Bradford District Care
NHS Foundation Trust

TRUST BOARD MEETING

25 May 2017

Paper Title:	Committee Annual Reports for 2016/17
Section:	Public
Lead Director:	Committee Chairs
Paper Author:	Margaret Waugh, Deputy Director of Quality, Governance and Informatics
Agenda Item:	**15**
Presented For:	Assurance

1. Purpose of this Report:

The Terms of Reference for each Board Committee require that they submit an Annual Report to the Board to summarise their work and to identify how they have fulfilled the duties required by the Board. Attached to this paper are approved Annual Reports of the following Board Committees:

- Mental Health Legislation Committee (MHLC) (considered at its meeting on 20 April 2017);
- Quality and Safety Committee (QSC) (considered at its meeting on 5 May 2017); and
- Finance, Business and Investment Committee (FBIC) (considered at its meeting on 26 April 2017).

2. Summary of Key Points

The Finance Business and Investment Committee Mental Health Legislation Committee and Quality and Safety Committee reports provide positive assurance that these Committees are operating effectively, that they are fulfilling their terms of reference and that there is strong commitment from individual Board members in their roles as Committee members. There has been no negative impact as a result of changes to the membership of either Committee during the year.

3. Board / Committee Consideration

To seek assurance from the relevant Committee Chairs about the work of each Committee during 2016/17, which supports the consideration of the 2016/17 Annual Governance Statement.

4. Financial Implications

Revenue [Y *] Capital [ ]

- For Mental Health Legislation Committee only

5. Legal Implications

None

6. Assurance

	Assurance provided?
Board Assurance Framework	Yes
CQC Themes (see below)	Yes
NHSI Single Oversight Framework	No
Other (please specify):	

This paper provides assurance in relation to the following CQC Themes:

Safe:	People who use our services are protected from abuse and avoidable harm
Caring:	Staff involve people who use our services and treat them with compassion, kindness, dignity and respect
Responsive:	Services are organised to meet the needs of people who use our services
Effective:	Care, treatment and support achieves good outcomes, helps to maintain quality of life people who use our services and is based on the best available evidence.
Well led:	The leadership, management and governance of the organisation make sure it's providing high-quality care that is based around individual needs, encourages learning and innovation, and promotes an open and fair culture.

7. Equality Impact Assessment

No Equality Impact Assessment is required for this report.

8. Previous Meetings/Committees Where the Report Has Been Considered:

Audit Committee		Quality & Safety Committee	y	Remuneration Committee		FB&I Committee	y
Executive Management team		Directors Meeting		Chair of Committee's Meeting		MH Legislation Committee	y

9. Risk Issues Identified for Discussion

None

10. Links to Strategic Drivers

Patient Experience	**Quality**	**Value for Money**	**Relationships**
All three committees have an important role in scrutinizing governance issues which can impact on the Trust's strategic objectives			

11. Publication Under Freedom of Information Act

This paper has been made available under the Freedom of Information Act

12. Recommendations:

That the Board:

- Considers the Annual Report of the Finance Business and Investment Committee, the Mental Health Legislation Committee and the Quality and Safety Committee.

Mental Health Legislation Annual Report 2016/17

1. Background

This report provides an overview of the governance arrangements that support the application of the Mental Health Legislation in the Trust and details of the Mental Health Act activity for the period 01 April 2016 to 31 March 2017

2. Governance arrangements

2.1 Committee Membership and meeting attendance

The membership of the Committee consists of the Medical Director, Director of Nursing and three Non-Executive Directors (NEDs). One NED Chairs and one is Deputy Chair. The Chief Executive and Chair are invited/reserve the right to attend any meeting.

2016/17	**MHLC Meetings (5/5)**
Ralph Coyle, Chair until April 2016 (left April 2016), Non- Executive Director	1/5
Nadira Mirza, Chair from July 2016, Non- Executive Director	3/5
Rob Vincent, Non-Executive Director	2/5
Zulfi Hussain, Non-Executive Director	1/5
Nicola Lees, Chief Executive	2/5
Dr Andy McElligott, Medical Director	4/5
Debra Gilderdale, Director of Nursing	2/5
Paul Hogg, Trust Secretary	4/5

Ralph Coyle stepped down as Chair in April 2016.
Nadira Mirza is the current Chair of the Mental Health Legislation Committee
Rob Vincent is the current Vice Chair
Other Non-Executive Directors attend on rotation as there is no designated Non-Executive Director

2.2 Committee Terms of Reference

Changes to the Terms of Reference were updated and approved in April 2016

2.3 Provision of assurance to the committee

The following sub groups have provided assurance to the committee during the year

- The Mental Health Legislation Forum
- The Associate Hospital Managers Group
- The MCA/LIN Group

Further detail is provided in section 4 of this report

2.4 Assurance to Board from the committee

Through the committee chair's report to the Board, the Mental Health Legislation Committee has provided the Trust Board with information and assurance on key issues arising during 2016/17; those issues are summarised in section 3 of this report.

