure for the year
- an unqualified conclusion in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources
- an unqualified limited assurance report in respect of the Trust's Quality Report
- a group assurance certificate, issued to the National Audit Office, in respect of Whole of Government Accounts which identified one income disagreement; and one payables disagreement with counter-parties. We are satisfied the Trust reported the correct income and payables balances but we are required to report mismatches advised by Monitor to the NAO.

Acknowledgements

This Letter has been agreed with the Director of Finance and will be presented to Audit Committee in July 2015.

We would like record our appreciation for the assistance and co-operation provided to us during our audit by the Trust's staff.

Grant Thornton UK LLP
July 2015

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Section 2: Audit of the accounts

01. Executive summary
02. Audit of the accounts
03. Use of Resources
04. Quality Account

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Audit of the accounts

Audit of the accounts

The key findings of our audit of the accounts are summarised below:

Preparation of the accounts

The Trust presented us with draft accounts on 23 April 2015, in line with the national deadline.

The accounts presented for audit were of a good quality, and were supported by comprehensive working papers. The working papers were made available from the start of the audit fieldwork, which commenced on 27 April 2015.

Trust staff were responsive to our audit queries and a positive dialogue was maintained throughout the audit process. The positive input of Trust staff was a key facet leading to the issue of our opinion on the accounts on 22 May 2015, one week ahead of the deadline.

Issues arising from the audit of the accounts

From our audit, we identified relatively few adjustments and none that affected the Trust's retained deficit position, which demonstrated the efficiency and effectiveness of the Trust's processes for preparing the financial accounts. The draft and audited accounts recorded a retained deficit of £166k.

There were no major findings in our audit findings report. The key messages reported in the report were:

- Land Valuation Prior Period Adjustment (PPA)- following the audit the Trust amended the disclosure.
- Provisions – the Trust is subject to an employment tribunal. It is uncertain what the outcome of the tribunal will be or the cost and losses that the Trust may incur. On the basis of the information presented to us we were satisfied that the Trust made an appropriate provision. However, as the final judgement has not been issued the amount is uncertain and this represents a non –material uncertainty in the Trust accounts. We requested management representations on this issue to confirm that the Trust is aware of this uncertainty and have disclosed all related information to us.

We also made a number of minor adjustments to improve the presentation of the accounts.

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Audit of the accounts

Annual Governance Statement and Annual Report

We examined the Annual Governance Statement (AGS).

The AGS was well prepared and the Trust sought early feedback on its AGS to ensure it complied with best practice. We were satisfied that the statement was consistent with our understanding of the Trust.

We reviewed the Annual Report and were satisfied it was consistent with our understanding of the Trust. The Report was prepared to a good standard with only a small number of modifications required to the Remuneration Report to ensure compliance with the ARM:

- the draft report did not disclose the types of taxable benefits provided
- the remuneration report in the draft did not include the pensions disclosure requirements. The Trust had prepared the disclosure and associated working papers but had omitted the table from the draft provided
- the statement that the remuneration report is "subject to audit" was not visible in the draft provided.

This final version included the modifications.

Conclusion

Prior to giving our opinion on the accounts, we are required to report significant matters arising from the audit to 'those charged with governance' (defined as the Audit Committee at the Trust). We presented our report to the Audit Committee on 22 May 2015.

We issued an unqualified opinion on the Trust's 2014/15 accounts on 22 May 2015, one week in advance of the deadline set by Monitor. Our opinion confirms that the accounts give a true and fair view of the Trust's financial affairs and of the income and expenditure recorded by the Trust.

Section 3: Use of Resources

01. Executive summary
02. Audit of the accounts
03. Use of Resources
04. Quality Account

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Use of Resources

Use of Resources

Monitor requires us to issue a conclusion on whether the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

To support our work on Use of Resources we reviewed:

- the Trust' Annual Governance Statement (AGS) for consistency with our knowledge of the Trust
- the work of other regulatory bodies for impact on our responsibilities
- the Trust's Annual Report to ensure consistency with our knowledge and understanding of the Trust and that there are no apparent misstatements of fact or material inconsistencies with other key documents.

We also paid particular attention to the Trust's ability to continue as a going concern and how a number of underlying factors impacted on the financial statements, Annual Governance Statement and Annual Report. The key conditions and considerations informing that review are set out in the following table.

Conditions	Key considerations
Financial	• Monitor risk ratings • Borrowing and working capital facilities • Financial plans and cashflow forecasts • Commissioning intentions • Major cost improvement programmes and the risk of non-achievement
Operating	• Monitor's governance risk rating • Reports and activity of other regulators (eg Care Quality Commission) • Workforce and management arrangements

Conditions	Key considerations continued
Other	• Arrangements to ensure compliance with laws and regulations • Whether there were any significant pending legal or regulatory investigations • Changes in legislation that may adversely affect the Trust

In addition, using the information available to us at the time, we considered the impact of:

- the clinical and financial performance of the wider local health economy
- the Trust's on-going response to the Francis report;
- the Trust's response to the NHS England Five Year Forward View and the Dalton Report
- the Trust's financial sustainability and ability to maintain its financial risk rating.

We were satisfied that the above matters were incorporated into the Annual Report and Annual Governance Statement to transparently and publicly report these risks: which is a key feature of the Use of Resources conclusion.

Use of Resources conclusion

On the basis of our work, we are satisfied that in all significant respects the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the period ending 31 March 2015.

[1] Under the going concern assumption, a trust is viewed as continuing in operation for the foreseeable future with no necessity of liquidation or ceasing trading.

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Section 4: Quality Report

01. Executive summary
02. Audit of the accounts
03. Use of Resources
04. Quality Report

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Quality Report

Introduction

The Quality Report is an annual report to the public from providers of NHS healthcare about the quality of services they deliver. The primary purpose of the Quality Report is to encourage boards and leaders of healthcare organisations to assess quality across all the healthcare services they offer. It allows leaders, clinicians, governors and staff to show their commitment to continuous, evidence-based quality improvement, and to explain progress to the public.

We were engaged by the Council of Governors of the Trust, as required by Monitor, to perform an independent assurance engagement in respect of the Trust's Quality Report for the year ended 31 March 2013 and certain performance indicators contained therein. Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

• the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual.*

• the Quality Report is not consistent in all material respects with the information sources specified in Monitor's *2014/15 Detailed Guidance for External Assurance on Quality Reports.*

• the two indicators in the Quality Report, identified as having been the subject of limited assurance, are not reasonably stated in all material respects in accordance with the NHS Foundation Trust *Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

Work performed

We checked that the Quality Report had been prepared in line with the requirements set out in Monitors *Annual Reporting Manual.* We also checked that the Quality Report is consistent in all material respects with the sources specified in Monitor's *Detailed Guidance for External Assurance on Quality Reports 2014/15.*

Finally, we undertook substantive testing on certain indicators in the Quality Report. In line with the auditor guidance, we reviewed the following indicators:

- 100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital: selected from the subset of mandated indicators based on discussions with the Trust and the Council of Governors in April 2015
- admissions to inpatient services that had access to crisis resolution home treatment teams: selected from the subset of mandated indicators based on our discussions with the Trust and the Council of Governors in April 2015.

In 2014/15, NHS foundation trusts also needed to obtain assurance through substantive sample testing over one additional local indicator included in the Quality Report, as selected by the Council of Governors. Although the foundation trust's external auditors were required to undertake the work, it is not proposed that this is subject to a formal limited assurance opinion in 2014/15 (this may be reviewed by Monitor in future years). The indicator reviewed was:

- settled accommodation.

Conclusions

We concluded that the Quality Report had been prepared in line with Monitor's guidance and that it was consistent with the sources specified by Monitor'. Our testing of the three indicators did not identify any errors.

We provided an unqualified limited assurance opinion on the Trust's Quality Account, in accordance with requirements, on 22 May 2015.

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Appendices

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Appendix A: Reports issued and fees

We confirm below our final fees charged for the audit and provision of non audit services.

Fees

	Per Audit plan £	Actual fees £
Total audit fees	**38,210**	**38,210**

Fees for other services

Service	Fees £
Tax Advisory	4,800

Our Associate Director, Employment Taxes has liaised with Finance and HR to design a professional subscriptions salary sacrifice arrangement. The implementation of the scheme awaits the return of an HR team member who is currently on long term sick leave. Once implemented, the arrangement will enable the Trust to achieve tax savings.

Reports issued

Report	Date issued
Audit Plan	January 2015
Audit Findings Report	May 2015
Quality Account Report	May 2015
Annual Audit Letter	July 2015

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Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 29th July 2015

Annual Members' Meeting (AMM)

Purpose of Report

To update the Board on arrangements for the forthcoming AMM.

Executive Summary

The Annual Members' Meeting will take place on Wednesday 23 September 2015, in the Ashbourne Centre on the Kingsway site in Derby.

The AMM will open with a market place event, reflecting Trust services and innovations. This will commence at 2pm in training rooms 1 and 2 (on the same floor as A&B), with light refreshments provided from 3pm.

The formal meeting will start at 4pm in rooms A&B.

Strategic considerations

The theme for this year's AMM will be 'valuing people'.

Presentations will be given by the Trust's Finance Director (and auditors), Director of Nursing and Patient Experience and the Acting Chief Executive, who will provide both a look back at the 2014/15 financial year and outline priorities for 2015/16.

The Annual Report and Quality Report for 2014/15 will be presented at the AMM.

This year the event will take place on Trust premises, to reduce the level of expenditure associated with external venue hire.

(Board) Assurances

Please ensure (where relevant) you have considered and covered the following within the paper.

Arrangements for the AMM have been discussed with the Governor's membership development group and at the Executive Leadership Team.

Consultation

Arrangements for the AMM will continue to be discussed with the Trust's governors, through the membership development group.

Governance or Legal issues

The AMM will be widely promoted, in line with the requirements of the Trust's Constitution.

Equality Delivery System

Support will be provided for all members of the Trust to attend the AMM – for example BSL interpreters will be provided on request.

Recommendations

The Board of Directors is requested to NOTE the arrangements for this year's AMM.

Report presented by: **Jenna Davies**
Interim Director of Legal and Corporate Affairs

Report prepared by: **Anna Shaw**
Deputy Director of Communications and Involvement

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 29th July 2015

Medicines Management Update

Purpose of Report

The purpose of this report is to update the Trust Board in relation to:

1. Work that has been carried out by pharmacy and trust-wide relating to medicines management over the last 4 months and to clearly identify non-compliance with regulatory medicines management standards (e.g. CQC) thus highlighting areas of concern
2. Current status of the trust in relation to medicines management related training
3. Status of the trust in relation to medicines related incidents (Datix - April and May 2015)
4. Information on medicines related queries – out of hours
5. information on pharmacy activity data (May 2015)
6. Actions taken to date or in progress – pharmacy and trust-wide
7. Proposed recommendations

Executive Summary
Data and evidence gained from a variety of sources demonstrates that concerns exist regarding compliance with regulatory medicines management standards at a Trust-wide level. Various actions have been taken or are in progress to address this situation (some led by pharmacy). However in order to ensure that the Trust is making clear, sustained progress in this area, several recommendations have been proposed including; ensuring strong local leadership at local level in relation to medicines management; ensuring a Trust-wide consistent approach to managing areas that demonstrate non-compliance with standards on an on-going basis; sharing and learning lessons in relation to medicines management across the Trust and feeding back to staff at local level; giving consideration to improving pharmacy input into high risk areas or areas that currently have no or very limited, ad-hoc input; giving consideration to improving medication management-related education, training and awareness support for service users / carers and Trust-wide healthcare staff; and supporting areas that do not currently have the facilities to ensure compliance with medicines management standards e.g. air conditioning facilities within clinic rooms storing medicines

Strategic considerations

- Non-compliance with regulatory medicines management standards thus impacting on quality of care provided
- Non-compliance with Mental Health act regulations

(Board) Assurances

- Chief pharmacist in post
- Regular local audit work being conducted – future plan is for regular review by quality committee via a medicines management dashboard
- Regular review of Trust-wide medicines-related incidents via the Medicines Safety group

Consultation

- Local service and divisional managers
- Acting Chief Executive
- Director of Nursing, Quality and Patient Experience

Governance or Legal issues

Non-compliance relating to medicines prescription and administration in line with the Mental Health Act

Non-compliance with regulatory medicines management standards

Equality Delivery System

Recommendations

The board is requested to note the concerns raised in this report in relation to medicines management, the work carried out to date in this area and the Trust-wide recommendations proposed going forward.

Report presented by: **Sangeeta Bassi, Chief Pharmacist**

Report prepared by: **Sangeeta Bassi, Chief Pharmacist**

Medicines Management Update

Report For Trust Board

Sangeeta Bassi – Chief Pharmacist, DHCFT

July 2015

Executive Summary

Data and evidence gained from a variety of sources demonstrates that concerns exist regarding compliance with regulatory medicines management standards at a Trust-wide level. Various actions have been taken or are in progress to address this situation (some led by pharmacy). However in order to ensure that the Trust is making clear, sustained progress in this area, several recommendations have been proposed including; ensuring strong local leadership at local level in relation to medicines management; ensuring a Trust-wide consistent approach to managing areas that demonstrate non-compliance with standards on an on-going basis; sharing and learning lessons in relation to medicines management across the Trust and feeding back to staff at local level; giving consideration to improving pharmacy input into high risk areas or areas that currently have no or very limited, ad-hoc input; giving consideration to improving medication management-related education, training and awareness support for service users / carers and Trust-wide healthcare staff; and supporting areas that do not currently have the facilities to ensure compliance with medicines management standards e.g. air conditioning facilities within clinic rooms storing medicines.

Background

The purpose of this report is to update the Trust Board in relation to:

1. **Work that has been carried out by pharmacy and trust-wide relating to medicines management over the last 4 months and to clearly identify non-compliance with regulatory medicines management standards (e.g. CQC) thus highlighting areas of concern**
2. **Current status of the trust in relation to medicines management related training**
3. **Status of the trust in relation to medicines related incidents (Datix - April and May 2015)**
4. **Information on medicines related queries – out of hours**
5. **Information on pharmacy activity data (May 2015)**
6. **Actions taken to date or in progress – pharmacy and trust-wide**
7. **Proposed recommendations**

Medicines Management Standards

The Care Quality Commission (CQC) guidance (Guidance for Providers on Meeting the Regulations, March 2015) highlights specific medicines management standards that must be in place within all healthcare Trusts in order to support appropriate person-centred care and treatment. These standards are detailed within appendix 1 for information.

The sections below present the work that has been completed within the Trust in order to assess the Trust's compliance in relation to these medicines management standards

1. Local Audit Work

A series of medicines management audits have been developed and are conducted jointly at ward level by pharmacy and nursing staff in order to assess compliance against medicines management standards.

The findings from the most recent completed audits are summarised below and include issues that have been identified by CQC at visits within other hospital Trusts (appendix 3):

a. Monthly Medicines Management Ward Audits (May 2015)

Some issues of non-compliance identified:

i. Safe and Secure Storage of Medicines
   - a. Inappropriate management of medicines and controlled drugs cupboard keys
   - b. Inappropriate security of clinic rooms where medicines are stored – clinic room doors left open
   - c. Unsecure medicines transit boxes and bags
   - d. Inappropriate room and medicines fridge temperature monitoring
   - e. Expired medicines kept on ward (6-monthly checks carried out by pharmacy staff)
   - f. Opening dates not stated on medicines - thus resulting expiry dates are unclear
   - g. Packaging of medicines not kept intact with visible batch numbers and expiry dates

ii. Controlled Drugs
   - a. Inappropriate storage of controlled drug registers and ordering paperwork

iii. Inadequate Systems in Place To Reduce the Risk of Medicines Administration Errors
   - a. Inappropriate storage of internal and external medicines together
   - b. Loose dose units stored in medicines cupboards and trolleys
   - c. Medicines not stored alphabetically
   - d. Patient's Own medicines mixed with ward stock medicines
   - e. Ward stock lists not up-to-date

iv. Inadequate Access to Medicines Resources at Ward Level
   a. No ward access to up-to-date medicines information resources e.g. BNF, Trust Medicines Code, Pharmacy contact details (not visible)

b. 6-Monthly Medicines Management Ward Audits (Jan – May 2015)

a. Safe and Secure Storage of Medicines
   a. Expired medicines kept on ward and opening dates not stated on medicines e.g. liquids
   b. Inappropriate re-calibration of fridge thermometers

ii. Inadequate Systems in Place To Reduce the Risk of Medicines Administration Errors
   a. Inappropriate storage of stock and non-stock medicines together, thus increasing risk of medicines administration errors

c. 3-Monthly Controlled Drug (CD) Audits (Jan – July 2015)

a. Recording and management of Patients Own CDs not in line with Medicines Code
b. Stock checks of CDs not in line with Medicines code i.e. daily and monthly checks via ward staff
c. Audit trial with regards to CD medicine transfers not robust i.e. CD medicines receipt notes unsigned at ward level on numerous occasions and requisition numbers unrecorded
d. Record keeping within CD register not in line with Medicines code i.e. recording of doses and strengths of medicines and associated requisition numbers. Signatures for those administering and witnessing CD administration incomplete in CD records
e. Wastage of CD medicines not recorded in line with Medicines code
f. CD documentation not stored correctly on the ward, in line with Medicines code
g. Transfer of CD medicines between wards not in line with Medicines code
h. CD cupboards not fit for purpose i.e. CD light which indicates the opening of the CD cupboard not working

d. **Weekly Ward Audits**

A weekly audit is also completed at ward level by nursing staff, however full completion of these audits in the recent months has been challenging in view of the current staffing situation. According to ward managers, the main areas that have demonstrated non-compliance with standards include; medicines administration gaps on medicines charts and medicines and adherence to mental health act requirements (T2 and T3) forms.

For information, the following areas are monitored via the weekly ward audits, and interestingly non-compliance in these has been linked to recent DATIX incidents e.g. PGDs, administration stop dates, T2 and T3 form adherence:

- Correct ward marked on card
- Patient Identifiers on all sides
- Prescriptions legible
- Number of blank medicines administration boxes
- Any medicines administered after stop date?
- T2 or T3 attached to drug card where applicable
- T2 or T3 matches prescription/administration
- IM benzodiazepine or antipsychotic given prn?
- If yes: physical monitoring documented as per RT policy
- Patient Group Directions (PGDs) given as policy

2. Unannounced Ward Visits To Assess Compliance Against Medicines Management Standards

In April 2015, the Chief Pharmacist initiated a rolling program of unannounced inpatient ward visits in order to assess compliance against medicines management standards in addition to the regular ward audits. This was a way of facilitating close working with ward managers and ward based healthcare staff around key issues and increasing awareness of the standards.
To date six wards have been audited (3 wards at the Radbourne unit and 3 wards at the Hartington unit), with three being re-audited after a period of 3 months (Radbourne unit).

Key areas of non-compliance identified can be seen below. An action plan is currently in place to address these issues (see appendix 2):

- **Safe and Appropriate Storage And Disposal Of Medicines:**
    - Fridge and room temperatures not recorded in line with medicines code guidance and no local action being taken when temperatures are out of range. It was also identified that several wards do not have local air conditioning facilities in place within the clinic rooms thus resulting in non-compliance with this standard e.g. ward 36, wards 1 and 2
    - Clinical room doors being left open
    - Medicines fridges unlocked
    - Medicines (including inhalers and compliance aids containing medicines) left on clinic room benches unsecured
    - Expired medicines in clinic room cupboards
    - Depot antipsychotic medication being stored out of the fridge

  - No clear audit trail relating to ward medicines receipt
  - Loose blister packs stored in the medicines trolley
  - No guidance on disposal of medicines and medicines being disposed of in clinical waste bins
- **Safe Administration of Medicines:**
  - Medication being left in pots on top of medicines trolleys unattended
  - Medicines administration gaps on medicines charts
- **Safe Prescribing of Medicines:**
  - Allergy status information unsigned on medicines chart and 'source' of information missing
  - Start date of medication on medicines chart unclear
- **Medicines and the Mental Health Act:**
  - Medicines prescribed not being in line with T2 and T3 forms
  - T2 and T3 forms being unclear
- **Controlled Drugs:**
  - Controlled drugs stock not being checked in line with medicines code guidance
  - Controlled drug records not being stored securely in line with medicines code guidance
- **Medicines Information Resources To Support Safe Medicines Management:**
  - No current medicines code on the ward for bank / temporary staff use
  - No current BNF on the ward

It is important to note that the above mentioned issues have been clearly identified as concerns during previous CQC visits at other hospital Trusts (see appendix 3).

