Derbyshire Healthcare
NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust
Board of Directors Meeting

Conference rooms A and B, First Floor, Centre for Research and Development, Kingsway Hospital
7 May 2019 09:30 - 7 May 2019 12:00

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Derbyshire Healthcare
NHS Foundation Trust

NOTICE OF PUBLIC BOARD MEETING – TUESDAY 7 MAY 2019
TO COMMENCE AT 9:30am IN CONFERENCE ROOMS A&B
FIRST FLOOR, CENTRE FOR RESEARCH & DEVELOPMENT, KINGSWAY HOSPITAL

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks, apologies and Register of Interests	Caroline Maley
2.		Minutes of Board of Directors meeting held on 2 April 2019	Caroline Maley
3.		Matters arising – Actions Matrix	Caroline Maley
4.		Questions from governors or members of the public	Caroline Maley
5.	9:40	Chair's Update	Caroline Maley
6.	9:50	Chief Executive's Update	Ifti Majid
OPERATIONAL PERFORMANCE, QUALITY, STRATEGY AND GOVERNANCE			
7.	10:05	Integrated Performance and Activity Report	C Wright/A Rawlings/ C Green/M Powell
8.	10:30	Quality Report – focus on CQC essential standard of responsiveness	Mark Powell
9.	10:45	Trust Strategy Review and Update	Gareth Harry
11:00 B R E A K			
10.	11:15	Business Plan Monitoring close down of 2018/19	Gareth Harry
11.	11:25	NHS Improvement Year-End Self-Certification	Justine Fitzjohn
12.	11:35	Summary of Year-end Governance Reporting from Board Committees and approval of Terms of Reference	Justine Fitzjohn
13.	11:45	Board Committee Assurance Summaries and Escalations: Quality Committee 9 April, People & Culture Committee 23 April, Audit & Risk Committee 30 April, 2019 *(minutes of these meetings are available upon request)*	Committee Chairs
CLOSING MATTERS			
14.	11:50	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Draft Forward Plan for 2019/20 - Meeting effectiveness	Caroline Maley
FOR INFORMATION			
Glossary of NHS Acronyms			

Questions that are applicable to the agenda, and at the Chair's discretion, can be sent by email to the Board Secretary up to 48 hours prior to the meeting for a response provided by the Board at the meeting. Email: sue.turner17@nhs.net

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

The next meeting will be held at 9.30am on 4 June 2019 in
The Post Mill Centre, Market Street, South Normanton, Alfreton. Derbyshire DE55 2EJ
Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.
Participation in meetings is at the Chair's discretion

Derbyshire Healthcare
NHS Foundation Trust

Our vision

To make a positive difference in people's lives by improving health and wellbeing.

Making a positive difference

Our values

As a Trust, we can only provide good quality services through our dedicated staff, working together with a common purpose. Our values reflect the reasons why our staff choose to work for the NHS and Derbyshire Healthcare and the principles that bind us together in a common approach, no matter what our employed role is.

Our Trust values are:

People first – We put our patients and colleagues at the centre of everything we do.
Respect – We respect and value the diversity of our patients, colleagues and partners and support a respectful and inclusive environment.
Honesty – We are open and transparent in all we do.
Do your best – We work closely with our partners to achieve the best possible outcomes for people.

Derbyshire Healthcare
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DECLARATION OF INTERESTS REGISTER 2019/20		
NAME	**INTEREST DISCLOSED**	**TYPE**
Margaret Gildea Non-Executive Director	• Director, Organisation Change Solutions Limited • Non-Executive Director, Derwent Living	(a, b) (a)
Carolyn Green Director of Nursing & Patient Experience	• Husband employed by Derbyshire Probation Service	(d)
Gareth Harry Director of Director of Business Improvement & Transformation	• Chairman, Marehay Cricket Club • Member of the Labour Party	(d) (e)
Geoff Lewins Non-Executive Director	• Director, Arkwright Society Ltd	(a)
Ifti Majid Chief Executive	• Board Member NHS Confederation Mental Health Network • Kate Majid (spouse) Chief Executive of the Shaw Mind Foundation which is a global mental health charity	(e) (a, d)
Mark Powell Chief Operating Officer	• Chair of Governors, Brookfield Primary School, Mickleover, Derby	(e)
Amanda Rawlings Director of People and Organisational Effectiveness (DHCFT)	• Director of People and Organisational Effectiveness, Derbyshire Community Healthcare Services (DCHS) • Co-optee Cross Keys Homes, Peterborough	(e) (e)
Dr Julia Tabreham Deputy Trust Chair and Non-Executive Director	• Non-Executive Director, Parliamentary and Health Service Ombudsman • Director of Research and Ambassador Carers Federation	(a) (d)
Dr John Sykes Medical Director	• Undertakes paid assessments of patients at the request of the local authorities under the Mental Health Act and Mental Capacity Act and acts likewise for solicitors representing patients.	(e)
Richard Wright Non-Executive Director	• Executive Director, Sheffield Chamber of Commerce • Chair Sheffield UTC Multi Academy Trust • Board Member, National Centre of Sport and Exercise Medicine Sheffield	(a) (a) (d)

All other members of the Trust Board have nil interests to declare.

(a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those dormant companies).
(b) Ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
(c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
(d) A position of authority in a charity or voluntary organisation in the field of health and social care.
(e) Any onnection with a voluntary or other organisation contracting for National Health Services, or hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or any other body which could be seen to influence decisions you take in your NHS role (see conflict of interest policy -loyalty interests).

Derbyshire Healthcare
NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Tuesday 2 April 2019

MEETING HELD IN PUBLIC

Commenced: 9.30 Closed: 12:15

PRESENT	Caroline Maley	Trust Chair
	Dr Julia Tabreham	Deputy Trust Chair and Non-Executive Director
	Margaret Gildea	Senior Independent Director
	Geoff Lewins	Non-Executive Director
	Dr Anne Wright	Non-Executive Director
	Richard Wright	Non-Executive Director
	Ifti Majid	Chief Executive
	Claire Wright	Director of Finance & Deputy Chief Executive
	Mark Powell	Chief Operating Officer
	Carolyn Green	Director of Nursing & Patient Experience
	Dr John Sykes	Medical Director
	Amanda Rawlings	Director of People Services & Organisational Effectiveness
	Gareth Harry	Director of Business Improvement & Transformation
	Suzanne Overton-Edwards	Non-Executive Director under NHSI NExT Director scheme
IN ATTENDANCE	Anna Shaw	Deputy Director of Communications & Involvement
	Sue Turner	Board Secretary (minutes)
	Gail Tivey	Team Administrator Eating Disorders Service
	Michaela Gilbert	Higher Specialist Trainee
For item DCHFT2019/047	Rachel Kempster	Risk and Assurance Manager
VISITORS	Lew Hall	Public Governor, Erewash
	Lynda Langley	Public Governor, Chesterfield
	Jo Foster	Staff Governor, Nursing
	Kelly Sims	Staff Governor, Admin & Allied Support Staff
	Sandra Austin	Derby City & South Derbyshire Mental Health Carer's Forum and Trust Volunteer
	Noel O'Sullivan	Trust Volunteer and Peer Support Worker

DHCFT 2019/037	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** The Trust Chair, Caroline Maley, welcomed all to the meeting. Introductions were made to Gail Tivey, Team Administrator from the Eating Disorders Service who attended meeting to shadow the Chair and Michaela Gilbert a Higher Specialist Trainee who was shadowing Chief Executive, Ifti Majid.

	Incoming Trust Secretary, Justine Fitzjohn was welcomed to her first meeting with the Board prior to her official start date in June. A warm welcome was extended to Deputy Trust Chair and Non-Executive Director, Julia Tabreham after her extended leave of absence. No declarations of interest in agenda items were raised.
DHCFT 2019/038	**<u>DECLARATIONS OF INTEREST REGISTER</u>** The Declaration of Interests Register annual report provided the Board with an account of Directors' interests during 2018/19. It was noted that all Board members have personally reaffirmed in writing their agreement to comply with the NHS Codes of Conduct and Accountability, and the Seven Principles of Public Life (Nolan). The Declaration of Interests Register will be listed in the Trust's annual report and accounts for 2018/19 and will include the declarations relating to the Chief Operating Officer, Mark Powell that had not been included in the report. Declarations raised at the meeting by Suzanne Overton-Edwards who is undertaking a placement through the NHSI NExT Director scheme are not required to be disclosed within the Declaration of Interests Register as they have been recorded in the Trust's Fit and Proper Person Test (FPPT) files in line with the FPPT Policy. **ACTION: Register of Interests to be updated to include declarations made by the Chief Operating Officer** **RESOLVED: The Board of Directors:** **1) Approved the declarations of interest as disclosed, subject to the addition of declarations relating to the Chief Operating's Officer** **2) Acknowledged that the Register of Interests is accessible to the public at the Trust Head Office and will be listed in the Trust's annual report and accounts for 2018/19** **3) Recorded and noted that all Directors have signed as to compliance with the NHS Codes of Conduct and Accountability and Nolan principles; no relevant audit matters have been declared.**
DHCFT 2019/039	**<u>PATIENT STORY</u>** Today's story featured the voice of a child told through School Nurse, Stephanie Coglan who relayed the experience of a fourteen year old girl who disclosed a two year episode of inter familial sexual abuse. Stephanie conveyed how this disclosure was made to her during one of the drop in sessions that she holds for students to talk to her about their worries and anxieties. Initially this student wanted to talk about the relationship difficulties she was experiencing at home and eventually disclosed that a family member had been sexually abusing her for around two years. This was the first time she had told anyone and to begin with she felt relieved to have finally had the courage to speak about it. The student was referred to a specialised service called The Keep which is

	commissioned collaboratively between Derby City Council and Southern Derbyshire CCG and delivered by a specialist team of Clinical Psychologists and Therapeutic Social Workers from Derby Teaching Hospitals NHS Foundation Trust. The Board heard how she had found treatment extremely difficult as she was not ready to undergo psychological work around her abuse. In addition to this she was not provided with person-centred goals as there appears to be a gap between psychological services when a person is pre-therapy. Ifti Majid observed the wider issues relating to this complex case and reflected on the importance of listening to people and providing them with appropriate treatment that is aligned around person centred care. This is a change that should be made to the way that the system and the Trust works with its partner services so that a better trauma informed practice can be provided for children and young people in similar situations in the future to eliminate all gaps. The Board recognised that school nursing is critical to enabling children to make disclosures. The anxiety felt by children and young people is overwhelming and a large part of a school nurse's working week is spent dealing with students who are suffering from anxiety based issues. The main themes being disclosed are general anxiety and social anxiety, issues relating anger management as well as self-harm. The Board discussed how important it is that lessons are learnt about interagency working and responding to the needs of people so that the individual can decide on the trauma therapy and psychological support treatment to be received at a pace that is meaningful to them. As a mental health system it is important to join up with multi-agency partners and work with a trauma service across the system to improve the service for children and young people who have access to our services. In this case the CAMHS (Child and Adolescent Mental Health Service) team decided not to treat the trauma from sexual abuse. This was to be treated by The Keep that supports children and young people who have suffered sexual abuse by providing evidenced based interventions on a one-to-one basis. The Board resolved to learn from this case and committed to taking this learning forward with the Trust's system partners to ensure that a trauma and person centred approach is provided for young people. This will be raised through the children and young people's work stream to ensure this story serves as an example to drive commissioning of children's services across Derbyshire. This story will be articulated as evidence of the need to change and improve the service provided for children. **RESOLVED: The Board of Directors committed to taking the learning from this case forward with the Trust's system partners to drive commissioning and improve the delivery of children's services across Derbyshire**
DHCFT 2019/040	**MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 5 FEBRUARY 2019** The minutes of the previous meeting, held on 5 March 2019, were accepted as a correct record of the meeting.
DHCFT 2018/041	**MATTERS ARISING** **DHCFT2019/032 Flu Self-assessment report:** Director of People and Organisational Effectiveness, Amanda Rawlings advised the Board that following the previous meeting a review of staff flu vaccination data had determined that the

	vaccination rate had increased from 51% to 54%. Work is taking place within the People and Culture Committee and Executive Leadership Team to ensure improved staff vaccination rates during next year's campaign.
DHCFT 2018/042	**ACTIONS MATRIX** The Board agreed to close all completed actions. Updates were provided by members of the Board and noted on the actions matrix. All completed 'green' actions were scrutinised to ensure that they were fully complete and actions that were not complete were challenged with Executive Director leads.
DHCFT 2019/043	**QUESTIONS FROM GOVERNORS OR MEMBERS OF THE PUBLIC** No questions had been received from members of the public or governors in advance of the meeting.
DHCFT 2019/044	**CHAIR'S UPDATE** This report provided the Board with the Trust Chair's summary of activity undertaken since the previous Board meeting held on 5 March 2019. Caroline gave a brief overview of the visits she had made to some of the Trust's services. She referred to her visit to the Eating Disorders team in Belper where she attended a clinical meeting. She also attended a team meeting and was pleased to have Eating Disorders, Team Administrator, Gail Tivey attending today's Board meeting as her shadow. Caroline reported on the positive feedback received from the NHS Providers regional governor workshop that the Trust hosted on 26 February. She was pleased with the engagement by the Trust's governors who attended and was extremely proud of the presentation that she made with Lead Governor, John Morrissey on how the relationship between the Board and the Council of Governors has developed and what they considered were the elements of success. Caroline also welcomed new governors following the outcome of Council of Governor elections held in March. Of particular note was the business that the Remuneration and Appointments Committee discussed. This included succession planning and consideration of the impact that changes to pension taxation rules that affect wider staff which is a national issue. The Committee agreed to escalate these changes to the Board and to include the risk that arises from these changes on the retention of a number of senior staff and consultants in the Board Assurance Framework (BAF). Special thanks were made in Caroline's report to Director of Corporate Affairs and Trust Secretary, Sam Harrison who is leaving the Trust after her three year tenure. Appreciation was shown for her support during the transition to incoming Trust Secretary Justine Fitzjohn over the next few weeks. Caroline drew attention to the Operational Plan meeting held on 27 March that she attended with the Chief Executive, Chair of Audit and Risk Committee, Chair of Finance and Performance Committee, the Director of Finance and Deputy Director of Finance to scrutinise the Trust's 2019/20 plan ahead of submission to NHS Improvement on 4 April. She confirmed that, with delegated authority on behalf of the Board, they were able to sign off the plan.

	RESOLVED: The Board of Directors noted the activities of the Trust Chair since the last meeting held on 5 March 2019
DHCFT 2019/045	**CHIEF EXECUTIVE'S UPDATE** This report provided the Board of Directors with feedback on changes within the national health and social care sector as well as providing an update on developments occurring within our local Derbyshire health and social care community. The report reflected on a wider view of the Trust's operating environment and served to highlight risks that may affect the organisation. Risks identified will be taken forward to assess their operational and strategic impact and recorded on operational risk registers or the BAF. Ifti Majid drew attention to the key findings of the 'Addressing the Care Deficit' particularly with regard to the pressures being experienced with demand for services outstripping supply. He intends to discuss addressing the MHIS (Mental Health Investment Standard) in our organisation with the CCGs as it is clear that changes to universal credit and benefits has increased demand for services, particularly with issues such as loneliness, homelessness and wider deprivation here in Derbyshire. The Board noted the uncertainty about the future role of mental health specialist organisations and the care that will support the governance of the Integrated Care Systems (ICS) and how people with complex health problems will have their needs met. Discussion focussed on the ICS proposal and how this will be worked through Joined Up Care Derbyshire (JUCD). Ifti thought that this work sounded encouraging. An integrated data source across all organisations across Derbyshire is helping us understand how cohorts of people using services would benefit from the revision of services within the county. Ifti proposed bringing a paper to the Board that will outline the new plan of the integrated care offer that will be considered when work commences with the refresh of our Trust Strategy and the new care model. This paper will enable further discussions on changes within system care. The report also provided an update on developments within work streams of the Mental Health System Delivery Board. Ifti and Non-Executive Director Anne Wright had both attended this meeting on 21 March and were pleased to see that notable progress had taken place with regard to the planning of the development of wellbeing hubs. There is more to understand about what the expectation standards are for mental health services and the work that Chief Operating Officer, Mark Powell is undertaking with a working group reviewing mental health standards will mean that the Trust will be at the forefront of embracing this work. Non-Executive Director, Geoff Lewins referred to the proposals to modernise the four hour wait target in A&E departments. He asked about waiting time access and whether there are liaison teams already in place within hospitals. Ifti was pleased to assure him that we have a very strong liaison team in our two main hospitals in Derbyshire who work to make sure that if someone presents with a mental health disorder they will be seen within an hour. The Board was pleased to note that the Trust has continued to perform strongly in data security and protection through the Information Governance Toolkit. In response to Non-Executive Director, Richard Wright's reference to the Trust's increased posting of news and features on Facebook and Twitter, he was assured

	that the relevance of these messages was being measured and controlled by generating activity around key subjects with the aim of addressing some of the stigma regarding mental health diagnoses and services. **RESOLVED: The Board of Directors scrutinised the Chief Executive's update, noting the risks and actions being taken.**
DHCFT 2019/046	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT** The Integrated Performance Report (IPR) provided the Board with an integrated overview of performance as at the end of February. The focus of the report is on workforce, finance, operational delivery and quality performance. This month's report included benchmarking data that demonstrates how the Trust is performing in comparison with other trusts. The Trust continues to perform well against many of its key indicators with maintenance or improvements continuing across many of the Trust's services. In terms of workforce performance it was noted that sickness absence levels had improved throughout February. The new adjustments in sickness absence management and the introduction of the wellbeing support process were seen as a positive initiative that will help improve sickness absence rates. Director of People and Organisational Effectiveness, Amanda Rawlings reported that a new style induction welcoming new starters to the Trust had commenced this week. New staff now carry out a five day induction that includes the completion of mandatory training enabling them to be fully prepared when they move into their role. Richard Wright noted the increased levels of recruitment that have occurred following a range of new and innovative techniques were introduced and asked how the pipeline of new staff was being built up. Amanda Rawlings advised that the People Services team is working closely with universities and increasing nursing apprenticeships are helping to grow and develop our workforce. We are also working closely with schools and colleges to promote nursing as a career within the Trust as well as helping people return to practice. The increased activity that took place on recruitment resulted in the enrolment of over 360 staff in 2018/19. A number of consultants have also been recruited to the workforce. Medical Director, John Sykes added that although we have been successful in recruiting consultants, retention is proving challenging due to changes to taxation and pensions which has resulted in a number of consultants moving into the private sector. Some specialities are difficult to recruit to but we are seeing success with new workforce models that have been designed for new generations to encourage young consultants to join us. There are also a high number of cases of maternity leave. Geoff Lewins asked whether the high health visitor caseload was due to the need to recruit and retain staff or whether it is due to lack of commissioning. Mark Powell explained that there is a real difficulty in recruiting health visitors. This area of work is quite challenging and the recruitment of more staff would result in reduced caseloads. A significant amount of safeguarding work is a specific part of this service and discussions are taking place with commissioners to make them aware of the type of cases we are dealing with and the need to develop an improved specification. Discussion took place on out of area placements. The split of out of area

	placements between adult acute and PICU (Psychiatric Intensive Care Unit) shows that two out three out of area placements are within PICU which is due to the Trust not being commissioned for PICU. It was thought that having access to our own PICU facilities would be beneficial as 880 beds are across adult acute and PICU, most of which are provided by private providers. A report on the plans that are being developed and the PICU clinical operational detail will be reported to the Finance and Performance Committee in May. It was also suggested that a Board Development session takes place to enable us to develop the Trust's PICU position. Mark Powell drew attention to the NHS complaints benchmarking information. The Quality Committee regularly analyses themes arising from complaints contained in reports on patient experience. Key themes are often related to access to services and waiting times and shows we are rated comparatively with other trusts. Other benchmarking data covered the use of IAPT services which showed that the Trust is performing well. It was understood that commissioners are potentially looking for a lead provider that will take responsibility of this high volume complex service. Mark Powell proposed bringing a report to the Board outlining how this service will be commissioned which will provide an opportunity for strategic options to be explored. Director of Finance and Deputy Chief Executive, Claire Wright reported on the Trust's financial position. The Trust is expecting to achieve its control total for 2018/19 and she waits to be informed whether we will qualify for bonus provider sustainability funding. The Board concluded that good debate had taken place on the Trust's strategic options for the future. An update report on responsiveness will be included as an addendum to the IPR next month that will set out our response to access standards as well as our performance. **ACTION: Development of PICU to be captured in Board Development programme** **RESOLVED: The Board of Directors received the report and obtained limited assurance on current performance across the areas presented**
DHCFT 2019/047	**<u>BOARD ASSURANCE FRAMEWORK</u>** This report presented by Risk and Assurance Manager, Rachel Kempster, provided the Board with details of the fifth and final issue of the Board Assurance Framework (BAF) for 2018/19. The report also included the first issue of the 2019/20 BAF. At year end eleven risks are identified in the BAF for 2018/19. Since Issue 4 of the BAF, the risk ratings for two of the risks have been revised: • Risk 18_19 1d. *There is a risk that the Trust will fail to redesign the Care Programme Approach (CPA) processes, which may impact upon the quality of care provided to patients and their carers* has been reduced from a risk rating of high to moderate due to strong performance of CPA in line with compliance against national standards. Target risk rating achieved and risk appetite accepted. • Risk 18_19 3a *There is a risk that the Trust fails to deliver its financial plans*

	has been reduced from a risk rating of high to moderate based on Month 11 finance report and the financial forecast for year end. Target risk rating achieved and risk appetite accepted. The Board noted the decision taken at the Audit & Risk Committee on 21 March relating to Risk 18_191d *There is a risk that the Trust will fail to provide full compliance with the Mental Health Act and the Mental Capacity Act*. This risk was expected to have been reduced from high to moderate by the Mental Health Act Committee at its meeting on 8 March but gaps in controls had not been reduced enough for the risk to be downgraded. On that basis the Audit and Risk Committee was satisfied to accept the closure of the BAF for 2018/19on the basis that remaining gaps in controls would be worked through the next round of discussions and articulated in the next issue of the 2019/20 BAF. Following significant discussion and consideration by the Executive Leadership Team throughout February and March and the Board Development Session in February 2019, it is proposed the number of BAF risks for 2019/20 be reduced from eleven to five. The changes for 2019/20 were noted: • Following the review of the Trust's Strategic Objectives at Board in February 2019, risks have been identified to achieving these revised objectives with an enhanced focus on high level strategic actions to ensure that once completed the risk is mitigated and the risk rating reduced This has resulted in the number of gaps in controls and assurances for each risk being reduced, to identify only high level key gaps • Clear measurables have been included for each action identified to outline what is required to close the gaps in controls and assurances. These will be assertively monitored and regulated through the Executive Leadership Team The Board agreed and approved the closure of the fifth and final issue of the BAF for 2018/19. It was acknowledged that the BAF will evolve to include the Trust Strategy and the work of the Board Committees over next year with the approval of the first issue of the BAF for 2019/20. It was noted that Issue 2 of the BAF will be submitted to the Audit and Risk Committee on 23 May and will be received by the Board in June. **RESOLVED: The Board of Directors:** **1) Agreed and approved the fifth and final issue BAF for 2018/19 and the significant assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives, including the amended risk ratings for risk 1d and 3a** **2) Received and agreed the proposed BAF version 1.0 for 2019/20** **3) Agreed to receive a quarterly update of the 2019/20 BAF risks as outlined in the forward plan.**
DHCFT 2019/048	**<u>PREPARATIONS FOR BREXIT</u>** The Trust's EU Exit Senior Responsible Officer, Mark Powell provided Board members with a report on the Trust's preparations to operate under the conditions of a no deal Brexit. As part of this planning, the Trust is making regular returns to NHS England

	regarding the state of our preparedness. The Board noted the content of the submission that was made following Chair and CEO approval on 22 March by the Trust's EU Exit Senior Responsible Officer along with nominated colleagues from the Trust's EU Exit team. **RESOLVED: The Board of Directors noted the submission returned to NHS England**
DHCFT 2019/049	**LEARNING FROM DEATHS MORTALITY REPORT** This report presented to the Board by Medical Director, John Sykes was produced to meet requirements set out in the 'National Guidance on Learning from Deaths' as part of our wider focus on patient safety. The Board acknowledged that the Trust's services are under intense operational pressure dealing with patients with potentially high clinical risk. Services are run as safely as possible and the concept of a safety culture is continually being developed. It was noted that no trust in England has an outstanding rating for safety and that 37% of mental health trusts (including our own) are rated as 'require improvement'. The Board understood the need to avoid significant incident investigations and mortality reviews becoming a source of excessive anxiety for staff. Learning from deaths is vitally important will be fundamentally driven through the Trust Strategy in order to achieve continuous improvement. Assurance was received that actions contained in the action log within the report are closely monitored by the Quality Committee and the Serious Incidents Group. The main causes of death to people open to our services for Derbyshire are no different to other trusts across the country. Anne Wright made the point that people who have mental health issues tend to have a reduced life expectancy of twenty years and that understanding how this can be improved should be a focus of our learning. John Sykes as Executive Lead assured the Board that he is working to improve the prevention of any further mortality wherever possible and will take this up with the Mortality Group. **ACTION: Mortality Group to explore how to improve the life expectancy of people who have mental health issues by sampling cases of premature death** **RESOLVED: The Board of Directors accepted this Mortality Report as assurance of our approach and noted that it is published on the Trust's website as per national guidance**
DHCFT 2019/050	**BOARD EFFECTIVENESS SURVEY REPORT AND POLICY FOR ENGAGEMENT BETWEEN THE BOARD AND COUNCIL OF GOVERNORS** This report provided the Board with the results of the Board Effectiveness Survey conducted in September/October 2018. Caroline Maley was pleased to note that the survey results showed a sustained improvement but was disappointed that only eleven out of fourteen Board members had responded to the survey. It was agreed that the survey would be completed again in September and reported to the Board in November. It was noted that a review of the policy for engagement between the Board and

	Council of Governors had demonstrated the development of engagement opportunities that are now embedded as business as usual which ensured that a positive relationship has been upheld. **ACTION: Results of Board Effectiveness Survey to be reported to the Board in November 2019 and captured in the forward plan** **RESOLVED: The Board of Directors:** **1) Noted the outcome of the Board Effectiveness Survey October 2018** **2) Agreed that the survey should be completed again in September 2019 and reported to the Board in November** **3) Noted the activity to positively implement the Policy for Engagement between the Trust Board and Council of Governors which has been presented to the Council of Governors in November 2018**
DHCFT 2019/051	**<u>BOARD COMMITTEE ASSURANCE SUMMARIES AND ESCALATIONS</u>** Assurance summaries were received from the Board Committees and highlights were provided by the respective Non-Executive Chair. **Mental Health Act Committee 8 March:** Committee Chair, Anne Wright reported that discussion during the meeting had focussed on reviewing improvement activity in areas of high occupancy/workload levels and compliance with the Mental Capacity Act and Mental Health Act and the approach to be taken to facilitating positive and safe practice. The Committee requested that the Chief Executive produces a report to the Board clarifying the strategic importance and outcome of reverse commissioning to ensure that meaningful input can be made by the Committee. Ifti Majid proposed that this report be included as part of the next Equality and Diversity report to the Board due in July. **Quality Committee 12 March:** Acting Chair, Margaret Gildea highlighted the wider strategic impact of overloaded services and suggested that an improvement strategy is addressed by the Board through a Board Development session. The Board observed that a similar demand on capacity was highlighted by the Mental Health Act Committee and supported this proposal. **Finance and Performance Committee:** Chair, Richard Wright reported that the Committee had discussed next year's plan and commissioning which was also reported on in the IPR. The Committee's objectives for 2019/20 were considered when a review of the Committee's end of year effectiveness was held. It was thought that objectives relating to speaking up and equality, diversity and inclusion should be consistent throughout all the Board Committees. **Audit and Risk Committee 21 March:** Chair, Geoff Lewins advised that the Committee is in the process of year-end verification activity. Significant assurance was obtained that the 2017/18 annual report has been prepared in line with the requirements set out in the External Auditors' benchmarking report. The Committee also received significant assurance on lessons learned on counter fraud and bribery cases and the issues raised through a historic review of sickness absence. **ACTION: Report on the outcome of reverse commissioning to be received as part of the Workforce Race Equality Standard due in July** **ACTION: Board Development session to be scheduled to address the impact**

	of overloaded services **RESOLVED: The Board of Directors received and noted the Board Committee Assurance Summaries**
DHCFT 2019/052	**SUMMARY REPORT OF MEETING OF COUNCIL OF GOVERNORS HELD ON 5 MARCH 2019** This report was included for information purposes and was noted by the Board.
DHCFT 2019/053	**REGISTER OF TRUST SEALINGS 2018/19** In accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors the Trust Seal is affixed to legal transactions, including deeds, transfer and letting of contracts over £100,000. This report provided the Trust Board with an update of the authorised use of the Foundation Trust Seal since the last report to the Board in October 2018 and completes reporting on the use of the seal for the 2018/19 financial year. **RESOLVED: The Board of Directors noted the authorised use of the Foundation Trust Seal since 2 October 2018 and received full assurance that this has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.**
DHCFT 2019/054	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK** No additional issues were raised in the meeting for updating and including in the Board Assurance Framework.
DHCFT 2019/055	**DRAFT 2019/20 BOARD FORWARD PLAN** The draft 2019/20 forward plan was noted by the Board and would be further reviewed by the Executive Leadership Team. The schedule for quality reporting on essential standards set by the CQC is currently being worked into the forward plan. An update report on responsiveness will be brought to the Board next month that will set out our response to access standards as well as our performance.
DHCFT 2019/056	**MEETING EFFECTIVENESS** Attendees and visitors were thanked for their attendance at today's meeting. All Board members confirmed they felt included in today's discussions. Strategic discussions took place particularly with regard to the CEO's report and the IPR. Today's moving patient story had been at the forefront of the Board members' thoughts during the meeting and had enabled the Board to reflect on the action to be taken forward. Carolyn Green proposed conducting an impact analysis of patient stories received by the Board and would prepare a report so that the Board can be made aware of action taken. The Board was delighted that Noel O'Sullivan had attended today's meeting as a visitor as this showed the influence of the direction that can be taken from patient stories to the Board.