3 The Work of the Committee

Through 2016/17 the committee has steered, sought and received assurance on a range of issues and achievements which can be summarised as follows:

CQC Fundamental Standards: assurance against a number of the fundamental standards has been received in reports submitted.

Mental Health Act Action Plans in response to CQC Mental Health Act visits: the committee has received routine updates on action plans throughout the year and sought additional assurance where necessary. The medical director now routinely circulates CQC reports following their visits to individual ward to all relevant doctors within the Trust.

Update report on the use of restraint: the committee received a report on further analysis of restraints following an initial report in January 2016, looking at whether individuals from ethnic minority communities were over represented proportionally. The report indicated that whilst some ethnic minority cases were under represented proportionally, this was not the case for persons of Pakistani and Bangladishi backgrounds. The incident rates overall had fallen due to better staff training , staff on duty being able to speak community languages, and the use of de-escalation techniques.

Committee dashboard: the committee received an integrated Performance Report (dashboard) at each of the meetings in 2016/17. Areas covered in the dashboard included: manager and tribunal data, restraint data, ethnicity data and section data, including issues relating to sections which had lapsed. New data included in the dashboard for 2016/17 related to consent to treatment issues under Section 62 urgent treatment and 2nd opinion (SOAD) requests. The committee requested that information relating to the use of Electro-Convulsive Treatment (ECT) be added to the dashboard for 2017/18. The data provided in the dashboard reports had assisted the committee in assessing the Trust's performance and progress in delivery of key mental health legislation targets and indicators.

Care Programme Approach Audit update: the April 2016 committee had received a CPA audit which had been carried out via peer review covering wards and community teams. The audit had highlighted 9 areas where no assurance could be given. A further audit was carried out in September and submitted to the October meeting where there had been a slight improvement reported, but still with 7 areas where no assurance could be given. It had been agreed that ongoing work was required and agreed to receive a further report at a future meeting.

Audit on the use of Section 17 leave: a report was received at the October 2016 meeting, updating the committee on issues relating to Section 17 leave which had focussed on 50 detained patients. 38 of the 50 patients had been smokers and concerns relating to leave for smokers were considered in the report. It was reported that a significant amount of nursing time was taken up with regards to administration of section 17 leave. Concerns raised were acknowledged and a request was made for a further report to be submitted in October 2017.

Section 117 aftercare implementation update: Mark Trewin attended the January 2017 meeting to provide an update following attendance at the Integrated Personalised Commissioning Board meeting. He reported that the CCGs and the Local Authority had a legal responsibility for Section 117 aftercare and the MHA office retain and update the register. He reported that the Local Authority had to make substantial savings in relation to adult social care and that these savings were to be made from more efficient services. Mark suggested that the committee receive the papers from the Integrated Personalised Commissioning Board for assurance.

Health based place of safety presentation: Dr Helen Haylor, service evaluation lead and Dr Antony Sparkes, lecturer, faculty of Social Services at the University of Bradford had presented a report on work conducted during the summer of 2016 which had focussed on collaboration between WY police and the First Response service in relation to section 136 arrests.

Mental Health Legislation Half Year Report: The paper provided an overview of MHA activity for the period 01.04.16 to 30.09.17 which provided assurance towards the CQC themes identified and agreed to receive a full report in April 2017.

Mental Capacity Act and DoLs Annual Update
Julie Laslett, MCA Clinical Lead presented the annual update to the committee which had reflected on the actions and targets agreed in the action plan. The following key points were noted: training compliance had continued to improve, with over 60% of the workforce now trained; the roll-out of the MCA specialists in adult community services had proved to be very successful and there were plans for this to be launched to inpatient services; links had been established with other NHS providers in the region to share ideas and benchmark performance.

Mental Health Act Policy Updates: a paper was received which provided an update on some procedures to be added to the MHA Policy & Procedures following further review of the MHA Code of Practice. Amendments related to professional responsibilities in regard to Community Treatment Orders and in relation to Children & Young People. The committee approved the proposed amendments to the MHA Policy and confirmed that the paper provided assurance in relation to the CQC theme of "well led" in that effective governance arrangements were in place in relation to the policy updates.