Finally, although the re-audits demonstrated some improvement in key areas e.g. temperature monitoring and the locking of fridges, it is of concern that several standards remained non-compliant. In order for the Trust to be CQC-ready, it is essential that any improvements achieved are sustained and that any new areas of non-compliance identified are addressed in a timely manner.

3. Crisis Team Reports

Following pharmacy concerns regarding medicines usage and a lack of robust pharmacy input into the crisis team, and several serious incidents relating to the Mental Health Crisis team and medicines management whereby the Serious Incidents Requiring Investigation (SIRI) group made recommendations to improve practice and organisational learning, two detailed reports were prepared by the pharmacy department relating to the teams in Derby City and County South and Chesterfield.

The key findings are shown below:

- **Non-compliance with local medicines management guidance, including the trust medicines code, and national (i.e. CQC) standards:**

  100% of records showed a problem with the ordering, collection or delivery of medication, specific problems identified included:

  - medication not delivered in a timely manner thus delaying the start of antipsychotic treatment
  - the same medication ordered twice
  - no adequate system to ensure that medicines are ordered at all
  - physical health medication recorded in notes but not on medication chart
  - no audit trail for medication supply
  - illegal storage of a controlled drugs
  - inaccurate record keeping
  - medication unaccounted for

- **Lack of allergy status recording:**
  - **50%** (City & County South team) and **60%** (Chesterfield team) of records did not have a clear record of allergy status in the clinical notes
  - **60%** (South team) and **10%** (Chesterfield team) of medication charts did not have the allergy status recorded

- **Incomplete recording of patients' current medication regimen:**
  - **50%** (City & County South and Chesterfield teams) of medication charts did not fully summarise the patient's current medication, including physical health medicines

- **Ineffective relevant information transfer from primary care:**
  - **0%** (City & County South team) and 10% (Chesterfield team) of records had evidence of a fax, Summary Care Record printout or other written information being received from the GP or Summary Care Record

It is important to note that some of the above mentioned issues have specifically been identified as concerns during previous CQC visits at other hospitals (see appendix 3) including the lack of pharmacy (and pharmacist) input into crisis teams.

4. Medicines Management Related Training For Healthcare Professionals

Within previous Trust reports, CQC have identified concerns relating to the percentage of healthcare staff completing medicines management related training – see appendix 3. The CQC management of medicines standards expect the Trust to have robust systems in place to ensure the competency of staff in relation to medicines prescribing and administration.

Currently, the only training relating to medicine management that is classified as 'mandatory' within the trust and included as part of 'staff passports', is the e-learning module - 'drug management of the acutely disturbed patient'. This training is for inpatient staff only i.e. staff that are involved in the prescribing and administration of medicines - nursing staff and prescribers (to be completed every 3 years).
Figures from the training department (June 2015) demonstrate 57% staff compliance with this training requirement. Other e-learning medicines management modules are available to be completed by new nursing staff / preceptorships, but again compliance is low approximately - 32-43% staff compliance.

Face-to-face medicines management training delivered by pharmacy staff is limited due to capacity and not sustainable. Other trust-wide training includes that provided by a pharmaceutical drug company relating to the administration of depot antipsychotics and psychopharmacology. Governance systems in place with regards to this training are unclear, and during the June 2015 Drugs and Therapeutics meeting (25/06/15) concerns were raised by the committee regarding this issue. Also this training will not be tailored towards the needs of the service e.g. taking into account lessons learnt relating to local and trust-wide incidents / errors.

Finally, it is important to note that training, including e-learning modules are not currently focused on areas that CQC have raised as concerns in other organisations e.g. management of controlled drugs, covert administration, medicines calculations for all staff etc. Also poor attendance and completion of mandatory training has been highlighted as an area of concern by CQC in other Trusts (see appendix 3).

For information, the Trust does not currently have a dedicated medicines management training lead (as in other similar hospital Trusts), in order to address some of the issues identified above and in section 6 below, and to support service users and carers in the area of medication education / awareness (also see section 7).

5. Medicines Related Incidents

Medicines-related incidents and trends have been routinely reviewed by the Trust Drugs and Therapeutics Committee over the years. From September 2015 onwards, this role will be taken up by the Medicines Safety Committee (a sub-group of the Drugs and Therapeutics Committee).
The detailed report for April 2015 and May 2015 gives an idea of some of the recent medicines-related incidents that have occurred across the Trust.

Areas of concern include:

- **The medicines administration process** – including medicines administration in line with Patient Group Directions, the pre-preparation of medicines in pots left unsecured in the clinic room before administration, lack of appropriate recording on the medicines card in relation to medicines administration, administration of expired medicines, an intravenous medication preparation administered by a different route (intramuscular), medicines (including antibiotics) being administered after the specified 'stop date'
- **Medicines storage** e.g. loose blister packs left in trolleys, unclear opening dates for liquid medicines,
- **The medicines prescribing process** – unclear medicines and doses on medicines charts ('insulin clear' and 'insulin cloudy') , unsigned prescriptions, missed medicines on transcription, untimely review of medicines in line with electrolytes levels
- **Controlled drugs (CD) management**[*] – administration records incorrect, second checks during the administration process, transfer of controlled drugs not accurately recorded
- **Mental Health Act and Medicines** – mental health act forms (T2 and T3 forms) not in line with medication prescribed on medicine charts

Following the presentation of this report during the June 2015 Drug and Therapeutics meeting (25/06/15), the committee requested that these incidents be investigated further by the Medicines Safety committee in September 2015 and clear joint actions be identified / developed.

Again, some of the medicines-related incidents reported during this period relate to issues identified by CQC during other hospital Trust visits – see appendix 3.

[*] Please note that these incidents relating to controlled drug (CDs) have been reported to the Local Intelligence Network (Derbyshire / Nottinghamshire) as part of the quarter one (2015/16) report. For information, out of the 22 incidents (related to CDs) reported during this period (April to June 2015), 55% related to non-compliance with Trust CD policies and procedures – with 45% relating specifically to inpatient wards.

6. Medicines Related Queries – Out Of Hours

If we consider the calls that have been received by the on-call pharmacy out-of-hours service between Jan 2015 – June 2015, out of 144 calls 15% related to basic advice from the trust medicines code, 3.5% related to queries about medicines administration and the mental health act, and approximately 5% related to controlled drugs and confirming doses / volumes of medicines (usually parenteral) that needed to be administered by nursing staff. The remaining calls related to the supply of medicines.

Case study– one on-call session (Friday night) resulted in four calls to the pharmacy on-call service that related to confirming the volume of either a depot antipsychotic or enoxaparin to be administered by nursing staff. One case related to a high risk pregnant patient who required a dose of 60mg enoxaparin. The emergency cupboard only stores syringes containing 100mg/ml. When the ward had obtained the enoxaparin box from the emergency cupboard, the on-call pharmacist phoned the ward to ensure that nursing staff were clear of the volume to be administered. The staff nurse stated 'yes, I'm going to administer 0.4mls'. The pharmacist then talked her through the calculation so that she understood that she needed to administer a volume of 0.6mls (100mg/ml enoxaparin). **This was a near miss, but demonstrates that there is a potential need to increase training in this area.**

7. Pharmacy Activity Data

In May 2015, the pharmacy department introduced a system which captures data relating to activities conducted by pharmacists and other pharmacy staff relating to the following:

- clinical interventions made on wards
- number of education sessions delivered
- number of medicines reconciliations carried out (i.e. the function of ensuring that medicines taken on transfer into the hospital are checked to be accurate with what is prescribed on admission).

This data is shown below for the month of May 2015, and gives an indication of areas in which pharmacists / pharmacy staff have intervened or offered advice in relation to e.g. prescribing and administration functions, and areas such as the mental health act and medicines use.

Total number of interventions made by pharmacy staff during the period of May 2015 was **484.** The number of interventions made per 1000 Occupied Bed Beds was **247,** which in the authors experience compares favourably with other mental health Trusts.

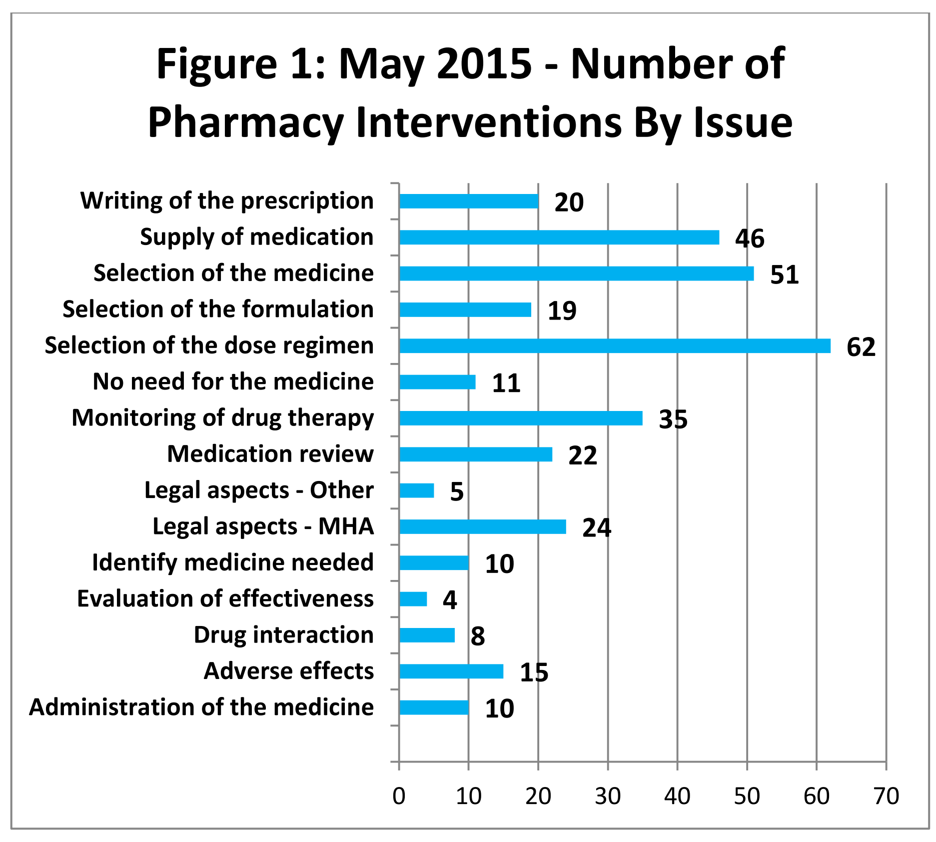


Figure 1: May 2015 - Number of Pharmacy Interventions By Issue
Writing of the prescription
20
Supply of medication
46
Selection of the medicine
51
Selection of the formulation
19
Selection of the dose regimen
62
No need for the medicine
11
Monitoring of drug therapy
35
Medication review
22
Legal aspects - Other
5
Legal aspects - MHA
24
Identify medicine needed
10
Evaluation of effectiveness
4
Drug interaction
8
Adverse effects
15
Administration of the medicine
10
0
10
20
30
40
50
60
70

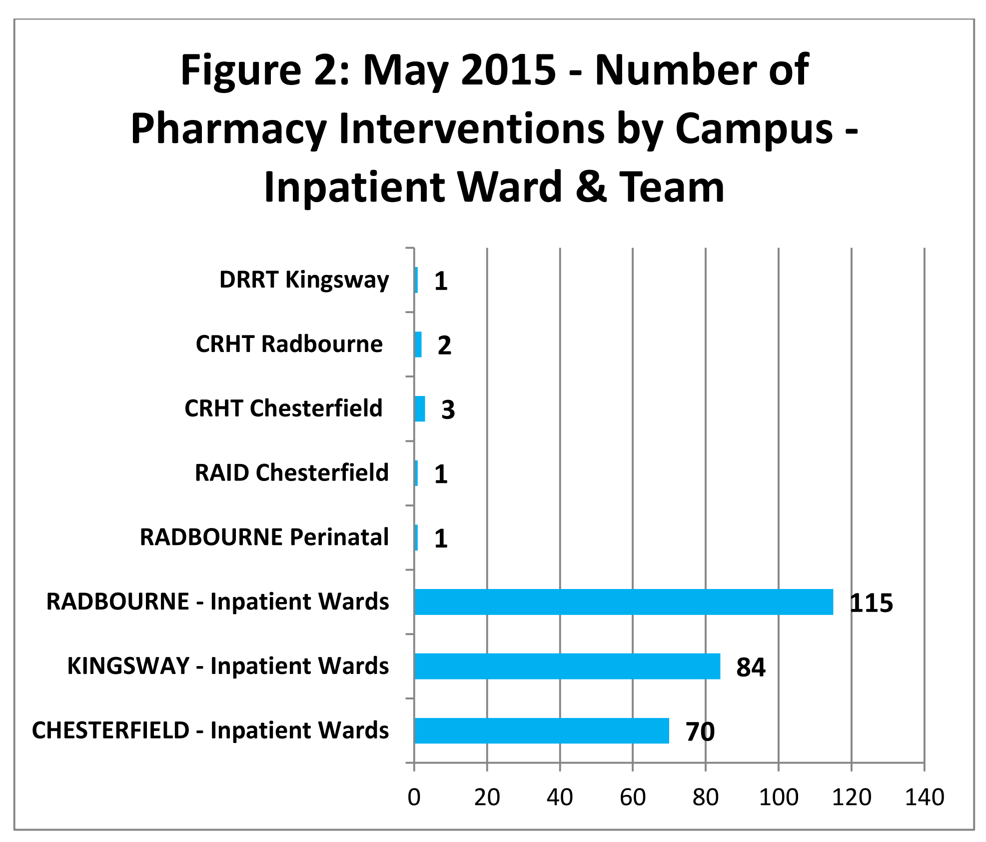
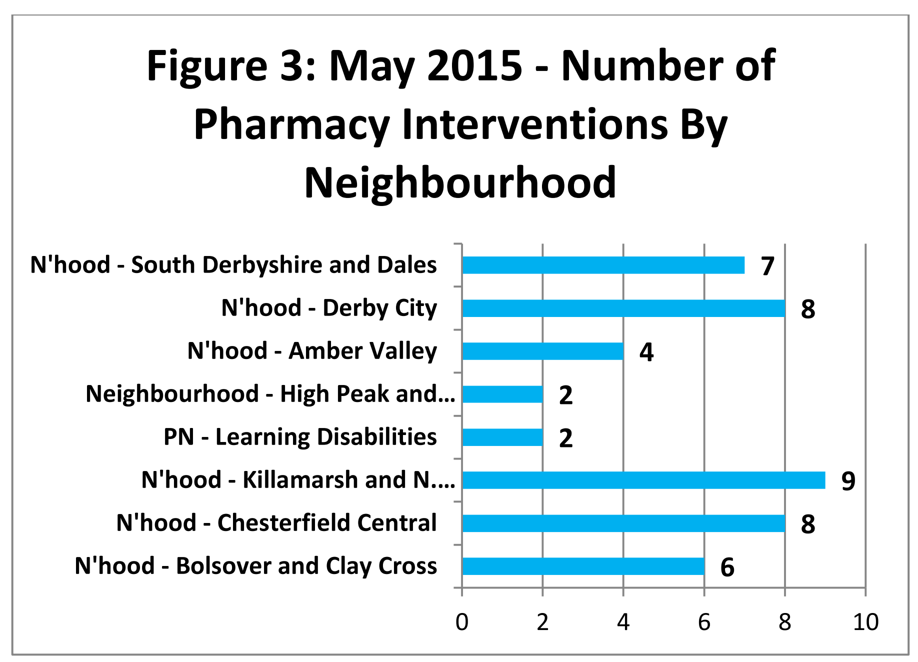


Figure 2: May 2015 - Number of Pharmacy Interventions by Campus - Inpatient Ward & Team
DRRT Kingsway
1
CRHT Radbourne
2
CRHT Chesterfield
3
RAID Chesterfield
1
RADBOURNE Perinatal
1
RADBOURNE - Inpatient Wards
115
KINGSWAY - Inpatient Wards
84
CHESTERFIELD - Inpatient Wards
70
0
20
40
60
80
100
120
140



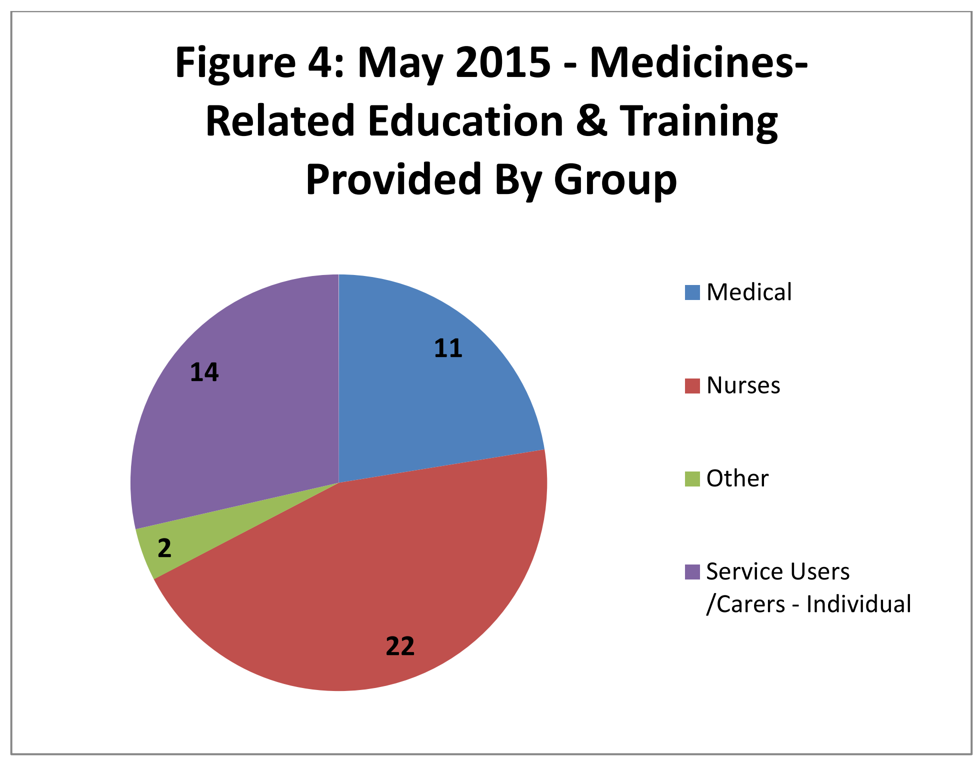


Table One: % Medicines Reconciliations Completed By Pharmacy Staff

Month / Year	Number of Inpatient Admissions (from Connect Intelligence Inpatient Dashboard)	Number of Medicines Reconciliations Completed By Pharmacy Staff	% of Medicines Reconciliations Completed Within The Trust
May 2015	113	100	88.5%

It is important to note that interventions by pharmacy staff are largely restricted to areas where there is an existing regular pharmacy service in place i.e. inpatient wards.
Teams such as the Crisis (see section 3 above) and RAID teams do not have dedicated pharmacists / pharmacy technicians working as part of their teams, and support to mental community teams and other community-based services e.g. Children's services, Learning disabilities, CAMHS is provided on an ad hoc basis and has not been historically resourced.

Again, medicines-related education is provided on an ad hoc basis only for both service users / carers and healthcare staff due to existing capacity within the pharmacy services.

This is supported by the results of the 2014 Trust Mental Health Inpatient Survey which found the following:

- Did Hospital Staff Explain The Purpose Of The Medication In A Way That You Could Understand = 50%
- Did Hospital Staff Explain The Possible Side Effects Of This Medication In A Way That You Could Understand = 22%

It also found that 94% of patients were given medication as part of their treatment for mental health. Thus there is potential for improvement in the way that patients are informed about their medication at ward level.

As discussed earlier there are potential improvements that can be made within the area of education and training (see sections 4 and 6).

SUMMARY

Based on the triangulated data and evidence presented above, concerns clearly exist within the area of medicines management at DHCFT.

In order to put these concerns into context, and to understand the extent of these concerns, the Chief Pharmacist has reviewed several previous CQC reports relating to other hospital Trust visits, which were chosen due to similarity with DHCFT in relation to services provided and population or due to these being neighbouring Trusts where CQC concerns were identified.
The areas of concern as identified by CQC relating to medicines management have then been distilled out of these reports, and an exercise has been carried out to indicate which of the identified issues would also be issues for DHCFT, based on the internal data / evidence that has been presented above (see appendix 3).