	Gail Tivey who shadowed Caroline Maley was pleased to see how the Board had discussed issues that concerned the Eating Disorders team, these included waiting times and the lack of capacity and high demand felt by staff which she would feed back to the team. Michaela Gilbert enjoyed her involvement shadowing Ifti Majid. She found it reassuring that the Board had talked seriously about concerns felt by front line staff. She was pleased that the Trust is getting more involved in social media which she felt will have a positive effective on reducing the stigma associated with mental health. Having returned to the Trust after a leave of absence Julia Tabreham found it interesting to observe the evolution of the Board. She felt this had been an extremely positive meeting and had found the development of the BAF extremely effective. **ACTION: Forward plan to feature reporting of Patient Story outcomes**
The next meeting of the Board to be held in public session will take place at 9.30 on Tuesday 7 May 2019 in Conference Rooms A&B, Research and Development Centre, Kingsway, Derby DE22 3LZ.	

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - MAY 2019			
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
2.4.2019	DHCFT2019/046	Integrated Performance and Activity Report	Mark Powell	Development of PICU to be captured in Board Development programme	7.5.2019	Scheduled for July Board Development	Green
2.4.2019	DHCFT2019/049	Learning from Deaths Mortality Report	John Sykes	Mortality Group to explore how to improve the life expectancy of people who have mental health issues by sampling cases of premature death	7.5.2019	Added to Mortality Group work plan for progression	Green
2.4.2019	DHCFT2019/049	Board Effectiveness Survey Report	Justine Fitzjohn Sue Turner	Results of Board Effectiveness Survey to be reported to the Board in November 2019 and captured in the forward plan	7.5.2019	Board Effectiveness Survey Report captured in the forward plan for November 2019	Green
2.4.2019	DHCFT2019/051	Board Committee Assurance Summaries and Escalations	Ifti Majid	Report on the outcome of reverse commissioning to be received as part of the Workforce Race Equality Standard due in July	7.5.2019	Report on outcome of reverse commissioning captured in the forward plan for July 2019	Green
2.4.2019	DHCFT2019/051	Board Committee Assurance Summaries and Escalations	Mark Powell	Board Development session to be scheduled to address the impact of overloaded services	7.5.2019	Acute Service review scheduled for July Board Development	Green
2.4.2019	DHCFT2019/056	Meeting Effectiveness	Carolyn Green	Forward plan to feature reporting of Patient Story outcomes	7.5.2019	Report on Patient Story outcomes factored into forward plan for September	Green

Resolved	**GREEN**	**6**	**100%**
Action Ongoing/Update Required	**AMBER**	**0**	**0%**
Action Overdue	**RED**	**0**	**0%**
Agenda item for future meeting	**YELLOW**	**0**	**0%**
		6	**100%**

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 7 May 2019

Trust Chair's report to the Board of Directors

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on my activity with and for the Trust since the previous Board meeting on 2 April 2019. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

1. I continue to make a point of visiting as many front line services as possible, so that my leadership is grounded on the reality of what our staff face every day, and also to ensure that I have a good understanding of the services provided by the Trust.

2. I attended the induction day for undergraduate students (fourth year) from the University of Nottingham on 25 March 2019 as they began a five week placement with the Trust. I also attended two of their masterclasses – on anxiety disorders and on personality / substance misuse over the course of the month. I shadowed Simon Rose, an expert by experience, who works for the Trust and I was able to meet several other experts by experience who work as volunteers for us. The students can work on our wards, in the community and crisis teams and also engage in training with actors in the masterclasses. It was good insight into how we deliver this work. I hope that the students leave their placement with a desire to become psychiatrists, or if not that, having gained a good grounding in mental health which they can use in their future work in any line of medicine.

3. I visited Crisis Team North on 3 April. It was encouraging to hear how the team has grown a multi-disciplinary staff group with the addition of occupational health and social care workers, and the recruitment of band 5 nurses with experience of working in the inpatient units. I also sat with staff and watched them carrying out their work and was impressed by the patient centred and calm manner in which they assessed their patients. I look forward to returning in the future to join them out in the community visiting patients. I will be shadowed at the June Board Meeting by Lisa-Anne Mack, Senior Nurse on the team.

4. I met the training team of People Services on 10 April. It was a useful insight for me into the breadth of work that the team carries out, looking after both our staff and Derbyshire Community Health Services Foundation Trust (DCHS), some 7,500 staff in all. New recruits to the team were based in our offices, and it was good to meet them. It is clear that there are different needs for each trust, and different terminology for the team to get up to speed with, but there is no doubt that they were passionate about delivering what the Trust needs on all its training fronts.

5. I attended TMAC (Trust Medical Advisory Committee) with Mark Powell, Gareth Harry and Ifti Majid on 11 April. This is an important group of staff who we need

to engage on several fronts – from the development of our clinical strategies to the leadership programme that we have put in place. It is obvious that there is a tension between clinical work and engaging in leadership and other non-clinical meetings, but we need to enable this to happen wherever possible.

6. On 18 April, I joined the BME Network for their regular meeting. It was good to get an insight into the agenda that they are facing, and I would like to support them in achieving their aims and objectives. I am sad when I hear that individuals have been bullied and targeted because of the colour of their skin. No member of staff should face any bullying or harassment, and we need to find a way of spreading the message of zero tolerance for this behaviour. Sharon Rumin chaired the meeting, and I have invited her to shadow me at this month's Board Meeting. We also need to be supporting the group with a clear remit and enable them to deliver on these over the course of a year – whether it be with budget, opportunity or other resources.

7. Next month I am visiting the Community Team as St Oswalds, and the Substance Misuse team at St Andrew's House.

Council of Governors

8. On 26 March I met the newly elected governors at their induction training. This is an afternoon where we set out what the role of a governor in our Trust is and the support and help that they can expect from the Trust. Four governors attended, and as always it is good to see the passion and skills that they bring to their role.

9. I met with John Morrissey, Lead Governor on 4 April. This is a regular meeting with John, and hopefully he will be joined in future by the Deputy Lead Governor when elected in due course.

10. The Governance Committee met on 9 April and was chaired for the first time by Kelly Sims following her election as chair of the Governance Committee. A substantial part of the meeting was devoted to the consideration of the draft Quality Report, which governors are expected to provide feedback on under the NHS Improvement's (NHSI) requirements for quality reports. It was reassuring to see governors providing comments on the draft report, and even suggestions for improvement for next year's report.

11. The next meeting of the Council of Governors will be on 7 May 2019 after the public Board meeting. A Governors Nominations and Remuneration Committee meeting is planned for 22 May and will commence planning for the recruitment of a clinical Non-Executive Director (NED) over the course of the summer. The next Governance Committee takes place on 12 June.

Board of Directors

12. Board Development in April was cancelled due to the Easter Holidays impacting attendance. However, I am pleased to report that we have developed a comprehensive Board Development Programme, which is attached as Appendix 1 to this report. I am grateful for Senior Independent Director, Margaret Gildea's support in developing the programme, but also to other Board members

for their input both the programme, and in the future delivery of sessions. I firmly believe that the Board Development Programme needs to be a balanced programme, addressing the four lenses of development as set out in the Appendix.

13. The Board met on 2 April in Derby and once again I was pleased with the attendance by governors and members of the public.

14. I have not had any NED development meetings in this month, due to Easter holidays. In May I will be meeting with Anne Wright, Geoff Lewis and Suzanne Overton-Edwards. During these meetings we review performances against objectives set at the beginning of the appointment / review cycle, as well as discuss generally mutual views on the progress of the NED and the Trust and any personal development requirements.

15. Margaret Gildea, as Senior Independent Director, and I have worked together on a governor issue. I am grateful for the support I received from Margaret and other members of the Board in this matter, which is now resolved, and no formal report is required.

16. The Board Committee chairs met on 2 April, following the Board Meeting. This meeting was chaired by Geoff Lewins and time was spent considering end of year Committee reporting, cross Committee actions and other issues raised by NEDs.

System Collaboration

17. I attended the JUCD (Joined Up Care Derbyshire) Board on 18 April 2019. There continues to be a positive approach to collaboration and system working, which is reassuring. The main areas of discussion included financial reporting for the year and the future financial settlement; the development of primary care networks and the GP strategy, and the progress made on the development of a digital strategy. This will be covered in more detail in the CEO report.

18. Attached as Appendix 2 and 3 are the key messages noted from the meeting and the closedown reports for information.

Regulators; NHS Providers and NHS Confederation and others

19. Our planned quarterly catch up with Fran Steele, Delivery and Improvement Director, NHSI, was again postponed, and will now hopefully take place in May. There is a potential debate at JUCD on how the relationship with the regulators will develop, given the increasing focus on the ICS, indicating that the “old style” individual Trust PRM meetings (performance review meetings) with NHSI may not support a new way of working. I will keep you updated on how this develops.

20. In May we will be hosting Saffron Cordery, Deputy Chief Executive of NHS Providers. We are pleased that she requested a visit to our Trust, and we will be hearing from her at our Board Development day.

21. On 1 May I will be attending the NHSI Chairs meeting, which will be held in Birmingham. This is the first meeting since the announcement of the regional Director appointments of NHSI/NHSE (NHS England), and it will be interesting to see how this will change the focus or relationships at the meeting.

Beyond our Boundaries

22. I met with Dr Paula Holt from the University of Derby. It is pleasing to hear that we work well with the University in supporting our workforce of the future.

23. I met with Mark Hawkins, CEO of Factor 50, a small start-up company seeking to identify ways of supporting the NHS with digital analysis of data. They are currently exploring an option with Nottinghamshire Healthcare NHS Foundation Trust. The meeting was simply to find out more about mental health work and pressures and the system that we operate in. I worked with Mark more than 15 years ago.

24. I am taking part in the assessment panels for the Regional Talent Board (Aspire Together). The vision of Aspire Together is to move talent management from individual organisations to a place where it is owned and valued by the whole system. The first of the assessment days that I took part in was held on 3 December in Leicester. This is a pilot scheme being carried out in the Midlands and East and Dido Harding (Chair of NHSI) has an appetite to move faster with the pilot to identify more potential directors for a national talent pool.

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

Assurances

- The Board can take assurance that the Trust level of engagement and Influence is high in the health and social care economy.
- Feedback from staff and other stakeholders is being reported into the Board.

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

None

Public Sector Equality Duty & Equality Impact Risk Analysis

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

There are no adverse effects on people with protected characteristics (REGARDS).	x
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	

Actions to Mitigate/Minimise Identified Risks

This report reflects a wide range of activities across the Trust, and consideration relating to ensuring inclusion is embedded in operational work of the Trust. The specific services visited provide support to those with protected characteristics by the nature of their work.

With respect to our work with governors - we work actively to encourage a wide range of nominees to our governor elections, and strive that our Council of Governors is representative of the communities they serve. We also provide support to any current or prospective governors to enable them to carry out their role to address any specific needs they may have. This includes providing transport for those who may not be able to access public transport due to physical needs, accommodating communication requirements and providing support workers at meetings.

Demonstrating inclusive leadership at Board level

Through the Trust's involvement in the NeXT Director scheme, hosting a placement for Suzanne Overton-Edwards, we are supporting the development of those who may find it more difficult to be appointed as a NED in the NHS. We will also consider this as we look at succession planning for NEDs and Executives in the future.

Recommendations

The Board of Directors is requested to consider the content of this report, and to ask for any clarification or further information.

Report prepared and presented by: **Caroline Maley**
Trust Chair

Board Development

"NHS Boards need to operate as an entity and both comprehend and challenge a very complex and changing NHS environment. We therefore believe that all board should consider ongoing board development, but that this should be based on an understanding of the unfolding needs of the board and the likely future for their local services and market." [1]

In structuring the Board Development Programme for Derbyshire Healthcare, NHS Foundation Trust, we have attempted to adopt the following structure:

"Lenses of Development"	Purpose	Examples
Strategic	How to develop our strategic thinking and visioning capabilities of the whole board and provide regular opportunities to create, recreate and review strategic capabilities in the light of internal and external feedback.	• Strategy development and review • Stakeholder Management plan • BAF and risk planning • OD planning
Operational	How to build our effectiveness in the day to day working of the board; creating the opportunity to discuss, agree decision making processes, implementation / execution and review processes	• GGI Board Maturity Matrix (tool?) and Board effectiveness assessment / actions • Board to Ward – understanding the organisation we lead • CoG / Board holding to account and working relationships
Interpersonal	Building our softer skills; to build effective working relationships, identify and understand styles and appreciate diversity in the Board; to enable Board member to provide each other with constructive and developmental feedback on performance and behaviour within the Board team and its impact on others.	• Getting to know each other better • Understanding diversity of board skills and how best to deploy them Building better relationships – how to work as a team • Building the culture in the board that we want to see in the Trust
Wider needs	Beyond our boundaries; horizon scanning and time spent understanding the strategy implications of policy development and trends, scenario planning future proofing organisation and service developments	• Partnership working • Input from regulators / NHS Providers / other sectors • 3rd sector / voluntary sector deep dives • Board to Board with another organisation
Mandatory training	Board level mandatory training delivered appropriate to the needs of the Board that meets the need to demonstrate training compliance	• Training (MHA eg) • Information Governance • Safeguarding • Health and safety

Note: In 2018/19 we focussed on the 4 top lenses, but in 19/20 it is proposed that we separate out the mandatory training that is required to be done appropriately for the Board, so as to be explicit in allocation. It is the ambition to ensure that we have a balanced programme of Board development across the year, demonstrating growth and development in each of the lenses above.

[1] Developing board and senior teams: the how to do it guide (edited by Dr John Bullivant"

BOARD DEVELOPMENT PROGRAMME 2019/20

Board Dev Date	Development Lens 2019/20	Topic	Purpose of Session	Session Lead
No April meeting due to Easter school holiday break				
15 May	Strategic	Clinical pathway work part 1	9:30 – 10:00 Progress and high level themes coming out of the clinical strategy work to date	Gareth Harry
	Strategic	Digital Readiness	10:00 - 10.45 Update on current status of the readiness work and what, if anything, we would like to see included in the final report	Mark Powell
	Wider Needs	Visit by Saffron Cordery	11.00 – 12.30 presenting to Board a NHS Providers strategic scan followed by Q&A; lunch provided together at 12.30 – 1.00	Ifti and Caroline hosting
	Interpersonal	Board Skills assessment	1:00 – 3:00 Develop an understanding of the skills across the unitary board; an outcome for the session would be a better way of working playing to the skills of the whole board - more defined and comprehensive than the NEDs' skills assessment already undertaken	Margaret Gildea
	Mandatory training	Fire Safety	3:15 – 4.00 Fire Safety training to include all Board members - *compliance expires June 2019*	Carolyn Green (Carrina Gaunt to facilitate)
26 Jun (Remcom 9am)	Strategic	Clinical pathway work part 2	10:00 – 10:30 Outcome/next steps from clinical pathway work part II (including Clinical Champions)	Gareth Harry
	Strategic	Data usage	10:30 – 12:00 Making data count for Trust Boards: how to make more effective use of data to provide assurance and focus discussion.	Mark Powell
	Strategic	Corporate Governance structure	1:00 – 3:00 Aligning the Corporate Governance structure with the revised strategy; including Board Committees and membership and Exec leads	Caroline Maley / Ifti Majid / Justine Fitzjohn
	Mandatory training	Health & Safety training	*3:15 Compliance expires end of July. Mainly applicable to NEDs will be useful to include all Board members*	Carolyn Green (Carrina Gaunt to facilitate)

Board Dev Date	Development Lens 2019/20	Topic	Purpose of Session	Session Lead
17 Jul	Mandatory training?	Safeguarding	*This session was requested by the Safeguarding Committee to cover digital social media and a high level Serious Case Review KD17 which is relevant to Trust Strategy and care pathways - tbc*	Carolyn Green
	Operational / Strategic	Quality Improvement story	Developing a compassionate approach to patient care: understanding the work of Jenny Hartman and Stephanie Page and Cubleys (see email from John Sykes on 5/4/2019)	John Sykes
	Operational	Acute Units deep dive	To include staff teams/leaders *(Clarify outputs)*	Mark Powell
No August meeting (summer school holidays)				
18 Sep (Remcom 9am)	Interpersonal	Learning from constructive feedback	Developing a feedback culture in the board to enable personal learning and growth and to model the culture and behaviours that we expect from all in the organisation	Facilitated session: Clive Lewis; Sean; Simon Wilson?
15 Oct	Wider needs opportunity			
	Strategic	Board and CoG strategy and planning session	Board and Council of Governors Development Session (pm) *(Could this include Co-Production of Strategy)*	Justine Fitzjohn / *Carolyn Green?*
13 Nov	Strategic	Well-led self-assessment	Well-led self-assessment Session - *clarify exact purpose*	Justine Fitzjohn (360 Assurance)
	Wider needs opportunity			
18 Dec (Remcom 9am)	Mandatory training	Mandatory IG Training	Mandatory Data Security and Protection (IG) Training including cyber security	Claire Wright/Alex Rose
	Interpersonal	Christmas lunch	Build effective working relationships, identify and understand styles and appreciate diversity in the Board;	Caroline Maley

Board Dev Date	Development Lens 2019/20	Topic	Purpose of Session	Session Lead
15 Jan				
19 Feb	Strategic	Board Assurance Framework	BAF session and development of BAF for 2020/21(360 Assurance)	Justine Fitzjohn
18 Mar (Remcom 9am)	Mandatory training	Mental Health Act and Mental Capacity Act	Ensure compliance with required training; opportunity to understand implications of the changes to the MHA?	John Sykes
	Mandatory training	Equality and Diversity	Ensure Compliance with required training; option to extend to another opportunity to explore diversity and inclusion across the whole organisation	Amanda Rawlings Harinder Dhaliwal

Other sessions to be arranged in 2019/20:

- Leadership for Improvement – Board Development Programme - we have applied to be involved in this programme during 2019/20 and await details whether this will go ahead. The modules are as follows:
    - Organising for Improvement
    - Cultures and Behaviours for Improvement
    - Governing for Improvement
    - Measurement for Improvement
- Other meetings scheduled on 2019/20 Board Development Dates:
    - Remuneration and Appointments Committee meetings scheduled: 26 June, 18 September, 18 December, 18 March
    - NED visits following 4 June external Board meeting – to be planned!

Other topics to be scheduled:

Strategic	Interpersonal	Wider Needs	Operational
Stakeholder Management (Ifti Majid) Workforce – ten year plan (Amanda Rawlings) Co-production of Strategy (Carolyn Green)	Margaret Gildea and Caroline Maley to liaise and arrange	Board to Board with Northamptonshire Healthcare NHS Long term plan (Claire Murdock? (IM))	NHSI Session Freedom to Speak Up (Justine Fitzjohn)

JUCD Board – 18 April 2019 – Key Messages

1. Strategy for Primary Care

Primary Care remains at the heart of the local health and care system. The local GP vision, the CCG priorities and the national strategy for the sector continue to support this, build on existing success and to support practices to remain sustainable, to work at scale and in partnership and to continue to innovate in the provision of integrated care. A local primary care strategy is in development and this will be co-produced with primary care and other colleagues during the summer.

Primary Care Networks (PCNs) are being established to help practices work at scale and deliver an ambitious vision. Our local approach is that as much of the implementation is determined by PCNs to ensure they are locally owned. There are 14 proposed PCNs for Derby and Derbyshire and these largely reflect the geography of places and practices. We must confirm our final list of PCNs during May.

A transfer of resources from hospital-based care to primary and community care is required to deliver the agreed Derbyshire model. This will require some very detailed analysis, understanding and agreement about what this resource is needed for and how it can be released from secondary care in a meaningful way to support place-based services, tailored to local need.

2. Digital Developments

In 2015 all health economies were required to create a joint Local Digital Roadmap (LDR) including all NHS and social care partners. The focus in Derbyshire has been on 'converge and connect' strategy, supporting standardisation of information on common systems to support joined up care. There has been a significant amount of progress across the county, lots of which isn't immediately visible but has made a significant difference to patients and clinical services.

Developments have included:

- Shared records across community, mental health and social care to improve timeliness of care
- Supporting clinicians to transfer electronic readings from automated diagnostics and incorporate into patient records (eg BP monitoring)
- interoperability between services, particularly to support out of hours, end of life and infection control, including future support for patients to access own records
- Migration of mental health system to TPP SystmOne, as used in 80% of GP practices
- Safely sharing patient data across GP extended access hubs, supporting 108,200 additional and flexible GP appointments
- 100 mobile laptops to enable GPs to working in patient homes
- GP practice improvements, including patient display systems, security systems and equipment for consulting rooms to support practice expansions
- Wifi installed in care homes

3. System Finances

At month 11, the NHS element of the Derbyshire system is reporting an overspend of £13m, but it is expected that as month 12 information is validated that the NHS will achieve their final plans, including related sustainability funds from NHS England and NHS Improvement. The JUCD Board reflected that this a significant achievement for the system, considering the extent of the challenge we faced at the start of the financial year, and expressed their thanks to everyone involved for delivering this.

We begin 2019/20 with a £136.6m system deficit. It remains a challenging position, but the recovery plans to address the challenge are increasingly detailing transformation approaches which see parallel improvements to the quality and experience of care, whilst also providing financial savings.

A System Savings Planning Group has been established, including invitations to local authority colleagues, to ensure that our change programmes are properly coordinated across the system and to understand how we can share learning from previous work. We are also looking towards a system approach to how we engage with the new, joint health regulator, further evidencing that the system is increasingly working as a single unit in how it plans and is held accountable for change.

Joined Up Care Derbyshire

Our partnership

NHS, local councils and the voluntary and community sector have come together in 44 areas across England to develop proposals to improve health and care. They have formed new partnerships – known as sustainability and transformation partnerships – to plan jointly for the next few years. Our local sustainability and transformation partnership is known as Joined Up Care Derbyshire. It brings together twelve partner organisations and sets out ambitions and priorities for the future of the county's health and care.

All the organisations that provide health and care aim to work and plan much better together, focusing on new ways of working to:

- Help keep people healthy
- Give people the best quality care
- Run services well and make the most of available budgets.

In 2019 we will be reviewing our original plan, checking that our priorities still reflect the views of local people and that it is in line with requirements set out in the new NHS Long Term Plan.

Overview *[turn copy below into an infographic]*

<u>A review of 2018-19 – what is working well</u>

- Two new Dementia Rapid Response Teams introduced, supporting the new model of care for older people with mental ill health in the north of the county
- *£1.4m funding secured from East Midlands Cancer Alliance for four priority projects in southern Derbyshire - lung, prostate, colorectal (FIT) and living with and beyond cancer*
- The Intensive Home Support service for children and young people in mental health crisis led to a reduction in use of in-patient beds
- *'Single points of access' have been implemented within the four main Derbyshire health providers*
- £8.5 million was awarded to help develop the Bakewell community hub
- *An increase in the amount of patients achieving three NICE treatment targets (HbA1c, cholesterol and blood pressure) and reduced length of stay for in-patients with diabetes at University Hospitals of Derby and Burton*
- More efficient use of Chesterfield Royal's emergency department with GP streaming and an enhanced emergency department 'pit stop'
- *More than 3,700 online holistic wellbeing assessments have been completed in Derbyshire, helping our prevention agenda*
- A Quality Conversations Model has been developed, supporting the health and care workforce to maximise the health outcomes of their interactions with patients/carers
- *100% coverage across Derbyshire for extended access to GP practices, leading to 108,264 additional GP appointments available a year*

- Place Alliances have benefited from an organisational development programme, Leading Across Boundaries, helping clarify aims and accelerate change
- *A review of rotas in paediatric medicine at Chesterfield Royal has enabled a consultant presence on wards until 9pm, every day of the week*
- A programme to support GP retention has been run – 50 GPs have accessed the services to date
- *Services are being transformed for people with learning disabilities and/or autism so that fewer people require inpatient secure care, and acute and long-term inpatient care*
- Training and additional support has helped contribute to a reduction in the stillbirth rate, exceeding the local target of 4.79 stillbirths per 1,000 birth set for 2019
- *Access and recovery rates for Improving Access to Psychological Therapies are above national target*
- 1,422 members of the health, social care and voluntary sector have completed online delirium awareness training
- *Eight Place Alliances have been formed with clear reporting to the Place Board*
- A Derbyshire-wide Frailty Model has been launched
- *A Clinical Assessment Triage Service for MSK has been implemented across Derbyshire.*

A review of 2018-19 – our challenges

Our challenges have included capacity and resourcing – the difficulties of balancing organisational duties against working on STP priorities, resourcing the workstreams, and having sufficient project management capacity. We have faced difficulties with establishing pooled budgets, contracting mechanisms which do not support the new models of care being introduced, and challenges to services as a result of the CCGs' financial recovery plans. We know we need to improve communications between partners across the system. The Place Alliances need to become embedded and there needs to be greater clarity on roles and responsibilities for the workstreams. We also face challenges on recruitment and retention, with some 'hot spot' areas such as in pathology, radiology and oncology. These issues will be addressed in 2019-20.

Workstream highlights

Better Care Closer to Home

Better Care Closer to Home in North Derbyshire aims to improve care for older people by transferring the provision of care wherever possible from hospitals to the community. One initiative as part of this programme is the provision of community support beds, the number of which increased from 25 to 44 in 2018-19. These beds are for patients who are medically well enough to leave hospital but are not quite ready to return home or to the place they will call home.

https://www.youtube.com/watch?v=7nnEwAxLxFs&t=4s

Cancer

Our work aims to improve prevention, improve early diagnosis and treatment of cancer, and enable people to live well with and beyond a cancer diagnosis. In one area of diagnosis and treatment we secured £1.4m of funding from the East Midlands Cancer Alliance for four priority projects – lung, prostate, colorectal, and living with and beyond cancer. This has helped improve care and treatment across many services: speeding up diagnosis and testing using CT scanners and ECHO for lung cancer, providing MRI scans allowing one in four men with suspected prostate cancer to avoid an invasive biopsy, and providing more bowel cancer screening throughout the county.