4 The work of other groups reporting to the Committee

4.1 The Mental health Legislation Forum
The Forum reports direction to the MHL committee and provides professional opinion and explanations on areas of the Act where trends may occur or outlying results emerge. It meets 6 weekly and provides practitioners with a forum to share news, promote good practice and flag up concerns that may need escalating to the committee. The committee receive the minutes of these meetings for assurance.

4.2 Associate Hospital Managers Group
This meeting provides associate hospital managers with a forum to receive training on subject areas relevant to their role as well as providing an opportunity to comment on and improve systems and processes to ensure hearings run smoothly. It meets 4 times per year and each meeting has an element of business and an element of training. The committee receive the minutes of these meeting for assurance.

4.3 The MCA/LIN Group
This group meet 4 times per year and membership includes MCA representatives from the two acute Trusts, a Safeguarding Lead, IMCA representative from Choice Advocacy, a Workforce Development Lead from the Bradford Council, and a representative from Marie Curie Hospice as well as the MCA Clinical Lead from BDCFT. Complex cases are considered as are issues relating to DoLs. The committee receive the minutes of these meetings for assurance.

Finance, Business and Investment Committee Annual Report 2016/17

Introduction

1. The Finance, Business and Investment Committee (FBIC) was established in September 2012 under Board delegation with approved terms of reference and meets every 6 weeks. The Committee's terms of reference require that an Annual Report is submitted to the Board to summarise its work over the past year and to identify how it has fulfilled the duties required by the Board. This report therefore outlines the work of the FBIC during 2016/17, highlighting key areas of work and areas of assurance.

FBIC Membership and meetings

2. The Committee comprises of Non-Executive Directors (NEDs) and members of EMT along with the Deputy Director of Finance. Membership of the Committee has changed during the year to reflect changes in NED portfolios. The FBIC has met nine times during 2016/17 and attendance at FBIC meetings is summarised below.

Membership	Attendance
Rob Vincent (Chair)	9/9 meetings
David Banks	7/9 meetings
Ralph Coyle	1/1 meetings
Zulfi Hussain	3/5 meetings
Michael Smith	3/3 meetings
Simon Large	2/3 meetings
Nicola Lees	6/6 meetings
Liz Romaniak	9/9 meetings
Sandra Knight	9/9 meetings
Paul Hogg	8/9 meetings
Claire Risdon	9/9 meetings

3. The FBIC works to an annual plan of scheduled agenda topics, along with a range of specific issues which are subject to review. A rolling programme of actions is maintained and monitored accordingly. The Committee Chair has also updated the Board on any significant issues arising from each Committee meeting through his regular written/verbal reports and Committee minutes are circulated to all Board members. The remainder of the report is divided under the Committee's three key objectives and then wider governance issues:

(i) Monitor financial performance of the Trust against plan, reporting any proposed remedial action to the Board as necessary

4. The FBIC's terms of reference require the Committee to scrutinise the Trust's in-year financial performance, delivery against Cost Improvement Plans (CIPs), review the annual budget and the level of capital expenditure. The Committee has also paid particular attention during the year on the quarterly financial return to NHS Improvement and consideration of control totals. The following items are highlighted from the discussions during the year:

- The Committee agreed a number of changes to the **FBIC finance dashboard** to support more transparent monitoring of agency costs and compliance against targets, provide business units with their own control total for agency expenditure and provide a greater emphasis on financial run rates and scrutiny of forecast spend. The dashboard has been used to scrutinise financial performance throughout the year and enabled the Committee to make informed decisions about introducing additional controls to mitigate emerging financial risks;

- The Committee has spent considerable time on the scrutiny and review of the **quarterly submissions to NHS Improvement** to confirm the Trust's Finance Sustainability Risk Rating (FSRR). Foundation Trusts were assessed against the Risk Assessment Framework (RAF) in the first half of the financial year but this was replaced by a new process, the Single Oversight Framework, from Quarter 3. Under the new system, Trusts were segmented into one of four categories, where 4 reflected providers receiving the most support, and 1 reflected providers with maximum autonomy (the opposite categorisation from the RAF). The Committee (and Board) approved the following FSRR returns: Quarter 1: 3; Quarter 2: 3; Quarter 3: 2; and Quarter 4: 1.
- The Committee has closely monitored the key **financial risks** throughout the year, some of which related to key projects within the Change Programme Board update, highlighted at paragraph 6. The risks on the Corporate Risk Register allocated to the Committee were considered at its September meeting. The Committee concluded that the risks associated with (i) de-commissioning of contracts/re-procurement activity and (ii) agile working were being properly addressed;
- The Committee has held regular discussions about the **Capital programme**, monitoring a capital budget of £3,856k. The Committee has seen a number of re-prioritisation exercises undertaken to manage in-year pressures, delivering a small aggregate under spend of £3k at Month 12;
- Progress on **Cost improvement Plans** has also been regularly reported to Committee via the performance dashboard and a number of substitution schemes identified where necessary. The Trust has experienced a very challenging environment to deliver a budgeted CIP programme of £5.8m, representing 4.42% of planned expenditure. The Trust delivered 95.9% of the 2016/17 CIP of £5.8m;
- Given the significant and sustained financial challenges experienced throughout 2016/17, the Committee met on 16 January to consider in detail the year to date financial position, forecast, risks and mitigating actions. The Committee recommended the Board **submit a re-forecasted financial position to NHS Improvement in Quarter 3** that presented a £500k potential shortfall against the Trust Control Total of £1,352k plan surplus. The Committee endorsed a number of actions/mitigations to target an outturn that was as close as possible to the Board approved control total recognising the lack of uncommitted reserves or balance sheet flexibility. At the end of 2016/17, through a great deal of hard work and tight financial management, the Trust was able to report it had achieved its planned surplus.