8. Actions Taken To Date or In Progress

Actions that have been taken to date by the Chief Pharmacist since taking up the post in March 2015 (as well as those mentioned above) are shown below:

a. **Medicines management audits (inpatients) -** Inpatient medicines management audits have been reviewed in line with national guidance and work is currently being carried out in conjunction with IT to convert the paper-based audits into electronic versions that are more user-friendly and can be jointly completed locally (on the wards and in teams). The system will require the completion of joint action plans for areas of non-compliance (so that actions taken in relation to non-compliance, leads and timescales can be easily tracked and audited). This data will then be used to populate an electronic medicines management Trust-wide dashboard to inform assurance in this area

b. **Medicines management audits (community teams)** – pharmacy are currently reviewing and developing these audits

c. **Action Plans for Areas Where Non-Compliance Has Been Identified**- Following the unannounced inpatient ward visits by the Chief pharmacist, action plans have been developed jointly with ward managers to address areas of concern – Radbourne unit and Hartington unit

d. **Prescribing Audits** - the pharmacy department are currently working with medical staff and nurse managers to produce a prescribing audit and it is envisaged that this audit will be completed on a monthly basis by the local ward team

e. **Drugs and Therapeutics Committee (DTC)** - the Drugs and Therapeutics Committee Terms of Reference are currently being reviewed. This will ensure that there are clear links in place with divisions and other Trust-wide committees / groups / teams to ensure that information regarding medicines management (including concerns) is being reviewed and addressed at an appropriate level within the organisation e.g. Trust Training Board, Quality Leadership Teams, Research and Development Committee, Physical Healthcare Committee, Trust Medical Advisory Committee

f. **Medicines Safety Committee** – in line with national guidance (MHRA Patient Safety Alert PSA (NHS/PSA/D/2014/005) this committee is due to be in place in September 2015 (sub-committee of the DTC). It's remit will be to promote and advance a culture of medication safety as a priority across the Trust, through encouraging increased reporting of medication errors, improving the quality of error reports, and

disseminating learning from medicines errors across the Trust to improve and inform future practice

g. **Medicines Code –** work is being carried out (led by pharmacy) to update the Trust-Wide Medicines Code taking into account national and local guidance and information from incidents and audits to ensure that the document robustly supports safe medicines management practice. This work will be completed by the end of August 2015 and thereafter the Medicines Codes will be reviewed and updated on a regular basis via the DTC and Medicines Safety committee

h. **Net Formulary** – work is being carried out by pharmacy to develop a more user-friendly IT system (via Connect) which will allow easier access to local medicines management related codes, policies and procedures and easier access to national and local information relating specific medicines in order to support staff practice and inform service user decisions relating to treatments

i. **Medicines Optimisation Technician (pilot) –** pharmacy are working jointly with the inpatient wards within specialist services to develop and pilot a new proactive pharmacy technician role. The function of this role will be to support medicines administration on the wards (drug rounds), in conjunction with nursing staff, and to support local medicines management (standard compliance) and education & training / increased awareness for service users and healthcare staff

j. **Work to assess medicines management standard compliance in areas with no / limited formal pharmacy support** e.g. Children's services (joint visits between teams and a senior pharmacist)

k. **Provision of specialist pharmacist support for healthcare staff in areas relating to e.g. patients in seclusion and medicines use**

l. **Clear pharmacy input into the Trust-Wide Serious Incident Team**

9. Proposed Recommendations

a. Defined local leadership in relation to medicines management issues with clear responsibility and accountability being taken at ward or team level

b. An actively engaged Trust-Wide approach for the management of areas where non-compliance with medicines management standards and local guidance e.g. Medicines code, is demonstrated on an ongoing basis and limited improvement is noted following local action planning

c. An effective process in place to ensure that lessons are shared and learnt on a Trust-wide basis and feedback is given at local level following medicines management related issues / incidents / errors

d. Taking into account the information in sections 3 and 7 above, consideration needs to be given by the Trust to increasing pharmacy support within high risk areas e.g. Crisis teams, and within community-based mental health and Children's services. It is important to note that current pharmacy capacity does not allow for this support. In fact if we consider the Trust's position in relation to clinical pharmacy staff just to cover the inpatient wards and crisis teams, in accordance with national pharmacy staff requirements (*The Sainsbury Centre for Mental Health 2007 'Delivering the Government's Mental Health Policies – Services, Staffing and Costs*) the Trust demonstrates a deficit of 4 pharmacist posts and 1 technician post. This is reflected by the fact that pharmacists are only able to attend and professionally support a third of MDTs (Multi-disciplinary team meetings) across Trust-wide inpatient services

e. Taking into account the information in sections 4,6,7, consideration needs to be given by the Trust as to how to improve medicines-related education & training and awareness for service users / carers and healthcare staff (current pharmacy capacity does not allow this)

f. Support for inpatient areas and teams that do not have the facilities in place to ensure compliance with medicines management standards e.g. areas where there is no adequate air conditioning in place and thus medicines are being stored at above recommended room temperatures on an on-going basis thus affecting the integrity of medicines administered to patients and potentially contributing to inadequate patient safety and care

10. Next Steps and improvement actions

a. To design a work plan on all aspects of this report in conjunction with nurse managers, clinical directors, and other relevant healthcare staff / senior managers. A significant element of the audit and findings are culture and diligence in clinical practice. Although the pharmacy team are feeding back to clinical teams, this is not resulting in sustained improvements in clinical practice.

b. The Chief Pharmacist and Chief Nurse have agreed a trial of warning light process / safety certificates, where staff are issued with a named notice stating that they are making errors and to assist them to see the risks associated with their practice. This is the driving equivalent of a safety notice without points on your licence, however eventually safety notices do lead to accountable practice but not part of a capability or misconduct process. It is to raise issues of reflective practice and safe practice, where verbal feedback has not had an impact. This would be in line with reflective practice and staff being asked to give a reflective account of practice improvement they have taken. This is in line with patient safety and quality improvement methodology such as step forward from the patient safety checklist.

c. A new issues log will also be developed as issues are established to enable a running log of improvement issues to be noted with associated service improvements.

d. These will then be fed back to the Medicines Safety group and escalated to the Quality Committee to have an overview of the work plan.

APPENDIX 1: DHCFT Recommended Medicines Management Standards in Line With CQC Regulations

Regulation	Section	Action Required
9 – Person Centred Care ***Each person receives appropriate person-centred care and treatment that is based on an assessment of their needs and preferences***	9(3)(e) providing opportunities for relevant persons to manage the service user's care or treatment	• People using the service and/or those lawfully acting on their behalf must be given opportunities to manage as much of their care and treatment as they wish and are able to, and should be actively encouraged to do so. 'Manage' in this context may mean being actively involved, overseeing or making decisions about their care or treatment depending on how much they need or want to be involved. **This may include managing their medicines**
12 – Safe Care and Treatment Care and treatment must be provided in a safe way for service users ***Medicines must be supplied in sufficient quantities, managed safely and administered appropriately to make sure people are safe***	12(2)(b) doing all that is reasonably practicable to mitigate any such risks	• Providers must comply with relevant **Patient Safety Alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS)** • Medicines must be **administered accurately**, in accordance with any prescriber instructions and at suitable times to make sure that people who use the service are not placed at risk • When it is agreed to be in a person's best interests, the arrangements for giving **medicines covertly** must be in accordance with the Mental Capacity Act 2005 • There must be arrangements to request a **second opinion** in relation to medicines for people who are detained under the Mental Health Act 1983 • **Medication reviews must be part of, and align with, people's care and treatment assessments**, plans or pathways and should be completed and reviewed regularly when their medication changes

	12(2)(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely	• Only relevant regulated professionals with the appropriate qualifications must plan and prescribe care and treatment, including medicines. **Only relevant regulated professionals or suitably skilled and competent staff must deliver care and treatment**
	12(2)(f) where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs	• People's medicines must be **available in the necessary quantities at all times to prevent the risks associated with medicines that are not administered as prescribed**. This includes when people manage their own medicines • The equipment, medicines and/or medical devices that are necessary to meet people's needs should be **available when they are transferred between services or providers** • **Sufficient medication should be available in case of emergencies**
	12(2)(g) the proper and safe management of medicines	• **Staff responsible for the management and administration of medication must be suitably trained and competent** and **this should be kept under review** • Staff must follow policies and **procedures about managing medicines**, including those related to infection control • These **policies and procedures** should be in line with current legislation and guidance and address: o Supply and ordering o Storage, dispensing and

		preparation o Administration o Disposal o Recording
	12(2)(h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated	• When assessing risk, providers should consider **the link between infection prevention and control, antimicrobial stewardship, how medicines are managed** and cleanliness

APPENDIX 2:

Joint Medicines Management Action Plan – Following Unannounced Ward Visits (Radbourne Unit)

Date: 01/05/2015 01/07/15	Review Date: July 2015 Updated: 1st July 2015	Action Plan Owners: Sangeeta Bassi (Chief Pharmacist) and Ward Managers: 32 – Carol Gilligan 33 – Lea McGowan 34 – Sarah Ford 35 – Trina Heaton 36 – Julie Cooper • Meeting with all ward managers following Ward Visits on Wards 33, 34, 36 on the 16/04/15 • Meeting between Sangeeta Bassi (Chief Pharmacist) and Ward Managers 33 – Lea McGowan and 34 – Sarah Ford following Re-audit on Wards 33, 34, 36 on the 30/06/15 and 01/07/15

Action Status Code:	(green) Action Achieved	(amber) Action started	(red) No Action commenced

Identified Problem	Action Required	Responsibility	Timescale	Progress Comments / Resources Required / Evidence	Status	Further Actions
1. Administration Gaps on Medicines Charts	Pharmacy Staff To Pilot - Highlighting Administration Gaps on Medicines Charts	Stephen Jones	May – July 2015	Review date – July 2015 1st July 2015 - Some improvement noted on some wards (e.g. ward 34), however wards generally still non-compliant		Warning Lights Process – Linked to Patient Safety for Staff Demonstrating On-going Non-Compliance with Standards. Leads – S.Bassi and C. Green Timescale - August 2015
1. Administration Gaps on Medicines Charts	Trust To Consider The Development of A New Medicines Chart That Will Accommodate A Larger Range Of 'Drug Non-Administration Codes' *Work To Be Done In Conjunction With Medical & Nursing Staff – including RU Staff*	Pharmacy Nursing Staff Medical Staff Managers	2015	1st July 2015 – Beverley Thompson leading on this work. Draft version due July 2015		Warning Lights Process – see above. Bite size local awareness training. Leads – S. Bassi and C. Green Timescale - August 2015

Identified Problem	Action Required	Responsibility	Timescale	Progress Comments / Resources Required / Evidence	Status	Further Actions
2. Locking of Clinic Room Fridges	Communication To All Nursing Staff Signs To Be Attached To All Medicines Fridges As A Reminder	Ward Managers	May 2015	1st July 2015 – Wards re-audited were compliant i.e. wards 33, 34, 36		
3. Hard Copy of Medicines Code To Be Kept on All Wards	Sangeeta To Check If All Managers Happy With This Action – Including Divisional Nurses, General Managers If Agreed - Wards To Then Print Off Copies Pharmacy To Communicate Clearly To Wards When The Medicines Codes Has Been Updated / Amended	Sangeeta Bassi Ward Managers Pharmacy Staff	May 2015	1st July 2015 – Either no copy available (ward 34) or no up-to-date copy available (wards 33, 36)		Warning Lights Process – see above. Bite size local awareness training. Leads – S. Bassi and C. Green Timescale - August 2015

Identified Problem	Action Required	Responsibility	Timescale	Progress Comments / Resources Required / Evidence	Status	Further Actions
4. No Clear Audit Trail For Medicines Received On Wards	Ward Managers To Communicate This Requirement To Nursing Staff in Regular Meetings	Ward Managers	May 2015	1st July 2015 – Some improvement noted on all wards. However wards are still not fully compliant with this standard		Warning Lights Process – see above. Bite size local awareness training. Leads – S. Bassi and C. Green Timescale - August 2015
5. Disposal of Medicines	SOP for Disposal of Medicines To Be Printed Off and Kept In A Visible Place In Clinic Room	Ward Managers	May 2015	1st July 2015 – All wards had a copy of the poster up in the clinic room, however is was not always in a visible place (ward 36)		Warning Lights Process – see above. Bite size local awareness training. Leads – S. Bassi and C. Green Timescale - August 2015

Identified Problem	Action Required	Responsibility	Timescale	Progress Comments / Resources Required / Evidence	Status	Further Actions
6. Daily Fridge & Room Temperature Checks	Ward Managers To Communicate This Requirement To Nursing Staff in Regular Meetings Pharmacy Staff To Make the Nurse-in-Charge aware and DATIX The Incident	Ward Managers	May 2015	1st July 2015 – Wards 33 and 34 compliant with recording (June 2015 record checked), however days missed on ward 36's record. Also all wards need to clearly note action taken when temperatures are out of range. Ward 36 had no air conditioning facilities in place in the clinic room		Warning Lights Process – see above. Bite size local awareness training. Leads – S. Bassi and C. Green Timescale - August 2015

Identified Problem	Action Required	Responsibility	Timescale	Progress Comments / Resources Required / Evidence	Status	Further Actions
7. Medicines Left In Pots In Unattended Clinic Room	Pharmacy Staff To Make the Nurse-in-Charge aware and DATIX The Incident Ward Managers To Communicate This Requirement To Nursing Staff in Regular Meetings	Stephen Jones Ward Managers	May 2015	1st July 2015 – No issues found during ward re-audit		
8. Review Of Ward and Pharmacy Audits	Sangeeta To Meet With Kate Sargeson To Consider If It Is Possible To Rationalise Medicines Management Audits ? Amalgamate Ward And Pharmacy Audits – But Ensure That Audits Are Completed Jointly Between Nursing & Pharmacy Staff	Sangeeta Bassi Kate Sargeson	May 2015	1st July 2015 – Work in process regarding audit tool development relating to prescribing		

Identified Problem	Action Required	Responsibility	Timescale	Progress Comments / Resources Required / Evidence	Status	Further Actions
9. Medicines Calculations	To Consider If Trust Will Add Medicines Calculations To Nursing Staff Training Passports – In Response To Local Concerns Regarding Competence?	Training Board?		1st July 2015 – Work in progress. Meeting arranged between chief pharmacist and chair of Trust Training Board		
10. Medicines Management Link Nurses	Ward Managers To Consider Introducing 'Medicines Management Link Nurses' On Wards To Develop A Stronger Link Between The Pharmacy And Ward Staff. They Will Also Act As A Lead For All Local Medicines Management Issues. Ward managers to put forward names if agreed.	Ward Managers		1st July 2015 – Still in discussions		

Identified Problem	Action Required	Responsibility	Timescale	Progress Comments / Resources Required / Evidence	Status	Further Actions
11. Pharmacy Technicians Support On Wards	All Ward Managers Supported A Pilot Which Involved Pharmacy Technicians Working Together As A Team With Nursing Staff To Deliver The Drug Round (Second Check). Ward Managers Agreed That this Would Also Help To Support Medicines Management Standards Compliance Locally. To be Discussed Further with Nurse Managers When Funding Becomes Available.	ALL		Medicines Optimisation Technician pilot due to start on specialist service wards. PID developed & being presented at QC in August. Lead - S.Bassi Supported by – C. Green and C. Gilby Current hesitation and concern in this area wrt Radbourne team		

Identified Problem	Action Required	Responsibility	Timescale	Progress Comments / Resources Required / Evidence	Status	Further Actions
Additional Comments	Next Review Meeting With Ward Managers – Radbourne Unit and Chief Pharmacist = 1st July 2015 Further Issues May Be Added Between Meetings After Communication With Ward Manager 1st July 2015 meeting attended by Lea McGowan (33) and Sarah Ford (34). New issues identified included on individual ward report. Discussion included the following potential ways forward (to be discussed with divisional managers) 1.Input when staff are non-compliant with standards 2. Joint bite size mandatory training sessions for ward staff relating to medicines management standards and CQC					

APPENDIX 3:

Please note that sections in red are those where DHCFT has also demonstrated non-compliance with medicines management standards. This is based on work that has been carried out within urgent care services (inpatient wards and crisis team) to date – see main report. Other areas may or may not demonstrate non-compliance in these areas, however this work has not been completed yet.

Key Concerns Identified Within A Sample of Recent CQC Reports
Norfolk and Suffolk NHS Foundation Trust **Inspection date: Feb 2015** **Rated: inadequate**
ADULT and OLDER PEOPLE INPATIENT WARDS **Medicines prescribed to patients who use the service are not stored, administered, recorded and disposed of safely. management tasks were not carried out to ensure patients safety** **MEDICINES STORAGE, MANAGEMENT & ACCESSIBILITY** ➢ temperature of the clinic rooms and medicine fridges were not monitored consistently (adult inpatient and community, older people) ➢ medicines were kept in an unlocked medicine trolley which could be a risk to patients' safety ➢ medicine fridge key was kept in the door that was unlocked ➢ date that creams and liquid medicines had been opened or the expiry date was not recorded. This could mean medicines that were no longer effective could be given to patients who used the service ➢ medicine to reverse the effects of a drug prescribed to one person was not available, which could impact on the person’s wellbeing ➢ found an insulin injectable pen that was not named or suitably boxed **MEDICINES ADMINISTRATION** ➢ gaps on five of the patients’ medicine charts we looked at ➢ no record of one patient having received their depot medication ➢ medication 'acuphase' was administered to an acutely disturbed patient. However we were concerned that no pre or post administration physical observation was undertaken ➢ another person had been administered more medication in one day than prescribed

- incidents of medication not being signed for during administration
- one patients prescribed medication on their treatment chart was not signed by the prescriber but was being administered
- one patient's regular administration of high dose antipsychotic medication was not recorded as such on their treatment chart

CONTROLLED DRUGS

- One person was prescribed a controlled drug to be given twice daily. There were two gaps on the patients' chart. This had been recorded in the controlled drug book as given. However nurses had not noticed the chart was not signed. The qualified nurses audited the controlled drugs three times each day but this discrepancy had not been identified and investigated. This meant it was not clear whether or not patients' medicines had been given as prescribed
- inconsistent printing of the name and designation of nurses when signing in the controlled drug book for administering medication or checking stock levels

PRESCRIBING

- prescribed antipsychotic medication for one patient was over the recommended limits and was not recorded as high dosage antipsychotic medication
- medication record of one patient who was receiving medication prescribed 'as required' had not been signed and dated by the medical team
- no clarity in the titration dose to administer clozapine given to one patient which could lead to administration errors
- two patients had medication prescribed as required that was above the recommended dose limits
- one patient's route of medication was prescribed as oral when intramuscular was required
- one patients prescribed medication on their treatment chart was not signed by the prescriber but was being administered

CARE PLANNING AND MEDICINES

- found medication care plans in place but these were generic and not specific to the individual needs of the person
- one patient's care plan for rapid tranquillisation provided staff with guidance on how to give the medicine but not on how to monitor the person afterwards to ensure they had no ill effects of receiving the medicine

TRAINING

- a sample of staff records showed that only four of seven qualified nurses had received updated training in medicines management

INCIDENT MANAGEMENT

- INCIDENTS - local governance process in place to review incidents. We saw in response to these how discussions had occurred locally at monthly team meetings or daily ward handovers; There were weekly multi-disciplinary meetings which included a discussion of potential risks relating to patients, and how these risks should be managed. However *staff told us that they did not always receive feedback following incidents they had reported and they were unaware of any learning following incidents at other services*; All the ward managers we spoke with told us how they fed back learning from incidents to their teams. However some managers said that they relied on their own knowledge to do this rather than receive information from the trusts risk manager

MENTAL HEALTH ACT AND MEDICINES

- two incidents where patients' authorised treatment certificates (T2/T3) did not correlate with what was prescribed by the medical team and was being administered by the nurses
- one person was being regularly administered medication that was not authorised on the certificate

FORENSIC INPATIENT SERVICES

- medicines in current use were stored in a medicine trolley which was not secured at the time of the inspection
- there was not a medicine refrigerator available on one ward. Medicine that needed to be stored in a refrigerator was stored on a neighbouring ward
- 28 day medicine chart was used which required frequent re-writing. It was noted that there was an agreement that a continuation sheet could be attached to the chart to minimise the need to re-write this. However, these sheets were attached by a staple to the original chart and could introduce an element of risk to the prescription and administration process
- unit was trialling an electronic prescribing project which had been shown to reduce prescribing errors, uncoded doses and missed doses and to enable monitoring of the amount of when required medicines given in a time period. However due to concerns regarding patient safety, one ward had decided to abandon their participation and reinstate traditional prescribing. The ward also had concerns around the extra time taken to complete the medicine rounds
- staff were unsure of the process for rapid tranquilisation and supporting policies did not clarify the agreed process. This is a significant risk
- three people we spoke with told us that they did not always feel listened to and engaged in decisions about their medicines. They said they would be put on a drug without discussion or enough information about it