Children's

Our work for children and young people covers various programmes including those with special educational needs and disability (SEND), delivering on the Future in Mind programme, and reducing use of urgent care. Future in Mind seeks to support mental wellbeing in children and young people through prevention and building resilience as well as improving access to services. In 2018-19, more than 1,500 'Be a mate' anti-stigma ambassadors were trained in schools; more children and young people were seen within the one and four-week waiting times in the community for eating disorder services; there was investment in third sector provision for early intervention; and the Intensive Home Support service for children and young people in mental health crisis helped reduce the number of inpatient bed days needed.

Digital

Health and care services have long been held back by a dated IT infrastructure and the inability of different organisational systems to work with each other. The digital workstream has been advancing plans to increase efficiency in the system and open up access to services. Primary care extended access has been delivered to all GP practices, new IT infrastructure is being installed (replacing the obsolete N3 data network), and online consultation pilots are being set up for patient signposting and renal telehealth.

Estates

Our health and care footprint across Derbyshire is constantly changing as we seek to make the best use of our land and buildings. Over the past year £8.5m has been awarded for the Bakewell Community Hub, we have gained income from selling land for housing at various sites including Walton Hospital, plans are in place for more integrated health and care

community hubs, and we are advancing plans for site developments and disposals linked to Better Care Closer to Home.

Knowledge and intelligence

In order to provide more insight to inform our plans, leaders in knowledge and intelligence have been working on various initiatives. These include the development of an outcome based accountability approach, helping gain a better understanding of the outcomes for patients/citizens who use the services, the establishment of a business intelligence working group, and a business intelligence sharing platform.

Learning disabilities and/or autism

Partner organisations have come together to improve the care and support available for people living with learning disabilities and/or autism in Derbyshire. People with a learning disability and/or autism are citizens with rights, who should expect to lead happy, safe, active lives in the community and live in their own homes just as other citizens expect to. In April 2018 there were 25 people in NHS England-commissioned secure beds – this is anticipated to be 16 people in March 2019. Organisations, including commissioners, NHS and local authority service providers, and the voluntary and community sector, have been working together in 2018-19 as the Transforming Care Partnership. Plans will be taken forward next year under 'Building the Right Support' – see the team's YouTube channel - https://bit.ly/2HgOFJm

Building the Right Support in Derbyshire - an introduction

Maternity

There are several priorities for maternity, including supporting safety, choice, continuity of care, post-natal care and improving access to place-based care. Improvements in maternity care over the past year have seen increased smoking cessation rates, a reduction in stillbirths, and further detection of growth restricted babies. Breastfeeding uptake has been promoted through a social marketing campaign, a pilot alternative model of postnatal care has taken place at the Queen's Burton unit (UHDB) and five continuity of care pilots are set to be launched.

Mental health

Mental health is being taken forward across four key areas – primary care, responsive communities, delirium and dementia, and complex care and forensic. In the case of primary care, there have been a number of advances made in 2018-19. Access and recovery rates for Improving Access to Psychological Therapies (IAPT) are above national target, the IAPT employment advisor service and IAPT long term conditions pilots are in place, a primary

care and responsive communities joint working group and a primary care/wellbeing hub interface working group have been established.

Place

'Place' involves commissioners, community services providers, local authorities, primary care, the voluntary and community sector, and the public working together to meet the needs of local people. Eight 'Place Alliances' have been established across Derbyshire. Place Alliances have been focused on supporting people to stay well for longer through a consistent set of work areas which include frailty (the Derbyshire-wide frailty model launched in September 2018), falls and care homes, as well as having the opportunity to develop tailored approaches to particular issues in their area. Projects have included interventions based on high intensity users of services (saving £220,000 in A&E attendances) and work with East Midlands Ambulance Service to reduce the number of people needing to attend hospital via ambulance.

Planned Care

Planned care relates to clinical services which patients access when they need scheduled operations, including the diagnostic and outpatient services which support clinicians in providing care. Clinicians can now use a new pilot service check whether patients need referring for a wide range of health conditions related to problems with muscles and bones. These can include back pain, hip replacements and physiotherapy. The aim is to have 50% of all appointments provided in the community. There is also ongoing work to move services from hospital settings into the community, where this is medically appropriate, and latest developments have seen some joint injections now provided outside of hospital. The way in which patients with heart, urology, ear nose and throat and respiratory conditions access services has also been improved.

Prevention

The main aim of the prevention work is to keep people well and avoid unnecessary admissions or contacts with other health services. In the last 12 months over 3700 holistic wellbeing assessments have been undertaken, providing clients with health and wellbeing plans and support or information into relevant services. The local community have been able to access stop smoking & Weight management support and referral into wider support services available in a variety of community venues across the county. 1059 smokers have accessed the stop smoking service and of those 568 have quit smoking. 774 people accessed the weight management service and 357 completed the programme, with 74% losing weight.

In Derby to date during 18/19, 538 people have joined the weight management programme, 52% achieving a 5% weight loss. 1303 have joined the stop smoking programme and 863 have achieved a 4 week quit rate.

Primary Care

All Derbyshire GP practices now offer extended access to patients, meaning there are now more than 108,000 additional weekend and evening appointments available. GP practices have also begun to work more closely in other ways, supporting their long-term resilience and sharing services for local patients. £800,000 has been invested in buildings and IT systems to improve care, with £1.5m spent on technology to support frontline GPs.

Urgent Care

Urgent Care incorporates all services which deal with patients who have unplanned, emergency or urgent health needs, including emergency departments, minor injury units, NHS 111, 999 and urgent care centres. A redesign of the way patients are received through the 'front door' of Royal Derby Hospital has seen a full business case submitted to NHS Improvement, along with designs being developed. This will bring benefits to both patients and the wider system in terms of improvement in flow in to the acute, improved outcomes, progress against the Derbyshire model of care, such as increased primary care streaming, an enhanced frailty provision, integration of teams and implementation of the Same Day Emergency Care Standards. This work has already been completed at Chesterfield Royal Hospital and despite increases in emergency department attendances of 130 patients per week compared to the same period last year, the Trust has maintained ED performance against agreed trajectory. A pilot study where clinicians validate potential NHS 111 referrals to emergency departments has seen a 75% reduction in the numbers of patients ultimately being referred, ensure patients receive care closer to home at the same time as saving the NHS money. The number of beds occupied by patients for more than 21 days has been significantly reduced by having an increased focus on their care planning.

Chief Executive's Report to the Board of Directors

Purpose of Report

This report provides the Board of Directors with feedback on changes within the national health and social care sector as well as providing an update on developments occurring within our local Derbyshire health and social care community. The report also updates the Board on feedback from external stakeholders, such as our commissioners, and feedback from our staff. The report should be used to support strategic discussion on the delivery of the Trust strategy. The Board should note that the report reflects a wider view of the Trust's operating environment and serves to horizon scan for risks that may affect the organisation. Risks identified are highlighted in the report and taken forward to assess their operational and strategic impact, and recorded on operational risk registers, or the Board Assurance Framework as appropriate.

National Context

1. Board members will be aware that the Secretary of State has announced the formation of a new department to lead the NHS in its aim to optimise the use of digital technology in enhancing productivity, efficiency and patient outcomes.

   Responsibility for technology, digital and data policy is currently split across lots of organisations and teams within the NHS infrastructure. From 1 July, this change will bring together teams from different organisations into one department to drive digital transformation and lead policy, implementation and change. NHSX combine teams from the Department of Health and Social Care, NHS England and NHS Improvement.

   Matthew Gould has been named CEO of NHSX and will join the organisation in the summer. Matthew is currently the Director General for Digital and Media at the Department for Digital, Culture, Media and Sport. NHSX will report directly to the Secretary of State and the Chief Executive of NHS England and NHS Improvement. NHSX will deliver the Health Secretary's Technology Vision, building on the NHS Long Term Plan, aiming to speed up the digital transformation of the NHS and social care. The core aims of NHSX are:

   - help people stay well and manage their own care by giving them easy access to quality digital services and their data
   - help NHS staff to focus on patients by freeing up their time through digital technology
   - work with providers and the Local Government Association to understand how technology can help staff and users of social care services

   NHSX will have nine core responsibilities:

   - Coordination and consistency
   - Setting standards
   - Driving implementation
   - Radical innovation
   - Common technologies and services

- Reforming procurement
- Cyber policy
- Digital capability
- Governance

As we review our strategy as an organisation, it is essential we note the digital expectations emerging through the long term plan and consider likely compliance requirements associated with governance, linked to both organisations and systems.

2. NHS England and Improvement have announced the membership of the new NHS Assembly. The NHS Assembly will bring together a range of individuals from across the health and care sectors at regular intervals to advise the joint boards of NHS England and NHS Improvement on delivery of the NHS Long Term Plan (LTP). The Assembly members are drawn from national and frontline clinical leaders, patients and carers, staff representatives, health and care system leaders and the voluntary, community and social enterprise sector.

   The Assembly will have an agreed programme of work to allow for tier two engagement activities to be conducted in advance of meetings to help bring wider insight to the membership as appropriate. For clarity, the Assembly is not itself responsible for LTP implementation, and nor does it cut across the current statutory accountabilities of NHS England and NHS Improvement.

   The first meeting of the group will be in spring and it will be co-chaired by leading GP, Dr Claire Gerada, and former head of the King's Fund think tank, Professor Sir Chris Ham.

3. NHS Improvement have published their six monthly official statistics update on patient safety incidents reported to the National Reporting and Learning System (NRLS). The national patient safety incident reports (NaPSIRs) set out the number of patient safety incidents reported to the NRLS and describe their patterns and trends. The data includes all patient safety incidents reported by NHS organisations in England.

   Two sets of data and analysis are presented in each NaPSIR data report:

   - the number of reports made to the NRLS by quarter, using data based on the date that the report was received
   - an overview of patterns and trends in incident reports using data based on the date that the incidents occurred

   The report reminds us that reporting to the National Reporting and Learning System (NRLS) is largely voluntary as this encourages openness and continual increases in reporting. As we as a Board are aware, increases in the number of incidents reported reflect an improved reporting culture and should not be interpreted as a decrease in the safety of the NHS. Equally, a decrease cannot be interpreted as an increase in the safety of the NHS.

   The report shows that the number of incidents reported to the NRLS for England continues to increase. The 488,242 incidents reported from July to September 2018 represents a 4.1% increase on the number reported from July to September 2017 (485,156).

Nationally there are still peaks every six months in the number of incidents reported. This is when users submit large batches of data at the cut-off for the six-monthly official statistics publications. It is of note that the overall profile of incident characteristics (incident type, degree of harm, care setting where the incident occurred) reported as occurring is consistent between October 2017 to September 2018 and October 2016 to September 2017.

A new data collection system (PSIMS) is currently being developed to replace the NRLS. The system will affect the exact type of data we as a Trust are required to collect and we hope to see more up to date complete reporting moving forward.

Local Context

4. The Joined up Care Derbyshire (JUCD) Board met on the 18 April 2019. Key issues discussed included:

- Noting that the 4 previous CCGs in Derbyshire have now completed their planned merger into a single organisation that will move to develop its role as the strategic commissioner for Derbyshire. The new Organisation is known as NHS Derby and Derbyshire. It is very helpful from an STP perspective to have a single CCG over the whole footprint.
- The second meeting as part of the 'system organisational development programme' focussed on system Chairs and Non-Executive Directors. Following this session it was agreed that a group of NEDs would be part of the STP refresh taking place over the summer. The importance of ensuring that all NEDs were kept up to date with developments within the STP (increased joint reporting into Boards) was requested. This will be taken forward by the STP communications team.
- System financial performance was off plan at month 11 with an aim to support all Organisations to reach their control total by month 12 close. All Organisational plans were submitted as required for 19/20 with 3 out of 4 Organisations having signed contracts.
- Ongoing development of a risk share agreement between all Health Organisations in Derbyshire, to optimise both efficiency and income into the system, and ensuring all Organisations reach their planned position by year end. Prior to agreement about a risk share, a single mitigation plan is being developed, as well as a set of pre-conditions for being part of the risk share agreement. This single approach to planning is a big step forward for our local system.
- The Board approved the timeline for the development of primary care networks with the aim that the new networks 'go live' on the Primary Care Network Contracts by July 2019.
- We received an update on the development of the system digital strategy which will be focussed on:
    - Analytics
    - Enabling people to support their health through use of digital (NHS App, remote monitoring and so on)
    - Innovations supported by partnerships
    - Ensuring colleagues across the system are digitally competent

- Foundation in high functioning infrastructure

Within our Trust

5. 2019 marks the 100th anniversary of Learning Disability (LD) Nursing. It was great to join colleagues in our Trust at a very inclusive, engaging and high energy event on the 15 April. Through the 100 years it is notable that LD nursing has gone from a medically led profession, focussed on institutional care, to a profession focussed on individuals and families in their local communities at the forefront of new professional roles.

6. Work continues to successfully increase positive media coverage of the Trust, our services and colleagues in local papers. A key feature from the Derby Telegraph last month was our Community Psychiatric Nurse, Amy Harcombe (based at our Killamarsh Clinic), who has been volunteering her time as part of the Inspiring the Future programme, which aims to inspire young people to train as NHS healthcare professionals.

   My role as co-chair of the NHS BME Network also received national coverage online during the month and I am pleased to note the Trust's association with such features, which helps to demonstrate our commitment to equality and inclusion to our staff, patients and communities.

   We also continue to generate conversations via social media – for example this month on International Women's Day, 100 years of Learning Disability Nursing and Allied Health Professions (AHP) Day. Posts regarding our DEED (Delivering Excellence Every Day) winners continue to be overwhelmingly positive and receive a number of comments and shares each week.

7. 10 April was our regular monthly staff forum event, this month focussed on developing a compassionate culture within Team Derbyshire Healthcare, with conversations focussing on supporting individuals to take more responsibility for their environment,

use of alternative transport methods, such as cycles, and optimising the use of our electronic patient record.

I was also delighted that a sub group presented an approved email etiquette and guidelines aimed at reducing pressure on colleagues through high volume use of emails and use of emails out of hours - the new etiquette and guidelines, which for example recognises individuals' flexible working practices and doesn't aim to control when emails are sent, but does make it clear not to expect a response out of somebody's normal working hours, will 'go live' in May.

8. During April, engagement visits have continued. I have held *Ifti on the Road* engagement events at the Radbourne Unit, London Road Resource Centre and Corbar View, Buxton.

   Importantly, I have also spent a day with our South County Crisis Team, a morning shadowing a consultant and nurse led clinic at the Hartington Unit and a morning shadowing one of our Health Visitors in Derby. This time spent in direct clinical services is a really effective way of understanding local challenges, innovations and opportunities for transformation driven by our front line colleagues.

   Key themes that emerged from these sessions are very numerous but included:

   - Some great examples of innovations to avoid the need for admission for titration or commencement of medication i.e. Clozapine.
   - Improvements in how we monitor the physical health of patients on anti-psychotic medication.
   - The positive impact that ward OTs have had on flow. More work to do but green shoots clearly present.
   - Inpatient staffing pressures continue but feel to have improved.
   - Community caseload pressures have a clear knock-on impact up to the ability to avoid hospital admission.
   - The current lack of a team focussed on working with individuals with complex trauma means some people are being admitted when alternatives might have been possible.
   - The importance of a strong relationship with primary care.

   Through my visits to clinical services, I do have some concerns that capacity pressures driven by ever increasing demand, are resulting in a lack of effective connectivity between our services, something that our clinical strategy work must address.

   Feedback from each visit has been logged on our engagement spreadsheet, actions allocated and shared with our Freedom to Speak up Guardian.

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

Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

There are no adverse effects on people with protected characteristics (REGARDS).	
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	X

Actions to Mitigate/Minimise Identified Risks

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

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

The new NHSX digital strategy development must ensure that it takes into account those individuals who are not able to access or use digital technology due to language, culture or disability.

Some great practice from our Learning Disability colleagues in how to hold an inclusive event, supporting individuals with a learning disability to attend and vitally actively take part in celebrations in a meaningful way.

Capacity and demand pressures in services, leading to patients receiving care in suboptimal environments i.e. admitted to an inpatient ward due to lack of community alternatives, is leading to differential services being delivered, and this is something that must be addressed through our clinical strategy work, supported by an equality impact assessment of the final models of care delivery.

Any equality impact assessment carried out will determine a response to the three aims of the general equality duty:

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

Recommendations

The Board of Directors is requested to:

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 7 May 2019

Integrated Performance Report (IPR) Month 12

Purpose of Report

This paper provides the Board of Directors with an integrated overview of performance at the end of March 2019. The focus of the report is on workforce, finance, operational delivery and quality performance.

Executive Summary

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

The Trust met its control total surplus and as a result received additional Provider Sustainability Fund (PSF) income from NHS Improvement (NHSI) of £1.4m which further increased our surplus to £3.8m at the end of the financial year.

There are a number of areas where performance is below the required standard in the month, or where trends might indicate an overall change in performance. In order to ensure that there is a focused discussion on key issues these have been listed below:

1. Regulatory Compliance dashboard:

    - Out of area placements
    - Sickness absence
    - Annual appraisals

2. Strategy Performance dashboard:

    - Cost improvement programme
    - Delayed transfers of care
    - Neighbourhood waiting lists
    - CAMHS waiting list
    - Paediatric referral to treatment
    - Health Visitor caseloads

This month's integrated performance report is supplemented by a more detailed report that focuses on the 'responsiveness' of several Trust services. This provides more specific detail on a number of the issues that are described in this IPR.

As the Trust's strategy has recently been refreshed, the same will need to happen to the IPR so that it reflects these changes. A review of the strategy dashboard will be undertaken over the next three months with a revised IPR presented to September's Trust Board meeting.

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

Assurances

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

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

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

Consultation

This paper has not been considered elsewhere, however some content supporting the overview presented is regularly provided to Finance and Performance Committee, People and Culture Committee and Quality Committee.

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

There are no adverse effects on people with protected characteristics (REGARDS).	
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	X

Actions to Mitigate/Minimise Identified Risks

This report reflects performance related to our whole staff and service receiver population and therefore includes members of those populations with protected characteristics in the REGARDS groups.

Any specific impact on members of the REGARDS groups is described in the report itself.

Recommendations

The Board of Directors is requested to:

1) Confirm the level of assurance obtained on current performance across the areas presented.
2) Determine whether further assurance is required and if so, at which Committee this needs to be provided and by whom.

Report presented by:	**Mark Powell, Chief Operating Officer**
	Claire Wright, Director of Finance/Deputy CEO
	Amanda Rawlings, Director of People and Organisational Effectiveness
	Carolyn Green, Director of Nursing and Patient Experience
Report prepared by:	**Liam Carrier, Assistant Head of Systems & Information/ Project Manager**
	Peter Charlton, General Manager, IM&T
	Peter Henson, Head of Performance, Delivery & Clustering
	Rachel Kempster, Risk and Assurance Manager
	Rachel Leyland, Deputy Director of Finance
	Celestine Stafford, Assistant Director of People & Culture Transformation
	Darryl Thompson, Deputy Director of Nursing

1. Regulatory Dashboard

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	DQ
Finance	Finance Score	Finance Scorecard	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Capital Service Cover	YTD	2	2	G	→		
			Forecast	2	2	G	→		
		Liquidity	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Income and Expenditure Margin	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Income and Expenditure variance to plan	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Agency variance to ceiling	YTD	1	1	G	→		
			Forecast	1	1	G	→		
	Single Oversight Framework	Agency costs as % of total pay costs	YTD	2.91%	2.83%	G	→		
			Forecast	2.87%	2.83%	G	→		
		NHS I Segment	YTD		2		→		
Quality and Operations	KPIs	CPA 7 Day Follow-up (M)	Mar, 2019	95.00%	96.72%	G	→		
			Feb, 2019		96.55%	G			
		Data Quality Maturity Index (DQMI) - MHSDS Data Score (Q)	Mar, 2019	95.00%	96.19%	G	→		
			Feb, 2019		96.56%	G			
		IAPT RTT within 18 weeks (Q)	Mar, 2019	95.00%	100.00%	G	→		
			Feb, 2019		100.00%	G			
		IAPT RTT within 6 weeks (Q)	Mar, 2019	75.00%	96.72%	G	↓		
			Feb, 2019		98.40%	G			
		Early Intervention in Psychosis RTT Within 14 Days - Complete (Q)	Mar, 2019	53.00%	100.00%	G	↑		
			Feb, 2019		94.12%	G			
		Early Intervention in Psychosis RTT Within 14 Days - Incomplete (Q)	Mar, 2019	53.00%	93.33%	G	↓		
			Feb, 2019		100.00%	G			
		Patients Open to Trust In Employment (M)	Mar, 2019		10.01%	G	→		
			Feb, 2019		10.24%	G			
		Patients Open to Trust In Settled Accommodation (M)	Mar, 2019		58.04%	G	↓		
			Feb, 2019		59.15%	G			
		Under 16 Admissions To Adult Inpatient Facilities (M)	Mar, 2019	0	0	G	→		
			Feb, 2019		0	G			
		IAPT People Completing Treatment Who Move To Recovery (Q)	Mar, 2019	50.00%	55.47%	G	↓		
			Feb, 2019		57.31%	G			
		Physical Health - Cardio-Metabolic - Inpatient (Q)							
		Physical Health - Cardio-Metabolic - EI (Q)							
		Physical Health - Cardio-Metabolic - on CPA (Community) (Q)							
		Out of Area - Number of Patients Non PICU (M)	Mar, 2019		21		↑		
			Feb, 2019		19				
		Out of Area - Number of Patients PICU (M)	Mar, 2019		27		↑		
			Feb, 2019		24				
		Out of Area - Average Per Day Non PICU (M)	Mar, 2019		10.0		↑		
			Feb, 2019		7.3				
		Out of Area - Average Per Day PICU (M)	Mar, 2019		15.3		↑		
			Feb, 2019		13.0				
		Written complaints – rate (Q)	Q42018/19		0.03		→		
			Q32018/19		0.03				
		Staff Friends and Family Test % recommended – care (Q)	Q3 2018/19	81%	61%	R	↓		
			Q22018/19		73%	R			
		Occurrence of any Never Event (M)	Mar, 2019	0	0	G	→		
			Feb, 2019		0	G			
		Patient Safety Alerts not completed by deadline (M)	Mar, 2019		1		↓		
			Feb, 2019		2				
		CQC community mental health survey (A)	1905		6.9/10		↑		
			2017		7.3/10				
		Mental health scores from Friends and Family Test – % positive (M)	Mar, 2019	81%	97%	G	↑		
			Feb, 2019		95%	G			
		Potential under-reporting of patient safety incidents per 1000 bed days(M)	Apr18-Sep18		40.90	G	→		
			Oct17-Mar18		36.10	G			
Workforce and Engagement	KPIs	Turnover (annual)	Mar, 2019	10.00%	10.31%	G	↑		
			Feb, 2019		10.11%	G			
		Sickness Absence (monthly)	Mar, 2019	5.00%	6.11%	R	↓		
			Feb, 2019		6.73%	R			
		Sickness Absence (annual)	Mar, 2019	5.00%	TBC	R	↑		
			Feb, 2019		5.74%	R			
		Vacancies (funded fte)	Mar, 2019		8.87%		↑		
			Feb, 2019		9.30%				
		Appraisals All Staff (number of employees who have received an appraisal in the previous 12 months)	Mar, 2019	90.00%	75.30%	R	↑		
			Feb, 2019		75.52%	R			
		Medical Appraisals (number of medical employees who have received an appraisal in the previous 12 months)	Mar, 2019	90.00%	85.00%	A	↓		
			Feb, 2019		90.00%	G			
		Compulsory Training (staff in-date)	Mar, 2019	85.00%	85.59%	G	↑		
			Feb, 2019		84.32%	A			
		NHS Staff Survey (A)	Work		60.92%				
			Treatment		72.77%				

Key:

Period Current Month / Previous Month

Achieving target
Not achieving target
Within tolerance
No Target Set

Target

↑ → ↓ Trend compared to previous month/quarter with tolerance of 1%

1.1 Finance position

The Trust met its control total surplus and as a result received additional Provider Sustainability Fund (PSF) income of £1.4m increasing the surplus to £3.8m.

The overall finance risk rating score of a '1' is in line with plan, with all individual metrics achieving individual plans.

Comparing the actual expenditure on Agency to the ceiling, we are below the ceiling value by £130k at the end of the financial year. This generates '1' on this metric within the finance score.

The agency expenditure equates 2.8% of the pay budgets. National NHSI benchmarking information from 2017/18 showed agency expenditure at 4.5% of pay budgets, with the Midlands and East region at 5.2%.

1.2 Inappropriate out of area adult placements (non-PICU)

The number of patients whom the Trust admitted to out of area beds in March increased slightly to an average of 8-10 patients on any given day. The Trust continues to take part in the regional learning collaborative that is focused on supporting Trusts to reduce out of area placements. A paper is being prepared for Trust Management Team and commissioners and will include an overarching project plan for eliminating out of area placements and a work plan reflecting key deliverables for the next 2 years.

This report will be presented and discussed at May's Finance and Performance Committee.

1.3 People position

Sickness absence levels have continued to improve over the last two months showing a reduction from 6.73% in February 2019 to 6.11% in March 2019 which is a 0.62% improvement. Long terms sickness has increased slightly by 0.05% from February 2019 to March 2019 and short term sickness has improved from 3.07% in February 2019 to 2.41% in March 2019, an improvement of 0.66%.

The focus is now moving to better recording and closing of absences and improving the advice and support to managers when considering phased returns and return to work interviews. As part of the Leadership Development programme to support all line managers, a module "Managing Health & Attendance" is now available to book onto, this will be mandatory for all line managers to attend and sessions are available throughout 2019.

Compulsory training compliance has improved with a compliance rate of 85.59% an improvement of 1.27% from February 2019.

Appraisal completion has dipped slightly this month at 75.30% from 75.52% in February 2019. It is expected that completion rates should begin to improve with the rollout of the new appraisal paperwork and the supporting training for all line managers. This is a mandatory course module which is part of the new Leadership Development programme.

The Trust vacancy rate includes funded Fte surplus for flexibility including sickness and annual leave cover and is currently running at 8.87% an improvement from February 2019 of 9.30%.

Recruitment activity across the Trust continues to move at a fast pace and remains a key focus for inpatient areas in particular. During March 2019, 16 people have been recruited externally, comprising of 6 Nursing and Midwifery Registered, 5 Additional Clinical Services, 2 Administrative and Clerical, 2 Additional Professional and Technical and 1 Medical and Dental.