(ii) Consider the Trust's medium to longer term financial strategy.

5. During the year the FBIC has focused on a number of **workforce issues**, in the light of changes introduced by regulators and the impact on the Trust's financial position. Reports received have included:

- Two **'deep dives' into workforce planning issues** in September 2016 and January 2017. The Committee focused on those hotspot areas of recruitment which had historically been hard to recruit to, such as Band 5 inpatient nurses and district nurses, specialist therapy roles (such as speech and language therapy) and medical positions. The deeper dive also provided information on the age profile of these areas, staff turnover, sickness levels and the short to medium term actions identified to tackle these recruitment areas;
- A **review of medical staffing** (permanent and locum workforce) in March 2017. The Committee received a presentation from the Medical Director which focused on actions to reduce locum expenditure, attract more high calibre medical staff to substantive roles and work with other local mental health trusts to agree a common price cap for locums. The Committee also asked that further work be undertaken to review the structures that support medical leadership across the Trust; and
- A follow-up report on the benefits associated with the **introduction of the E-rostering system** (see below).

6. Change Programme Board updates were presented using a RAG rated system to provide assurance against projects seeking to implement significant change and transformation as originally set out in the Trust's Integrated Business Plan. Projects are highlighted that were rated either red or amber during the year and required regular discussion:

- **Closure of the Intensive Therapy Centre (ITC):** the Committee received regular updates on the planned closure of the ITC, monitoring the work of the Steering Group which managed the safe discharge of service users and re-deployment of staff working on the unit. Financial implications were closely monitored and a final closure report presented in October. In December, a lessons learned paper highlighted the need for realistic assessments of actual demand (translated into commissioner investment) and the importance of strong marketing skills for future ventures. The Committee acknowledged that changes is national policy made the timing of the ITC investment challenging;
- **Agile programme:** this programme considered how the Trust utilises technology and improves skills to enable the BDCFT workforce to work in a more 'agile' way, enabling the organisation to make efficiencies in three key areas: workforce reductions, reduced travel costs and estates rationalisation. In the early part of the year the Committee was assured that expected in-year efficiencies were on track. Subsequently, as the Operational Plan was developed, reports highlighted risks to the achievement of staffing savings targeted for 2017/18 and 2018/19 (to meet the levels planned in the original business case) were unlikely to be achieved from the Adult Mental Health and Adult and Community Nursing Business Units.

  As a result, the Committee considered a 'deep dive' into the agile programme in March 2017 and the 2 year operational plan now includes a revised and reduced forecast for 2017/18 and 2018/19 staffing reductions. The deep dive reported that Agile savings to date (since roll out commenced) are higher than planned and costs to implement lower than had been anticipated. Even taking into account reduced future savings the net benefit to the Trust over the business case period had been achieved. The business case and Trust IBP had assumed a 1% per annum CCG demographic investment. This had not materialised and set alongside unfunded cost pressures had changed the operating environment. The Committee and Board had been aware of these strategic risks which were reflected in the BAF and in the Trust's downside scenario mitigation planning.