COMMUNITY ADULT MENTAL HEALTH SERVICES

- fridge was locked the key was kept in the main key cabinet which was accessible to all staff
- medicine stock checks were not completed within five locations
- stocks within the cabinets were out of date as well as medicines received from patients
- medicines received from people - records seen did not identify the medicines received and we found that the locations did not have a systematic way of recording medicines received
- we reviewed the Medicine Administration Record (MAR) for the administration of depots at each location (depot clinic). We found that there were no evidence of people's allergy status recorded on their own MAR chart
- we reviewed individual care and treatment records and found no care plan or risk assessment in place in one person's records to guide and support staff regarding the management and administration of medicines for that person
- teams visited did not use clear policy and procedures to protect people from the risks associated with the unsafe use and management of medicines

COMMUNITY OLDER PEOPLE

- no routine monitoring of the temperature of stored medicines to ensure they were kept within ranges recommended by the manufacturers. This meant their effectiveness was potentially compromised

LEARNING DISABILITIES

- there was no specialist training available for staff in relation to specific conditions, such as dementia or Down's Syndrome, which patients may have

GOOD PRACTICE FOUND:

ADULT INPATIENT SERVICES

- we saw and people who used the services told us that a pharmacist met with people to discuss the medicines they were prescribed either individually or in a group. People told us this helped them to understand why they were taking their medicine and what the possible side effects may be
- patients' medicines *were taken to them* and discussed with them in private. Staff told us that this has reduced incidents on the ward and ensured they were focussed on how to meet each patient's needs
- the pharmacist visited the wards regularly and talked with patients about their medicine

OLDER PEOPLE INPATIENT SERVICES

- we saw good medicines management and pharmacy input

CRISIS

- we found robust systems in place for the safe management of medicines throughout this service

CAMHS

- young people had access to 'MedEd' sessions and people told us pharmacist visit once a week and they could ask them any questions they had about their medicines

LEARNING DISABILITIES

- the training records confirmed that the majority of staff had attended all of their mandatory training. This included training in, for example, medicines management

Avon and Wiltshire Mental Health Partnership NHS Trust
Inspection date: September 2014
Rating: Requires Improvement

ADULT INPATIENT
MEDICINES STORAGE, MANAGEMENT & ACCESSIBILITY

- we found that the temperature of the room where medicines were stored on the ward was not recorded. In one location the manager acknowledged this was an issue but nothing had been done to remedy this situation. An air conditioning unit had been installed as a temporary measure
- fridge unlocked
- the temperatures of the medicines refrigerators were being recorded daily but had been over the required temperature for the six days prior to our visit *with no report or action taken*
- *no recording system for the receipt or management of stock medicines on the ward*. This meant that medicine could be missing without anyone's knowledge. There was no evidence of auditing of medication related paperwork. On our return visit, we were informed the pharmacist had begun a weekly audit of all medicines on the ward
- *open bottles of liquid medication had no dates* on them meaning that the ward could not ensure they were disposed of within the

recommended timescale

- we checked emergency resuscitation and safety equipment. We found some items were out-of-date in the crash trolley, even though the records showed that the trolley had been checked on a daily basis
- medical staff expressed concerns about nurse staffing levels and the number of bank staff employed. They also voiced concerns about poor communication with regard to medication
- the ward was divided into three teams for *auditing* purposes. Audits included care planning, legal documentation, health and safety issues and *medication*. We sampled the audits from each team and found *inconsistency in the quality of these across the teams*. Some were very detailed and up to date whilst others were vague and lacking in detail

MEDICINES ADMINISTRATION

- there were also four unexplained gaps on one prescription chart
- a patient described a situation when the night medication was delayed by approximately 90 minutes due to the staff nurse having to manage a situation elsewhere. The patient added that delays in medication rounds were a common problem. This information was put to the manager during the inspection and they agreed this was not acceptable but may not have happened as described.
  We noted that on our return visit, this issue had been escalated to senior management for further consideration

CONTROLLED DRUGS

- controlled drugs were not being checked daily in line with trust policy

PRESCRIBING

- we looked at the medication charts and found recording errors including missing signatures. These had not been reported as incidents and had not been investigated

TRAINING

- staff told us they do not assess competency of staff for medicines administration but were planning to bring this in

ECT SUITE

- two items in the emergency drug boxes that had expired, four items in the psychiatric and medical emergency box that had expired, and nine items on the stock list that had expired
- we found one item in the medication fridge that should have been kept in the medication cupboard and had also expired
- we also found a disposable injection tray prepared for use in the medication cupboard. This should have been discarded at the end of

the last treatment clinic to ensure there was no risk of infection

- room temperature not monitored and the minimum and maximum temperature of the medicines refrigerator was not being measured leading to a risk that the medicines were not viable

CRISIS SERVICES

- the pharmacist had a limited number of sessions with the team. We noted the pharmacy did not visit daily and staff within the service maintained the medicines. We found that stock checks were not completed
- there were not always appropriate arrangements in place for managing and disposing medicines. We saw three sealed pharmacy buckets containing waste medication on the side in the clinic room, which could easily be removed. There was not an accurate record completed to indicate what medications were to be disposed of
- the locked medication cupboard was kept within a large cupboard, with access by all staff via a key-code
- for three crisis teams there were no clearly defined procedures for managing medicines
- the manager for the unit was a prescriber and we reviewed the trust's guidelines. The manager confirmed that they were unable to administer medicines if they had been the prescriber
- we observed within the metered dosage system that one person's tea-time and evening medicines were administered and given at tea-time. We found no evidence within the records read that this practice had been discussed or authorised by the doctor or consultant. The service did not have clear procedures in place to protect people who use the service against the risks associated with the unsafe use and management of medicines
- learning from incidents not always shared effectively
- recent changes within the trust had led to the introduction of a centralised pharmacy service. Since this, staff reported delays in obtaining some medication and some dispensing errors

FORENSIC INPATIENT SERVICES

- there was poor recording of *fridge and clinic room temperatures* and this could potentially lead to the denaturing of drugs
- we also found out of date '*patient group directions*' (guidance on who can be given certain medicines) and there was no list of staff who were able to administer these medicines
- *liquid medicines did not have the opening date* which meant they could potentially be unsafe for patients
- the trust did not always follow NICE guidelines on medicines
- we found that there were no care plans in place for the management of 'as required' (PRN) medicines to guide nursing staff

OLDER PEOPLE SERVICES – INPATIENT AND COMMUNITY

- recent changes within the trust had led to the introduction of a centralised pharmacy service. Since this, staff reported some errors in the *reconciliation of medicines being ordered and dispensed*
- we noted there was *no recording system for the receipt or management of stock medicines*
- waste medicines were not stored securely
- open bottles of medicine were not dated
- clinic room temperatures unchecked
- there were delays in receiving medicines from pharmacy
- no audits / measures relating to a number of measures on important topics including temperatures of the medication room, medication fridge, training of staff

REHABILITATION INPATIENT SERVICES

- it was observed during handover that staff mentioned an incident when medicines had been found in a person's room but on enquiry this had not been reported. Therefore it is unclear whether all staff understood the types of incidents to be reported
- no evidence of completed stock checks during our visit
- medicines had not been given although they had been placed into dosset boxes in readiness for people to access them. We noted that two of the tablets administered were moisture absorbent and were accessible to the moisture and heat within the medicine room
- we observed people coming to the medicine room to access their medicines. We saw that during their administration the door remained open and other people entered the room unannounced. We saw no practice in place whereby staff requested people to vacate the room and wait until they had completed the task in hand and were ready to address their needs. This process did not provide the privacy or confidentiality required for people in respect of their medicines and could also be a potential cause of error in view of the risk of distraction to staff administering medicines
- we reviewed the medicine chart for one person whose medicines had been placed in their dosset box in readiness or their access and noted that the 18.00 medicines had already been signed for. We brought this to the attention of the staff member concerned who checked with the person and found that their medicines had already been administered. We spoke with staff and they confirmed that their practice would have been to return the medicines to their containers. They were unaware of the procedures to report this as a 'near miss' incident
- staff informed us that if necessary they took medicines to people to ensure that they received them. We found no confirmation of this practice within the care plans reviewed and found no guidance for staff about prompting people to access their medicines

- during our visit the person dropped their medicine and we observed staff picking up the tablet and re-placing it within the person's dosset box without checking that the person wished to take the dropped medicine

COMMUNITY ADULT MENTAL HEALTH SERVICES

- staff could not identify if there was a lead within the team overseeing medication and infection control
- two of the teams did not *monitor or store medicines, or dispose of unwanted medicines*, in a safe manner. The trust's chief pharmacist had raised concerns beforehand about the monitoring, storage and disposal of unwanted medicines in community services
- pharmacy boxes which contained medications were left unsecured
- we were advised by staff that medications delivered by pharmacy were signed in by administrative staff
- staff told us they had concerns with the *transportation of medicines* and whether their insurance would cover them. The outcome of the concern was to have pharmacy speak with the team about how to manage this problem. We saw no evidence that this had taken place
- medicine care plans were in place to manage medicines and identified whether people self-medicated and the procedures for staff to follow when supporting people. We were informed that some qualified nurses conducted *secondary dispensing*. We found no evidence within the training records of secondary dispensing training to support staff
- a patient stated that felt they were not treated with respect regarding the administration of medicines
- in two teams we found that there was no appropriate procedures in place for the administration, management, storage, disposal and audit of medications
- in one team we found that the fridge was broken and there had been a delay in reporting this so the integrity of medications could not be assured
- it was not always clear how trust staff assessed and monitored people's physical health needs, particularly in relation to side effects from some of their mental health medication. For example, a young person working with the early intervention team had a high body mass index (BMI), continued weight gain and was taking antipsychotic medication. It was documented that they refused a physical health check but it was not clear how this would be monitored or followed up

GOOD PRACTICE

ADULT INPATIENT

Pharmacy Service

- a clinical pharmacy service was provided daily
- the ward staff reported good support from pharmacy, with regular visits from pharmacists or pharmacy technicians. Patients were able

to access advice form a pharmacist about their medication and its effects

- a clinical pharmacy service was provided daily for medicines reconciliation and the supply of medicines
- CRISIS SERVICES - we saw that the pharmacists visited the service and managed the medicines regularly. The pharmacy conducted stock checks and audits and maintained the stock for out-of-hour's services

Other

- staff were aware of when and how to report medicine errors and the action required
- self-administration of medicines by patients was risk assessed
- checks on controlled drugs were in place
- controlled drugs were appropriately secured and had been regularly checked
- medicine administration charts had been completed correctly and were accompanied by a National Early Warning Score (NEWS) physical observation chart
- we found that prescribing of anti-psychotic medicine was within the limits recommended by the British National Formulary (BNF)
- the drugs fridge was maintained at the correct temperature
- emergency medicines including crash drugs were available
- medication was covered by consent to treatment certificates which were in order. We noted that there was frequent discussion with patients regarding their rights under section 132 and found that patients were very involved with the planning of their care and medication
- we found that staff assessed and planned care in line with the needs of the individual. We saw that care plans reflected the individuals person`s needs and choices as far as possible. Service users were offered a copy of their care plan and were given full involvement with both their care and medication
- people we spoke with were able to discuss their medication and its use. Patient information leaflets about the range of medications were available. One person said, “I know all my meds and have information on them, they’re good like that”. We were told that doctors explain all medication and side effects when asked
- we saw good recording on notes regarding capacity and consent to treatment

CRISIS

- we saw that the pharmacists visited the service and managed the medicines regularly. The pharmacy conducted stock checks and audits and maintained the stock for out-of-hour's services
- there was an identified medication lead in the team
- the records showed us that people’s physical healthcare needs were addressed by the service and that assessments of their physical

health status were recorded. Examples included a list of all medicines prescribed, identified allergies, physical health problems or disabilities that need to be accommodated

- information leaflets about medicines were made available to patients on request and advice could be sought from the trust's pharmacy department

FORENSIC INPATIENT SERVICES

- we saw evidence that patients were involved in the management of their medicines and were able to speak with a pharmacist

OLDER PEOPLE SERVICES

- all medications were prescribed in line with section 58 of the MHA
- we reviewed the care records and medication charts for patients receiving covert medication. We found that this was being managed safely, with a care plan in place, and details of discussions held at best interest meetings

REHABILITATION WARDS

- the records showed us that people's physical healthcare needs were addressed by the service and that assessments of their physical health status were recorded. Examples included a list of all medicines prescribed, identified allergies and physical health problems or disabilities that needed to be accommodated. Regular monitoring of basic observations such as blood pressure, weight and temperature was carried out by the staff

Sheffield Health and Social Care NHS Foundation Trust
Inspection date: October 2014
Rating: Requires Improvement

ADULT INPATIENT

MEDICINES STORAGE, MANAGEMENT & ACCESSIBILITY

- room and fridge temperatures not properly monitored
- following rapid tranquilisation, nursing staff were required to record regular observations of the patient's blood pressure, temperature, oxygen saturation and respiratory rate. However, when we checked the care records for patients on two occasions who had been given rapid tranquillisation, we found that it was not clear that these observations had been recorded
- we were told that regular pharmacist support to the ward had been suspended for three months recently because of long term sickness. Ward staff and the Chief Pharmacist told us that this had led to reduced monitoring of medicines management during this period

CONTROLLED DRUGS

- regular small discrepancies in controlled drug stock (benzodiazepines) which had been identified but it was not always clear what action had been taken. These discrepancies were not always reported in line with the trust policy to ensure that they were properly investigated
- entries in the controlled drug register did not always include the signature of the witness observing administration and sometimes the dose given was not recorded

MENTAL HEALTH ACT AND MEDICINES

- ward staff did not have ready access to a copy of the current legal authority approving treatment for mental disorder (for example T2 or T3) attached. This meant that it was not always clear that nurses were checking whether they had the appropriate legal authority to administer medication for mental disorder to detained patients as required by the MHA Code of Practice
- the treatment for one detained patient receiving high dose antipsychotic medicines was not properly authorised
- for a second patient the category of one medicine being administered did not match the entry on the consent form for their treatment for mental disorder

OLDER PEOPLE INPATIENT SERVICES

- fridge temperatures not properly monitored
- entries in the controlled drug register did not include the signature of the witness observing administration and correct recording of the dosage of medication given to patients
- out of 52 ward staff, only 3% had completed medicines management training

CONTROLLED DRUGS

- we saw evidence of a patient's controlled drugs records – there were multiple incomplete records that did not have the date and specific medicines recorded
- entries in the controlled drug register did not always include the signature of the *witness observing administration*. Of 215 entries in the controlled drug register, 5 did not include the signature of the witness observing administration

MENTAL HEALTH ACT AND MEDICINES

- we found that one patient was receiving medication that did not appear on the T3 form
- another patient had been assessed as lacking the capacity to make decisions regarding medication but remained on a T2

REHABILITATION INPATIENT SERVICES

- medication cabinets on wards were located in the main nursing office where handovers took place and the main telephone for the ward was located. This resulted in staff having to manage a number of distractions whilst dispensing medication which could increase the risk of error

FORENSIC INPATIENT SERVICES

- the wards gave patients a satisfaction exit survey when they were being discharged. Overall, we saw that the results of the survey results for the past year were very positive. One issue was raised through the survey that patients would like more support in the multi-disciplinary meetings (MDT) meetings with asking about medication although patients also reported they understood and were given information about their medication generally

COMMUNITY OLDER PEOPLE SERVICES

- there was no dedicated pharmacist input into CMHT's to support the safe and effective management of medicines
- nursing staff routinely repackaged medicines into compliance aids on behalf of patients in the process of being discharged. Staff were repackaging medicines as part of monitoring patients' compliance with medication. Trust procedures were not followed and these compliance aids were not properly labelled with their contents and dose instructions

GOOD PRACTICE

PHARMACY

- an electronic prescribing and medicines administration system was in place on all wards and helped support safe and effective prescribing
- pharmacists were fully integrated into multi-disciplinary teams (MDTs) for inpatient services to support and ensure best outcomes from the use of medicines
- the ward pharmacist had a full understanding of medication use for all the patients on wards. The pharmacist carried out full drug histories of all patients who were admitted, and provided consultations to any patient who wished to question their medication
- a pharmacy technician worked proactively on a weekly basis with staff checking all medication was clearly labelled and stored correctly
- patients and their carers' were provided with information about their medicines and a pharmacist was available to support this

ADULT MENTAL HEALTH

- the clinic room used to dispense medication was clean and tidy

OLDER PEOPLE INPATIENT SERVICES

- using a neuro psychiatric inventory - this was used to assess neuropsychiatric symptoms of patients with Alzheimer's disease and other dementias. It captured treatment related behavioural changes in patients receiving anti dementia medication and other psychiatric medicines. The RC used this on the admission and discharge assessment of patients and used outcome measures to improve care and treatment
- using an excellent 'antipsychotic checklist' to monitor the impact of changes to a person's prescribed medicines
- on admission physical healthcare screening included review of medication with the pharmacist

REHABILITATION INPATIENT SERVICES

- there was a pharmacy medicines information drop in session to provide information to patients on their medication or this could be arranged on a one to one basis
- monthly controlled drug check carried out by a ward pharmacist
- had nurse non-medical prescribers
- there were opportunities for patients to self-medicate and lock their medication in a cabinet in their bedrooms

FORENSIC INPATIENT SERVICES

- on the rehabilitation unit, the team had worked with the pharmacy team to develop and implement robust step down procedures to support patients in managing their own medicines in preparation for when they moved on from the ward

Nottinghamshire Healthcare NHS Trust
Inspection date: April 2014
Rating: Good

ADULT INPATIENT SERVICES
MEDICINES ADMINISTRATION

- One person told us that medicines were dispensed into pot and then placed on medicine cards so when they arrived for their medicine the tablet was ready for them in the pot. The trust's Medicines policy states that dispensing in pots, and leaving them on medicine cards, is unacceptable practice due to the risk of the pot and medication card being separated or mixed up or the pot being knocked over. We discussed this practice concern with two staff who acknowledged that this practice did sometimes happen on the ward

CONTROLLED DRUGS (COMMUNITY MENTAL HEALTH ADULT SERVICES)

- we saw that the controlled drugs register did not always contain the signatures of two nurses
- we saw a list of nurse's signatures available in the drugs cupboard but this was in need of updating. This meant that safe prescribing practice was not being routinely implemented

COMMUNITY MENTAL HEALTH ADULT SERVICES

- we observed a home visit and the person did not have a clear understanding about medication and side effects

CAMHS

- the records and other evidence seen showed us that the trust were involved in the monitoring and measurements of quality and outcomes for people. For example, we saw that the unit's 'survey monkey' results were 100 per cent apart from information on prescribed medication which scored 66%

COMMUNITY SERVICES FOR CHILDREN, YOUNG PEOPLE AND FAMILIES

- systems to ensure safety of medicines were inadequate. There was a lack of pharmacy support to monitor arrangements
- the management team told us there has been no external pharmacy audit for two years and no internal pharmacy audit for nearly a year
- there was no local medicines management policy for staff guidance about safe medicines procedures for children and families. This represented a potential risk to patient safety. The trust could not be sure that medicines were being managed appropriately at this location

GOOD PRACTICE

ADULT INPATIENT

- appropriate arrangements were in place for the management of medicines. For example the wards had good links with the pharmacy, pharmacy link nurses and medicines were handled safely. The pharmacist attended the ward weekly and saw new admissions when required
- staff discussed what they would do if they identified a medication error and how lessons would be learned from this
- pharmacy produced a lessons learned bulletin which covered the common medication themes across the trust

CAMHS

- evidence was seen of actions being taken by the trust when concerns had been identified with clinical practice. For example, following a

number of medication errors staff had attended a specific training session with the trust's pharmacist. This had led to improved clinical practice and fewer identified medication errors

Leicestershire Partnerships NHS Trust
Inspection date: March 2015
Rating: Requires Improvement

ADULT INPATIENT
MEDICINES STORAGE, MANAGEMENT & ACCESSIBILITY

- the trust must ensure that medicines prescribed to patients who use the service are stored, administered, recorded and disposed of safely
- there were limited records of discussions between patients and their responsible clinicians (RC) to show patients' understanding of their prescribed medicines and their consent or refusal to take it
- the rapid tranquilisation policy confirmed that the trust defines rapid tranquilisation as only injectable treatments not oral. This means that some patients could receive additional doses of psychotropic oral medication with no automatic physical monitoring
- safety syringes and needles were not available on the wards in line with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. During the inspection we witnessed staff on older people's ward administer insulin using a pen with no safety needle
- the trust had reported one 'never event' in August 2014. In this case a patient was prescribed a daily dose of the drug methotrexate that should be administered weekly. We found the trust had investigated the never event, actions regarding medicines management and prescribing had been implemented and learning had been disseminated to staff throughout the directorate. We did not find any other incidents that should have been classified as never events during our inspection
- only 81% of staff had received medicines management training
- medicines, including those requiring cool storage, were not always stored appropriately as records showed that they were not always kept at the correct temperature, and may not be fit for use
- none of the emergency trolleys were sealed and so could be tampered with