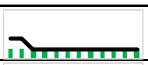
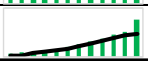
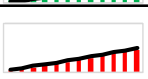
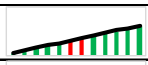
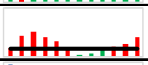
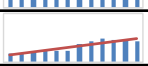
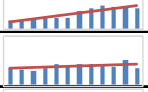
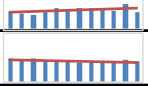
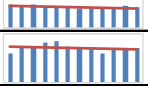
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sickness Absence KPI	5%	5%	5%	7%	6%	6%	7%	7%	7%	8%	7%	6%
Corporate Services	4%	3%	3%	4%	5%	4%	6%	5%	5%	6%	6%	5%
Business Improvement + Transformation	2%	1%	0%	6%	9%	1%	0%	0%	0%	0%	2%	1%
Corporate Central	0%	0%	0%	0%	5%	4%	1%	3%	1%	1%	1%	1%
Estates + Facilities	5%	4%	5%	6%	6%	6%	8%	7%	7%	9%	8%	7%
Finance Services	3%	1%	1%	0%	1%	1%	3%	2%	5%	8%	11%	10%
Med Education & CRD	2%	1%	1%	1%	1%	0%	3%	0%	1%	2%	0%	2%
Nursing + Quality	7%	7%	7%	7%	9%	8%	12%	11%	7%	8%	9%	5%
Ops Support	3%	2%	3%	3%	2%	2%	5%	4%	3%	2%	4%	4%
IT, Information Management + Patient Records	3%	3%	3%	1%	2%	3%	8%	5%	2%	1%	3%	2%
Ops Management	0%	0%	0%	0%	0%	0%	2%	8%	16%	11%	13%	12%
Pharmacy	3%	0%	4%	6%	2%	2%	3%	3%	1%	3%	3%	4%
People Services	24%	22%	N/A	N/A	N/A	N/A	0%	0%	0%	0%	0%	0%
Operational Services	5%	5%	6%	7%	7%	7%	8%	7%	7%	8%	7%	6%
Campus	6%	8%	8%	11%	10%	9%	10%	8%	9%	11%	8%	8%
Central Services	4%	4%	4%	4%	4%	4%	5%	6%	5%	5%	5%	5%
Children's Services	3%	4%	4%	4%	5%	5%	7%	7%	6%	8%	7%	6%
Clinical Serv Management	4%	0%	3%	3%	3%	2%	1%	2%	0%	3%	3%	4%
Neighbourhood	5%	4%	5%	6%	6%	6%	7%	8%	7%	7%	7%	6%

NB “People Services” consists of 2 staff members employed by the Trust

Compulsory Training KPI	86%	86%	82%	83%	83%	83%	83%	84%	84%	84%	84%	86%
Corporate Services	84%	84%	82%	83%	83%	82%	85%	85%	86%	85%	85%	86%
Business Improvement + Transformation	87%	94%	97%	90%	93%	94%	94%	94%	89%	89%	87%	85%
Corporate Central	73%	73%	70%	72%	76%	77%	78%	80%	79%	77%	78%	79%
Estates + Facilities	82%	82%	81%	81%	81%	78%	82%	82%	83%	84%	83%	84%
Finance Services	98%	97%	98%	97%	99%	98%	99%	99%	97%	98%	98%	97%
Med Education & CRD	77%	79%	77%	77%	73%	76%	80%	81%	80%	76%	76%	78%
Nursing + Quality	85%	85%	83%	85%	87%	88%	86%	88%	87%	86%	86%	88%
Ops Support	91%	91%	88%	88%	90%	89%	92%	92%	93%	93%	92%	94%
IT, Information Management + Patient Records	95%	98%	98%	95%	97%	95%	99%	99%	98%	99%	98%	99%
Ops Management	92%	92%	86%	78%	78%	73%	74%	77%	80%	71%	70%	87%
Pharmacy	87%	85%	77%	80%	83%	84%	85%	86%	90%	90%	89%	90%
People Services	89%	89%	89%	67%	72%	72%	72%	52%	72%	72%	72%	67%
Operational Services	86%	86%	82%	83%	83%	83%	83%	84%	84%	84%	84%	85%
Campus	87%	87%	83%	83%	83%	81%	82%	82%	84%	83%	83%	84%
Central Services	86%	87%	83%	84%	84%	86%	86%	86%	86%	86%	87%	88%
Children's Services	85%	83%	80%	80%	81%	82%	82%	82%	83%	82%	83%	84%
Clinical Serv Management	68%	68%	61%	64%	66%	67%	70%	72%	74%	72%	73%	77%
Neighbourhood	87%	87%	83%	84%	84%	84%	84%	85%	85%	85%	86%	87%

NB “People Services” consists of 2 staff members employed by the Trust

2. Strategy Delivery

Category	Metric	Period	Target	Actual	Variance	Trend	Last 12 Months	DQ
Finance Scorecard	Finance Scorecard	YTD	1	1	G	→		
		Forecast	1	1	G	→		
	Control Total position £000	YTD	2331	3764	G	↑		
		Forecast	2331	3764	G	↑		
	CIP achievement £m	YTD	4.871	4.584	R	↑		
		Forecast	4.871	4.584	R	→		
		Recurrent	4.871	1.466	R	→		
	Agency £m	YTD	3.030	2.900	G	↑		
		Forecast	3.030	2.900	G	↑		
	Cash £m	YTD	21.608	27.445	G	↓		
		Forecast	21.608	27.445	G	↑		
Quality and Operations Scorecard	RTT Incomplete Within 18 Weeks (%)	Mar, 2019	92%	96.1%	G	→		
		Feb, 2019		96.7%	G			
	CPA Review in last 12 Months (on CPA > 12 Months)	Mar, 2019	95%	95.2%	G	→		
		Feb, 2019		95.2%	G			
	Delayed Transfers of Care (%)	Mar, 2019	0.8%	2.03%	R	→		
		Feb, 2019		1.22%	R			
	North Neighbourhood Average Wait (weeks)	Mar, 2019		7.5		↑		
		Feb, 2019		7.2				
	North Neighbourhood Current Waits (number)	Mar, 2019		1787		↑		
		Feb, 2019		1775				
	City Neighbourhood Average Wait (weeks)	Mar, 2019		8.3		↓		
		Feb, 2019		8.6				
	City Neighbourhood Current Waits (number)	Mar, 2019		1455		↓		
		Feb, 2019		1487				
	South Neighbourhood Average Wait (weeks)	Mar, 2019		8.5		↓		
		Feb, 2019		10.1				
	South Neighbourhood Current Waits (number)	Mar, 2019		1801		↑		
		Feb, 2019		1674				
	CAMHS Average Wait (weeks)	Mar, 2019		8.9		↓		
		Feb, 2019		9.6				
	CAMHS Current Waits (number)	Mar, 2019		865		↓		
		Feb, 2019		895				
	Community Paediatrics Average Wait (weeks)	Mar, 2019		17.0		↓		
		Feb, 2019		25.8				
	Community Paediatrics Current Waits (number)	Mar, 2019		859		↓		
		Feb, 2019		876				
	Number of Adult Acute Inpatients (Hartington and Radbourne) LoS > 50 Days	Mar, 2019		69		↑		
		Feb, 2019		66				
	Health Visiting 0-19 Caseload (based on 50.8 WTE)	Mar, 2019	250	327	R	↑		
		Feb, 2019		327	R			
	Distinct LD Caseload	Mar, 2019		1061		↓		
		Feb, 2019		1067				
	Distinct Substance Misuse Caseload	Mar, 2019		5465		↑		
		Feb, 2019		5351				
	RTT Incomplete Within 18 Weeks inc Paediatrics (%)							
Workforce and Engagement Scorecard	RETAIN - Staff engagement score	2018 Annual	To see an improvement in the staff engagement score	0.540	G	↑		
		2017 Annual		0.450				
		Q2 Sep 2018		74%	G	→		
		Q1 Jun 2018		74%				
	DEVELOP - Recruitment of preceptorship staff	2018/19	Number of students recruited into preceptorship	50	R	↓		
		2017/18		52				
	ATTRACT - Retention of preceptorship staff	2018 Annual	Number of students recruited into preceptorship who stay for at least one year	96%	G	↑		
		2017 Annual		85%				
	LEADERSHIP & MANAGEMENT - Employee relations cases	Q4 Mar 2019	To see a reduction in the number of cases	31	G	↓		
		Q3 Dec 2018		34	G			
		Q2 Sep 2018		34	G			
		Q1 Jun 2018		40				

Key:

Period Month / Previous Month

Achieving target / Not achieving target / No Target Set

Target / Trend

↑ → ↓ Trend compared to previous month with tolerance of 1%

2.1 Cost Improvement Programme (CIP)

At the end of the financial year £4.6m of CIP has been assured in the ledger with no further schemes to deliver. This then leaves a gap to delivery of the full plan by £287k. Of the total savings only 32% is to be saved recurrently.

2.2 Delayed Transfers of Care

Currently there are 5 patients whose discharges are being delayed. We continue to work with relevant partners to address and minimise delays to avoid unnecessary waits in beds.

2.3 Neighbourhood Waiting Lists

As reported previously, the number of referrals received has been steadily increasing over time. This is likely to continue in line with population growth. A clinical strategy is under development for both working age and older adult community mental health services.

Service Managers in all areas review their waiting lists regularly and Area Service Managers review at management meetings. Datix is used to report growing wait lists in specific areas. All teams prioritise inpatient and crisis referrals for allocation; because of this there is a group of patients of lower priority need who are waiting longer, most of whom are open to outpatients and therefore reviewed by medics during their wait for care coordination.

The Waiting Well Protocol has recently been reviewed and teams are working towards compliance with the changes that this has generated. Patients awaiting allocation are written to advising of who to contact should their condition deteriorate and duty workers can be contacted to escalate need for more urgent interventions.

2.4 CAMHS Waiting List

Work is still in progress to seek to reduce waiting times within the resources available. This includes clearly mapping interventions to specific pathways. An action plan is in place and was reviewed at Trust Management Team in February. The action plan includes administrative processes, proactive appointment booking, follow-up of DNA and enhanced clinical oversight. This is monitored at divisional level.

We are also in dialogue with commissioners regarding a planned review of CAMHS capacity. A weekly trajectory has been devised to monitor progress. CAMHS ASIST is currently offering 20 assessments per week. This will be increased to 27 assessments per week from May 2019 which will have a positive impact on the waiting list.

2.5 Paediatric Waiting List

As reported in the last 2 months, the CCG have suggested that a joint working group be set up and we proactively responded with suggested representatives and dates. We await confirmation from the CCG. We continue to working internally to maximise current capacity, respond to referrals and actively reduce long waits and review the 18 week referral to treatment process and reporting.

2.6 Health Visitor Caseloads

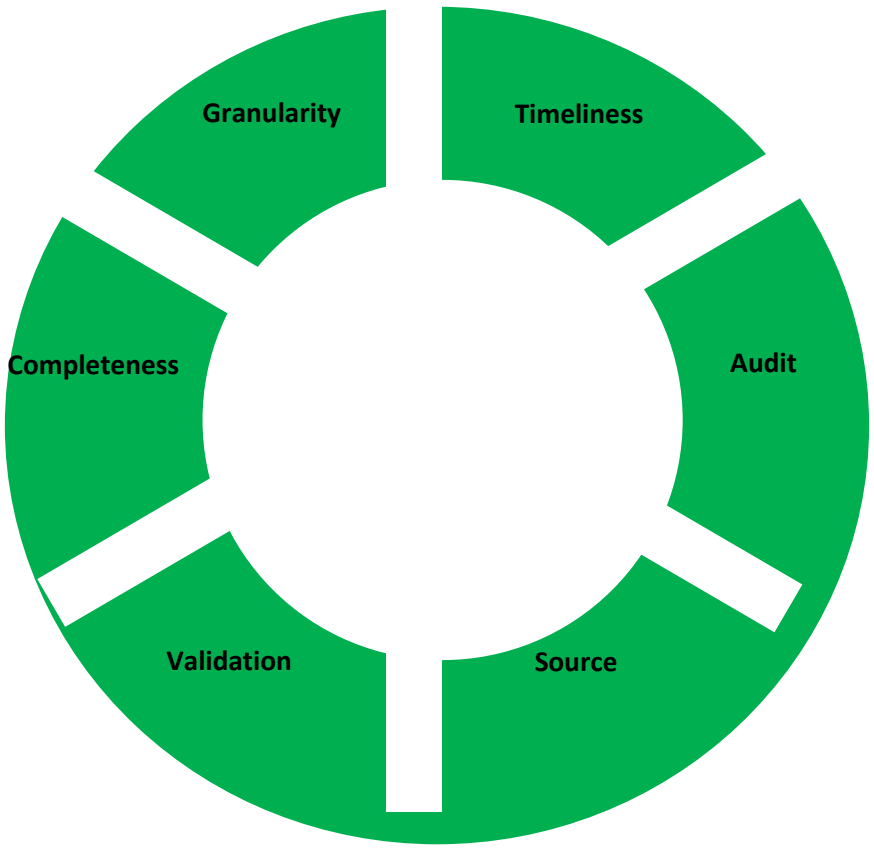
Caseloads and staffing have been reviewed. Findings are being considered and options will be explored with commissioners in due course. The safeguarding workload remains high and of concern in this service and rising demand will be explored with commissioners.

Data Quality Kite Mark

Background

A number of Trusts prepare data quality kite marks to support members' review and assessment of performance indicator information reported in integrated performance reports (IPRs). Alternative methods include a simpler data quality scoring in a range, such as 1-5 which are more reliant on judgement. The kite mark is used to assess the system against six domains: timeliness; audit; source; validation; completeness; and granularity to provide assurance on the underlying data quality.

Approach



The Trust has adopted this Data Quality Kite Mark. The assessment of each domain will be based on the following criteria:

Data Quality Indicator	Definition	Not yet assessed	Sufficient	Insufficient
Timeliness	Is the data the most up to date and validated available from the system?	Not yet assessed	The data is the most up to date available.	Data is not available for the current month due to the time taken to extract / prepare from the system.
Audit	Has the system or processes used to collect the data been subject to audit (Internal Audit/ External Audit / self-audit) in the last 12 months?	Not yet assessed	The system and processes involved in the collection, extraction and analysis of the data have been audited and presented to the oversight committee.	No formal audit has taken place in the last 12 months. Exceptions have been identified and corrective action has not yet been implemented.
Validation	Prior to publication, is the data subject to validation,	Not yet assessed	The data is validated against a secondary	No validation has taken place. The information

Data Quality Indicator	Definition	Not yet assessed	Sufficient	Insufficient
	e.g. spot checks, random sample checks, involvement of a clinician, the associated service or approval by Executive Director?		source. The indicator owner can assure the data is a true reflection of performance, supported by a sign off process and underlying information.	owner cannot assure that the data truly reflects performance. A random sample may reveal errors.
Source	Is the source of the data fully documented and understood?	Not yet assessed	All users understand how to extract the data in line with the indicator definition. The data source is well documented in the event that there is a change in personnel producing the indicator.	The data source is poorly documented and could be inconsistently extracted.
Completeness	Is the indicator a reflection of the complete performance of the Trust	Not yet assessed	All the appropriate activity has been included within the indicator	A material amount of activity has not been included within the indicator that may alter the Trust level performance.
Granularity	Can the data be disaggregated into smaller parts? E.g. evaluated at a division or ward level as well as a Trust level.	Not yet assessed	Data can be drilled down to a division or ward level in order to understand and drive performance improvement.	Data is only available at a Trust level.

Each indicator on the operational component of the NHSI Dashboard has been reviewed and rated against these dimensions. As issues are identified and addressed, the ratings will change to reflect the work undertaken.

KPI Data Quality Reviews

A review will be undertaken every 6 months of 5 to 10 indicators to review their compliance with the defined indicators of quality. This will be done to complement any reviews undertaken by internal or external audit. The results will be shared with the Finance and Performance Committee together with any remedial action required.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 7 May 2019

Quality Report – Responsiveness

Purpose of Report

This paper provides Trust Board with a focused report on 'responsiveness' as part of wider reporting relating to Care Quality Commission (CQC) domains.

The report is intended to provide an overview of performance in this domain and to prompt a strategic discussion about our approach and help identify whether further development or focus may be needed.

Executive Summary

This report presents information relating to one of the five key questions which the Care Quality Commission considers when reviewing and inspecting services:

1. Are they safe?
2. Are they effective?
3. Are they caring?
4. Are they well-led?
5. Are they responsive to people's needs?

The report has been split into a number of sections:

1. Introduction – this section provides national regulatory context to help inform and focus our discussion on strategic issues. It also provides further detail on requirements and commitments set out in the NHS Long Term Plan and recent clinical review of national access standards.

2. 'Responsiveness' performance in a number of service areas – this section provides detailed data and information about the responsiveness of a number of Trust services. In addition, it seeks to show performance against newly proposed national access standards.

   This section has been split into the following;

   - Community Mental Health Services (all ages)
   - Childrens Services
   - Acute Services
   - Autism Spectrum Disorder assessment service

3. Conclusion and key strategic questions arising out of this report (see below).

In order to facilitate a strategic discussion using the information contained within this report, along with other triangulated information from Committee reports there are a number of key strategic questions arising out of this report that the Board of Directors might wish to consider.

- Is the Board assured that there are sufficiently robust delivery plans in place to address long standing waiting time issues in the short, medium and long term?

- Has the Board agreed the level of risk that it is willing to tolerate with respect to services that are not yet delivering national/local 'responsiveness' requirement and also considered any impact of this on patient safety?
- Given the ongoing and unrelenting increase in demand for autism assessments and lack of commissioned post assessment intervention service, should the Trust consider a different approach with commissioners?
- Is the Board assured that the Clinical Strategy development work that is being undertaken will adequately address the long standing waiting time issues identified in this report?
- Is the Board assured that there is sufficient management oversight and consideration of the recently proposed national access standards and that this oversight is influencing service change and transformation?

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

Assurances

This paper relates directly to the delivery of the Trust's strategy on providing responsive services.

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

The content of the report provides assurance across several BAF risks related to service delivery and regulatory compliance.

Consultation

This paper has not been considered by any other Committee.

Governance or Legal Issues

Information supplied in this paper is consistent with the Trust's responsibility to deliver the requirements set out by the CQC.

Public Sector Equality Duty & Equality Impact Risk Analysis	
The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people) (Public Sector Equality Duty & Equality Impact Risk Analysis) The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation).	
There are no adverse effects on people with protected characteristics (REGARDS).	
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	X
Actions to Mitigate/Minimise Identified Risks	
This report reflects performance related to our whole staff and service receiver population and therefore includes members of those populations with protected characteristics in the REGARDS groups. As the report relates specifically to access to Trust services, we will need to ensure that any changes or agreed improvements take account of the evidence that shows variable access to services from different population groups.	

Recommendations

The Board of Directors is requested to;

1. Consider the key strategic questions set out in the Executive summary
2. Agree any further action that is required and update the 2019/20 Board Assurance Framework accordingly

Report presented by: **Mark Powell, Chief Operating Officer**

Report prepared by: **Pete Henson, Head of Performance**

1. Introduction

The current access standards in mental health are detailed in the Handbook to the NHS Constitution and are listed below:

- 75% of people referred to the Improving Access to Psychology Therapies (IAPT) programme should begin treatment within six weeks of referral and 95% of people referred to the IAPT programme should begin treatment within 18 weeks of referral.

- More than 53% of people experiencing a first episode of psychosis currently will start treatment within a NICE-recommended package of care with a specialist early intervention in psychosis service within two weeks of referral. This is due to rise to 60% by the end of 2020/21.

In addition, the NHS has committed that by 2020/21, 95% of children and young people referred for assessment or treatment for an eating disorder should receive NICE-approved treatment with a designated healthcare professional within one week for urgent cases and four weeks for every other case.

The NHS Long Term Plan (LTP) outlines a programme of service expansion and improvement for mental health, which builds on foundations set out in the Five Year Forward View for Mental Health finally to deliver parity of esteem between mental and physical illness.

The LTP sets out a number of key deliverables that are very much focused on accessibility to services and service responsiveness.

1.1 Urgent Care

1. In the next ten years is states that the NHS will provide a single point of access, ensuring that anyone experiencing mental health crisis can access 24/7 age-appropriate mental health community support via NHS 111.
2. For adults and older adults, the NHS Long Term Plan outlined a commitment to ensure that a 24/7 community-based mental health crisis response is available across England by 2020/21, with intensive home treatment available as an alternative to an acute inpatient admission.
3. For children and young people, by 2023/24 all children and young people experiencing a mental health crisis will be able to access crisis care 24 hours a day, seven days a week, with a single point of access through NHS 111. Every area will have age appropriate, urgent and emergency assessment, intensive home treatment and liaison functions in place.
4. Where people are accessing urgent and emergency mental health services in the community, they will receive a timely initial assessment of their needs. Where they have emergency needs they will receive expert care and nobody with urgent mental health needs will be expected to wait longer than 24 hours.
5. A&E is often not the best place for people in need of urgent mental health care; however in some cases it will be unavoidable. Those coming to A&E will receive a response from a 24/7 liaison psychiatry team (or equivalent children's and young people's service) within the first hour of their referral, and will receive the appropriate, timely support to meet their needs and an evidence-based package of care.

Alongside this will be an increase in alternative forms of provision for those in crisis. Sanctuaries, safe havens, and crisis cafés provide a more suitable alternative to A&E for many people experiencing mental health crisis, usually for people whose needs are escalating to crisis point, or who are experiencing a crisis but do not necessarily have medical needs that require A&E admission.

1.2 Non-urgent, community mental health care

The NHS Long Term Plan commits to offering more comprehensive mental health support for children and young people. This includes work with schools, colleges, parents and local councils to understand whether more upstream preventative support, including better information sharing and the use of digital interventions, improves outcomes and helps moderate the need for specialist child and adolescent mental health services.

With respect to waiting time standards, work is already underway to test what it would take to introduce a four-week waiting time for children and young people who need help from specialist mental health services. 12 waiting time pilots will run over the next three years alongside the introduction of new Mental Health Support Teams.

The NHS Long Term Plan also extended the commitment for more comprehensive mental health support to the design and roll out of a new integrated model of adult community mental health care. Adults with severe mental illness (SMI) receiving care from community mental health services includes, but is not limited to, those who have a diagnosis of psychosis, bipolar disorder, personality disorder, eating disorders, severe anxiety or severe depression, and those with co-morbid substance misuse. This cohort represents approximately 10% of mental health needs and 90% of spend: there is therefore not only a clinical, but a resource imperative, to have a dedicated focus on these patients and their families.

This will include the introduction of new and integrated models of primary and community mental health care across England for adults who have an SMI so they are supported to have greater choice and control over the care they receive, and so they can live well in their community. This includes developing new services for people who have the most complex needs.

1.3 Proposed access standards

In the recently clinically-led review of access standards there is a commitment to test a number of new standards set out in the table below, including considering any thresholds that might accompany the standards:

It is vitally important that future service developments align to these proposed changes. As part of section 2 in this report, performance against a number of these proposed standards has been presented to help support the discussion.

Ref	Measure	Clinical rationale	Implications for patient care
1.	Expert assessment within hours for emergency referrals; and within 24 hours for urgent referrals in community mental health crisis services.	While for many people with urgent mental health needs, A&E is appropriate; consensus among clinicians, patients and commissioners is that many urgent mental health needs could be met more effectively in the community. Appropriate response times will need to be explored as part of testing. Many local areas have already set a local	Rapid assessment of needs to determine urgency, and clear communication of expected next steps to the patient or referrer. Many needs will be met on the telephone or by facilitating access to non-urgent support. When people are assessed as having urgent or emergency

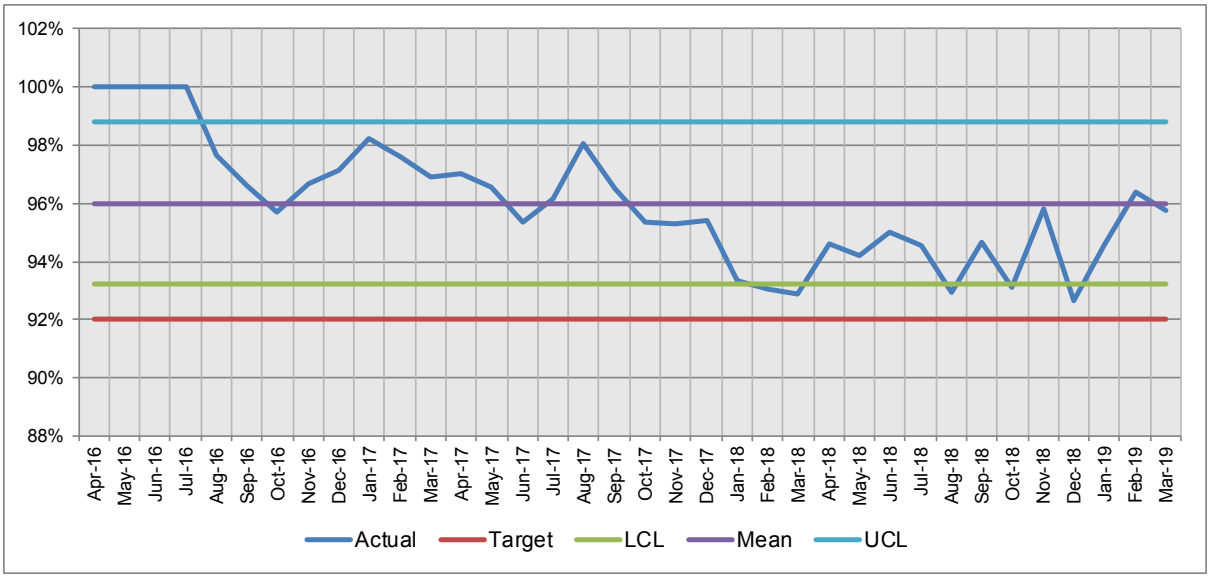
Ref	Measure	Clinical rationale	Implications for patient care
		target of four hours, for example. However, the severity and need of individual patients will need to be taken into account – some patients will need a quicker response.	needs, they will need timely face-to-face assessment from a specialist mental health professional.
2.	Access within one hour of referral to liaison psychiatry services and children and young people's equivalent in A&E departments.	Patients of all ages presenting in A&E in crisis require quick assessment to determine risk. If they are not seen quickly, the A&E environment can exacerbate symptoms and they may leave without treatment, potentially with risk of serious harm or suicide. Managing patients who have not been assessed adds pressure and anxiety to staff.	Someone experiencing a mental health crisis would receive a response from the liaison mental health service within one hour.
3.	Four-week waiting times for children and young people who need specialist mental health services.	Waits for treatment for children and young people's mental health services vary significantly from referral to treatment. Long waits can impact both clinically and on the individual waiting for treatment.	Maximum of four weeks from referral to an assessment and start of treatment or plan in NHS-funded services and/or appropriate sign posting or interface with other services, including outside the provider and specialist community services.
4.	Four-week waiting times for adult and older adult community mental health teams.	Clear waiting times are to be incorporated into the design of new integrated primary and community mental health services, to ensure that all individuals are seen within a clinically appropriate time.	Maximum of four weeks from referral to an assessment and start of treatment or plan in NHS-funded services and/or appropriate sign posting or interface with other services including outside the provider and specialist community services.

2. 'Responsiveness' performance in a number of service areas

2.1 Community Mental Health services (all ages) – Current Standards

2.1.1 Community Mental Health 18 week referral to treatment – Consultant led outpatients

The Trust continues to meet the national 18 week referral to treatment standard for Consultant led outpatient service.

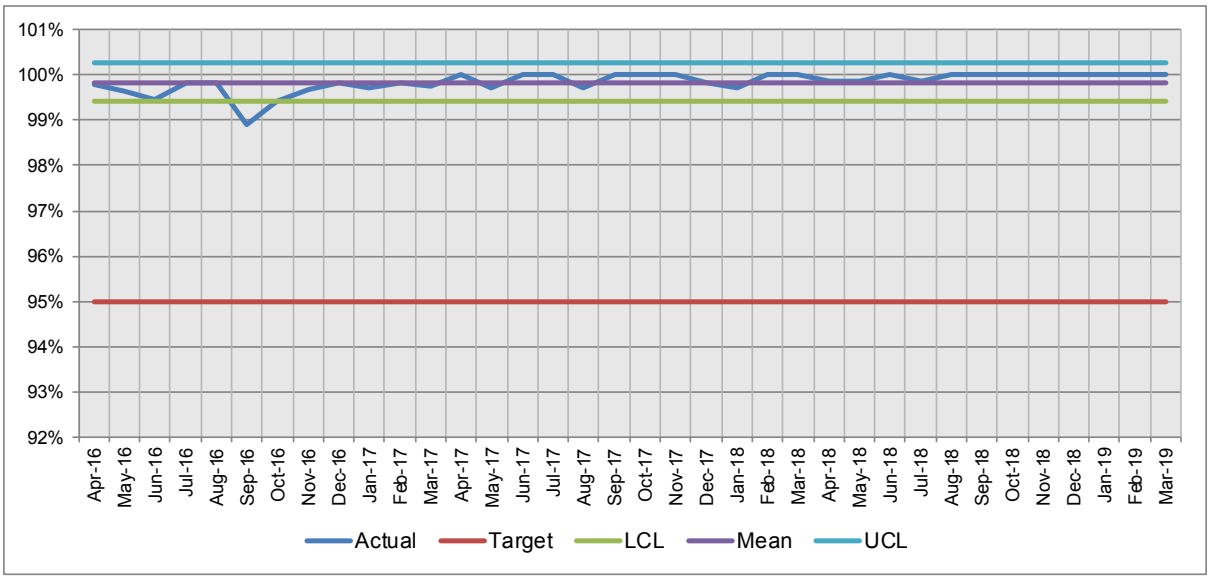


Standard definition: 92% or more of the patients currently on the waiting list for a consultant-led outpatient service must have been waiting less than 18 weeks.