  The adoption of the WorkSmart programme has been introduced to underpin delivery over the next two years and a further progress report will be presented in Quarter 1;
- **Telephony:** linked to the above programme, the Committee has received regular reports on the efficiencies associated with reducing the number of land lines/faxes and deployment of smart phones to community staff. A number of factors have contributed to not delivering the projected savings in 2016/17. The Committee received and endorsed a paper in March 2017 which reported a detailed action place was now in place to generate savings in 2017/18, provide detailed telephony reporting to the Informatics Board and re-visit the Trust's telephony strategy to ensure its vision to support agile working is still appropriate;
- **Care Pathways and Packages Programme (CPPP):** the Committee noted that leadership of the CPPP during 2016/17 moved from the Finance Department to an operational Deputy Director allowing clustering to be more integrated into operational performance and support improved clinical ownership. There has been no CIP associated with this project but work has continued to focus on training staff and embedding behaviour good practice. The Committee noted the CPPP performance has remained relatively stable at 80-85% (against a target of 95%); and
- **IMT:** at the request of the Trust Board, the Committee reviewed the IM&T strategy, structures and agency staffing pressures and in March 2017 received a progress paper on IM&T work streams including staff levels, key deliverables in 2016/17, clinical systems procurement and strengthened management and governance arrangements.

7. The Committee has received a regular update at each meeting on progress against the **Market Development Plan** (including the bid and tender log). These reports have provided assurance that the Trust has actively sought new business opportunities both within and outside its traditional footprint. The reports have also highlighted the changing environment where commissioners are using competitive tendering to introduce new efficiencies and alternative models of care. The Committee has considered and supported a number of successful tender opportunities both locally (e.g. enhanced diabetes and podiatry services in AireWharfe Craven and the Skills, Training and Employment Pathway in Bradford) and regionally (0-19 Children's Public Health Service and 5-19 Vaccination and Immunisation Service with Wakefield Council, and perinatal mental health community services with NHS England). A paper was submitted on lessons learned from the Wakefield tender highlighting the importance of geographical intelligence, submission of a financially credible bid, mobilisation of the internal bid team, and strong leadership to deliver the transfer of services.

8. Like other Committees, the FBIC has adopted a **'deep dive' approach** where a particular issue has been presented in detail for consideration. The Committee has refined its approach to deep dives and identified a set of key criterion to be used including current KPIs, financial position, benchmarking and service specification details. During the year the Committee has undertaken deep dives in the following areas: corporate support services (including estates), workforce planning (twice), agile working, and medical workforce (permanent and locum). Deep dives identified for 2017/18 include the STP approach to shared services and community dental procurement.

9. The Committee has also held detailed discussions about annual planning assumptions and risks and in relation to the contracting arrangements with commissioners leading up to the submission of the 2 year Annual Plan in December 2016 to ensure a robust financial plan could be recommended for approval by the Trust Board.

(iii) Provide an oversight of the development and implementation of financial systems across the Trust.

10. In October 2016, the Committee considered and supported a strategic overview of the principles, implications and approach for annual business and financial planning through a move towards more rigorous **Service Line Management**, following the rebasing of Local Authority and CCG Contracts and re-negotiation of NHS England local Low Secure Inpatient tariffs. As a result, a balanced score card approach was introduced to support service line management, bringing together a balanced set of targets and indicators for financial performance, workforce, operational efficiency and quality performance.

11. At the same meeting, the Committee was updated about initial benefits realisation following the roll-out of the Allocate E Rostering system and the introduction of the Trust's wider strategy to reduce bank and agency expenditure through the in-sourcing of the staff bank. The Committee endorsed this approach and supported further work with Meridian Consulting to help ensure that the necessary cultural changes take place within the Trust to ensure that the system is full optimised.

Wider governance issues – health and safety and estates

12. The Committee has paid particular attention to assurance on health and safety compliance during the year. The health and safety annual report highlighted the continued improvements in health and safety standards across the Trust achieving compliance with successful health and safety management standards (HSG65) and a third consecutive Gold Award from RoSPA. The Committee also received the annual reports on fire safety and local security management, with a focus on implications of adopting a smoke free environment. As a result of the Board's awareness training on corporate manslaughter the Committee received a corporate review against the

Institute of Directors/Health and Safety Commission's leadership checklist (INDG417) and recommended individual Board members to complete the self-assessment.

13. In March 2017, the Committee approved the Fire and Arson Policy, noting strong assurance in relation to current legislation and discussed the recent simulation exercise to test the Trust's procedures. The Committee also approved the revised Health and Safety Policy. David Banks, the Board's health and safety champion, regularly attends Health and Safety Group meetings and an annual report on health and safety will be presented to the Board in April.

14. The Committee has approved a revised Estates Strategy, which included a review of the Trust's major facilities and as service patterns change, a reduction in the work station : employee ratios linked to the agile working programme. In line with the Trust's Standing Financial Instructions, the Committee has reviewed a number of assets for potential disposal ensuring that, where it is appropriate, to seek a sale at a suitable market rate. During the year the Committee has approved three disposals: Thornton Road/Green Lane (Ashfield land); 6-8 Abelia Mount; and Stoney Ridge.