MENTAL HEALTH ACT AND MEDICINES

- on some of the wards we found treatment was not being given in line with the MHA Code of Practice
- on two wards we found T2 certificates, to evidence patients' consent to taking their medication, were not signed by the current RC
  on two wards not all prescribed medicines were included on the T2 certificate, which meant patients were being given medication they had not consented to

- similarly, we found examples of medication being given which had not been approved by a second opinion appointed doctor (SOAD) if the patient lacked capacity, or refused to consent to taking medication

REHABILITATION INPATIENT SERVICES

- two patients where necessary medical checks had not been undertaken following administration of high dose anti-psychotic medication

COMMUNITY MENTAL HEALTH ADULT SERVICES

- not all clinic rooms in community adult mental health team bases (where medicines were stored) had hand washing facilities which could increase the risk of infection or cross contamination

CRISIS

- we found that some medication was out of date in the crisis service
- there was no clear record of medication being logged in or out

SUBSTANCE MISUSE

- we were concerned about arrangements for medication management within the substance misuse service. There was no system to monitor and manage prescriptions within the service. This meant there was a risk that prescriptions could be lost or stolen. Prescriptions were not securely locked away overnight and were stored in an open office. Staff also took prescriptions home overnight to allow easier travel to neighbourhood services the following day
- naloxone medication was being given to people as a take home dose. This was being given without a Patient Group Direction (PGD) in place. PGD's are the legal framework that allows medication to be dispensed to people without the need to see a doctor, without compromising a person's safety

GOOD PRACTICE

- at most mental health units we saw input from pharmacy
- the trust used an electronic prescribing and medication administration record system for patients which facilitated the safe administration of medicines
- medicines reconciliation by a pharmacist was recorded on the electronic prescribing and medication administration record system
- controlled drugs were stored and managed appropriately
- the "cold chain" processes to ensure optimal conditions during the transport, storage, and handling of vaccines were outstanding
- emergency medicines were available for use and there was evidence that these were regularly checked

- following a recent never event, the trust has put in place systems to help prevent this happening again and was extending it to other high risk medicines in the interests of protecting patients
- medicines management audits

Sangeeta Bassi

Chief Pharmacist – Derbyshire Healthcare Foundation Trust

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 29th July 2015

POSITION STATEMENT ON QUALITY
(including Quality Dashboard)

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 The Commission to review the provision of acute inpatient psychiatric care for adults

In July 2015 the Acute Care Commission published its interim report for consultation on 'Improving acute inpatient psychiatric care for adults in England'. The Commission set out fine main themes and asked Trusts as part of the consultation to consider if these are the right ones to focus on, what other information or data may be helpful and what best practice and improvements might be shared. The Commission supports the work of NHS England in appointing a Mental Health Task Force. The themes the Commission are looking at are:

- Bed numbers, alternatives to admission and discharges.
- Variations in pressure and performance
- The views and experiences of patients and carers
- Data and information
- Staff support, training and motivation

1.2 A summary of some of the findings set out in the report

There has been a long term reduction in bed numbers in England

Total available beds for mental illness in 1955	150,000
Total available beds for mental illness in 2012	22,300

As a result of this the Commission reports a doubling of patients travelling out of area in two years, 1301 in 2011/12 to 3024 in 2013/14. The Commission refers to the report by Mind in 2011, where one of the recurrent themes was that patients did not meet the criteria for admission.

In order to explore this further the Commission undertook a survey of acute adult psychiatric wards. Consultants returned surveys which described activity in 119

acute wards in England and some of the key findings were:

- An average bed occupancy rate of 104% for each ward
- 16% of patients per ward could have been treated in alternative settings
- 38% of Consultants said they did not have enough beds
- 28% said there would be enough beds if improvements were made to other services
- 28% felt there were enough beds

The Commission held discussions on care pathways in order to explore what alternatives to admission there were. One of the key findings was the important role housing plays in the care of people with mental illness. They highlighted good practice where housing associations have invested in building purpose built flats for people with severe mental illness. They reported positive partnership working to support the people living there from the local mental health team.

The Commission undertook a survey in 20016 of crisis teams and found wide variations in service provision. A third were not involved in gatekeeping referrals and only two fifths offered 24/7 home visits. Lack of staff, low availability of crisis beds and a lack of whole system response were highlighted as barriers to effective crisis services. Where a Psychiatrist was part of the crisis team this resulted in increased ability to prevent admissions.

The Commission looked at accreditation for inpatients and crisis teams and how to achieve improvements will be explored further in the Commissions future work. An example of what good quality acute care looks like is set out in the report with some key messages for commissioners of services.

The working group of the Commission undertook an on line survey of patients and carers experiences and this resulted in very mixed findings from poor to excellent. Availability of a wider range of therapies and treatments was a common theme together more engagement with carers and families so that patients did not feel so cut off was called for. The Commission undertook focus groups with people from BME communities which resulted in recommendations to improve policies to prevent discrimination of patients from these backgrounds, more training for staff to understand different needs of people from BME backgrounds and more engagement with carers both in community and inpatient settings.

The Commission looked at staff support, training and motivation on wards as part of their work. Some reported problems with recruitment and the need to ensure an appropriate skill mix of staff on wards. The Commission highlighted the connection between good levels of staffing and good experiences and outcomes for patients.

1.3 What we will do?

On Friday 17th July 2015 the Commission will be visiting our inpatient wards at the Radbourne Unit in Derby and Hartington Unit in Chesterfield. The Commission will be split into two groups for the morning and will meet with staff, carers and service receivers of urgent care. In the afternoon they will meet with senior staff within the Trust who will speak about new initiatives, challenges and good practice within urgent care such as the PIPA model and consultant 7 day working.

- We will consider the outcome from this visit and the report in our future work.

- We will share the report with our commissioners

Some of our work on staffing, skill mix and outcomes was set out in last month's position statement in addition we will:

- Continue to implement the purposeful inpatient admission process on our acute wards.

- Complete the skill mix review is currently being undertaken by the interim Assistant Director of clinical practice and nursing.

- Report on feedback from the publication of our final draft of the Trusts strategy for reducing restrictive intervention.

- Develop our 7 day working practice for Consultants which is part of the work on purposeful inpatient admission process.

1.4 Positive and Safe - Winterbourne View Medicines Programme

The Winterbourne View Medicines Programme commissioned three reports to look at the use of medication (including chemical restraint) in people with Learning Disabilities. The three reports from the Care Quality Commission, Public Health England and NHS Improving Quality published on 13th July 2015 have found that:

- There is a much higher rate of prescribing of medicines associated with mental illness amongst people with learning disabilities than the general population, often more than one medicine in the same class, and in the majority of cases with no clear justification
- Medicines are often used for long periods without adequate review, and;
- There is poor communication with parents and carers, and between different healthcare providers.

1.5 What we will do?
We note the publication of these reports and the Positive and safe implementation group are looking into the findings and embed any key recommendations into our work plan.

2. CARING SERVICES

2.1 Better value in the NHS – report summary | The King's Fund

In July 2015 the Kings Fund published its report on 'Better Value in the NHS, the role of changes in clinical practice. The report outlines a wide range of opportunities to provide care more appropriately in the future resulting in reducing waste and inefficiency. It focuses on changes in clinical practice and the need to work in partnership with our patients, families and carers to take forward this work.

On page 8 an agenda for action is set out an agenda for action which includes for providers to ‘ Place better value as their overriding priority and:

- Develop a strategy for quality improvement and engage staff. in its implementation
- Adopt a quality improvement method and use it systematically
- Invest in leadership development and quality improvement training

2.2 What we will do?

- We will continue our work in defining quality with Quality Leadership teams setting quality priorities in line with the Transformation care model which promotes the expert by experience model through personalised and bespoke care planning development work, embedding this conceptual model into Quality Leadership thinking, to influence our clinical strategic thinking.

3. EFFECTIVE SERVICES

3.1 Health Profiles for Derby and Derbyshire

These profiles are produced by Public Health England to give a picture of people’s health in Derbyshire and Derby (2 separate reports). They are used by health services and local government to make improvements in people’s health and to reduce inequalities. Key findings for our Trust are:

3.2 Derbyshire summary (taken directly from the report)

3.2.1 Child health

In Year 6, 17.1% (1,258) of children are classified as obese, better than the average for England. The rate of alcohol-specific hospital stays among those under 18 was 45.4*. This represents 70 stays per year. Levels of GCSE attainment, breastfeeding and smoking at time of delivery are worse than the England average. Levels of teenage pregnancy are better than the England average.

3.2.2 . Adult health

In 2012, 24.7% of adults are classified as obese, worse than the average for England. The rate of alcohol related harm hospital stays was 718*, worse than the average for England. This represents 5,632 stays per year. The rate of self-harm hospital stays was 274.2*, worse than the average for England. This represents 2,076 stays per year. The rate of smoking related deaths was 283*. This represents 1,301 deaths per year. Estimated levels of adult excess weight are worse than the England average. Rates of sexually transmitted infections and TB are better than average. Rates of statutory homelessness, violent crime, long term unemployment and drug misuse are better than average.

3.3.Derby summary (information taken directly from the report by Public Health England)

3.3.1. Child health
In Year 6, 20.5% (545) of children are classified as obese. The rate of alcohol-specific hospital stays among those under 18 was 44.1*. This represents 25 stays per year. Levels of teenage pregnancy, GCSE attainment, breastfeeding and smoking at time of delivery are worse than the England average.

3.3.2.Adult health
In 2012, 24.3% of adults are classified as obese. The rate of alcohol related harm hospital stays was 801*, worse than the average for England. This represents 1,856 stays per year. The rate of self-harm hospital stays was 291.0*, worse than the average for England. This represents 760 stays per year. The rate of smoking related deaths was 303*. This represents 374 deaths per year. Estimated levels of adult smoking are worse than the England average. The rate of sexually transmitted infections is worse than average. The rate of people killed and seriously injured on roads is better than average.

The full reports can be found at Public Health England
Key: *rate per 100,000 population

3.4 What we will do?

- We will discuss the profiles at the Quality Assurance Group to be held in September 2015.
- We will continue our work on preventing suicide and self-harm.
- We will continue to focus on our physical healthcare commissioning for quality and innovation agreements.
- We will share these profiles with the QLTs to enable them to consider our population demographics and risk areas when overseeing the quality and design of our services.

4. RESPONSIVE SERVICES

4.1 Mental capacity and deprivation of liberty

The Law Commission is consulting on proposals to replace the “deeply flawed” Deprivation of Liberty Safeguards for people who lack capacity to consent to their care and treatment arrangements with a new system, to be called "protective care". The proposed system is not focused on authorising deprivations of liberty, but instead aims to reduce complexity and bureaucracy and improve the provision of appropriate care and better outcomes for people who lack mental capacity, and help their family and carers. Restrictive forms of care or treatment would need to be authorised by an independent professional to be known as an approved mental capacity professional. The Law Commission’s consultation closes on 2 November, with a final report, recommendations and a draft Bill to be published in 2016.

4.2 What we will do?
We will consider this report as part of our strategic thinking with regard to effective management of individuals who are at risk of deprivations of their liberty and consider these possible implications.

This report was circulated to the Executive lead for Mental Health Act and

Mental Capacity Act to respond to these issues to consider the potential implications for protective care.

5. WELL LED

5.1 Revalidation – What it means for us?

What is the new Code?

- The NMC has updated its Code of professional standards.
- The revised Code became effective on 31 March 2015 and all registered nurses and midwives are required to uphold its standards of practice and behaviours.
- The Code is centred around four themes, with public protection at the core, and builds on the existing foundation of good nursing and midwifery practice.
- The Code should be used as a 'living' guide at the heart of everyday nursing and midwifery practice.

Four themes brought together in one Code

Together they signify good nursing and midwifery practice.

What is REVALIDATION?

- Every three years, at the point of their renewal of registration, nurses and midwives will need to show that, as a professional, they are living by the Code's standards of practice and behaviour.
- This process will be called revalidation and will build on the current Prep requirements.
- Participation is on an on-going basis rather than a point in time assessment.
- Nurses and midwives will need to meet a range of requirements, designed to show that they are keeping up to date and actively maintaining their fitness to practise.
- Revalidation is about promoting good practice across the whole population of nurses and midwives. It is not an assessment of a nurse or midwife's fitness to practise.

5.2 What we will do?

- We have convened a task and finish project group to start work to assess what we need to do to support the Nursing Workforce.
- We are currently awaiting a commencement date of from the Nursing and Midwifery Council, the anticipated date is April 2016, this is subject to NMC policy sign off in July 2015.
- We have established links to the North Midlands area to share learning and support each other in this new model.

6. Our Overall Quality of Care Quality Dashboard

Our Quality Dashboard is attached at appendix one.

6.1 What new?

New indicators added to the dashboard for Q1 are:

- Commissioning for Quality and Innovation agreements 2015/16
- Duty of Candour
- New regulated activities and registration requirements which have replace the Essential Standards of Quality and Safety – 28 outcomes.
- Intelligent monitoring banding

Our Quality Strategy and Framework was refreshed in Q4 of 2014/15. Quality priorities and the commissioning for Quality and Innovation agreements presentations and information have been cascaded to staff through the Quality Leadership teams. The trajectories set for March 2015 remain in place up to and including March 2016.

We have added in a trend column, the trend is based on previous reporting data and comparisons with national average are also taken into account. The key is as follows:

Improving an upward trend overall	⇧
Equal to previous results or on track	⇨
Worsening an overall downward trend	⇩

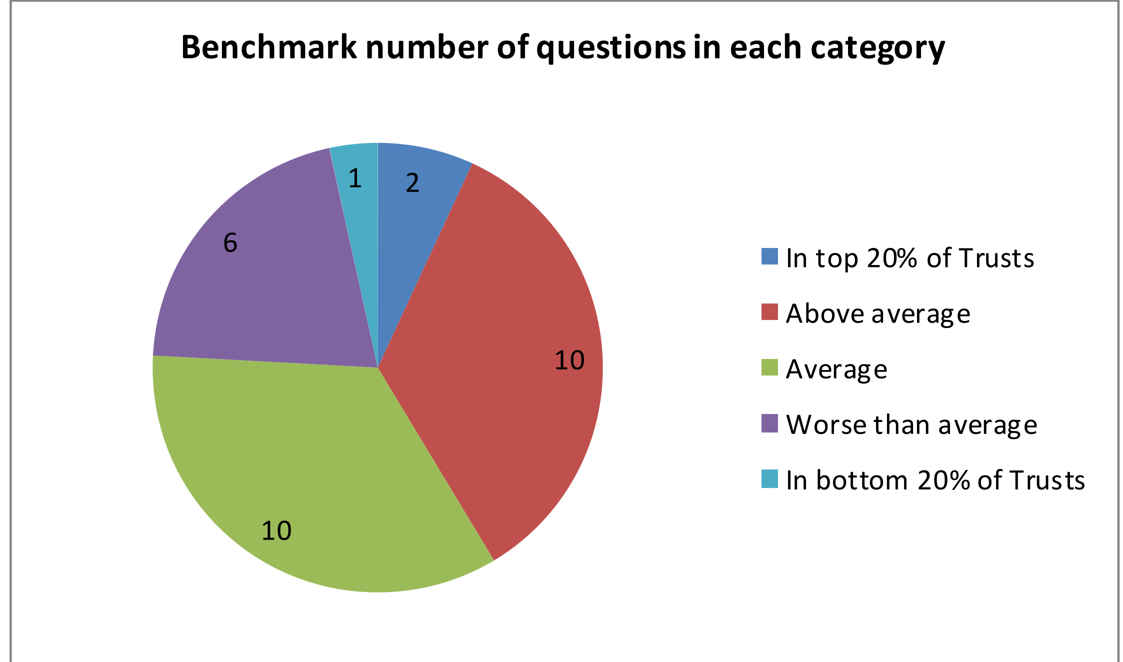
We have added in a summary of the number of indicators and the trend broken down by the 5 key areas. (Excluding area 6 which is our overall care section).

6.2 Summary of trends

Area	Upward trend	Downward trend	Equal or on track
Safe	6	1	8
Effective	2	1	5
Caring	0	1	2
Responsive	1	4	2
Well led	0	3	1
Total	9	10	18

6.3. Comments on trends

Responsiveness area has the most downward trend indicators with well led the second highest. The downward trends are mainly as a result of the Staff survey and the staff friends and family test which have been updated in this quarter. However when compared to other Trusts the overall picture is more positive. The survey covers 29 Key Findings (KFs). Compared against all Mental Health Trusts the survey breakdown for the Trust shows:



- The Community Patient Survey will be updated in Q2 following the publication of the latest survey which has now been completed, expected time for receiving the results in late July. In addition to this we will be taking part in the national inpatient survey, this survey is no longer mandatory but we continue to measure patient experience of our inpatient services as well as our community service. Work commences next month on the inpatient survey.

- We have a high number of staff in acting positions. (74 in Q1) this is our baseline for future reports.

- To note the high performance for Crisis Gatekeeping compared to national findings in section one.

- Our positive banding as a result of our intelligent monitoring report.

Strategic considerations

- The continuation of all our quality improvement work to maintain our positive risk based bandings with our regulator the Care Quality Commission.

- To consider Health Profiles in our future planning discussions with commissioners and through our transformation programme.

- To learn from other areas about their work on revalidation.

- To await the outcomes from the consultation on Mental capacity and deprivation of liberty

(Board) Assurances

- Assurance of learning from national reports and how we respond to findings and recommendations.
- That the new Code of Practice published by the Nursing and Midwifery Council is noted and that work is planned to delivery changes in practice by April 2016.
- To note the consultation on changes to the mental capacity and deprivation of liberty.
- Assurance that our work on preventing suicide and self-harm and physical healthcare commissioning for quality and innovation agreements is contributing to the overall health of our community in Derby and Derbyshire.
- To note the Winterbourne View Medicines Programme reports and work planned to respond to the recommendations.
- Assurance of quality improvements to our inpatient wards.
- Assurance on safety and partial assurance on responsiveness and well led based on the current trends set out in the dashboard.

Consultation
This report has not previously been presented.