2.1.2 Psychological therapy waiting time – Improving Access to Psychological Therapy (IAPT)

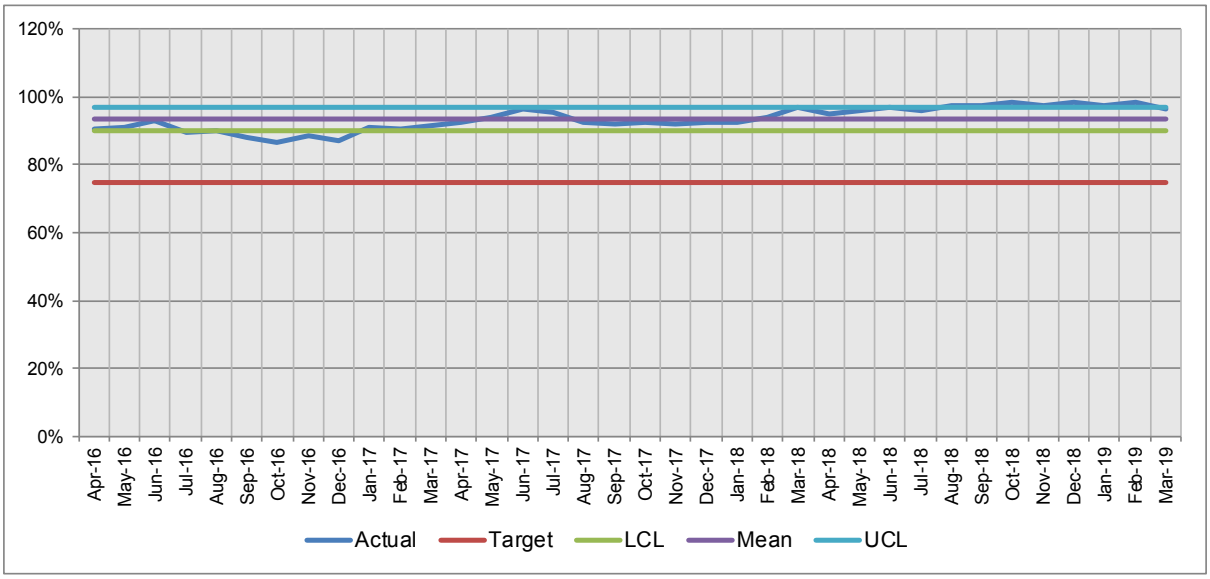
The Trust continues to exceed all IAPT referral to treatment targets. Waiting lists are monitored regularly to ensure the targets are met.

IAPT 18 week referral to treatment performance below



Standard definition: the majority (at least 95%) of people referred to an IAPT psychological therapy service should be seen within 18 weeks of the referral being received.

IAPT 6 week referral to treatment performance below



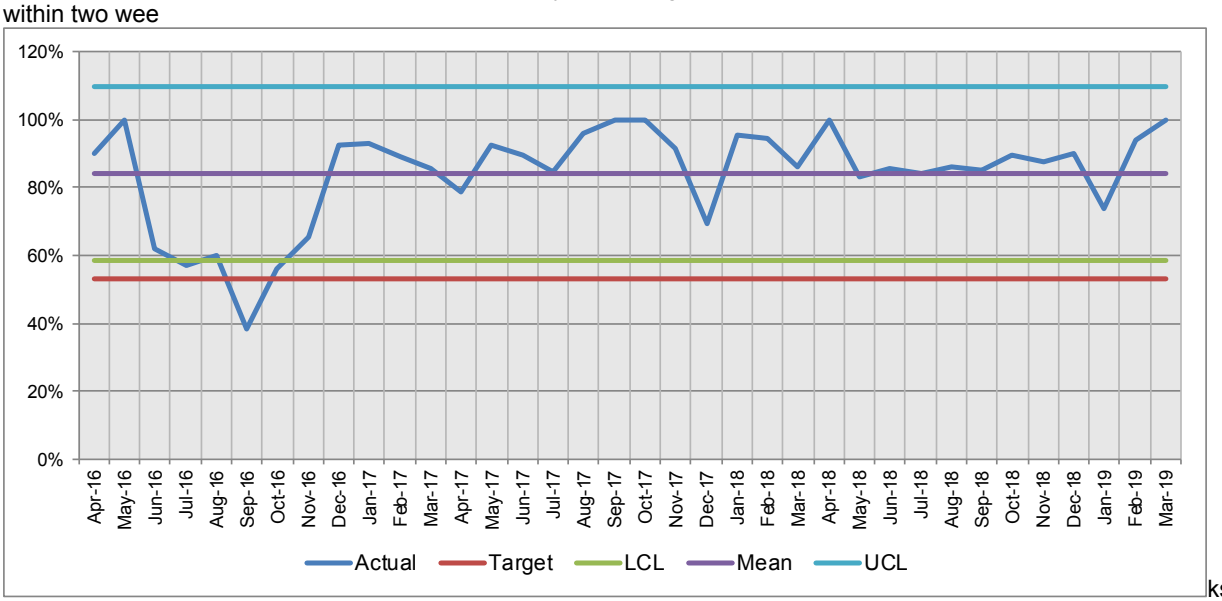
Standard definition: at least 75% of people referred to an IAPT psychological therapy service should be seen within six weeks of the referral being received.

2.1.3 Early Intervention to Psychosis Service

The Trust continues to meet the national standard for Early Intervention services.

2 week referral to treatment – early intervention in psychosis performance below

Standard definition: people with a first episode of psychosis begin treatment with a NICE recommended care package within two wee



ks of the referral being received

2.1.4 Waiting time for Psychology intervention

Although this is not a national or local access standard there continues to be a significant challenge with respect to the waiting time for psychology support. The table below shows the wait in days for fist appointment. This results in service users waiting a considerable amount of time for therapeutic intervention and support.

Wait For First Appointment (Days)												
Days From Referral To First Contact	Quarter 1, 2018-2019			Quarter 2, 2018-2019			Quarter 3, 2018-2019			Quarter 4, 2018-2019		
Team	Apr, 2018	May, 2018	Jun, 2018	Jul, 2018	Aug, 2018	Sep, 2018	Oct, 2018	Nov, 2018	Dec, 2018	Jan, 2019	Feb, 2019	Mar, 2019
Amber Valley - Psychology	42.70	37.00	298.64	429.78	267.80	508.77	407.67	121.13	172.43	76.18	60.78	38.00
Bolsover & Clay Cross - Psychology	412.43	260.57	158.40	268.80	242.50	198.25	198.23	144.25	136.33	243.83	201.57	168.50
Chesterfield Central - Psychology	251.88	129.00	125.77	228.50	121.14	181.73	110.60	152.38	216.00	140.00	95.45	114.00
Derby City - Psychology	100.87	251.19	333.19	150.86	110.92	378.83	111.40	81.20	226.85	114.17	75.50	126.50
Erewash - Psychology	51.89	76.67	55.50	62.86	62.50	58.33	61.50	62.14	36.57	253.17	24.00	167.50
High Peak & North Dales - Psychology	233.43	71.33	171.08	59.20	119.00	66.25	87.50	172.25	128.40	101.18	83.75	35.73
Killamarsh & North Chesterfield - Psychology	196.00	228.33	293.10	241.00	220.10	229.29	237.00	318.13	177.67	158.00	218.20	339.20

2.1.5 Proposed new access standards for Community Mental Health

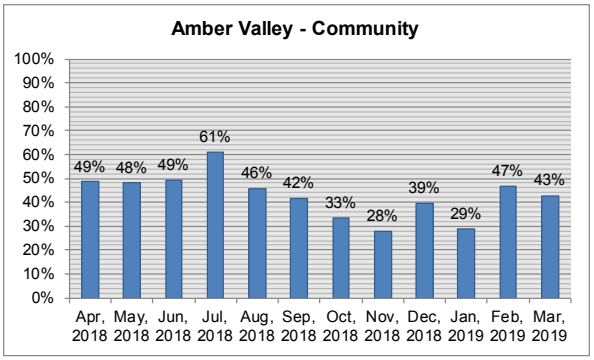
Within the clinically-led review of access standards the following has been proposed;

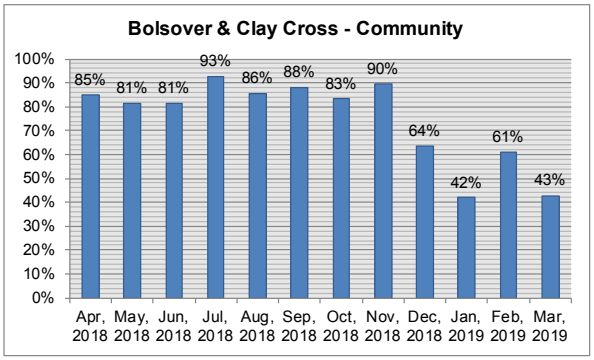
- Four-week waiting times for adult and older adult community mental health teams
- Clear waiting times are to be incorporated into the design of new integrated primary and community mental health services, to ensure that all individuals are seen within a clinically appropriate time
- Maximum of four weeks from referral to an assessment and start of treatment or plan in NHS-funded services and/or appropriate sign posting or interface with other services including outside the provider and specialist community services

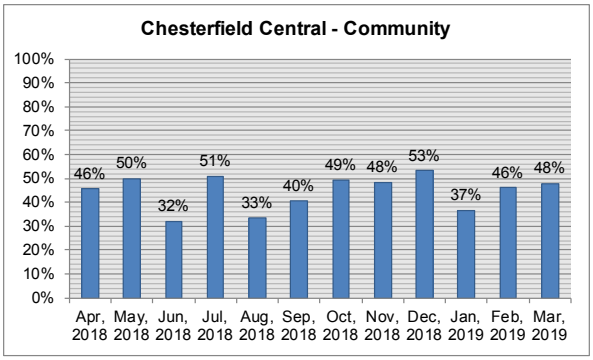
The information set out below provides an overview of current performance against the proposed 4 week standard across most of the Trust's Community Mental Health teams.

CMHT's, Learning Disability, Eating Disorders and Perinatal services have all been included for completeness.

The data shows that most teams would not meet this standard, with some being a considerable distance away.






Chesterfield Central - Community
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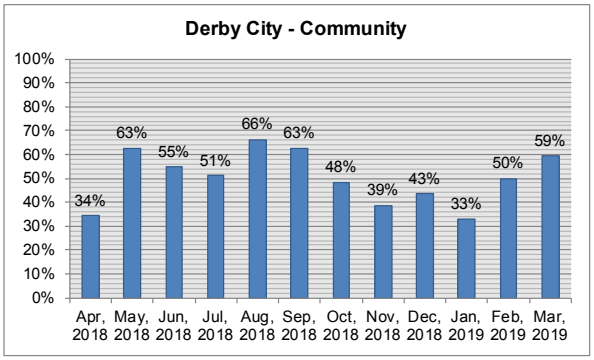
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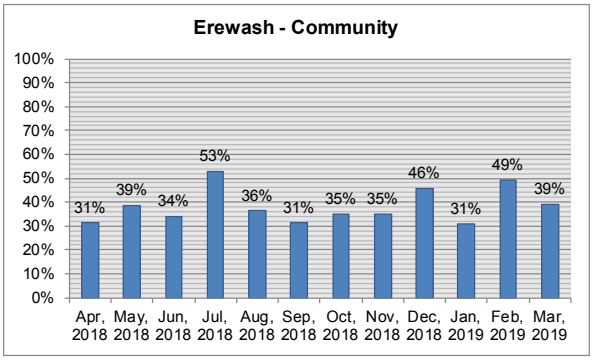
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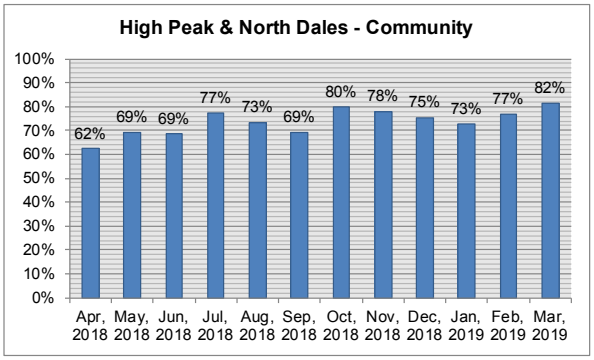
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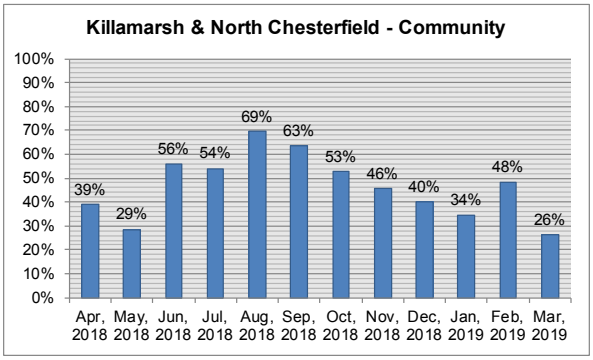
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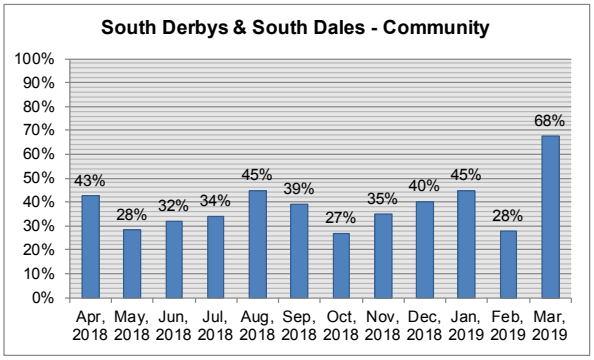
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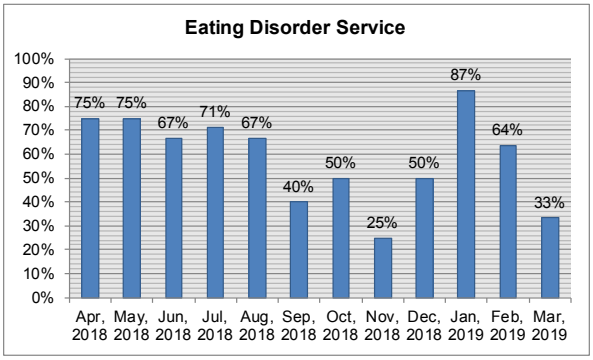
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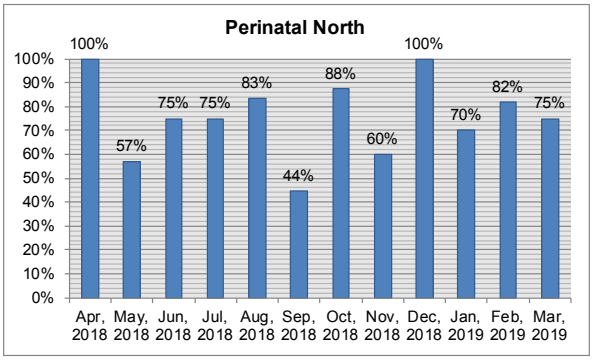
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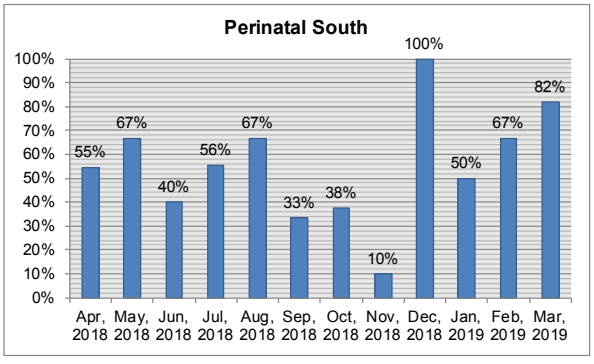
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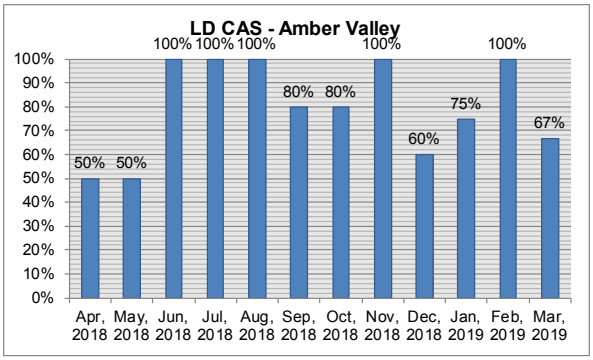
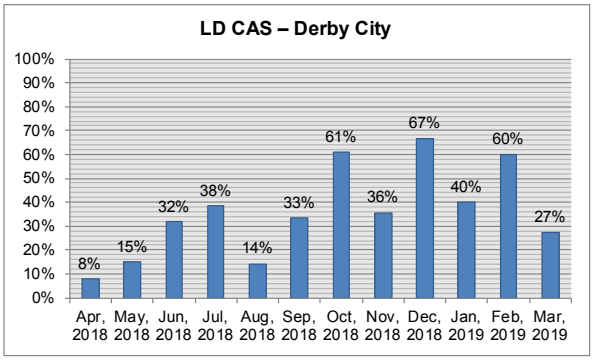
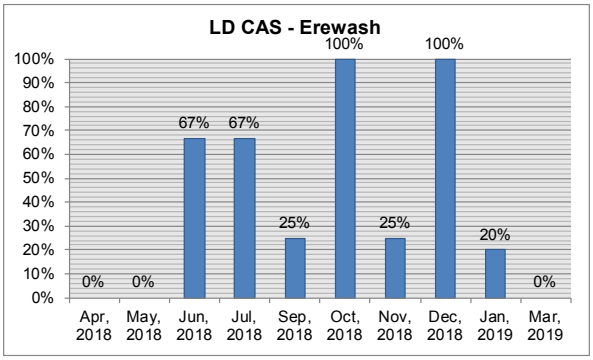
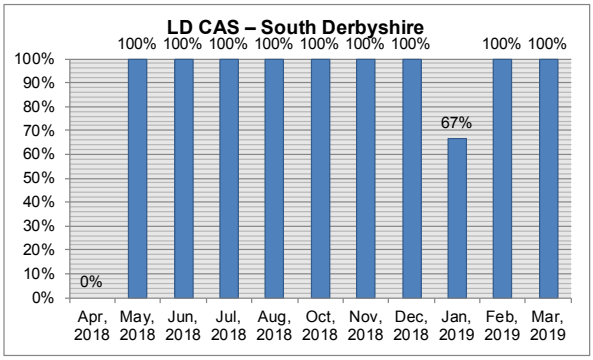








2.2 Children's Services – Current Standards

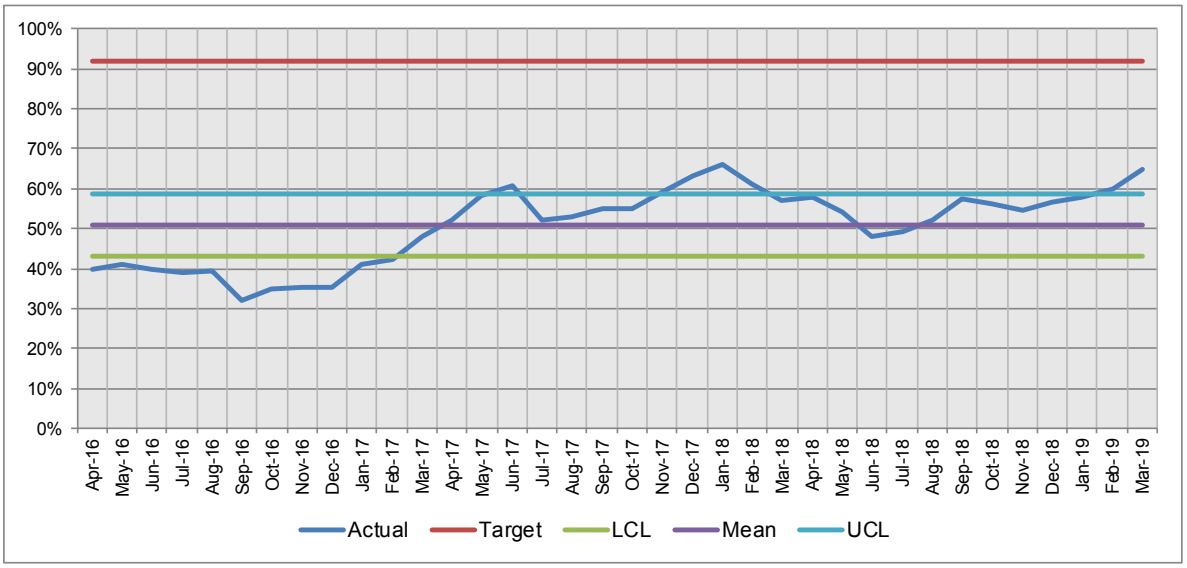
2.2.1 Community Paediatrics – Consultant-led outpatient service

Although over the last few years there has been significant improvement, the number of new referrals received each month continues to match / exceed capacity.

Further improvements have been made in the last 6 months as shown below; however, capacity remains a significant issue. Negotiations continue with the CCG regarding the service specification to ensure clarity and resource for the activity required in the localities.

Finance and Performance Committee will be receiving assurance on the current action plan for community paediatrics at the May meeting.

18 week referral to treatment – paediatric outpatients



Standard definition: 92% or more of the patients currently on the waiting list for a consultant-led outpatient service must have been waiting less than 18 weeks.

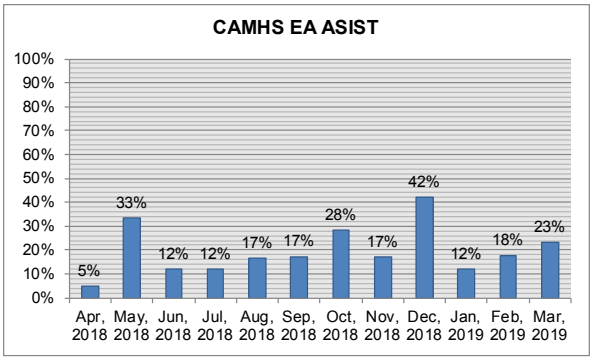
2.2.2 Proposed new access standards for Child and Adolescent Mental Health (CAMHS)

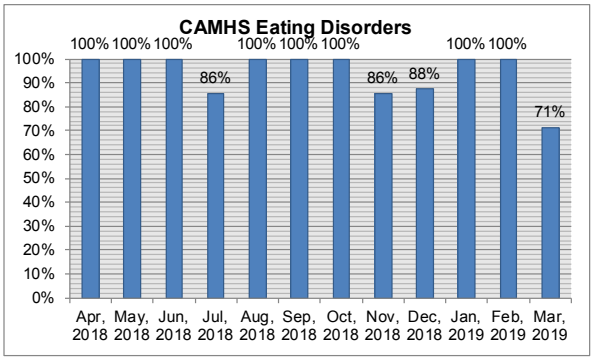
Within the clinically-led review of access standards the following has been proposed;

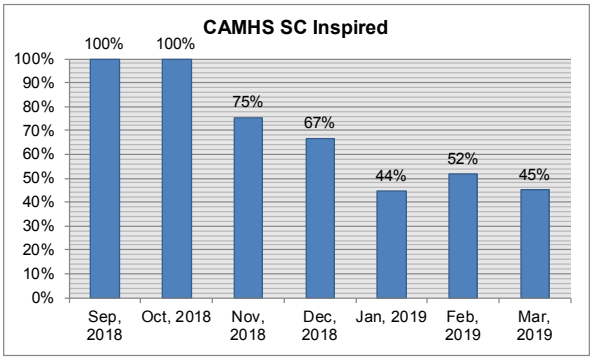
- Four-week waiting times for children and young people who need specialist mental health services.
- Waits for treatment for children and young people's mental health services vary significantly from referral to treatment. Long waits can impact both clinically and on the individual waiting for treatment.
- Maximum of four weeks from referral to an assessment and start of treatment or plan in NHS-funded services and/or appropriate sign posting or interface with other services including outside the provider and specialist community services

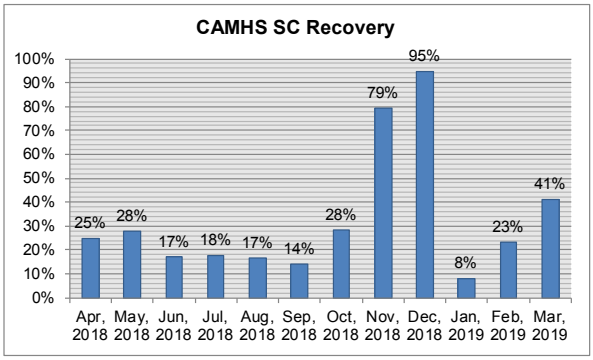
The information set out below provides an overview of current performance against the proposed 4 week standard across the Trust's CAMHS teams.

The data shows that most teams would not meet this standard, with some being a considerable distance away.









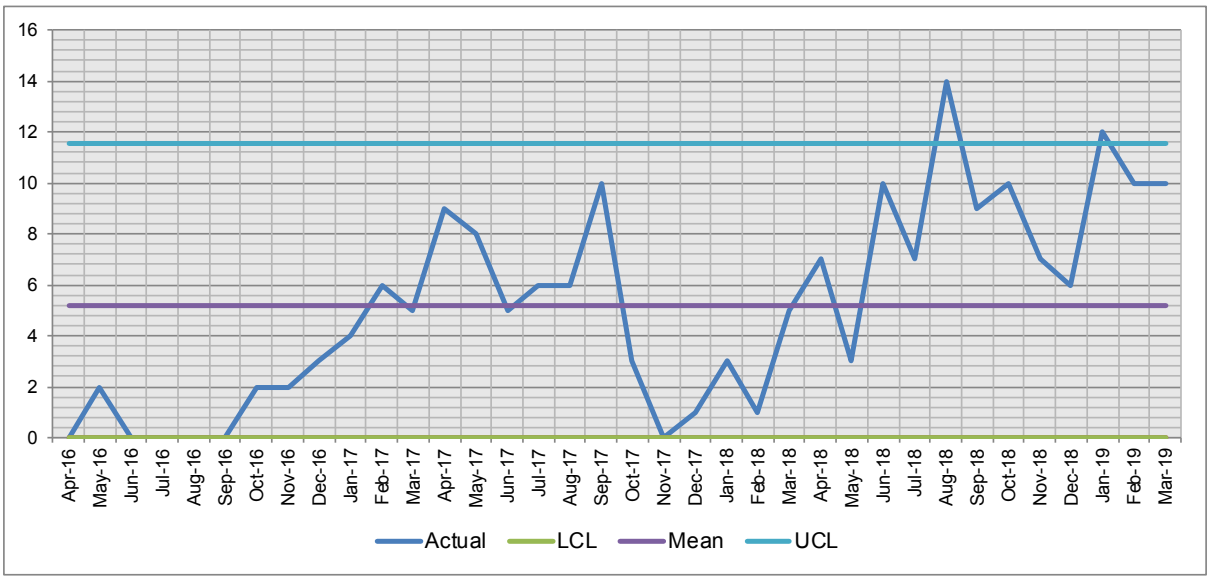
2.3 Acute Services – Current Standards

2.3.1 Out of Area Placements

There is a national ambition to eliminate Out of Area Placements by end of March 2021. Board members will know from previous discussions that this is influenced by many factors. Current performance for both adult acute and psychiatric intensive care patients are set our below.