15. Finally the Committee has closely monitored the work undertaken in response to the flood recovery refurbishments, overseeing the financial settlement with the insurers and the resulting capital expenditure for changes to Levels 1 and 5 at New Mill

BRADFORD DISTRICT CARE TRUST
ANNUAL QUALITY AND SAFETY COMMITTEE REPORT
2016 / 2017 AND QGIP 2016 / 17

1. Introduction

1.1 Report purpose

The purpose of this annual report is to summarise the work of the Quality and Safety Committee (QSC) during 2016 / 17 and to confirm progress against the 2016/17 Quality Governance Improvement Plan (QGIP)

The overall aim of the committee is to seek and obtain evidence of assurance on the effectiveness of the Trust's quality and safety systems and processes and the quality and safety of the services provided. This includes identifying and seeking assurance on the management of quality and safety related risks at operational and strategic level. The terms of reference of the group were reviewed and approved in March 2017 Committee meeting.

The 2016/17QGIP was tabled formally at QSC in December 2016 and the latest version is provided at Appendix 1.

1.2 Committee attendance by Board members

Board member attendance at QSC is key in terms of ensuring high level leadership and support for clinical quality, attendance during 2016 / 17 is as follows:

Members	June 2016	Aug 2016	Sep 2016	Nov 2016	Dec 2016	Feb 2017	Mar 2017
S Butler	apols	□	□	□	□	□	□
N Mirza	□	□	□	apols	□	□	apols
Z Hussain	□	□	□		□	□	
D Gilderdale	Nicola Lees	□	□	□	□	□	□
A McElligott	□	apols	□	□	□	□	□
	NB Mike Smith attended in March 2017						

1.3 Main changes to committee functioning during 2016 / 17

During the last year a number of recommended changes have been embedded into the committee programme including:

- Increased frequency of meeting to 6 weekly
- Alternating between corporate and operational business unit meetings which allows operational colleagues to attend only for those issues they provide assurance on
- Clarity of membership i.e. Board members only are committee members, others are in attendance
- Streamlining of the forward workplan and agendas to ensure the right assurances are being provided including the continued use of deep dives

- Minimising the time spent by authors presenting papers to allow maximum time for discussion

2. External reviews during 2016 / 17

2.1 Internal Audit

Following extensive scrutiny of QSC in the previous year Internal Audit undertook a review of committee. Results are yet to be formally published but significant assurance is expected.

2.2 Peer review

In December 2015 an external peer review was undertaken by the Chief Executive of Tees, Esk and Wear Valley Foundation Trust. Whilst a range of good practice was identified a number of areas for improvement were also identified. In response a set of actions were developed and incorporated into the trust's QGIP in line with the process following other external inspections. These have been fully implemented in year.

3. Achievement of objectives within the Quality Governance Improvement Plan 16/17

The QGIP, Appendix 1, encompasses a broad range of actions and was last tabled at QSC in December 2016. Throughout the year completed actions have been signed off. Currently, four actions remain amber:

Appendix 1 notes the anticipated update (in red text) for each of the four actions and it is likely all actions will be signed off as complete at the next formal review of the QGIP in June 2017.

4 Other significant issues

Specific issues which have been addressed through the business of the QSC or by sub-groups reporting to the QSC are as follows:

4.1 Ratification of key documents

In 2016/17 the responsibility for ratification of clinical policies passed to the Executive Management Team meeting.

The following ***strategies*** have been ratified during 2016 / 17:

- Nursing Strategy.

The following ***Terms of Reference*** for the following have been approved / ratified:

- Quality & Safety Committee
- Clinical Audit Steering Group
- NICE Guideline Implementation Group

4.2 Learning from and responding to External Reports

The QSC will review and monitor responses to external reports and recommendations as appropriate. An example in 2016/17 is the requirement to establish a mortality review process as required by the National Quality Board.

Oversight of learning from external reports sits with the Deputy Director of Quality Governance and Informatics and is monitored via Deputy Directors meeting on a quarterly basis.

4.3 Annual reports

The QSC has received and approved the following annual reports in year:

- Risk management
- Clinical audit
- Safeguarding
- Medicines management
- Infection prevention
- Emergency planning
- Research and development

4.4 CQC registration assurance

During 2016 / 2017 assurance for each paper presented provided assurances against the 5 CQC themes, rather than the Fundamental Standards. An annual paper to Board on CQC assurances is planned for June 2017.