Governance or Legal issues

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

Equality Delivery System

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

Recommendations

The Board of Directors is requested to:

1. Note the quality position statement and attached dashboard and trends.
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**

SUMMARY QUALITY DASHBOARD

(Areas updated in Q1 are shaded with a grey band)

1. ARE OUR SERVICES SAFE?					
Frequency	**Indicator**	**Baseline 2012**	**Trajectory Point for March 2016**	**Position as of June 2015**	**Trend**
INCIDENTS AND LEARNING					
Annually	Never events	0 In March 2015 NHS England published the revised Never Event and Serious Incident Framework. There is a revised list of Never Events for 2015/16: • Falls from poorly restricted windows • Chest or neck entrapment in bedrails • Transfusion or transplantation of ABO-incompatible blood components or organs • Misplaced naso- or oro-gastric tubes • Scalding of patients This indicator is monitored and reported in the monthly serious incident report to the Quality Committee.			→
Twice yearly	To decrease the level of harm of incidents reported	8.1% moderate or above	5.00%	7.9% Trend up Sept 2014 data was 7.5% (March 2015 data)	↑
Quarterly	Suicide prevention and safety planning commissioning for quality and innovation agreement 2015/16	New	New	Q1 work reported to Quality Committee. On track to achieve.	→
Quarterly	Number of serious incidents and range	New indicator 2014	N/A	Total of 43 major and Catastrophic in Q1 as reported in monthly serious	→

				untoward incident report	
ARE OUR SERVICES SAFE? (continued)					
Frequency	**Indicator**	**Baseline 2012**	**Trajectory Point for March 2016**	**Position as of June 2015**	**Trend**
ENVIRONMENTS					
Annually	PLACE scores	New indicator 2014	N/A	Cleanliness 98.75% Food 93.05% Privacy and Dignity 89.61% Condition 95.90% August 2014 results	↑
Annual Inpatient survey	Hospital ward or room "very clean" (Q10)	59%	90%	64% Above average for all Trusts of 57%.	↑
Annual Inpatient Survey	Toilets and bathrooms very clean (Q11)	44%	59.33%	49% Above average for all Trusts of 47%.	↑
Monthly	Overall score for Harm Free Care across all elements as measured by the 'Safety Thermometer'(falls, urinary tract infections, venous thromboembolisms, and pressure ulcers)	95.45% harm free	>95% harm free across the year as a median	>95% harm free across the year as a median	→
Annual Inpatient Survey	Patient saying that they "always" feel safe on our inpatient wards (Q6)	49%	56.33%	39% Trend downwards compared to 2013 by 15%. Below average for all Trusts of 40%.	↓
Annually National policy	Use of restraint	New indicator 2014	N/A	Positive and safe strategy sets out 9 key success criteria, the Quality Committee will monitor its	→

				implementation over 2 years.	
ARE OUR SERVICES SAFE? (continued)					
Frequency	**Indicator**	**Baseline 2012**	**Trajectory Point for March 2016**	**Position as of June 2015**	**Trend**
TRANSITIONS AND INTERFACES					
Monthly	CPA 7 day follow up Monthly collection using national datasets	95%	98%	99.15% June data	⇧
Annual Inpatient Survey	"Definitely" felt enough care taken of physical health (Q34)	47%	N/A	56% Trend upwards compared to 2013 by 1%. Well above average for all Trusts of 43%.	⇧
Quarterly	Physical Healthcare commissioning for quality and innovation agreement 2015/16	New	Achieve	Q1 Progress report submitted to commissioners. Mitigation in place to address none publication of national data.	⇨
Quarterly	Dementia and Delirium commissioning for quality and innovation agreement 2015/16	New	New	Milestones for indicator now agreed, first meeting with Derby Royal in July 2015.	⇨
Quarterly	To work with acute providers to reduce the rate of mental health re-attendances at A&E commissioning for quality and innovation agreement 2015/16	Achieve	Achieve	Q1 Progress report submitted to commissioners. Work commenced to work with both Derby Royal and Chesterfield Royal.	⇨

Frequency	Indicator	Baseline 2012	Trajectory Point for March 2016	Position as of June 2015	Trend
2. ARE OUR SERVICES EFFECTIVE?					
TRANSITIONS AND INTERFACES					
Monthly	Crisis Gatekeeping -Monthly collection using national datasets	95%	100%	100% July data Achieved	
Monthly	Delayed transfers of care National dataset- Monitor	<6.8%	<1%	0.34% Achieved Monitor target of <7.5%	
OUTCOME MEASURES					
Monthly	Patient clustered not breaching today National dataset	81.43%	100%	74.95% June data	
New Indictor 2014	Patient reported outcome measures and Patient reported experience measures	TBC	TBC	When implemented	N/A
COORDINDATION OF CARE					
Annual Community Survey	Quality of care plans taken from a number of questions in national community survey	7.2 out of 10	8.20 out of 10	7.3 Trend about the same as other MH trusts	
Annual Community Survey	Quality of care co-ordinators taken from a number of questions in national community survey	8.4 out of 10	9.0 out of 10	8.7 Trend about the same as other MH trusts	
Annual Community Survey	Quality of care reviews taken from a number of questions in national community survey	7.5 out of 10	8.5 out of 10	7.5 Trend about the same as other MH trusts	
MEDICATION					
Annual Inpatient Survey	Purposes of medications explained "Completely" 2012 (Q24)	34%	45.67%	50% Trend upwards compared to 2013 by 13%. Above average	

Frequency	Indicator	Baseline 2012	Trajectory Point for March 2016	Position as of June 2015	Trend
				for all Trusts of 43%.	
2. ARE OUR SERVICES EFFECTIVE? (continued)					
TRAINING FOR STAFF					
Monthly	Compliance with essential training for all eligible staff	70%	90%	81.50%	⇩
3. ARE OUR SERVICES CARING?					
PATIENT EXPERIENCE OF OUR COMMUNITY MENTAL HEALTH SERVICES					
Annual Community Survey	Overall Patient experience of community mental health	6.8 out of 10	7.4 out of 10	7.5 Trend about the same as other MH trusts	⇨
Annual Community Survey	Overall patients experience of health and social care workers	8.4 out of 10	9.0 out of 10	7.9 Trend about the same as other MH trusts	⇨
National indicator	Friends and Family Test -Staff How likely are you to recommend this organisation to friends and family if they needed care or treatment? How likely are you to recommend this organisation to friends and family as a place work?	N/A N/A 65% Yes in Q4 17% No in Q4 53% Yes in Q4 31% No in Q4 Trend down compared to Q1 and Q2. National benchmark data not yet available for Q4, Q1 and Q2 benchmarks indicated for DHCFT on 'How likely are you to recommend this organisation to friends and family if they needed care or treatment' are considerably below the national average score and results for DHCFT on 'How likely are you to recommend this organisation to friends and family as a place of work' were slightly below the national average score.			⇩

Frequency	Indicator	Baseline 2012	Trajectory Point for March 2016	Position as of June 2015	Trend
4. ARE OUR SERVICES RESPONSIVE TO PEOPLES NEEDS?					
EQUALITY AND DIVERSITY					
Annual	EDS Annual assessment grading – benchmark locally with health organisations	"Developing"	"Achieving"	Developing EDS2 assessment commences November 2015	→
Annual Staff Survey	% of staff having equality and diversity training in last 12 months (Q26)	72%	88%	70% Below internal trajectory but above average for MH trusts score of 67%. Trend downwards 80% in 2013	↓
RESPONSIVENESS IN OUR WARD ENVIRONMENT					
Annual inpatient Survey	When you arrived on the ward, or soon afterwards, did a member of staff tell you about the daily routine of the ward, such as times of meals and visitors times? (QA3)	37% said "yes"	60% saying "yes"	33% said "yes" Trend downwards compared to 2013 by 5%. Average for all Trusts of 35%.	↓
Annual inpatient Survey	Were you able to get the specific diet that you needed from the hospital? (Q8) Please note small numbers of patients responded to this question i.e. 6 patients.	25% said "yes"	60% saying "yes"	30% said "yes Below internal trajectory trend downwards compared to 2013 by 27%. Below average for all Trusts of 39%.	↓

Frequency	Indicator	Baseline 2012	Trajectory Point for March 2016	Position as of June 2015	Trend
4. ARE OUR SERVICES RESPONSIVE TO PEOPLES NEEDS?					
RESPONSIVENESS IN THE COMMUNITY					
Monthly National Dataset - Monitor	18 week referral to treatment, non-admitted patients started treatment	>95%	100%	94.47% June data	⬇
RESPONSIVENESS TO THE WIDER FAMILY					
Quarterly	When we assess a patient we will consider the wider family, in particular, any children within the home 'Think Family' standards, DOH guidance	New indicator 2014	100% achievement of CQUIN monies	Q1 monies secured as part of commissioning for quality and innovation agreements.(CQUIN)	⬆
Annual Community Survey	Have NHS mental health services involved a member of your family or someone else close to you as much as you would like? (Q37)	6.6 out of 10	8.50 out of 10	6.7 In middle ranking for trusts highest score for MH trust 7.6 lowest 5.9.	➡
5. ARE OUR SERVICES WELL- LED?					
STABILITY AND CLINICAL LEADERSHIP					
Monthly	Number of staff in acting positions	N/A	N/A	74 staff in acting positions	Baseline
Annual Staff Survey	Staff recommendation of the Trust as a place to work and receive treatment.(Q24)	3.33 out of 5	3.80 out of 5	3.60 out of 5 Above median for MH trusts 3.57.Trend slightly down compared to 2013 score of 3.68	⬇
Annual staff survey	Overall engagement of staff taken from a number of questions from staff survey	3.55 out of 5	3.80 out of 5	3.75 Better than average for MH trusts but trend slightly down on	⬇

Frequency	Indicator	Baseline 2012	Trajectory Point for March 2016	Position as of June 2015	Trend
				2013.	
5. ARE OUR SERVICES WELL- LED? (continued)					
Annual staff survey	% of staff having well-structured appraisals in last 12 months (Q8)	34%	51%	37% Below internal trajectory and below average for MH trusts score of 41%.	
SKILL MIX AND SAFER STAFFING LEVELS					
Annual staff survey	% of staff believing the Trust provides equal opportunities for career progression and promotion (Q27)	87%	96%	85% Below internal trajectory slightly below national average of 86%	
New Indictor 2014	Safer Staffing levels	N/A	N/A	Reported in performance report, exceptions reported where fill rate goes over 125% or below 90%. Displayed on the internet as required by NHS England.	N/A
6.OVERALL QUALITY OF CARE					
New Indictor 2014	Care Quality Commission Visits Actions outstanding	0	0	We have not had a visit since April 2013.	N/A
New indicator 2015	Intelligent monitoring banding	Based on our latest intelligent monitoring report for the end of March 2015, we remain in band 4 which is the lowest risk banding.			N/A

Frequency	Indicator	Baseline 2012	Trajectory Point for March 2016	Position as of June 2015	Trend
6.OVERALL QUALITY OF CARE					
New Indictor 2014	Mental Health Act Visits Actions recommended	2 visits in Q1 reports received and action plans submitted **Main themes** **Care Plans** Unable to find evidence of patient involvement **Patient's rights** Unable to find evidence in all patient's files **Leave of absence** Unable to find evidence in some cases on whether the information had been shared with or distributed to the patient and other relevant parties Old section 17 leave forms had not been scored through in some files **Consent to treatment** Unable to find evidence of initial or recurring assessments of capacity and consent			N/A
New Indictor 2014	Quality Visit bandings	33 Platinum 40 Gold 14 Silver 0 Bronze 4 Not visited			N/A
New Indictor 2014	Number and themes of complaints	130 formally investigated complaints were received during the 14/15 financial year. This is not significantly higher than last year (127). **Top the 3 themes** I. Availability of service/therapies or activities. II. Issues related to staff attitude III. Care planning			N/A
New Indictor 2015	New duty of Candour	Meeting our responsibilities			N/A
New indicator 2015	Health and Social Care Act 2008 (Regulation activities) regulations 2014 Part 3 and Care Quality Commission (Registration) Regulations 2009 (Part 4)	This has replaced the Essential Standards of Quality and Safety and its 28 outcomes. This is in the early stages of learning what it means to Trusts. Self- assessment has commenced.			N/A

Clare Grainger Head of Quality
July 2015

On behalf of Carolyn Green
Executive Director of Nursing and Patient Experience

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 29th July 2015

Finance Director's Report Month 3

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 June 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 quarter of the year; we are ahead of plan by £407k, the forecast is to hit the planned underlying surplus of £1.3m. 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.

- 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.
- Capital Action Team (which has now merged with Asset Planning) oversees the Capital Expenditure plan on a monthly basis.

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.

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
JUNE 2015

1. Overall Financial Performance

Income & Expenditure – key statistics

We have achieved an underlying surplus of £283k in the month which is £189k better than for the month of June. Operational profitability as measured by EBITDA[1] is better than plan by £151k in the month. This equates to 7.5% of income compared to a plan of 6.0%.

Year to date we are ahead of plan by £407k with EBITDA being ahead of plan by £365k. This equates to 6.8% of income compared to a plan of 5.6%.

The forecast position is an underlying surplus, excluding impairments, of £1.3m which is as per plan. EBITDA is forecast to be slightly behind plan by £103k 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	JUN 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	10,113	9,886	(226)	30,281	29,763	(517)	121,914	120,116	(1,799)
Non Clinical Income	961	997	36	2,634	2,615	(18)	10,248	9,681	(567)
Pay	(8,160)	(8,020)	140	(24,483)	(24,128)	355	(98,336)	(96,893)	1,443
Non Pay	(2,247)	(2,047)	200	(6,592)	(6,046)	545	(25,646)	(24,826)	820
EBITDA	**666**	**817**	**151**	**1,840**	**2,205**	**365**	**8,181**	**8,077**	**(103)**
Depreciation	(283)	(285)	(1)	(850)	(870)	(20)	(3,389)	(3,399)	(11)
Impairment	0	0	0	0	0	0	(300)	(300)	0
Profit (loss) on asset disposals	0	31	31	0	31	31	0	31	31
Interest/Financing	(181)	(173)	8	(592)	(561)	31	(2,221)	(2,139)	82
Dividend	(108)	(108)	0	(325)	(325)	0	(1,300)	(1,300)	0
Net Surplus / (Deficit)	**94**	**283**	**189**	**73**	**480**	**407**	**971**	**971**	**(0)**
Technical adj - Impairment	0	0	0	0	0	0	(300)	(300)	0
UnderlyingSurplus / (Deficit)	**94**	**283**	**189**	**73**	**480**	**407**	**1,271**	**1,271**	**(0)**

- Clinical income was behind plan in the month by £226k increasing the year to date under achievement to £517k due to two main drivers:
  - cost per case income is lower than planned due to lower activity levels and lower occupancy levels

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

- 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 £1.8m at the end of the financial year. This is an adverse movement in the forecast of £681k due to a change in cost per case income assumptions and changes in income-backed recruitment assumptions.

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 slightly ahead of plan in the month by £36k reducing the year to date position to £18k behind plan. The forecast has favourably moved by £239k this month and is now forecast to be £567k worse than the plan by the end of the financial year. Over this adverse variance £316k 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. There are other smaller improvements in the levels of non-clinical income which is helping to offset the wider under achievement.

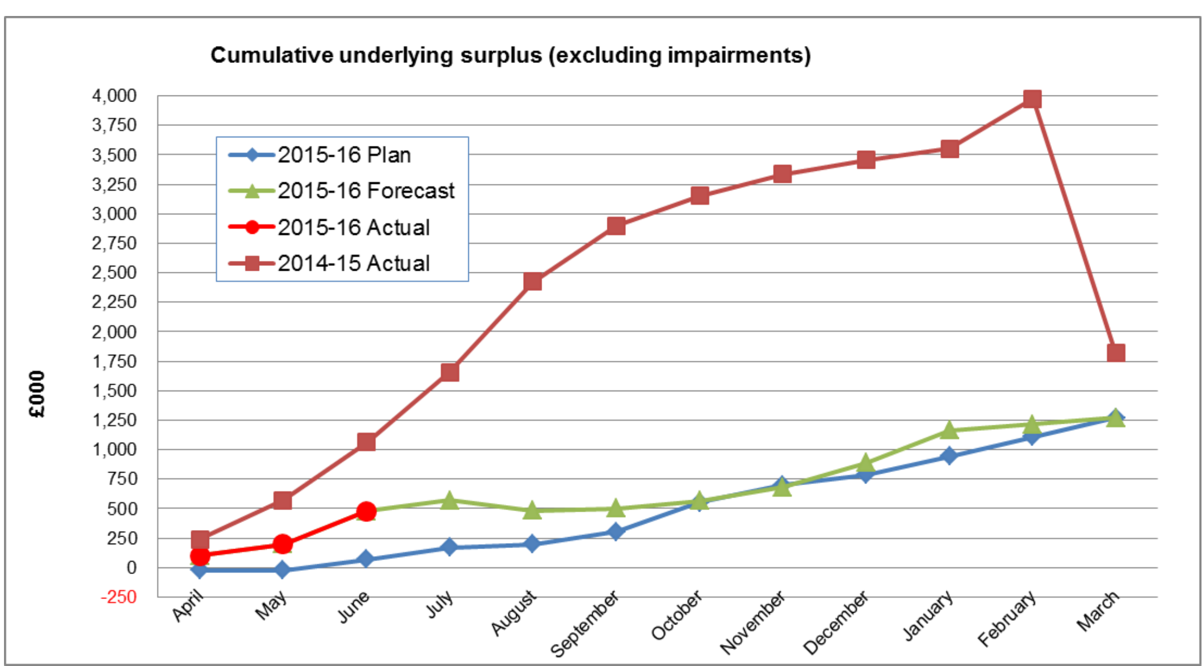
- Pay expenditure is underspent by £140k in the month which has increased the year to date underspend to £355k. The forecast has moved favourably by £493k and is forecast to be under budget by £1.4m at the end of the financial year. The main drivers within the forecast underspend are the later assumed start dates for service developments (less cost but also less income as above), most of 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 £200k increasing the year to date underspend to £545k. The forecast year end position is a favourable variance to plan of £820k. 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 actual for the first quarter is above plan which is mainly driven by lower expenditure levels than planned which is driven by changes to start dates for service developments and uncommitted contingencies as reported in the section above. July onwards is fairly consistent with regards to the level of surplus until October when the surplus level is in line with the plan. From December the surplus is slightly ahead of plan until the end of the financial year.

<u>Forecast Range</u>

Best Case	Likely Case	Worst Case
£0.88m favourable variance to plan	On plan	£2.63m adverse variance to plan

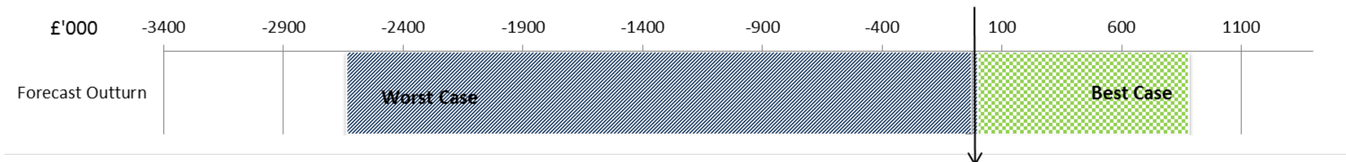
The best case of £882k better-than-plan assumes clinical income could improve by £341k from higher activity levels. The other elements are driven by staff cost savings being reduced by different recruitment timings and current cost pressures improve sooner than in the likely case.

The worst case forecast includes an assumption that clinical income could worsen by £969k due to reductions in activity levels and delays in service developments. Other factors include 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 by Executive Leadership Team on 13th July 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.

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.

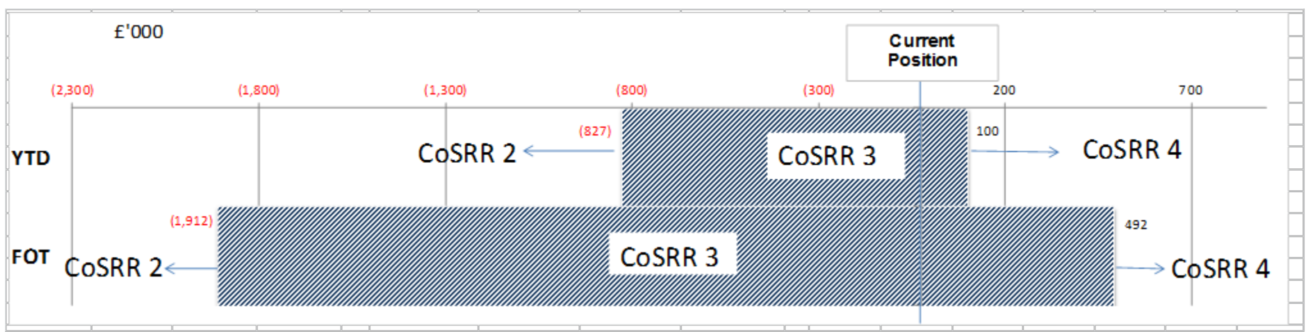
The liquidity ratio measures the Trust's ability to pay its bills from its liquid assets in terms of days and therefore the higher the number of days, the better. At the end of June the number of days is minus 0.3 and is forecast to be minus 1.5 at the end of the financial year (which would still generate 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.