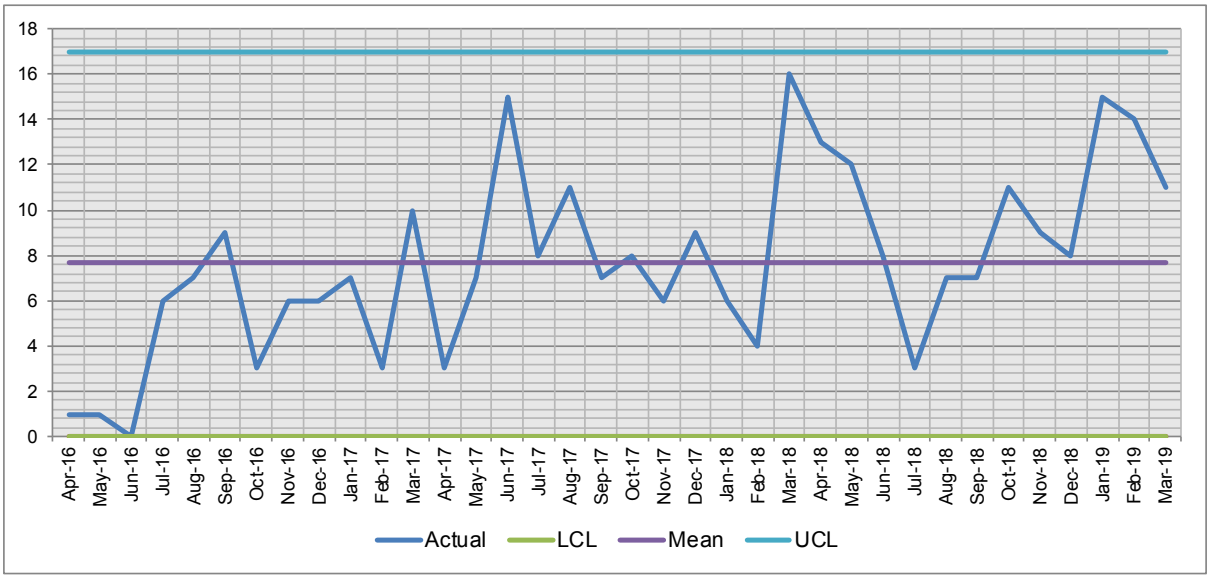
Finance and Performance Committee will be receiving assurance on the current action plan for community paediatrics at the May meeting.

Inappropriate out of area placements – adult acute



National ambition: to eliminate inappropriate OAPs in mental health services for adults in acute inpatient care by 2020-21.

Inappropriate out of area placements – PICU



National ambition: to eliminate inappropriate OAPs in mental health services for adults in acute inpatient care by 2020-21.

2.3.2 Proposed new access standards for Acute / Urgent Care services

Within the clinically-led review of access standards the following have been proposed;

Crisis Services

- Expert assessment within hours for emergency referrals; and within 24 hours for urgent referrals in community mental health crisis services
- While for many people with urgent mental health needs, A&E is appropriate; consensus among clinicians, patients and commissioners is that many urgent mental health needs could be met more effectively in the community. Appropriate response times will need to be explored as part of testing. Many local areas have already set a local target of four hours, for example. However, the severity and need of individual patients will need to be taken into account – some patients will need a quicker response

- Rapid assessment of needs to determine urgency, and clear communication of expected next steps to the patient or referrer. Many needs will be met on the telephone or by facilitating access to non-urgent support. When people are assessed as having urgent or emergency needs, they will need timely face-to-face assessment from a specialist mental health professional

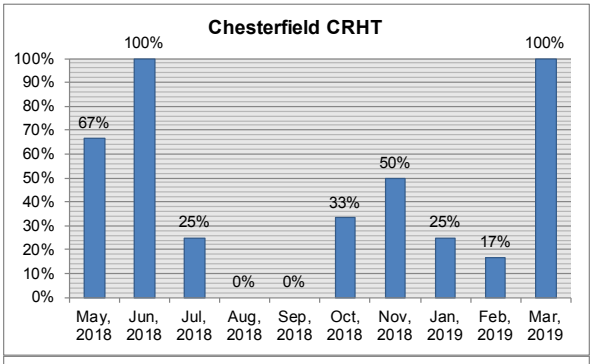
Liaison Psychiatry (within A&E)

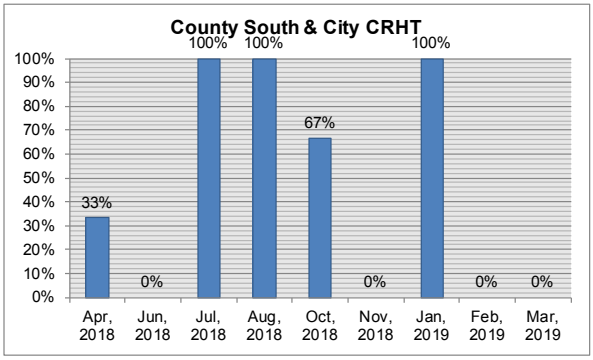
- Access within one hour of referral to liaison psychiatry services and children and young people's equivalent in A&E departments.
- Patients of all ages presenting in A&E in crisis require quick assessment to determine risk. If they are not seen quickly, the A&E environment can exacerbate symptoms and they may leave without treatment, potentially with risk of serious harm or suicide. Managing patients who have not been assessed adds pressure and anxiety to staff.
- Someone experiencing a mental health crisis would receive a response from the liaison mental health service within one hour.

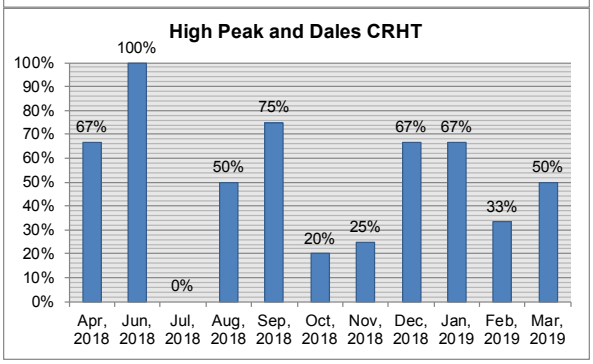
The information set out below provides an overview of current performance for both of these standards (based on Trust interpretation of the proposed standards)

2.3.3 Crisis Services

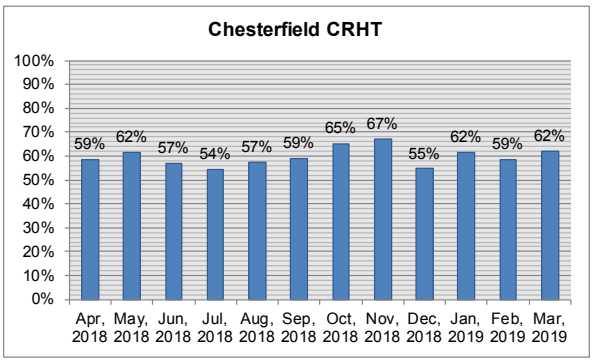
Crisis services – emergency referrals seen within 4 hours (target = "seen within hours")

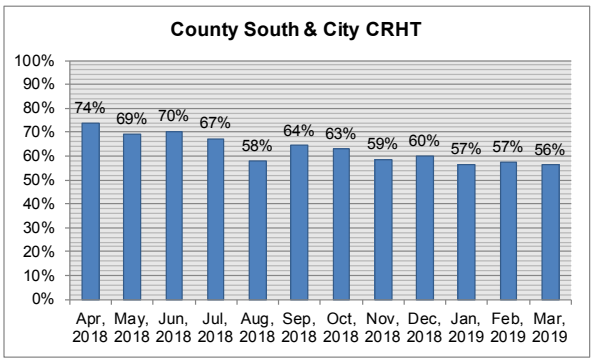


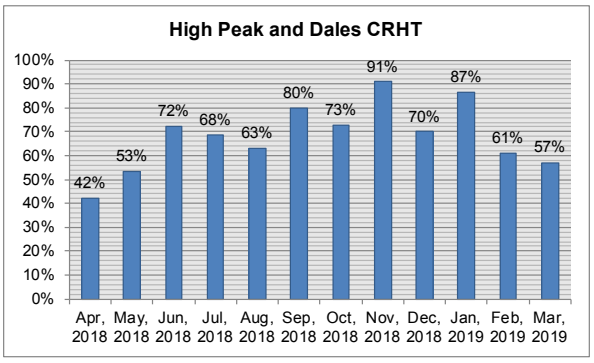




Crisis services – urgent referrals (target = 24 hours)



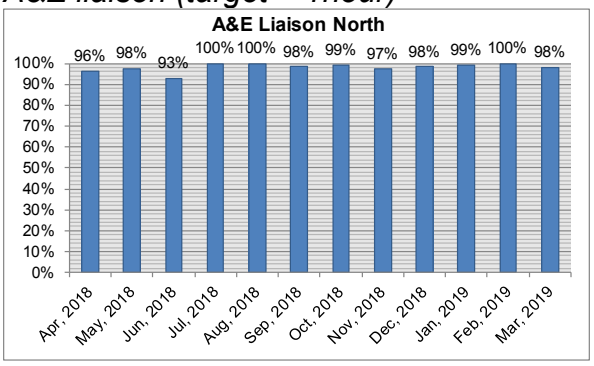


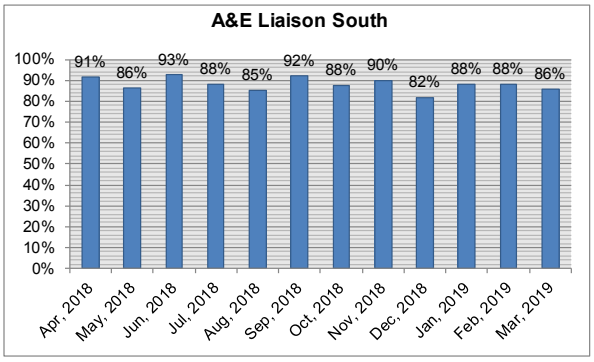


2.3.4 Liaison Psychiatry

The Liaison Team routinely collect data from the assessments and referrals they receive on a specified dashboard located on *'Connect confidential'*. This enables the team to view the quantitative and qualitative outcomes they meet in line with the national model of a Liaison Psychiatry

A&E liaison (target = 1hour)





2.4 Autistic Spectrum Disorder (ASD) assessment service

The NICE Quality Standard [QS51] on autism (2014) sets a standard of 3 months from referral to diagnosis.

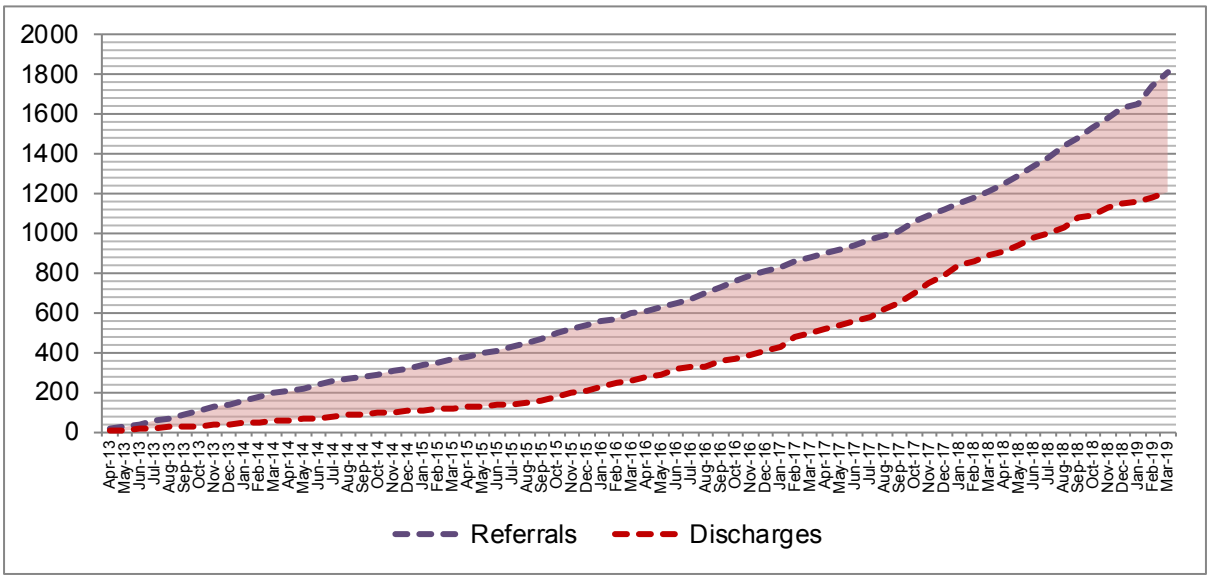
As the data shows below demand for ASD assessment continues to exceed capacity. The number of referrals received per month consistently exceeds the number of discharges.

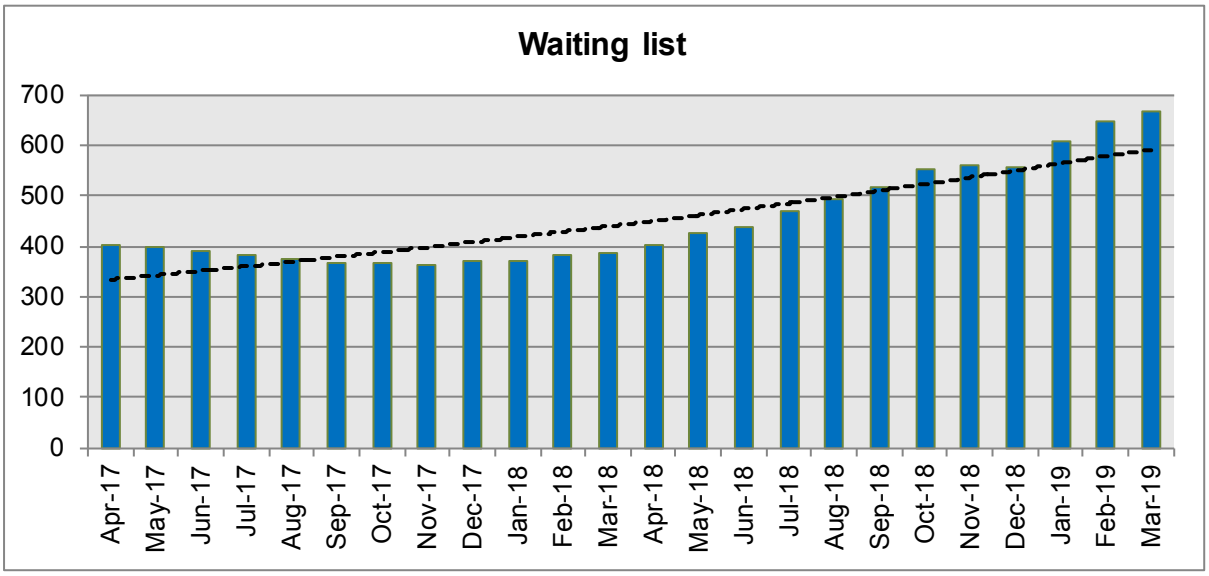
Staff retention continues to be a challenge owing to the "assessment only" nature of the roles.

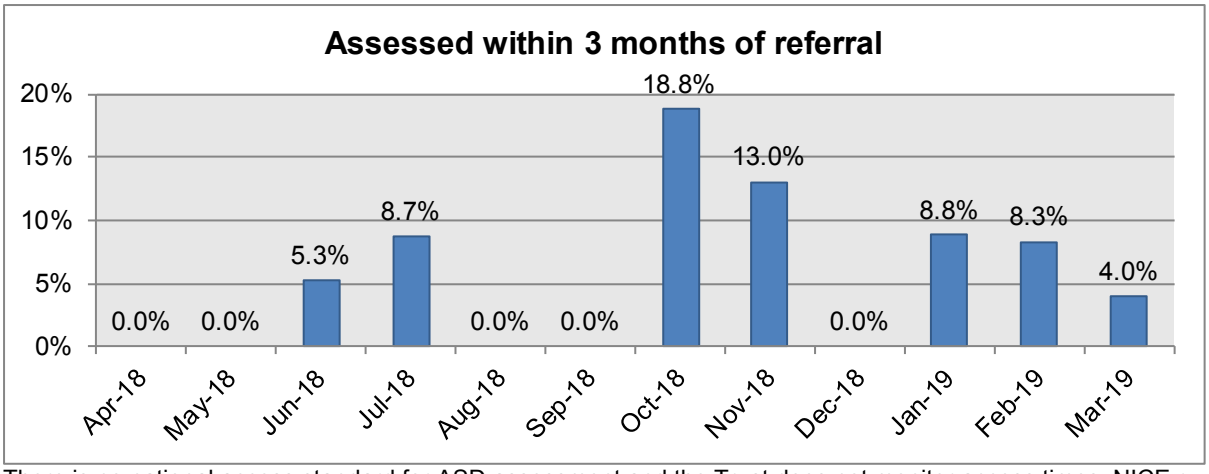
Members of Trust staff contribute to the ASD training requirements which we have a duty to provide under the Autism Act 2009. This task enables staff to retain their ASD expertise and also helps to develop staff within the organisation, but it reduces the team's capacity to undertake assessments.

The increase in the number of referrals for assessment and lack of commissioned post assessment provision is a significant concern for the Derbyshire population. As a result of this, the Trust receives regular complaints about waiting times and lack of provision, which need to be directed to commissioners of the service.

There remains ongoing discussion with commissioners about the need for extra investment into both assessment and treatment services for ASD. At this time commissioners have not made any commitment to do either.







There is no national access standard for ASD assessment and the Trust does not monitor access times. NICE quality standard 2014: people with possible autism who are referred to an autism team for a diagnostic assessment have the diagnostic assessment started within 3 months of their referral

3. Next Steps

The Trust continues to maintain a good level of responsiveness across many of the services it provides. However, there remain a number of services where being responsive continues to be a significant challenge, mainly owing to lack of capacity, underfunding issues or commissioning gaps.

In order to facilitate a strategic discussion using the information contained within this report, along with other triangulated information from Committee reports there are a number of key strategic questions arising out of this report that the Board of Directors might wish to consider:

- Is the Board assured that there are sufficiently robust delivery plans in place to address long standing waiting time issues in the short, medium and long term?
- Has the Board agreed the level of risk that it is willing to tolerate with respect to services that are not yet delivering the national 'responsiveness' requirement and also considered any impact of this on patient safety?
- Given the ongoing and unrelenting increase in demand for autism assessments and lack of commissioned post assessment intervention service, should the Trust consider a different approach with commissioners?
- Is the Board assured that the Clinical Strategy development work that is being undertaken will adequately address the long standing waiting time issues identified in this report?
- Is the Board assured that there is sufficient management oversight and consideration of the recently proposed national access standards and that this oversight is influencing service change and transformation?

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 7 May 2019

Trust Strategy Review and Update

Purpose of Report

To review progress made in 2018/19 against the key strategic actions within the Trust Strategy for 2018-21, refreshed in February 2018.

To receive the Draft Updated Trust Strategy for 2018-22 and to agree to move forward to engage with trust colleagues and stakeholders on the contents.

Executive Summary

The Board agreed its refreshed 2018-21 Trust Strategy (enclosed) in February 2018, following engagement with colleagues and stakeholders. The Strategy set out a clear statement of the Trust's Vision and Values and identified four strategic objectives. Under each strategic objective were short-term priorities for 2018/19:

1. Quality improvement
   - Completing the CQC action plan and the preparedness plan for next year
   - Deliver physical healthcare CQUIN

2. Engagement
   - Developing empowered and compassionate leaders
   - Enhancing colleague voice through action

3. Financial sustainability
   - Create and deliver a re-current cost-improvement-plan
   - Achieve agency ceiling

4. Operational delivery
   - Reduce vacancies to 5%
   - Redefine our Urgent Care and Neighbourhood Pathways

Progress made against the short-term priorities

The Trust Board reviewed the Trust Strategy and progress against the short-term priorities in October 2018 in a joint development session with the Trust Governing Body. We found that whilst significant progress had been made against some of the priorities, a number of them hadn't seen firm and improved outcomes at that stage. Before considering the updated Trust Strategy as a Board, it is important to review at the end of 2018/19 progress that has been made against our agreed short-term priorities.

Quality Improvement

1) The Trust-wide inspection by the CQC in July 2018, resulted in 91 actions being required of the Trust. Further site and service specific inspections at Cubley Ward and the Radbourne Unit, resulted in a total of 110 CQC actions received

in the year. Of these, 75 have been completed, with 35 outstanding. Of the 35, 16 are overdue against the agreed timescales. Progress against delivery is overseen on a monthly basis by Trust Management Team with escalation reports received by Executive Leadership Team. The Trust expects to deliver all the actions before the next Trust-wide inspection, expected in the early Autumn.

2) The physical healthcare CQUIN was not delivered in full in 2018/19. Improving our delivery of physical healthcare checks for our patients remains a priority and is part of our key actions for delivery in 2019/20 and is part of the updated Trust Strategy.

Engagement

1) During 2018/19 the Trust launched its new Management and Leadership Development and Training programme. A key focus of the programme is to embed the Trust's values in management and team behaviours. In the autumn, a Team Derbyshire Healthcare Conference was held, focussing on the importance of the team. This resulted in the creation of the Team Derbyshire Healthcare Promise, which sets out what employees can expect of the Trust and what the Trust can expect of employees. The Promise will form part of the updated Trust Strategy.

2) 2018/19 saw further development of our BME and LGBT Networks and the establishment of a Disabled People and Long Term Conditions Network, enabling people with protected characteristics to have their voices heard in the Trust. The Staff Forum is now well established, celebrating its first year in operation, directly contributing to changes in the Trusts approach to travel expenses, amongst other work

Financial Sustainability

1) The Trust's delivered CIP plan for 18/19 was again mainly reliant on non-recurrent savings, with only 38% of the savings delivered on a recurrent basis. The Operational Plan for 2019/20 requires a £4.6m CIP programme being delivered. £2.6m of the current plan is non-recurrent savings. The development of recurrent savings within the plan and delivery within 2019/20 and 20/21 remains an urgent priority action for the year ahead.

2) During 2018/19, the Trust's Agency spend was below the cap set by NHSI. Actual spend at Month 12 was at £2.9m against the cap of £3.03m, a delivery of 4% below the cap.

Operational Delivery

1) During 2018/19, the Trust's vacancy rate rose due to the significant investment in new posts at the start of the financial year in April, making the achievement of the 5% short-term priority very challenging. Over the course of the year, the Trust's vacancy rate fell from over 13% in April down to 9.3% in February. Retention and recruitment of staff remains a key strategic priority for the year ahead.

2) 2018/19 saw the agreement of the Neighbourhood Review. Implementation of

the recommendations to separate the management and teams for people of working age and older adults have started. The programme to develop Clinically-led Strategies for each of our service areas started in January and will run through to June. The two areas covered by this priority action were the first two service areas considered in the process and will be the first to come to Board for agreement in early July.

Updated Trust Strategy 2018-22

Enclosed with this paper is a final draft for consultation of the updated Trust Strategy for 2018-22. The Executive Leadership Team and senior managers have worked together to update the strategy to take account of the challenges of the next three years, to reflect the progress made since the strategy was last refreshed and to cross-reference with the organisational risks identified in the creation of the Board Assurance Framework for 19/20.

The updated Trust Strategy reconfirms the vision and values of the Trust and now includes the Team Derbyshire Healthcare Promise. The update now has three simple Strategic Objectives:

1) Great Care
2) Great Place to Work
3) Best Use of Money

Underneath each of the Strategic Objectives are a set of building blocks outlining what we need to achieve to deliver the objectives. Each of the building blocks has three priority actions, with improvement measures for each priority action. The priority actions cross reference with the Board Assurance Framework and brings together those actions that were previously reported separately as Quality Priorities.

The Updated Strategy is enclosed for discussion by the Board and to agree for it to move forward to consultation and engagement with staff, partners and stakeholders.

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

Assurances

This board paper provides an update on the progress against the short-term priorities in the Refreshed 2018-21 Trust Strategy and encloses the draft Updated Trust Strategy for 2019-22. It provides assurance against those priority actions that have seen significant progress in 2018/19 and that those areas that have not made the expected progress are included in the Updated Strategy for 2019-22.

Consultation

The work to update the strategy has involved the Executive Leadership Team and other senior managers. Subject to agreement by the Board, further engagement and consultation with the wider Trust workforce, our partners and our stakeholders will follow this Board meeting.

Governance or Legal Issues

- There is a requirement for the Trust to have a strategy for its future development, setting out its strategic objectives over the medium-long term.
- There is a requirement that the Trust Board Assurance Framework is informed by the Trust's strategic objectives.
- The Trust's strategic objectives and priority actions will inform the agendas and remit of the Trust's management committees and those of the Committees of the Board.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

There are no adverse effects on people with protected characteristics (REGARDS).	
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	X

Actions to Mitigate/Minimise Identified Risks

Our strategic objectives to provide Great Care and be a Great Place to Work will both need to take into account and address the existing disadvantages faced by people with protected characteristics within our care and our workforce. Systems are in place to monitor the impact on people with protected characteristics.

Recommendations

The Board of Directors is requested to:

1) Note the progress made against the short-term priority actions outlined in the Refreshed Trust Strategy agreed in February 2018.
2) Note that those areas that have not seen significant progress are included as key actions within the updated Trust Strategy for 2018-22
3) Receive and discuss the updated Trust Strategy for 2018-22 and agree that this updated version go forward for consultation and engagement with stakeholders and partners.

Report presented by:	**Gareth Harry** **Director of Business Improvement and Transformation**
Report prepared by:	**Gareth Harry** **Director of Business Improvement and Transformation**

NHS
Derbyshire Healthcare
NHS Foundation Trust

Trust strategy
2018-2022
(Refresh April 2019)

DHCFT @derbyshcft
www.derbyshirehealthcareft.nhs.uk

Making a positive difference

Foreword by Chief Executive Officer : Welcome to our refreshed Trust strategy (2018 – 2021)

We find ourselves at an exciting point in the development of our Trust. This strategy is important because it identifies the common purpose all of us who work in the Trust share, the way we go about doing business and what outcomes people can expect to see from us over the next few years.

It is important we continue to refresh our strategy because as a Board of Directors we have recognised the absolute need to focus on 'people first' and by that we mean colleagues who work in the Trust. We are clear that only by doing this, can we together, create a culture that supports continuous improvement, that learns from mistakes and promotes innovation. Focusing on people will enable us to attract colleagues to work with us and will ensure we create new and exciting roles to give more opportunity for personal development.

In this refresh we have simplified our strategic objectives (see P3) to make them clear and easy to use so colleagues and teams can simply identify how they contribute to the achievement of the Trust objectives

Things are changing in our wider health and social care environment too, a focus on delivering care as close to home as possible, more collaboration across clinical pathways and a focus on prevention; all things we need to take into account when working together to refine and improve how we deliver our services.

Nationally the launch of the NHS Long Term Plan has an impact on every single service we deliver with some great opportunities for service improvement but equally clarity on the challenges we face together in this new environment.

I look forward to working together to make our strategy a reality for the people of Derbyshire.

Ifti Majid
Chief Executive

TEAM
Derbyshire Healthcare

Introduction: Background

What is a trust strategy?

Derbyshire Healthcare NHS Foundation Trust is a provider of Mental Health, Learning Disability, Substance Misuse and Children's Services across Derbyshire

Derbyshire is a County that covers 1000 square miles with a population of about 1million people. The rural, semi-rural and urban landscape gives rise to a mixture of affluent and seriously deprived areas. The city of Derby is a vibrant place where over 300 languages are spoken.

Our Strategy is a way of setting out our shared ambition over a period of several years. It simply defines the main improvements and changes we together aim to make, how we will go about doing that and how we will measure the success of those actions.

Our strategy is not a static document but one that together we regularly review to make sure it remains relevant to our challenges and opportunities.