4.5 Deep dives

The committee has requested and received a number of 'deep dives' in order to seek additional assurance / understanding on a number of key areas as follows:

- Action plans in business units – assurances provided on the management and delivery of actions plans. Additional action added into the QGIP.
- Psychological therapies; the committee had previous concerns relating to the work of this team and following an initial deep dive deep received further assurances of progress.
- Pressure ulcers; committee sought assurances on the management of pressure ulcers.
- Incidents deep dive; provided assurances on the systems and processes to manage incidents.
- Quality issues on in –patient wards; provided assurances on the current and planned actions to support quality services on in-patient wards.

4.6 Additional assurance papers

In addition to the deep dives referenced above, the committee has received a number of papers and verbal updates providing assurance / updates against a wide range of topics as follows:

- Board walkabout programme
- Corporate risk register
- Equality delivery system
- Quality goals and quality indicators
- NICE guidance implementation
- Serious incidents
- Complaints
- Mortality review process
- CAMHS lightening review
- Dementia assessment unit report
- Quality governance Improvement Plan
- Patient experience report

- Outstanding care report
- Smoking cessation report
- Meridian in-patient report

In 2016/17 a new PowerPoint presentation by operational business units was embedded into the committee workplan. These were well received, informative and stimulated robust challenge and discussion in committee. A rolling program of business unit presentations are planned within the annual workplan, ensuring each business unit is reviewed twice in each year.

Significant assurances are also derived each quarter from the QSC dashboard which contains qualitative and quantitative information on a wide range of quality issue across the Trust.

4.7 The BDCFT Quality Report

The QSC has monitored progress against the 2016/17 Quality Report indicators relating to the Trust Quality Goals. A task and finish group consisting of Council of Governors has also been reviewing and contributing to the annual Quality Report and had oversight of performance against our quality indictors over the year. QSC reviews the annual Quality Report each May.

4.8 Quality and Safety Reporting to Commissioners

The commissioners of BDCFT services expect to receive a wide range of quality and safety information / reports throughout the year thorough two main quarterly meetings;

- Quality and Performance Group (QPG)
- Patient Safety and Quality sub group

All reporting requirements have been met during 2016 / 17 including the provision of additional assurances on request. It is important to note that all contractual and national audits have been completed in line with requirements and reported to commissioners and the QSC accordingly.

5. Quality Governance Improvement Plan 2017 / 18

Whilst the QSC will identify and agree any actions to be added to the plan throughout the year it is likely that all current actions will be completed by the next planned review of the QGIP in June 2017.

6. Conclusion

This has been another busy and productive year for the QSC which has seen a number of improvements in the way the committee functions.

The annual workplan of the committee will ensure that robust quality and safety governance arrangements will continue and that assurances regarding BDCFT quality and safety will continue to be challenged, monitored and recorded effectively.

7. Recommendations

It is recommended that the QSC:

- Considers the progress made and the assurance this provides
- Considers whether the content of this paper provides assurance in relation to the CQC themes identified above

BDCFT QUALITY GOVERNANCE IMPROVEMENT PLAN: MAY 2017							
RAG rating: Green – action complete Amber – action on track to meet agreed timescale Red – action has not been met within agreed timescale							
Source / ref	**Action**	**Lead Director**	**Lead**	**Progress**	**Evidence**	**Timescale**	**RAG**
QGIP 39a	Full review and revision of the Risk Management Strategy	A. McElligott	D. Webster	The revised risk strategy was approved at March 2016 QSC and will be ratified at Board in April 2016.	Revised RMS ratified at Board	April 2016	**Green**
QGIP 47 Source: Quality Goal c/f from 14/15	Ensure that learning from complaints makes a difference in terms of the outcomes of action planning	D. Gilderdale	C. Woffendin	All action plans are recorded in the case file. Every action plan is recorded on the master data base and broken down into individual actions. The database clearly indicates the status of all individual actions and a comment section for actions which are overdue. When evidence is submitted it is reviewed and saved into the Z drive. Where we have had confirmation the action is complete but evidence is not received, this remains rated 'Red' until evidence is received. Assurance and evidence that action plans are completed are presented to the Serious Incident, complaints, claims and litigation forum seeks. The complaints team provide monthly reports to all Heads of service in relation to complaints details and position statement on action plans within their areas of responsibility. These reports also identify any themes and trends requiring action or wider consideration. Clear evidence from local governance arrangements demonstrates robust systems and processes are embedded. Any actions which are out of date/overdue are escalated Data provided to audit to progress and we are awaiting the outcome.	Action plans Minutes of SI/Complaints and litigation meetings Evidence collated to substantiate actions and RAG rated Master database for complaints Locality databases Monthly reports Quarterly reports for Q&S.	Review March 16 Revised Review date August 2016	**Green**