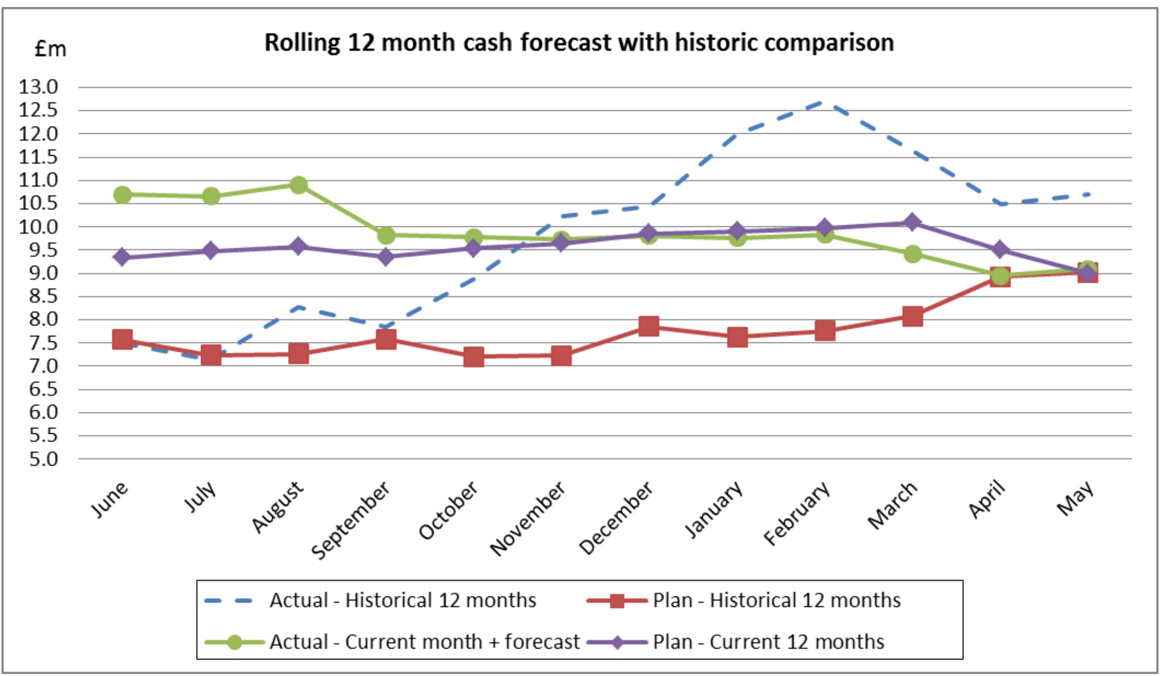
3. Efficiency / Cost Improvement Programme (CIP)

Year to date CIP is behind plan by £142k (13%) by the end of the first quarter. 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 June was £9.3m which is ahead of plan by £1.4m.
The levels of cash are forecast to remain at current levels until September when they reduce due to the payment of PDC. Cash then continues in line with plan until March when it ends the

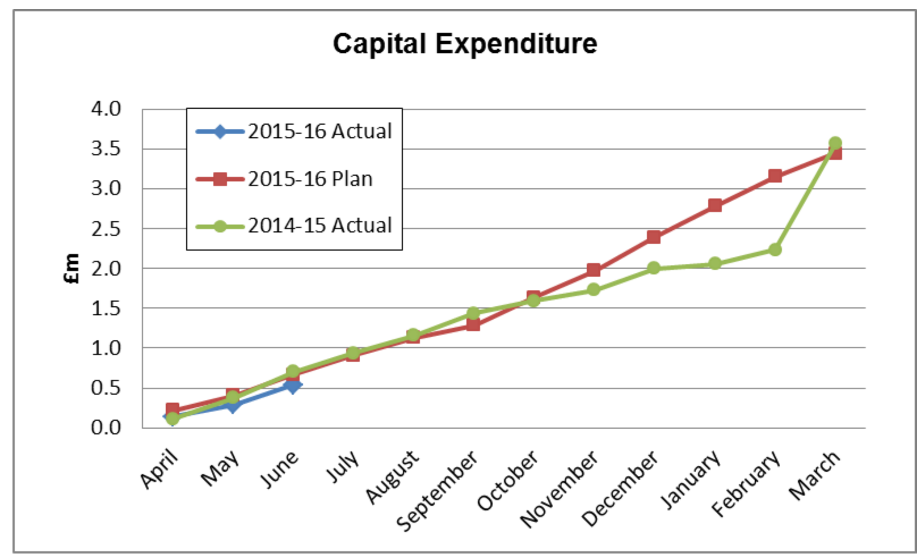
financial year behind plan by £0.7m which is driven by the Income and Expenditure forecast and forecast capital expenditure.



At the end of the first quarter we have just achieved a net current asset position. 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 £123k behind the plan at the end of June. However capital expenditure is forecast to spend to plan which is tightly managed by Capital Action Team (CAT). 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.



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Public Session

Derbyshire Healthcare NHS Foundation Trust

Report to Board of Directors 29th July 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 Trust continues to be compliant with most 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 an improvement this month.
- The rate of outpatients who did not attend is still causing concern
- 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, Enhanced Care, Ward 1, Ward 34 and Ward 35 are most adversely effected
- This report includes a 6 month review of staffing levels by ward.

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;
    - Performance related elements of schedule 6
    - Health Visitor
    - IAPT Performance (recovery rates only)
    - Fixed Submitted Returns
- The report provides partial assurance for ;
    - Monitor Targets
    - 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 June 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

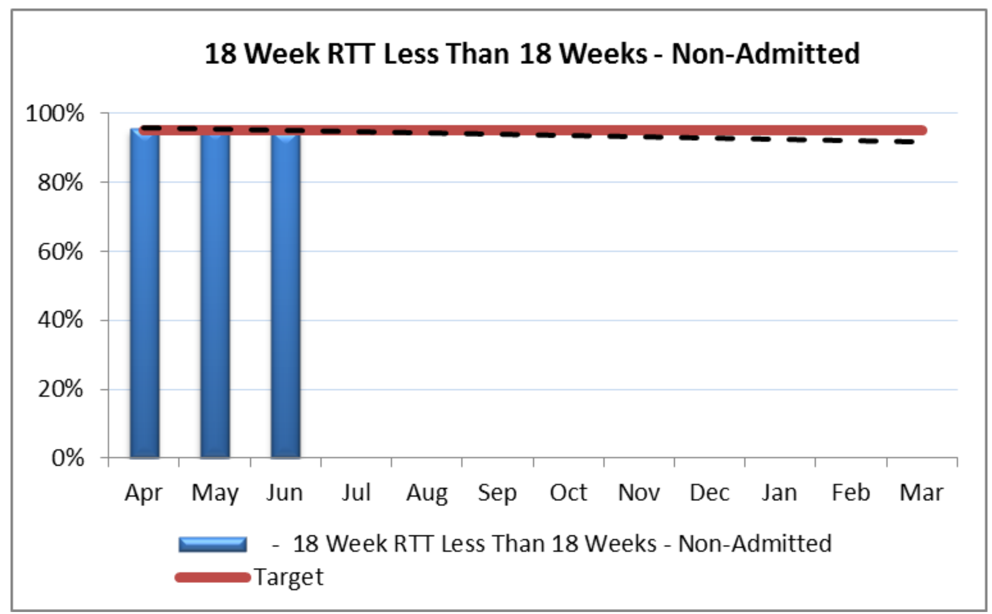
15-16 Performance Dashboard	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Trend
- Monitor Targets														
- CPA 7 Day Follow Up	95.00%	96.19%	97.59%	99.15%										
- CPA Review in last 12 Months (on CPA > 12 Months)	95.00%	96.80%	96.38%	96.08%										
- Delayed Transfers of Care	7.50%	0.41%	0.33%	0.34%										
- Data Completeness: Identifiers	97.00%	99.29%	99.29%	99.34%										
- Data Completeness: Outcomes	50.00%	93.99%	93.48%	93.19%										
- Community Care Data - Activity Information Completeness	50.00%	83.64%	82.97%	83.38%										
- Community Care Data - RTT Information Completeness	50.00%	92.31%	92.31%	92.31%										
- Community Care Data - Referral Information Completeness	50.00%	71.35%	70.99%	70.96%										
- 18 Week RTT Less Than 18 Weeks - Non-Admitted	95.00%	95.59%	95.98%	94.86%										
- 18 Week RTT Less Than 18 Weeks - Incomplete	92.00%	95.06%	94.52%	94.70%										
- Early Interventions New Caseloads	95.00%	163.60%	126.10%	126.50%										
- Clostridium Difficile Incidents	7	0	0	0										
- Crisis GateKeeping	95.00%	100.00%	100.00%	100.00%										
- Locally Agreed														
- CPA Settled Accommodation	90.00%	99.21%	98.99%	98.78%										
- CPA Employment Status	90.00%	99.36%	99.23%	99.20%										
- Data Completeness: Identifiers	99.00%	99.29%	99.29%	99.34%										
- Data Completeness: Outcomes	90.00%	93.99%	93.48%	93.19%										
- Patients Clustered not Breaching Today	99.00%	74.47%	74.72%	74.89%										
- Patients Clustered Regardless of Review Dates	100.00%	95.24%	95.11%	94.68%										
- CPA HoNOS Assessment in last 12 Months	90.00%	81.22%	79.93%	79.26%										
- 7 Day Follow Up – All Inpatients	95.00%	95.90%	97.78%	97.84%										
- Ethnicity Coding	90.00%	92.93%	93.48%	92.79%										
- NHS Number	99.00%	100.00%	100.00%	100.00%										

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%	4.94%										
- Consultant Outpatient Appointments DNAs	15.00%	15.79%	15.68%	17.26%										
- Under 18 Admissions To Adult Inpatient Facilities	0	0	0	0										
- Outpatient Letters Sent in 10 Working Days	90.00%	78.29%	69.68%	72.33%										
- Outpatient Letters Sent in 15 Working Days	100.00%	88.61%	86.23%	87.99%										
- Average Community Team Waiting Times (Weeks)	N/A	5.41	5.19	4.68										
- Inpatient 28 Day Readmissions	10.00%	11.89%	5.94%	4.76%										
- MRSA - Blood Stream Infection	0	0	0	0										
- Mixed Sex Accommodation Breaches	0	0	0	0										
- 18 Week RTT Greater Than 52 weeks	0	0	0	0										
- Discharge Fax Sent in 2 Working Days	98.00%	98.45%	98.95%	98.54%										
- Fixed Submitted Returns														
18 Week RTT Greater Than 52 weeks	0	0	0	0										
18 Week RTT Less Than 18 weeks - Incomplete	92.00%	93.66%	92.94%	94.48%										
Mixed Sex Accommodation Breaches	0	0	0	0										
Completion of IAPT Data Outcomes	90.00%	98.33%	97.65%	96.35%										
Ethnicity Coding	90.00%	93.62%	94.64%	93.65%										
NHS Number	99.00%	100.00%	100.00%	100.00%										

1.1 Exception Items and Specific Areas of Interest

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

1.1.1 Monitor – 18 Week Referral to Treatment Less Than 18 Weeks – Non-Admitted



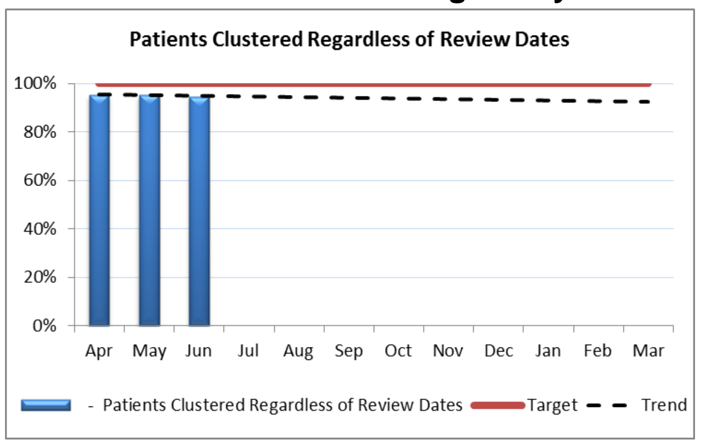
There have been issues with regard to patients not being allocated to Consultants, and the referring on from Teams to Consultant's not being followed correctly resulting in the Medical Secretaries not being aware that the referral has been made. This has now been addressed.

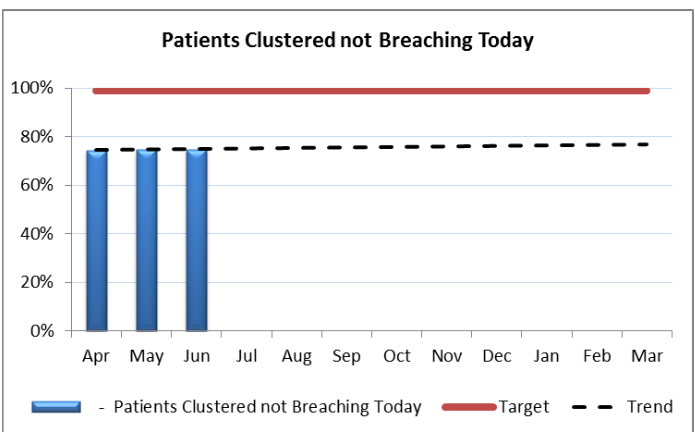
One secretary was not making their Consultant aware of potential breaches of the RTT. This has now been addressed.

Action planned:

- Continue to monitor the RTT waiting list on a weekly basis and liaise with the relevant secretaries to ensure patients are seen within 18 weeks where possible.
- A briefing has been sent out to all Team Administrators and Medical Secretaries relating to ensuring the Consultants are allocated at the appropriate time.
- The Medical Secretary involved has been advised to bring any potential breaches to the attention of the Consultant in order to address this.

1.1.2 Locally Agreed – Patients clustered regardless of Review Dates and Patients clustered not Breaching Today





Current position is that following the actions taken to data cleanse, make improvements in practitioner clustering and highlight to staff responsible for clustering the issues needing to be resolved, there has been an overall improvement which is continuing.

The trust position in June was:

- Patients Clustered Regardless of Review Dates – 94.6%
- Patients Clustered not Breaching Today – 74.7%

These figures place the trust in a positive position nationally. The actions will continue.

Feedback from Jane Elliott, Payment by Results Advisor: “The Information Management & Technology programme that picks up the un-ticked boxes on Health of the Nation / Payment by Results assessments and automatically ticks them (assuming that the clustering tool and cluster allocation have been completed) is now being run daily, so we will see a lot fewer ‘errors’ in this regard. Information Management & Technology have also introduced a new logic which has now linked all the un-linked referrals, which has removed all the duplicates that were skewing the ‘not clustered’ figures. The result of this has exceeded my highest expectations; I thought we might see a 500 reduction if we were lucky but it was more than 800. This represents a 4.9% reduction in ‘patients not clustered’ between 15/06/15 and 06/07/15 it also represents a lot of hard work by the Information Management & Technology team which it would be nice to acknowledge. This is also a permanent function, so all un-linked referrals should automatically be linked by the system in future. In practical terms, the above points mean that the exceptions we now see on reports should be ‘genuine’, so the picture we see will be more reflective of the work clinicians are doing (or not) and it will be easier for me to target the right people.”

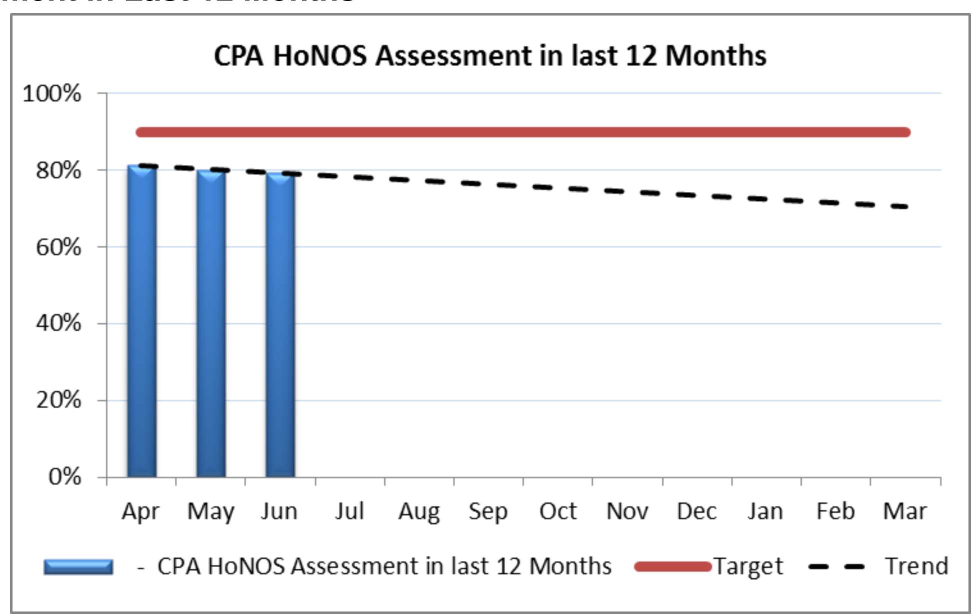
Benchmarking data taken from published Trust Board papers:

Trust	Month	Clusters in Date	Clustered
Nottinghamshire Healthcare NHS Foundation Trust	May-15	93.2%	97.4%
Norfolk and Suffolk NHS Foundation Trust	Apr-15		97%
Coventry and Warwickshire Partnership NHS Trust	May-15		95.6%
South West Yorkshire Partnership NHS Foundation Trust	May-15		95.6%
Derbyshire Healthcare NHS Foundation Trust	Jun-15	74.7%	94.6%
East London NHS Foundation Trust	Mar-15		94.1%
Camden and Islington NHS Foundation Trust	Mar-15		94%
Greater Manchester West Mental Health NHS Foundation Trust	Mar-15	83.2%	93.8%
Black Country Partnership NHS Foundation Trust	Apr-15	69.6%	92.9%
Dudley and Walsall Mental Health Partnership NHS Trust	May-15	42.7%	90%
Cumbria Partnership NHS Foundation Trust	May-15	81.1%	87%
Hertfordshire Partnership University NHS Foundation Trust	Mar-15	72%	85%
Barnet, Enfield and Haringey Mental Health NHS Trust	Apr-15		82%
5 Boroughs Partnership NHS Foundation Trust	Apr-15		81.8%
Berkshire healthcare NHS Foundation Trust	Apr-15		80%
Leeds and York Partnership NHS Foundation Trust	Mar-15	56.1%	75.1%

Action planned: A range of solutions has been identified and are currently being deployed:

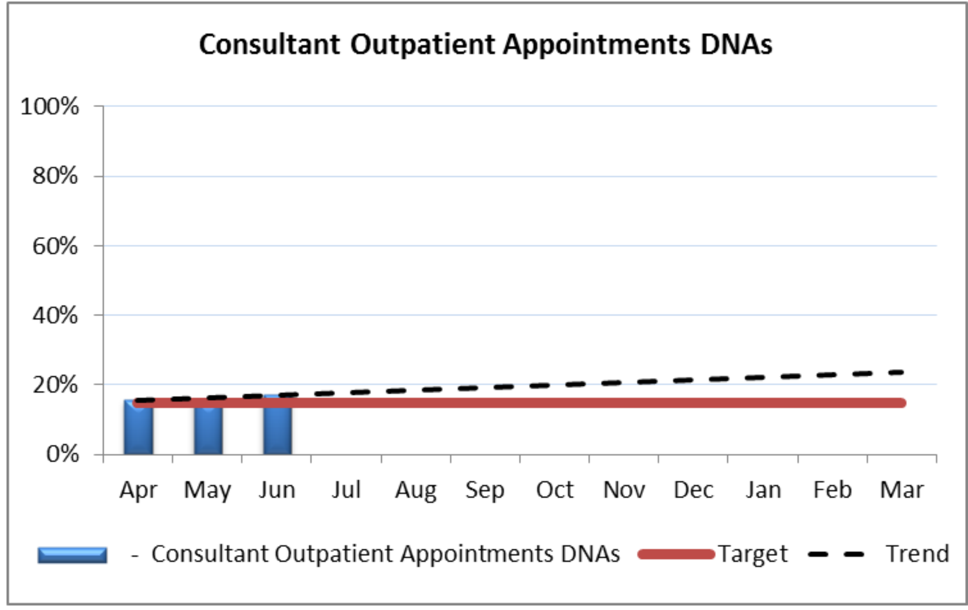
- to data cleanse,
- to make improvements in practitioner clustering
- to highlight to staff responsible for clustering the issues needing to be resolved

1.1.3 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

1.1.4 Schedule 4 – Consultant Outpatient Did Not Attends



Recent study: http://qir.bmj.com/content/3/1/u202228.w1114.full

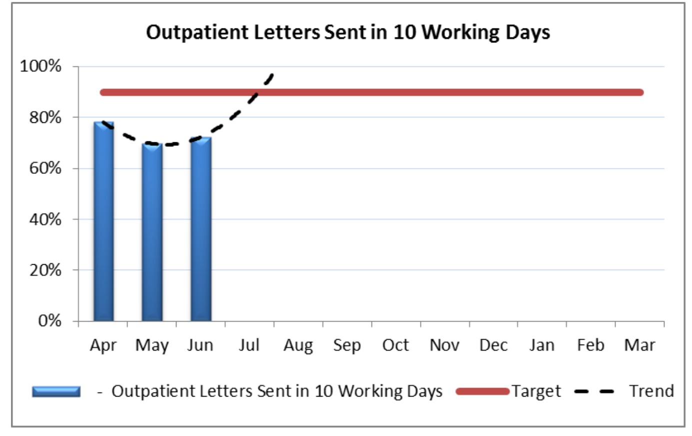
Research: http://ps.psychiatryonline.org/article.aspx?articleID=433008

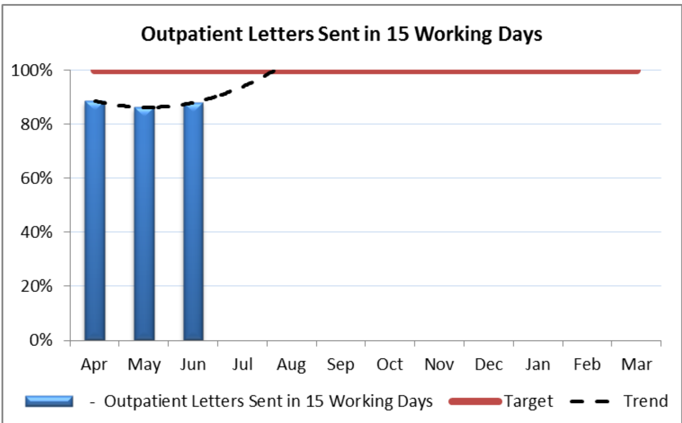
Both suggest that text message reminders are effective in reducing did not attends.