Some of the key things we have taken into account when developing and continuing to evaluate our strategy include:

- The NHS it at a point of change with a number of major policy changes being released in 2019 such as the NHS Long Term Plan and changes to the mental health act.
- Best practice is continuing to evolve and develop
- There is a growing focus on how organisations in a system work together to provide more integrated care. In Derbyshire this is called Joined up Care Derbyshire (JUCD). The purpose of JUCD is:
  - Improve Health and Wellbeing
  - Improve care and quality of services
  - Improve financial efficiency and sustainability
- Demand for all of our services is growing and we are seeing people with more complex needs living longer and of

Derbyshire pic

Our vision, values and strategic objectives

Our Vision

'To make a positive difference in people's lives by improving health and wellbeing'

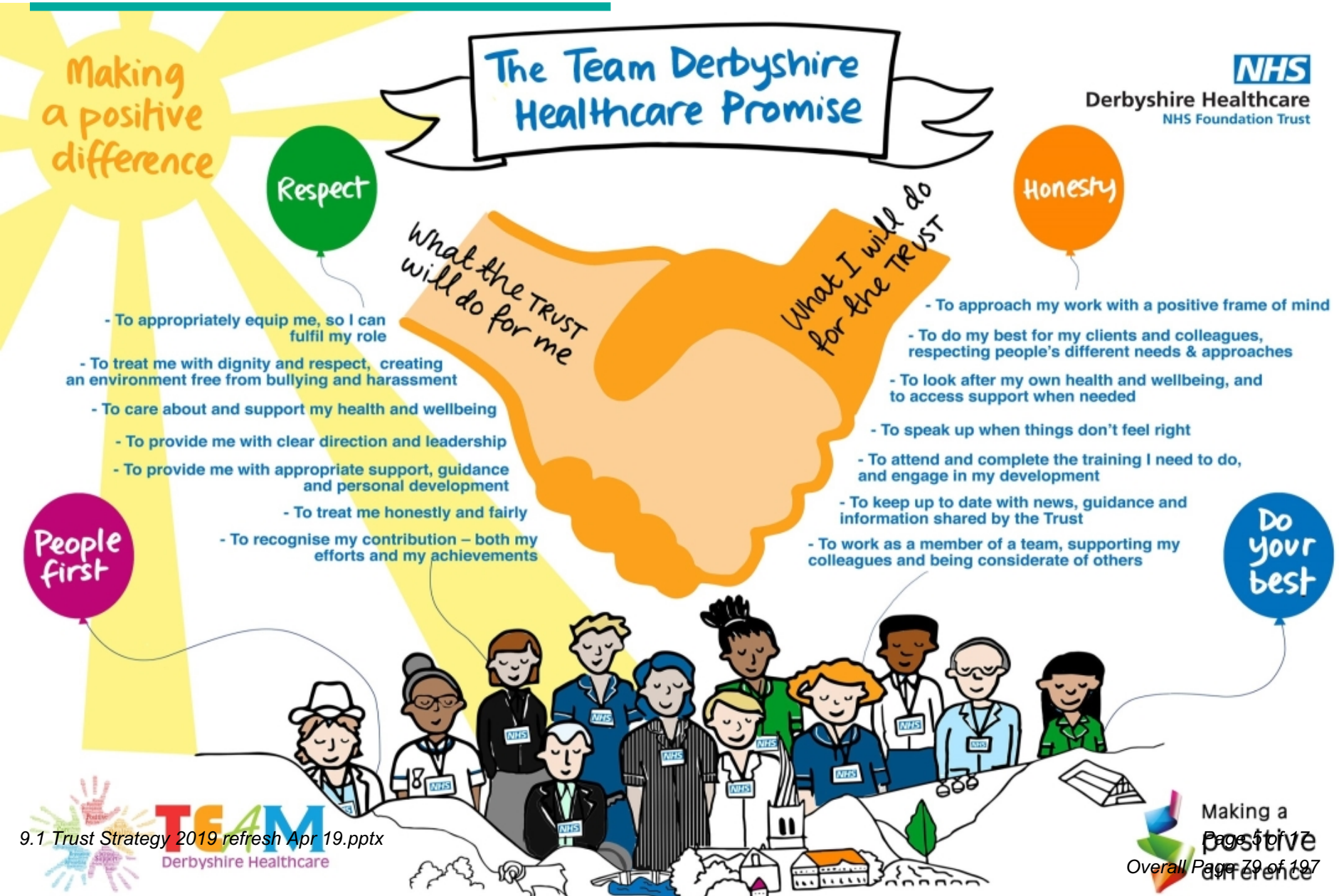
Our Values

Our vision is underpinned by four key values, which were developed in partnership with our patients, carers, colleagues and wider partners.

- **People first** – We put our colleagues at the centre of everything we do and by so doing improve outcomes for the people of Derbyshire
- **Respect** – We respect and value the diversity of our patients, colleagues and partners and support a respectful and inclusive environment.
- **Honesty** – We are open and transparent in all we do.
- **Do your best** – We work closely with our partners to achieve the best possible outcomes for people.

Our Strategic Objectives

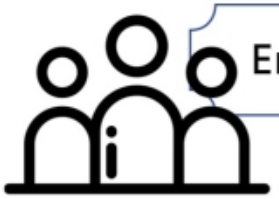
Our Vision: **Delivering GREAT care, GREAT place to work, BEST use of money together**



NHS
Derbyshire Healthcare
NHS Foundation Trust

1 Prevent ill health

2 Empower individuals



We will...

embrace principles of co-production

OUR CLINICAL AMBITION

We will be...

informed by clinical evidence

Be trauma informed

5

Keep inpatient stays short, in Derbyshire and in a healing environment 4

Slide to be designed following engagement

Our Vision: **GREAT Care, GREAT Place to Work, BEST use of money – means…**

Delivering **GREAT** Care

Delivering compassionate, person-centred, innovative and safe care.

Choice, empowerment and shared decision making is the norm.

GREAT Place to work

Attracting colleagues to work with us who we develop, retain and support by excellent management and leadership

An empowered, compassionate and inclusive culture that actively embraces diversity.

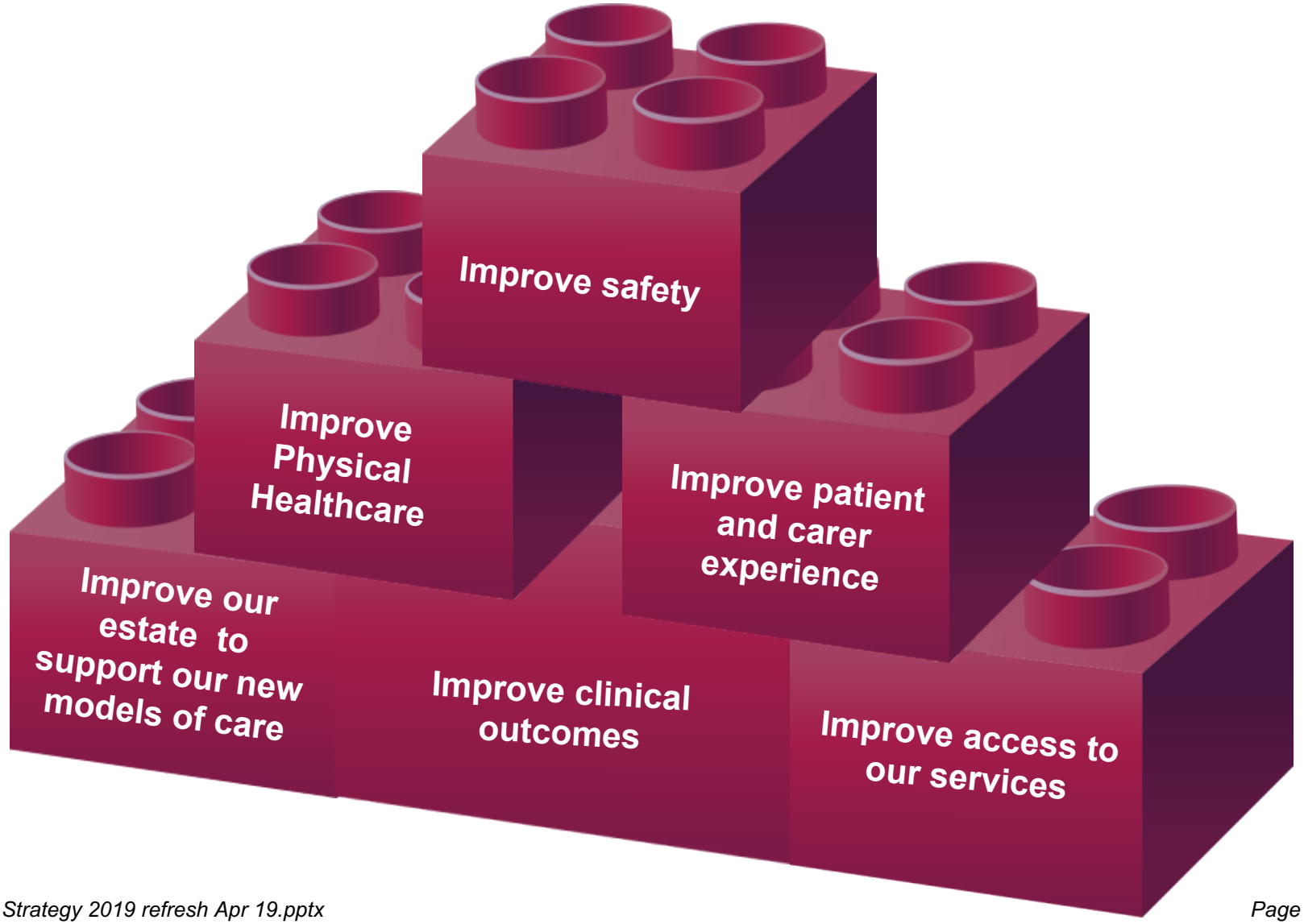
BEST use of money

Making financially-wise decisions every day and avoid wasting resources

Always striving for best value by finding ways to make our money go further.

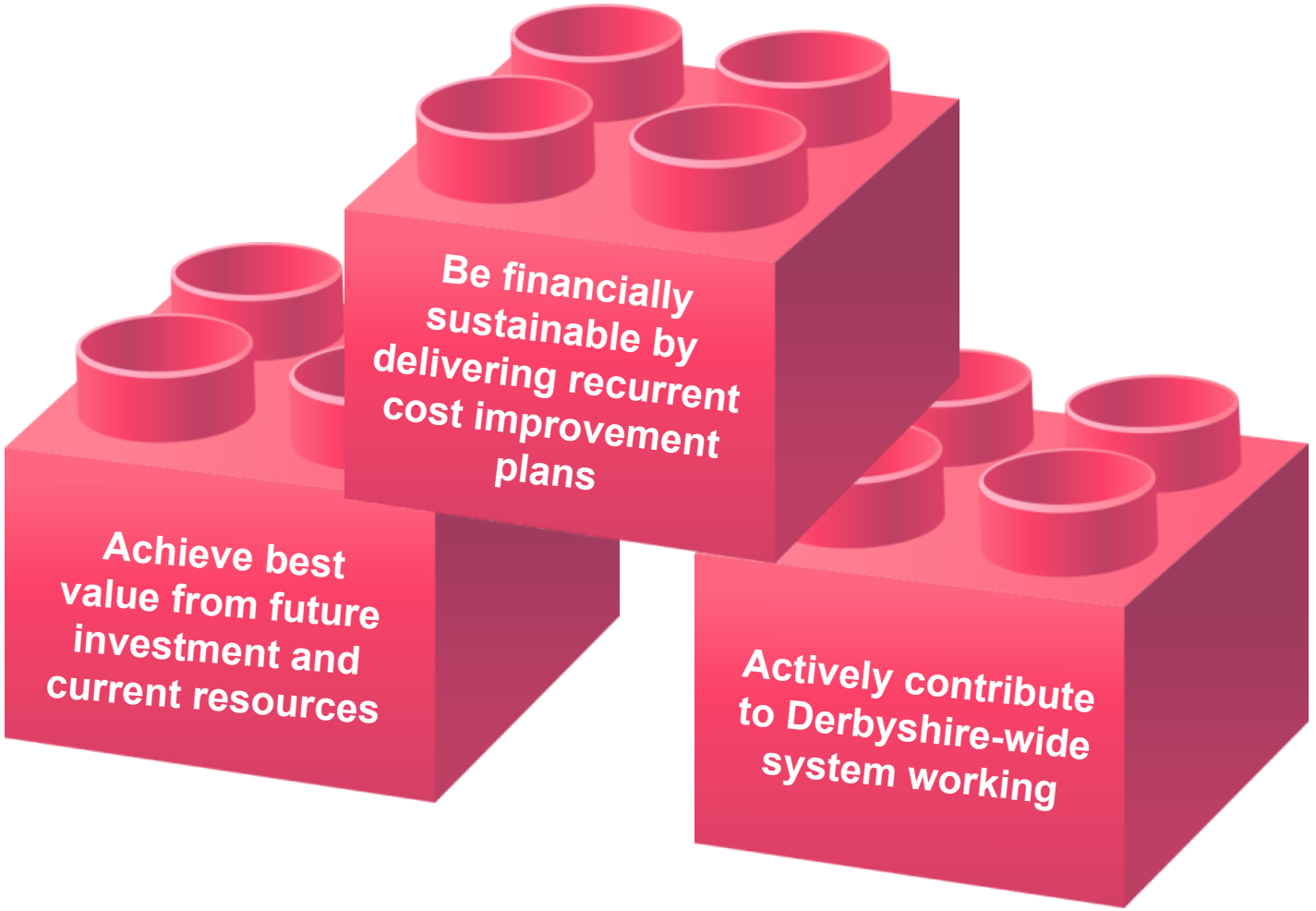
Achieving our vision

Achieving our vision: **What we need to achieve – To deliver Great care**



Achieving our vision: **What we need to achieve – To be a GREAT place to work**

Achieving our vision: **What we need to achieve – To make Best use of our Money**



Measuring the success of our Strategy

How will we measure our achievements?

Building Blocks to Deliver GREAT Care in all our Services	What are the three key priority actions?	How will we know we have improved?
Improving Patient and carer Experience	• Introduction of the 'EQUAL' approach to patient and carer engagement an involvement • Implementing effective care planning for everybody who uses our services • Implement a process to ensure we receive routine feedback on patient experience on discharge or service transition	• All service developments reporting co-production and evidence of impact • Feedback from patients and regulators • Feedback from carers/family and regulators • Evidence from services of using routine feedback, systematically and routinely in service improvement
Improving Physical Healthcare	• Deliver physical healthcare implementation plan	• PHC will feature as an active part in every patient's care plan • The LESTER tool approach will be embedded in all relevant care plans and smoking reduction/cessation will be an accepted approach throughout our care pathways • High fidelity to policies regarding for example SALT assessments, PHC in substance misuse services, PHC interventions after restrictive practices and in the eating disorder service
Improving Access to services	• Agree with Primary (Integrated) Care the principles of shared care across our care pathways • Develop a plan to meet the national and local access standards across all our service	• There will not be a "one way valve" effort when accessing our services • Reduction in waiting times, out of area placements. Increase in bed availability including PICU placements • Improved clinical outcomes and these are routinely measured in all services

How will we measure our achievements?

Building Blocks to Deliver GREAT care in all our Services	What are the key priority actions?	How will we know we have improved?
Improve clinical outcomes	• Review and revise our clinical pathways • Deliver the quality improvement strategy • Deliver implementation plan to achieve Royal College of Psychiatrists standards for acute services	• Implementation of new pathways • Comprehensive compliance/audit programme • Every individual/team able to demonstrate involvement in Quality Improvement • External accreditation from RCPsy for acute services • Acute services rated as good by the CQC
Improving Safety	• Implementation of medicines optimisation strategy • Delivery of a relapse prevention programme • Implementation of safety planning and suicide prevention strategy • Implement the digital transformation strategy	• Improvement in staff reporting in staff survey in safety. • Reduction in inpatient suicides • Reduction in suicide rates of patients open to Trust services
Improve our estate to deliver the new models of care	• Refresh Estates strategy and deliver the associated implementation plan based on outcomes from clinical strategies work • Implement the agreed interventions to enable the eradication of adults being placed out of Derbyshire to access a bed • Scope a long term plan for the eradication of dormitories • Reduce bed numbers per ward • Scope a plan for the delivery of PICU services locally	• No inappropriate gender/age mixes on wards • We are implementing our Estate strategy. With achievements year on year • Reduction in sexual safety incidents • Achievement of best practice norms • No waiting list for PICU services. Confirmed plans to establish PICU within Derbyshire

How will we measure our achievements?

Building Blocks to be a GREAT place to work	What are the three key priority actions?	How will we know we have improved?
Retain our colleagues	• Provide colleagues with health and wellbeing campaigns and a support package that provides rapid access to wellbeing services when needed • Increase staff involvement and engagement across all teams to ensure all colleagues work in a positive environment • Implement actions from the bullying and harassment working group	• Increased availability of staff who feel supported and engaged in their roles to be able to provide great care
Develop our colleagues	• To make available supervision, coaching and mentoring for staff • Provide career pathways for registered and un registered staff with access to the development, using the HEE money and apprenticeship levy where required • Development of an integrated workforce strategy and implementation plan	• Staff with the right skills and training to be able to provide Great Care

How will we measure our achievements?

Building Blocks to be a GREAT place to work	What are the three key priority actions?	How will we know we have improved?
Attract new colleagues	• Proactive recruitment campaigns to reach a broad range of applicants • Grow our bank to reduce the need to use agency staff • Offer flexible contracts to attract a broader range of colleagues to join and stay with our Trust	• Staff available to deliver Great Care who know our systems, processes and live our values.
Develop our Leaders and Managers	• All leaders to attend the Leading - Team Derbyshire Healthcare expectations session • All new and recent leaders in post to attend an induction and be supported with a mentor • Roll out the 360 process and coaching and a menu of master classes to support development	• Well run and engaged teams who can provide Great Care to our patients
Be a 'positively inclusive' and fair employer	• Thriving Staff Networks to guide the Trust on 'What Matters to Staff'' • Develop an quality improvement programme to ensure we record protected characteristics to evidence improvements in inclusion • Scale up the Reverse Mentoring Programme • Coproduce and implement a plan to reduce the gender pay gap	• To provide services that meet the needs of the people we serve, that is respectful and Inclusive • Reduction and closure of the gender pay gap • Metrics equalised with respect to disciplinary, grievances and training opportunities

How will we measure our achievements?

Building Blocks to make best use of our money	What are the three key priority actions?	How will we know we have improved?
Be financially sustainable by delivering recurrent cost improvement plans	• Achieve full CIP plan for current year • Meet the overall financial position as planned each year • Continually identify the pipeline of future efficiencies • Develop long term financial management strategy	Achievement of in-year CIP plan Achievement of Trust overall financial plan Approval of future year CIP plans
Achieve best value from future investment and current resources	• Monitor and hold to account for benefits realisation for delivery of all future investments • Deliver continuous improvement plans to improve productivity and reduce waste in current resources • Implement e-roster/e job planning and the new shift pattern	Achievement of planned benefits and efficiencies Improved outcomes from continuous improvement activity Reduced temporary staffing costs, reduced absence and improved productive time
Contribute to Derbyshire-wide system working	• Articulate and maintain up-to-date view of the risk mitigation and risk management of the whole system plans • Ensure that our specific workstreams deliver objectives as described (e.g. where SRO) • Ensure organisational capacity to deliver system objectives is directed appropriately	Evidence of Derbyshire-wide system delivery – in total and in workstreams Risk is managed as opposed to transferred Good governance is not compromised

NHS
Derbyshire Healthcare
NHS Foundation Trust

Trust strategy (Refresh)
2018-2021

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www.derbyshirehealthcareft.nhs.uk

Making a positive difference

Introduction and Background

Welcome to our refreshed Trust strategy (2018 – 2021)

We find ourselves at an exciting point in the development of our Trust. This strategy is important because it identifies the common purpose all of us who work in the Trust share, the way we go about doing business and what outcomes people can expect to see from us over the next few years.

It is important to refresh our strategy because as a Board of Directors we have recognised the absolute need to focus on 'people first' and by that we mean colleagues who work in the Trust. We are clear that only by doing this, can we together, create a culture that supports continuous improvement, that learns from mistakes and promotes innovation. Focusing on people will enable us to attract colleagues to work with us and will ensure we create new and exciting roles to give more opportunity for personal development.

Whilst we have identified four broad strategic objectives or areas for action (see P10), we will, together, constantly review what the 2 or 3 key priorities under each area are, if we have made improvements and if we need to change our focus.

TEAM Derbyshire Healthcare

Things are changing in our wider health and social care environment too, a focus on delivering care as close to home as possible, more collaboration across clinical pathways and a focus on prevention; all things we need to take into account when working together to refine and improve how we deliver our services

Our strategy should be read in conjunction with our Divisional 'plans on a page' that add more detail to how each area will deliver the vision and objectives (available on Connect)

I look forward to working together to make our strategy a reality for the people of Derbyshire

Ifti Majid
Chief Executive

Background and context

What is a trust strategy?
Our strategy was developed in early 2016 to meet the needs of our service users and to help colleagues understand their role in achieving the vision. It set out the direction of travel for Derbyshire Healthcare NHS Foundation Trust for the five years 2016-21 within the context of the wider health and care agenda, both nationally and locally. The strategy was written to provide a clear and concise vision for the future in order to deliver a *"…proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services" (Five year forward view for Mental Health – Feb. 2016, NHS England).*

However, since that time a number of things have happened which has meant that it is important to update the strategy to make it appropriate to our colleagues and external stakeholders. There were three key reasons for refreshing the strategy:

- The Trust's vision was updated in December 2017 as a result of feedback from our colleagues. Colleagues told us that they wanted a simpler, clearer vision of what the Trust will achieve in the years ahead. This was taken into account along with ideas on what makes Derbyshire Healthcare special.
- The proposed merger with Derbyshire Community Health Services NHS FT was not progressed following a Board decision in July 2017. It was agreed that with the proposed changes at a system level many of the clinical benefits could be achieved without a full merger. Therefore the strategy needed to reflect this change.
- In the original strategy (2016) reference was made to how the Sustainable Transformation Partnership (STP - now Joined-up Care Derbyshire) objectives would be delivered. However, much of the STP progress was stalled. The STP structure was reformed in the spring/summer of 2017 and this has made it clearer on the part Derbyshire Healthcare plays in the wider health and care economy.

There is now an opportunity through the strategy refresh, to more clearly articulate intentions around:

- How we aim to put people first in order to live our values
- How we develop our leaders to create the environment where people experience our values
- How the work of Derbyshire Healthcare fits within system-wide and partnership working.

How has the trust strategy been developed?
We have considered our commitment to colleagues, our performance, what services are core and which are strategically important to us (core plus). We have consulted with our colleagues, stakeholders, commissioners, governors and Trust Board members to gather ideas for strategic direction and these are detailed in this document. We have circulated the draft content to our colleagues, via the Staff Forum, to ensure that it clearly represents the views of the whole organisation.

We have also ensured that our strategy takes into account the wider health and care environment in which we work.

Our vision

The Trust's vision was updated in December 2017 as a result of feedback from our colleagues.

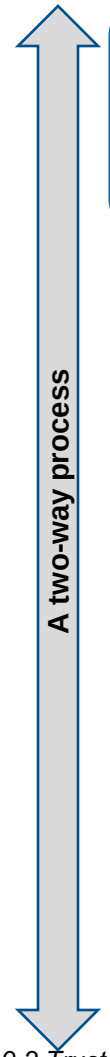
Colleagues told us that they wanted a simpler, clearer vision of what the Trust will achieve in the years ahead. This was taken into account along with peoples' ideas on what makes Derbyshire Healthcare special. Therefore the revised Trust vision is:

'To make a positive difference in people's lives by improving health and wellbeing.'

This strategy covers the period 2018 - 2021

Background and context

How will the Trust Strategy be implemented?



Sustainability and Transformation Partnership (Joined-up Care Derbyshire)

This outlines system level objectives in-line with the Five Year Forward View and national level planning documents

Derbyshire Healthcare NHS Foundation Trust Strategic Plan (Refresh) 2018-21

Our Trust Strategy clearly outlines how we are contributing to Joined-Up Care Derbyshire and the changes that we need to make in order to achieve our own vision working with our partners

Supporting Strategies
- **Quality**
- **People**
- **Information Technology**
- **Estates**

These 'enabling' strategies will clearly outline how we will change our structures and processes in order to meet our vision. These will set-out how we will make the changes and how things will 'look different' in 2021

Annual clinical/operational business plans

- **Sets objectives for services and corporate areas each year of the strategy**

- Annual clinical/operational business plans will enable teams and individuals to see how they are contributing to the overall strategy.
- Team and personal objectives will be aligned to the plans.
- Plans will allow us to track our progress.

Derbyshire Healthcare NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust (DHCFT) is a provider of community, children's and mental health services across the city of Derby and wider county of Derbyshire. We also provide a range of children's physical and mental health services in Derby and specialist services across the county including substance misuse, eating disorders and learning disabilities.

The Trust provides services to a diverse population, including areas of wealth alongside significant deprivation. The Trust's catchment includes both city and rural populations, with 71 languages being spoken. To demonstrate the diversity of our population it should be noted that 4% of the population of the County and 25% of population of Derby City are Black or another ethnicity. We have the second largest Deaf community outside of London. It is estimated 4-7% of local population are lesbian, gay or Bisexual.

The Trust works to the Equality Delivery System 2(EDS2) which is the national NHS performance framework designed to deliver better outcomes for patients, communities and better working environments for colleagues, which are personal, fair and diverse'. We have adopted EDS2 framework and will use it as a key enabler to support the delivery of this strategy, to ensure we consider equality in everything we do, including ensuring services and employment are equally good for everyone.

Successful partnership working is key to the delivery of many of our services. The Trust works in close collaboration with our commissioners and fellow providers of local healthcare services, together with local authority colleagues at Derby City Council and Derbyshire County Council, and voluntary and community sector organisations.

Our services

The Trust started to restructure its clinical services during 2015/16, following a large scale transformation programme that commenced in July 2013, when nearly 500 people took part in sessions to define how our services across Derbyshire might look in the future. From there, a vision was developed:

- Services will be wrapped around the needs of the patient and their community, they will be easy to access and re-access. The way in which we deliver care will be in line with an individual's needs and not simply dictated by how the service pathway is designed. We will not 'discharge' patients but will support their transition between services based on the individual's needs.
- Models of care will be service receiver needs led, not simply diagnostically led. Services will interconnect with other organisations to ensure that care is delivered in a truly integrated co-produced way.
- We will have fewer beds and instead care for service receiver within their communities as much as possible; services will support and enable the development of community, family and service receiver resilience. Our workforce will be flexible to support the service receiver's journey.

To date, hundreds of colleagues, service users, carers and external partners have been involved in deciding how this vision could be achieved. This has resulted in the identification of:

- A neighbourhood-based, needs-led approach to our community mental health services, with neighbourhood team members working closely with each other and other local health professionals, wrapping care around the person to keep them at home as long as possible. The teams draw on local community resources to help people rebuild their lives after an episode of mental ill health; and
- A campus based approach where our inpatient mental health services and the wider teams that support inpatients will focus on delivering high-quality care, as well as support within the community to prevent hospital admissions.