BDCFT QUALITY GOVERNANCE IMPROVEMENT PLAN: MAY 2017							
RAG rating: Green – action complete Amber – action on track to meet agreed timescale Red – action has not been met within agreed timescale							
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Source / ref	Action	Lead Director	Lead	Progress	Evidence	Timescale	RAG
QGIP 71 Review of QSC Dec 15	Operational locality assurance reports to state whether agreed actions have been completed and, if not, when they will be completed	Medical Director	Deputy Director Quality and Governance	The Business Unit report format has changed significantly in the last month or so; a further amendment has been made to ensure that future reports include timescales against actions and this will be evident in the BU reports in Feb 2017. NB – completed February 2017.	Business Unit Reports to QSC	6/5/2016	**Green**
QGIP 72 Review of QSC Dec 15	QSC to place more emphasis on assurance against resolution of local issues alongside assurance against CQC fundamental standards	Medical Director	Chair of QSC	Amendments have been made to the committee template to allow a broader view on assurances provided and a workshop with authors has been held to further support this. Papers now include a wider range of assurances.	Papers providing more robust assurances	31/12/2016	**Green**
QGIP 76 Quality Strategy comms.	Ensure that the strategy is placed on Connect and that an ecomms s issued with a link.	Medical Director	Deputy Director Quality and Governance	Action completed	E comms issued and strategy visible on Connect	30/04/16	**Green**
QGIP 77 Quality Strategy comms.	Develop a summary of the Quality Strategy as a quick reference / overview.	Medical Director	Deputy Director Quality and Governance	Summary developed including a video link re the quality goals.		31/05/16	**Green**
QGIP 78 Quality Strategy comms.	Ensure that the summary is placed on Connect and that an ecomms s issued with a link.	Medical Director	Deputy Director Quality and Governance	Action completed	E comms issued and summary visible on Connect	15/06/16	**Green**

Source / ref	Action	Lead Director	Lead	Progress	Evidence	Timescale	RAG
QGIP 79 Quality Strategy comms	Ensure that the summary is discussed at each BU Quality & Safety meeting	Deputy Chief Executive	Operational Deputy Directors	Summary issued by DD of Quality & Governance for discussion at meetings.	Minutes of meeting reflecting discussion	31/08/16	Green
QGIP 80 Implement Quality Strategy	Development of an action plan to support each Quality Goal with identified & measurable outcomes	Deputy Chief Executive	Operational Deputy Directors	Action plans in development All measures identified	Action plans in place to support implementation	30/06/16	Green
					Measures in place	30/04/16	Green
QGIP 81 Implement Quality Strategy	Ensure use of the Trust Quality & Safety Framework at BU Q&S meetings	Deputy Chief Executive	Operational Deputy Directors	All Business Unit level Q&S meeting utilise the framework routinely.	Agendas and minutes which evidence use the framework content	30/08/16	Green
QGIP 82 Implement Quality Strategy	Ensure use of the Trust Quality & Safety Framework at BU team meetings	Deputy Chief Executive	Operational Deputy Directors	All operational services confirm that this is the case.	Agendas and minutes which evidence use the framework content	30/08/16	Green
QGIP 83 Implement Quality Strategy	Ensure refresh of the self-assessment against CQC requirements on a six monthly basis	Medical Director	Deputy Director Quality and Governance	This work will be completed in time to support the annual Board assurance report; a full process is already in place. NB - completed April 2017	All self-assessments updated and provided to the Q&G Team	31/04/17	Green

Source / ref	Action	Lead Director	Lead	Progress	Evidence	Timescale	RAG
QGIP 84 Implement Quality Strategy	Undertake review of service user & carer engagement in Q&S meetings	Medical Director	Deputy Director Quality and Governance	A review of the QSC representative's role has been undertaken by the PE Lead, DD of Quality & Governance and current representative; amendments to the involvement agreement have been made as a result. Work re engagement in Business Unit Q&S Groups has commenced via the patient experience team. NB – Meeting held with QSC SU rep and chair of QSC. Work ongoing with SU recruitment for committees and other forums.	Clear picture of service user involvement in the QSC and Business Unit Q&S meetings is available.	31/03/17	Green
QGIP 85 Implement Quality Strategy	Undertake an annual well-led assessment	Trust Secretary / Medical Director	Trust Secretary/ Deputy Director Quality and Governance	The well led assessment has commenced with an initial paper to Board; key actions are currently in development. NB - Well led discussion at Board and EMT with agreed actions progressing	Well led assessment completed and signed off at Board; action plan in place if required.	31/03/17	Green