Action planned:

- Collection of mobile numbers and consent to use them for appointment reminders is ongoing.
- Information Management & Technology have been asked to set up a report to enable performance management of this data collection.

1.1.5 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.

- Service Level Agreement discussions are underway with Greater East Midland and Dictate IT support teams in order to improve the support service we receive when encountering problems.
- Business As Usual – handover to the Organisation. Initial meetings held and further planned to define Greater East Midland, Information Technology and any Super User tasks going forward. To look at handing over as soon as the new Client is deployed. Meeting arranged between Information Technology and Administrative Lead to drive forward arrangements and agree a sign-off date.
- 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.
- Benchmarking: a review of all mental health trust public Board papers found there to be just one other trust who has a similar target for letters:

Trust	Month	Letters in 10 Days
Derbyshire Healthcare NHS Foundation Trust	Jun-15	75.3%
Leeds and York Partnership NHS Foundation Trust	Mar-15	44.2%

Action planned

- New client switchover scheduled for w/c 17/08/15
- Information Technology to report back the outcome of discussions.
- Currently working on e-learning package.
- Training completed and start dates agreed. Trialling evening work shortly (5-8pm shift).
- To continue to review consultant performance in monthly Medical Management meetings

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	67.65									
Health Visitors in Post (Headcount)	N/A	82	81	80									
Number of Student Placements (Headcount)	N/A	9	9	9									
Number of Student Placements (FTE)	N/A	9	9	9									
Number of mothers receiving antenatal check	N/A	195	153	209									
% Births that receive NBV within 10-14 days	N/A	88.85%	89.56%	93.19%									
% NBVs undertaken after 15 days	N/A	11.10%	10.20%	6.20%									
% Children to received a 12 month review	N/A	98.40%	95.80%	95.30%									
% Children who received a 12 month review at 15 months	N/A	97.90%	96.30%	97.30%									
% Children who received a 2 to 2.5 year review	N/A	95.60%	94.70%	97.50%									
% Staff who have received child protection training	N/A	63.40%	63.00%	62.50%									
% 10-14 Day Breastfeeding coverage	95.00%	99.70%	99.20%	96.90%									
% 6-8 Week Breastfeeding coverage	95.00%	100.00%	100.00%	97.80%									
% Still Breastfeeding at 6-8 Weeks	65.00%	64.10%	69.70%	70.60%									

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	936	964	0	0	0	0	0	0	0	0	0	2881
3b	The number of active referrals who have waited more than 28 days for treatment	2073	372	338	0	0	0	0	0	0	0	0	0	
4	The number of people who have entered Psychological Therapies	564	733	840	0	0	0	0	0	0	0	0	0	2137
5	The number of people who have completed treatment (for any reason)	533	510	575	0	0	0	0	0	0	0	0	0	1618
6	The number of people who are "moving to recovery"	273	253	313	0	0	0	0	0	0	0	0	0	839
6b	The number of people completing treatment who did not achieve caseness at the commencement of treatment	39	51	38	0	0	0	0	0	0	0	0	0	128
7	The number of people moving off sick pay and benefits	34	40	46	0	0	0	0	0	0	0	0	0	120

	Recovery Rates KPI 6 / (KPI 5 - KPI 6b)	**55.26%**	**55.12%**	**58.29%**										**56.31%**
	Partial and Full Recovery Rates	**75.71%**	**72.33%**	**75.23%**										**74.50%**

3.1.1 Exception Comments

No exceptions regarding recovery rates.

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	99.0%	100.0%	100.0%	100.0%	No	NOT REQUIRED
Child Bearing / Perinatal Inpatient	120.7%	169.9%	107.1%	170.4%	Yes	The fill rate tolerances for care staff (day and night) were broken due to the level of activity which included observation levels, direct care of the infant or supporting the mother to and escorting of patients to appointments.
CTC Residential Rehabilitation	102.9%	98.2%	100.0%	100.0%	No	NOT REQUIRED
Enhanced Care Ward	80.0%	124.7%	96.7%	130.8%	Yes	We have three RN Vacancies that are recruited into, 2 RNs will start in late September and 1 first week of October . All three are unable to start earlier as are completing training. We have 1 NA on long term sick who may need redeploying on return but we are dealing with this supported by HR. We did have a fourth RN due to start but he was not able to produce satisfactory pre employment documentation or HR clearance so we have had to withdraw offer. We continue to ensure that all Nurse in Charge shifts are covered with own staff with ILS competency and that in conjunction with wider unit are able to provide C and R coverage.
Hartington Unit Morton Ward Adult	91.4%	114.6%	96.1%	110.0%	No	NOT REQUIRED
Hartington Unit Pleasley Ward Adult	97.8%	97.6%	110.0%	95.0%	No	NOT REQUIRED

Ward name	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
Hartington Unit Tansley Ward Adult	101.2%	79.7%	98.3%	91.9%	Yes	The ward has carried high levels of nursing observations throughout the month of June. This has meant increased numbers of unqualified staff being requested/planned for however unfortunately as the figures demonstrate we have not always been successful in getting this extra staff.
Kedleston Unit - Curzon Ward	101.6%	105.0%	100.0%	101.8%	No	NOT REQUIRED
Kedleston Unit - Scarsdale Ward	95.9%	104.2%	100.0%	100.0%	No	NOT REQUIRED
KW Cubley Court Female	101.4%	93.9%	100.0%	105.3%	No	NOT REQUIRED
KW Cubley Court Male	101.5%	97.2%	94.0%	96.9%	No	NOT REQUIRED
KW Melbourne House	98.4%	90.0%	93.1%	108.2%	No	NOT REQUIRED
KW Tissington Unit Older People	101.4%	93.5%	76.7%	115.8%	Yes	In June we has a high percentage of R/N off sick/maternity, hence the broken tolerance rate.
LRCH Ward 1 OP	98.5%	89.8%	90.5%	87.2%	Yes	The night fill rate has been dictated by long tern sickness levels and covered by Bank Staff (regular care staff are booked familiar with the ward). Efforts are made to rotate staff over a 24 hour period. Registered Nurses flex to cover deficits, current shortfalls of 1 x WTE Band 2 vacancy and 2x WTE long term sick Band 5 are now recruited into posts (1 re deployed who is undergoing a phased RTW. There are periods when where patient numbers are reduced and staff are utilised in other areas. There is the need for short term emergency measures where staff are needed to provide escorts to patients in other hospitals – June used 60 shift for pt. at RDH. The Temporary Staffing department cannot always backfill requests made, in addition the Band 6 and & nurses are required to cover the bleep on the Kingsway Campus so are unable to cover outstanding shift at LRCH

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 (%)		
LRCH Ward 2 OP	97.7%	96.4%	96.9%	101.6%	No	NOT REQUIRED
RDH Ward 33 Adult Acute Inpatient	98.4%	100.0%	97.6%	100.0%	No	NOT REQUIRED
RDH Ward 34 Adult Acute Inpatient	92.7%	126.2%	56.7%	225.0%	Yes	The ward is unable to fulfil safer staffing requirements due to continued high vacancy levels, this continues to be addressed with an on going recruitment programme
RDH Ward 35 Adult Acute Inpatient	95.0%	125.8%	123.3%	143.3%	Yes	REQUIRED BUT NONE RECEIVED
RDH Ward 36 Adult Acute Inpatient	103.2%	108.4%	95.1%	135.3%	Yes	the increase in levels is due to having high levels of clinical activity requiring extra staff for 1-1 engagement levels.

4.1 Safer Staffing – 6 month review

Ward Staffing Monthly Fill Rates

> 125%
< 90%

Ward	Shift	Resource	Jan-2015	Feb-2015	Mar-2015	Apr-2015	May-2015	Jun-2015
			Complete	Complete	Complete	Complete	Complete	Complete
AUDREY HOUSE RESIDENTIAL REHABILITATION	Day	Average fill rate - registered nurses/midw ives (%)	98.98%	100%	100%	98.92%	98.86%	99.02%
		Average fill rate - care staff (%)	100%	100%	97.87%	97.67%	100%	100%
	Night	Average fill rate - registered nurses/midw ives (%)	100%	100%	100%	100%	100%	100%
		Average fill rate - care staff (%)	100%	100%	100%	100%	100%	100%
CTC RESIDENTIAL REHABILITATION	Day	Average fill rate - registered nurses/midw ives (%)	100.78%	100%	93.7%	103.23%	102.16%	102.94%
		Average fill rate - care staff (%)	98.35%	96.2%	101.6%	98.88%	95.51%	98.17%
	Night	Average fill rate - registered nurses/midw ives (%)	100%	106.67%	100%	100%	100%	100%
		Average fill rate - care staff (%)	101.54%	100%	100%	100%	100%	100%
ENHANCED CARE WARD	Day	Average fill rate - registered nurses/midw ives (%)	68.31%	84.52%	80.65%	78.33%	83.33%	80%
		Average fill rate - care staff (%)	123.12%	110.29%	106.28%	121.83%	116.58%	124.71%
	Night	Average fill rate - registered nurses/midw ives (%)	72.41%	81.63%	76.36%	78.57%	90%	96.67%
		Average fill rate - care staff (%)	128.57%	118.06%	126.92%	132.53%	122.78%	130.77%
HARTINGTON UNIT - MORTON WARD ADULT	Day	Average fill rate - registered nurses/midw ives (%)	92.47%	110%	105.88%	110.87%	111.05%	91.43%
		Average fill rate - care staff (%)	107.86%	101.69%	101.57%	97.67%	93.8%	114.62%
	Night	Average fill rate - registered nurses/midw ives (%)	72.09%	86.84%	108%	87.5%	88%	96.08%
		Average fill rate - care staff (%)	118.33%	114.89%	92%	128.57%	116.33%	110%
HARTINGTON UNIT - PLEASLEY WARD ADULT	Day	Average fill rate - registered nurses/midw ives (%)	89.22%	84.66%	99.43%	97.22%	92.31%	97.78%
		Average fill rate - care staff (%)	78.66%	78.21%	88.02%	115%	105.84%	97.56%
	Night	Average fill rate - registered nurses/midw ives (%)	103.13%	73.47%	106.98%	100%	103.23%	110%
		Average fill rate - care staff (%)	90.91%	135.19%	95.24%	103.28%	100%	95%
HARTINGTON UNIT - TANSLEY WARD ADULT	Day	Average fill rate - registered nurses/midw ives (%)	88.37%	89.54%	106.32%	104.73%	101.78%	101.23%
		Average fill rate - care staff (%)	92.62%	96.89%	73.86%	82.47%	71.58%	79.75%
	Night	Average fill rate - registered nurses/midw ives (%)	73.47%	80.77%	73.02%	73.21%	93.22%	98.28%
		Average fill rate - care staff (%)	100%	119.23%	118.75%	103.17%	85.25%	91.94%
KEDLESTON UNIT - CURZON WARD	Day	Average fill rate - registered nurses/midw ives (%)	84.68%	84.68%	85.48%	104.17%	99.19%	101.63%
		Average fill rate - care staff (%)	111.2%	115.18%	113.71%	100.77%	97.71%	105.04%
	Night	Average fill rate - registered nurses/midw ives (%)	100%	100%	103.13%	100%	103.23%	100%
		Average fill rate - care staff (%)	101.61%	100%	106.45%	103.23%	100%	101.82%
KEDLESTON UNIT - SCARSDALE WARD	Day	Average fill rate - registered nurses/midw ives (%)	79.03%	91.51%	88.24%	96.64%	96.85%	95.9%
		Average fill rate - care staff (%)	110.85%	105.93%	112%	102.48%	102.44%	104.2%
	Night	Average fill rate - registered nurses/midw ives (%)	100%	100%	103.23%	100%	100%	100%
		Average fill rate - care staff (%)	100%	100%	101.64%	101.72%	100%	100%
KINGSWAY CUBLEY COURT - FEMALE	Day	Average fill rate - registered nurses/midw ives (%)	112.84%	98.37%	100%	99.29%	102.04%	101.36%
		Average fill rate - care staff (%)	90.18%	93.75%	88.97%	98.07%	93.88%	93.89%
	Night	Average fill rate - registered nurses/midw ives (%)	76.67%	75.56%	70.97%	71.67%	100%	100%
		Average fill rate - care staff (%)	113.54%	109.57%	106.93%	108.33%	109.38%	105.26%
KINGSWAY CUBLEY COURT - MALE	Day	Average fill rate - registered nurses/midw ives (%)	100.68%	97.66%	98.67%	99.32%	100%	101.49%
		Average fill rate - care staff (%)	95.04%	99.23%	90.77%	95.5%	96.98%	97.25%
	Night	Average fill rate - registered nurses/midw ives (%)	98.11%	93.18%	88.64%	94.44%	96.36%	94%
		Average fill rate - care staff (%)	100%	97.25%	99.2%	101.18%	100%	96.88%

Ward Staffing Monthly Fill Rates

> 125%
< 90%

Ward	Shift	Resource	Jan-2015	Feb-2015	Mar-2015	Apr-2015	May-2015	Jun-2015
			Complete	Complete	Complete	Complete	Complete	Complete
KINGSWAY MELBOURNE HOUSE	Day	Average fill rate - registered nurses/midwives (%)	102.36%	100%	97.58%	96.67%	97.6%	98.36%
		Average fill rate - care staff (%)	97.27%	98.81%	97.85%	98.32%	87.98%	90%
	Night	Average fill rate - registered nurses/midwives (%)	96.77%	96.43%	95.08%	98.33%	87.1%	93.1%
		Average fill rate - care staff (%)	100%	104.76%	97.87%	97.78%	104.4%	108.2%
KINGSWAY TISSINGTON UNIT - OLDER PEOPLE	Day	Average fill rate - registered nurses/midwives (%)	91.33%	95.62%	98.67%	98.6%	101.53%	101.38%
		Average fill rate - care staff (%)	96.06%	90.37%	93.63%	96.88%	94.19%	93.45%
	Night	Average fill rate - registered nurses/midwives (%)	90.16%	82.14%	96.77%	85%	67.74%	76.67%
		Average fill rate - care staff (%)	102.82%	105.88%	100%	113.33%	115.94%	115.79%
LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP	Day	Average fill rate - registered nurses/midwives (%)	98.01%	97.74%	99.3%	110.64%	102.8%	98.48%
		Average fill rate - care staff (%)	97.04%	95.87%	93.48%	103.88%	103.05%	89.81%
	Night	Average fill rate - registered nurses/midwives (%)	98.11%	83.33%	79.59%	91.49%	94.23%	90.48%
		Average fill rate - care staff (%)	106.25%	109.09%	108.33%	202.78%	161.54%	87.18%
LONDON ROAD COMMUNITY HOSPITAL - WARD 2 OP	Day	Average fill rate - registered nurses/midwives (%)	97.44%	95.58%	100.77%	100.75%	100.72%	97.69%
		Average fill rate - care staff (%)	96.89%	97.18%	95.04%	94.7%	96.4%	96.38%
	Night	Average fill rate - registered nurses/midwives (%)	95.24%	100%	100%	100%	100%	96.88%
		Average fill rate - care staff (%)	98.39%	93.22%	91.3%	91.8%	98.28%	101.61%
PERINATAL PSYCHIATRY INPATIENT	Day	Average fill rate - registered nurses/midwives (%)	101.61%	120.69%	121.54%	130.16%	117.14%	120.69%
		Average fill rate - care staff (%)	167.19%	138.18%	169.12%	172.97%	171.21%	169.86%
	Night	Average fill rate - registered nurses/midwives (%)	124%	155.56%	110.71%	111.11%	103.33%	107.14%
		Average fill rate - care staff (%)	110.71%	122.22%	170.97%	212.9%	190%	170.37%
RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT	Day	Average fill rate - registered nurses/midwives (%)	97.24%	98.82%	95.08%	98.32%	100%	98.38%
		Average fill rate - care staff (%)	101.35%	99.12%	101.47%	102.99%	101.27%	100%
	Night	Average fill rate - registered nurses/midwives (%)	98%	89.74%	94.44%	92.45%	95.83%	97.62%
		Average fill rate - care staff (%)	94.52%	101.67%	103.3%	97.7%	100%	100%
RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT	Day	Average fill rate - registered nurses/midwives (%)	96.25%	91.3%	82.35%	96.11%	88.71%	92.7%
		Average fill rate - care staff (%)	100%	110.87%	129.66%	133.58%	134.75%	126.19%
	Night	Average fill rate - registered nurses/midwives (%)	91.89%	58.82%	54.84%	52.54%	69.35%	56.67%
		Average fill rate - care staff (%)	102.22%	150%	271.43%	280%	164.15%	225%
RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT	Day	Average fill rate - registered nurses/midwives (%)	84.32%	92.81%	86.96%	83.62%	91.76%	95%
		Average fill rate - care staff (%)	120.16%	114.91%	107.09%	114.63%	119.55%	125.83%
	Night	Average fill rate - registered nurses/midwives (%)	108.11%	119.35%	105.26%	93.33%	82.98%	123.33%
		Average fill rate - care staff (%)	101.82%	92.59%	110.91%	120%	150%	143.33%
RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT	Day	Average fill rate - registered nurses/midwives (%)	97.44%	108.19%	103.57%	102.13%	99.51%	103.17%
		Average fill rate - care staff (%)	104.35%	94.4%	92%	104.93%	106.37%	108.39%
	Night	Average fill rate - registered nurses/midwives (%)	102.63%	117.86%	108.82%	100%	91.43%	95.12%
		Average fill rate - care staff (%)	129.33%	149.12%	126.47%	136.76%	117.98%	135.29%

It can be clearly seen that some wards are having to compensate for gaps in registered staff with other care staff. Perinatal, Enhanced Care, Ward 34 and Ward 36 consistently seem to require more staff than planned.

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

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	Apr-15	May-15	Jun-15	Jul-15	Sep-15	Oct-15	Nov-15	Jan-16	Feb-16	Mar-16	Apr-16
CW/CG	Annual Accounts and Annual Report and Quality Report & Annual Governance Statement (sign-off of final versions is delegated to Audit Committee annually)	FT Constitution	*Drafts* to be issued to Board for comment	Summary of key changes raised at Audit Com		Annual audit letter			Board to consider deleg'n of sign off to Audit Com				*Drafts* to be issued to Board for comment
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	People Strategy / Updates	Strategic Outcome 4 Licence Condition FT4		X		X		X		X			
JSy	Research & Development Strategy	Strategic Outcome 1 and 3			X					X Progress Report			
JSt	Staff Survey Results & Follow up activity	Strategic Outcome 3 and 4			Progress Report		Progress Report				X Results		
JD	Review S.O.'s, SFI's, SoD	FT Constitution Standing Orders					X						
JD	Trust Sealings	FT Constitution Standing Orders	X										
JD	Annual Review of Register of Interests	FT Constitution Annual Reporting Manual	X										
CG	Board Assurance Framework Update	Licence Condition FT4		X				X				X	
JD	Raising Concerns (whistleblowing)	Strategic Outcome 1 Public Interest Disclosure Act			X			X				X	
JD	Whistleblowing Policy - annual nomination of NED role (one year rotation)	Francis Report						X					

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Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	Apr-15	May-15	Jun-15	Jul-15	Sep-15	Oct-15	Nov-15	Jan-16	Feb-16	Mar-16	Apr-16
JD	Committee Reports (following every meeting) - Audit - Finance & Performance - Mental Health Act - Quality Committee - Safeguarding	Strategic Outcome 3	X	X	X	X	X	X	X	X	X	X	X
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	Position Statement on Quality (Incorporates Integrated Governance, Patient Experience and Patient Safety Reports) and Quality Dashboard	Strategic Outcome 1 CQC and Monitor		X	X	X	X	X	X	X	X	X	X
CG	Safeguarding Children	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					
CG	Integrated H & S Governance Annual Report (including H&S and Fire Compliance and Associated Training)	CQC and H&S Act					X						

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