Derbyshire Healthcare NHS Foundation Trust (Continued)

78,244 service users seen

271 Inpatient beds

Number of staff **2,384**

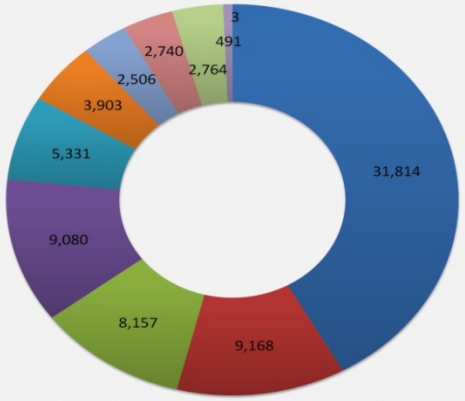
- 189 Scientific and technical
- 398 Additional clinical services
- 503 Administrative and clerical
- 117 Estates and ancillary
- 889 Nursing and midwifery
- 137 Medical
- 148 Allied health professionals
- 3 Students

The Trust cared for **3,172** babies born in Derby City

8,629 members

- 2,401 Staff members
- 6,254 Public members
- 22 Governors

75,957 service users open to Derbyshire Healthcare services on 31 March 2017



6 years ago we were licensed as an NHS Foundation Trust

1,014 Square miles covered

£ 136 million Annual operating income

During **2016/17** we reported an overall financial surplus

Background and context – to '*make a positive difference*' we must understand the wider system

Developing the Sustainability Transformation Plan

In response to the *NHS Shared Planning Guidance* (December 2015) it was agreed by health and care leaders across both City and County that all parties would contribute to the Sustainability Transformation Plan (STP) making it a truly system wide plan. The 12 organisations (NHS and Local Authority) agreed to create an ambitious local blueprint for accelerating the implementation of the Five Year Forward View (5YFV). The plan was submitted in October 2016 . However, owing to a number of changes nationally there was a 'pause' which meant that the STP was relaunched in spring/summer 2017 as the Sustainability and Transformation ***Partnership***. This has since been rebranded 'Joined-up Care Derbyshire'.

Joined-up Care Derbyshire continues to be developed based on the needs of local citizens and communities. Clinicians, professionals, colleagues and wider partners are central to the development of the plans. The Trust strategy needs to be in-line with the emerging system wide plan and be flexible in its approach. The strategy is aimed at providing the framework for the next three years whilst recognising that the health and care landscape will change for providers, commissioners and service users. A key feature of the system plan will be the move towards 'place based systems of care'. The emerging STP can be diagrammatically shown as:

Moving to Place Based Systems of Care

The move towards place based systems of care will enhance the concept of 'the team around the person' leading to a more integrated service, a reduction in duplication and greater efficiency. For a **defined geographical community with similar characteristics** all services – primary care, mental health, community services, social care and third sector sectors will operate as a **single team to wrap care around a person and their family.** There will be an equal focus to **empowering citizens** to self care and participate in shared decision making and promoting healthy lifestyles and well being, as there is to providing direct care. Links with the local community will be fostered, recognising that communities have a range of complex and inter-related needs, but also have **assets at the social and community level** that can help improve health and strengthen resilience to health problems. This integrated approach will meet the specific needs of local communities it will be **not one size will fit all** and will recognise that different communities will start with different services and facilities (including general practice)

Our communities

Derby City perspective

Derby City public health profile summary: Source narrative from Public Health England published June 2015.

Derby at a glance:

Health in summary - The health of people in Derby is generally worse than the England average. Deprivation is higher than average and about 23.8% (12,100) children live in poverty. Life expectancy for both men and women is lower than the England average.

Living longer - Life expectancy is 12.4 years lower for men and 8.9 years lower for women in the most deprived areas of Derby than in the least deprived areas.

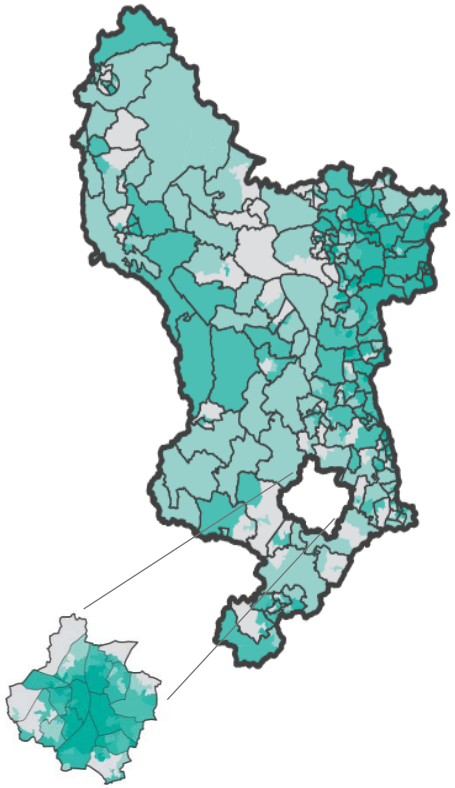
Child health - In Year six, 20.5% (545) of children are classified as obese. The rate of alcohol specific hospital stays among those under 18 was 44.1*. This represents 25 stays per year. Levels of teenage pregnancy, GCSE attainment, breastfeeding and smoking at time of delivery are worse than the England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

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.

Local priorities - Priorities for Derby include reducing inequalities, giving children the best start, risky behaviour change and substance misuse.

* *Mental health locality profiles - Derby City overview (East Midlands Public Health Observatory)*

Deprivation in Derbyshire: darker wards represent areas of higher deprivation.



Source: Derby City and Derbyshire County 2014 Public Health Profiles

Our communities

Derbyshire County perspective

Derbyshire public health profile summary: Source narrative from Public Health England published June 2015.

Health in summary - The health of people in Derbyshire is varied compared with the England average. Deprivation is lower than average, however about 16.3% (21,900) children live in poverty. Life expectancy for both men and women is similar to the England average.

Living longer - Life expectancy is 7.9 years lower for men and 5.8 years lower for women in the most deprived areas of Derbyshire than in the least deprived areas.

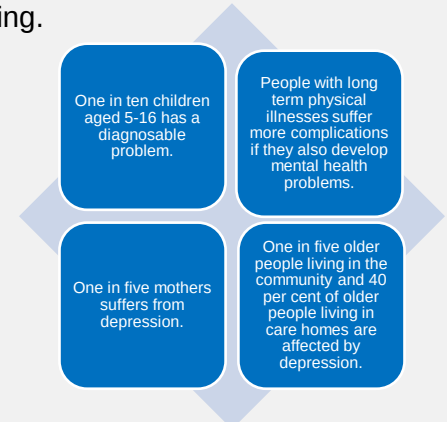
Child health - In Year 6, 17.1% (1,258) of children are classified as obese, better than the average for England. The rate of alcohol-specific hospital stays among those under 18 was 45.4*. This represents 70 stays per year. Levels of GCSE attainment, breastfeeding and smoking at time of delivery are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

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.

Local priorities - Priorities for Derbyshire include reducing smoking in pregnancy, reducing inequality in life expectancy and healthy life expectancy within the area and increasing breastfeeding.

In England:



* *Mental health locality profiles - Derbyshire overview (East Midlands Public Health Observatory)*

Introduction

Drivers for change

We have assessed the internal and external drivers for change in the development of this strategy. Examples of the drivers for change are listed below.

Internal	Our service users and families
• Need for clear direction - clear message to all colleagues, service receivers, partners and stakeholders. Promote a can do and creative approach in setting mutual expectations. • A strategy that assists with decision making. • Understand the direction of travel – how we can change to work in a changing health and care system. • Changing the culture of our organisation – putting our people first. • Embedding a listening, learning and solutions focused approach to all aspects of the organisation. • Managing and reducing the demand for our services. • Developing appropriate partnerships and collaboration.	• Services that put people at the centre – joined up and easy to access. • 'I tell my story once'. • Local services where possible. • Services within my own home where possible. • People that understand me and my needs. • Choices for service users and their carers. • Developing and embedding family and care inclusive practice. • Developing and setting mutual expectations. • 'Nothing about me, without me'.
System Level	**National**
• System wide sustainability – meeting the 'three gaps' - health and wellbeing, care and quality and finance and efficiency. • Move towards an Integrated Care System • Not progressing the merger with DCHSFT • Greater alignment of physical and mental health – parity of esteem. • More integrated services – 'I tell my story once'. • Developing seven day services. • Delivering high quality services. • Increasing demand for services linked to demographic change e.g. ageing population. • Delivering financial sustainability	A number of documents have been produced by NHS England, NHS Improvement and other national bodies which either provide guidance or are clear on the things we must do over the next five years. Examples of important documents are: • Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21 (December 15). • Five Year Forward View for Mental Health (February 2016) and 5YFV One Year On (March 17) • NHSE MH Delivery Plan (Summer 17) • NHS Constitution. • NHS Outcomes Framework. • Carter Review (February 2016). • National Standard Contract and National tariff • National 'must do's'. • The 'three gaps' - health and wellbeing, care and quality and finance and efficiency . **N.B.** *Documents available via NHS England or NHSI website*

Creating our vision

Our vision, values and strategic objectives

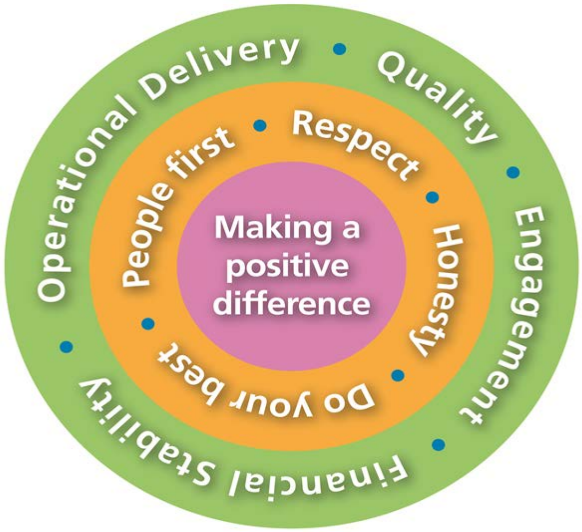
Our Vision

‘To make a positive difference in people’s lives by improving health and wellbeing’

Our Values

Our vision is underpinned by four key values, which were developed in partnership with our patients, carers, colleagues and wider partners. Our values were launched in May 2012, following consultation with colleagues, service users and partner organisations. They were refreshed in December 2017 as a result of feedback from colleagues.
We can only provide good quality services through our dedicated colleagues, working together with a common purpose. Our values reflect the reasons why our colleagues choose to work for the NHS and Derbyshire Healthcare.
Our Trust values are:

- **People first** – We put our patients and colleagues at the centre of everything we do.
- **Respect** – We respect and value the diversity of our patients, colleagues and partners and support a respectful and inclusive environment.
- **Honesty** – We are open and transparent in all we do.
- **Do your best** – We work closely with our partners to achieve the best possible outcomes for people.



Our Strategic Objectives

1. Quality Improvement

2. Engagement

3. Financial Sustainability

4. Operational Delivery

Our Vision

Engaging and Respecting Colleagues

To deliver our shared commitment to make a positive difference, we must work in capable teams where colleagues feel empowered, confident to be themselves and to raise concerns, share ideas for innovation and make decisions as close to the front line as possible. Our Team Derbyshire Healthcare engagement initiative provides a range of opportunities for engagement , support and development.

- Colleague Forum
- Team Brief
- Team Derbyshire Healthcare – Leaders
- Colleague magazine – ‘Employee Voice’
- CEO drop in sessions
- Schwartz Rounds

We are committed to active inclusion to support colleagues to have the opportunities to ‘do their best’ and succeed in their ambitions

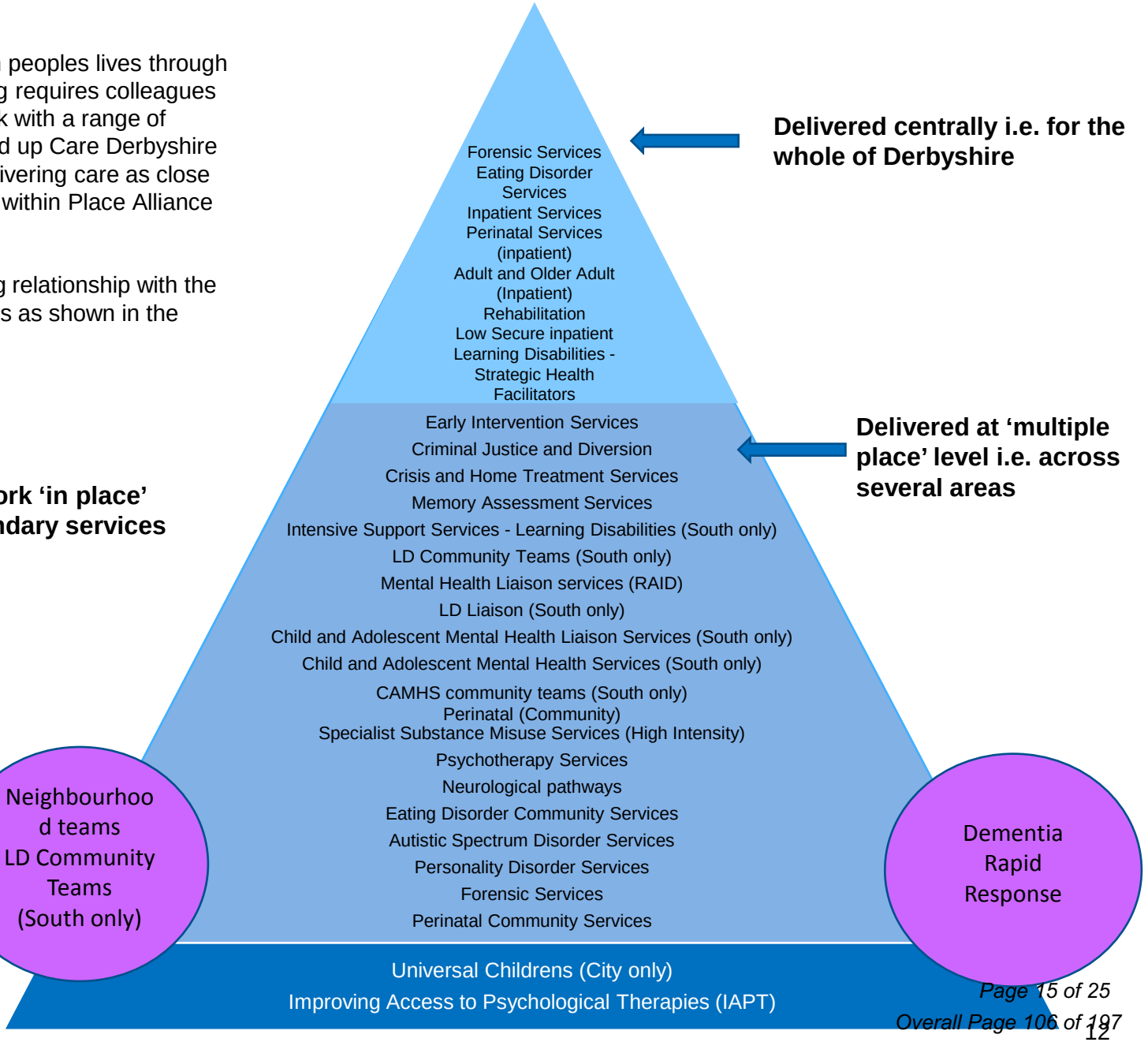
- BME colleagues network
- Commitment to LGBT+ inclusion
- Charter for British Sign Language (British Deaf Association)
- Reverse mentoring
- BME reverse commissioning.
- The Armed Forces Covenant

Trust Board members signing the Commitment to LGBT+ inclusion

Derbyshire Healthcare NHS Foundation Trust in 2021

Making a positive difference in peoples lives through improving health and wellbeing requires colleagues at all levels in the Trust to work with a range of partners. Delivery of the Joined up Care Derbyshire plan (STP) centres around delivering care as close to peoples homes as possible within Place Alliance Groups.

Our services will have a strong relationship with the emerging place alliance groups as shown in the pyramid model:



Our Vision

Closing the Gap - Health isn't just about health and care

We know that peoples health and wellbeing is effected by many things in todays society. To make a positive difference means thinking differently and if we are truly going to put people first we need to contribute to wellbeing as early as possible in peoples lives, as well as deliver services when things don't go so well.

The table below gives some examples of how we can make a difference under the four key areas that have been identified as contributing to peoples wellbeing.

How can Derbyshire Healthcare make a difference to the health and well-being gap?

Worklessness and Low Skills	Children and Young People	Crime and Offending	Health and Social Care
• Development of the Recovery College – learning new skills	• Early diagnosis of mental illness to allow young people to take ownership of their health	• Work closely with the police to help them understand the issues people with a mental illness or learning disability may face	• Making our services as accessible as possible – links to GP's and local facilities
• Individual Placement and Support (IPS) – helping people with serious mental illness or a learning disability back into work	• Working with other organisations to ensure we 'join-up' and know the whole person	• Work with people who have high levels of need so that they get support from mental health, the police and social care	• Making the links with other organisations so that people feel supported and not 'lost in the system'
• Rehabilitation in community settings for people who have had long periods of inpatient care	• Working with families and helping parents to give their children a good start in life both with their mental and physical health e.g. childhood obesity	• Support people who are in the criminal justice system	• Linking physical and mental health – making sure that people with a mental health or learning disability get good physical health checks
• Adopt best practice around personal and community resilience	• Continue to develop our Family first initiative	• Help people who have offended re-integrate into society by giving them the right support	• Work with our Commissioners to deliver the Five Year Forward View for Mental Health

Achieving our vision

What we need to achieve

‘To make a positive difference in people’s lives by improving health and wellbeing’

Meet our strategic objectives

1. **Quality improvement**
2. **Engagement**
3. **Financial sustainability**
4. **Operational delivery**

Our Focus for 2018/19

1. **Quality improvement**
    1. Completing the CQC action plan and the preparedness plan for next year
    2. Deliver physical healthcare CQUIN
2. **Engagement**
    1. Developing empowered and compassionate leaders
    2. Enhancing colleague voice through action
3. **Financial sustainability**
    1. Create and deliver a recurrent cost improvement plan
    2. Achieve agency ceiling
4. **Operational delivery**
    1. Reduce vacancies to 5%
    2. Redefine our Urgent Care and Neighbourhood Pathways.

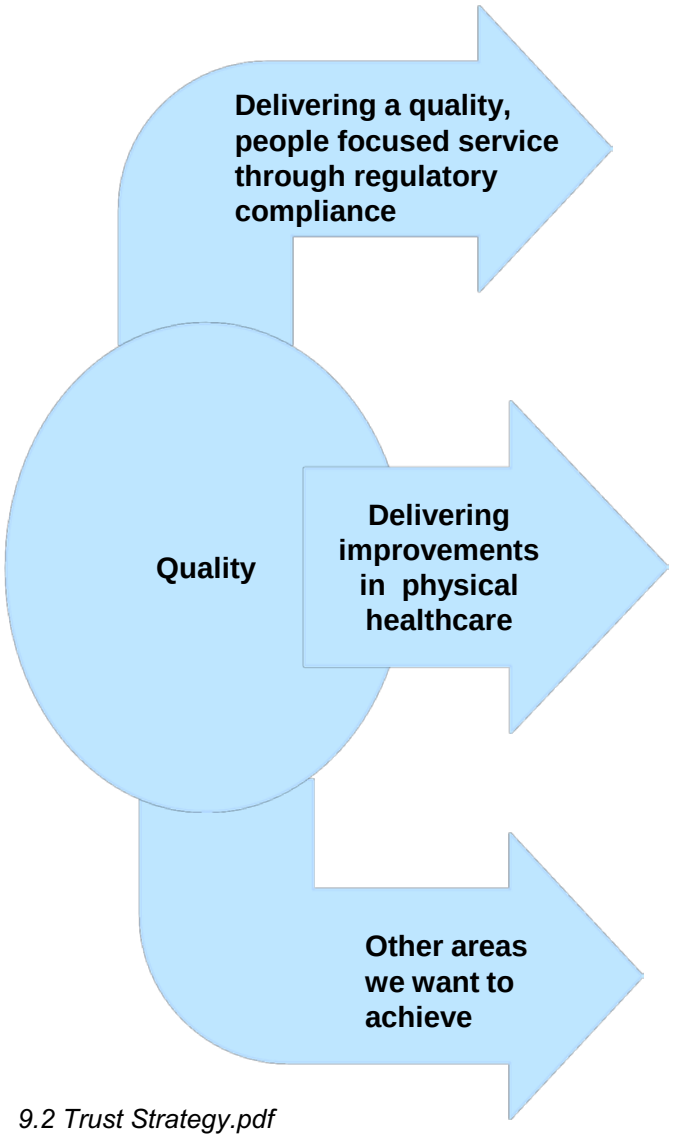
National ‘must do’s’

- **Focus on quality** – achieving the best results for service users within the resources available. Reducing variation in services and achieving ‘good’ or ‘outstanding’ in the Care Quality Commission ratings. Services will be delivered services seven days a week.
- **Focus on access** – meet the access standards for Improving Access to Psychological Therapies (IAPT) and Early Intervention. Improve access to other services.
- **Focus on finance** – rise to the efficiency challenge both internally and working with system partners to implement the Carter Review recommendations.

Achieving our vision

Achieving our vision

What we need to achieve - quality



- We will continue to change the balance of power in our clinical services and embed a contemporary inclusive health service, based upon **informed choices**, **time limited care , with focused measured outcomes** in line with regulatory standards
- We will maintain patient safety in our clinical care services, we will review levels of service and **focus expectations,** which may ultimately impact on patient experience
- We will reflect on our care delivery, learn the lessons and adopt our knowledge and systems from this learning.
- We will do our best **to improve our performance,** maintain our compliance with CQC clinical quality standards and embed them into the fabric of our organisation.

- We will implement our **Physical Healthcare Strategy**, both in our Mental Health and **Child Health plans (Education, Health and Care Plans - EHCP)** and implement **the Green light toolkit**
- We will eliminate **unwarranted variation** in the delivery of clinical services.
- We will use data and analysis to understand the **mortality gap** affecting those with serious and enduring mental ill health, working in an integrated way with our physical health and care partners.
- We will continue to develop our clinical interventions and embed our approach to **treating people in their community as close to home as possible**.
- We will **work with primary care** on a focused approach to annual health checks. Leaning from our Health facilitators and our intensive focused support in Substance misuse

- We will deliver a consistent, accessible and quality service. We will improve our knowledge and application of working with people with Autism
- **We will focus on our effectiveness,** both in adopting known research, NICE guidelines and sharing other teams good practices within our Trust
- We will refine our **clinical leadership**, ownership and **performance management** through a **defined accountability model** which champions an outcomes focus and **quality improvement**.
- We will continue work in improving clinical outcomes, and reducing the impact of ill health, through focused work on **reducing the likelihood for relapse**

What we need to achieve - engagement

Engagement – Focusing on our people

Develop empowered, compassionate and inclusive leaders

- Development of a new, focused management and leadership development programme for Team Derbyshire Healthcare Leaders
- Provide a management development offer that supports all managers of people and services to have the skills and knowledge to be able to successfully fulfil their role
- Build leadership capacity and capability to take Team Derbyshire forward
- Provide continuous learning and support; coaching mentoring and peer to peer support
- Revitalise our recruitment ,induction and appraisal process to the Team Derbyshire Leaders expectations
- Deliver on our inclusion ambitions by focused leadership, aligned actions through executive sponsorship, supported and developed networks, reverse commissioning and mentoring

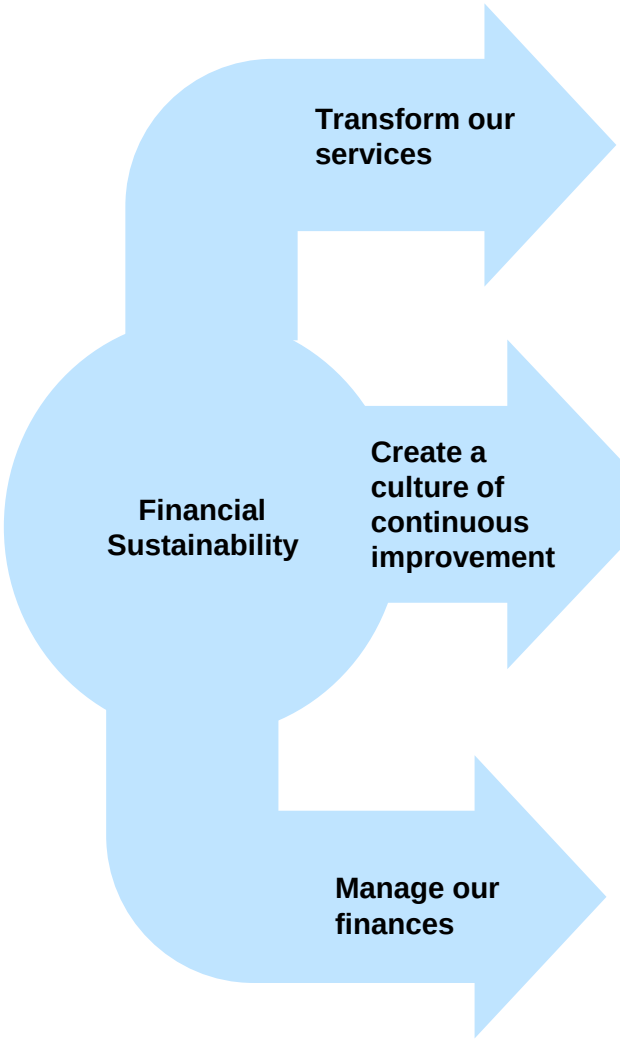
Enhancing colleague voice through action

- Provide mechanisms to recognise and celebrate employee achievements
- Co-create with colleagues a set of agreed expectations and responsibilities about what is required of members of Team Derbyshire Healthcare
- Provide clear opportunities for Trust employees to share their views, ideas and suggestions
- To ensure robust processes are in place for colleagues to raise concerns
- To develop mechanism for two-way communication to flow throughout the organisation at all levels
- To feedback to colleagues, demonstrating how their contributions have made a difference
- Increase visibility and access to Board members

Deliver Year 1 of our 2018 -2021 People Strategy

- **Retain**- Focus on the annual colleagues survey and the quarterly pulse checks to drive organisation and team improvement; all leaders will have colleague engagement as an annual objective; provide a benefits package that supports the needs of colleagues at every stage of their career; support and focus on colleagues wellbeing
- **Develop –** Offer a flexible approach to induction, preceptorship and development to meet the needs of new joiners, build flexible career pathways per occupation to grow and retain colleagues, ensure all colleagues have a meaningful and engaging annual appraisal that supports their personal development, align succession planning with workforce and business planning
- **Attract -** Strengthen the DHCFT brand ensuring that we are seen as a first choice place to work and develop innovative and targeted recruitment campaigns to reach a diverse range of applicants, provide an employment offer that is flexible to meet the needs of colleagues at all stages of their career

What we need to achieve – financial sustainability



- Services will be planned in such a way that they **deliver the vision** for our people using them in 2021 – we will work across boundaries, linking physical and mental health.
- We will review **clinical and operational best practice** to ensure that services meet the needs of service users and their carers, who access our services
- Transformation will be have **quality, access and affordability** at the heart of service change.
- We will use sound clinical evidenced based practice and business principles to achieve the transformation of our services – **clinically led and managerially supported changes.**
- We will follow a **clear and transparent process** for any service change
- We will work with our **partners** to deliver joined-up care.

- We will all be **encouraged to contribute ideas** which will help transform services to meet our vision.
- **Thinking differently** - there are no wrong ideas – we will develop a culture of innovation and embracing change.
- We will **continuously review our everyday working practices** to ask if we are doing things in the most efficient and effective way. Is what we are doing enhancing people's care and their experience?
- We will adopt **'lean principles'** – getting things right first time, working with partners to stop duplication, no waste and no wasted time.
- Everything we do will put people first**.**

- **Continuous business improvement** will be fundamental for us to meet our statutory requirements and deliver our financial plans.
- We expect to be able to **achieve a similar level of overall surplus** as in our current financial plan, following NHS guidelines.
- We will continue to work with **operational and clinical teams** to ensure everyone can make financially well-informed decisions.

Achieving our vision

What we need to achieve – operational delivery

- We will develop a new Urgent Care model for Adult Mental health Services across Derbyshire
- Continue to improve the consistency and purposefulness of inpatient care across the Trust by implementing and building on best practice
- Review our current Neighbourhood care model and deliver a revised model of care for Community Mental Health Services
- Fully implement a Dementia Rapid Response Team in North Derbyshire
- Review pathways for other services such as personality disorders
- Develop new models of care for patients who are currently in Locked Door Rehabilitation

- Deliver national waiting time targets for our services
- Review our service specifications with Commissioners so that they meet our patients needs and reflect the work we are doing
- Deliver our contractual targets as set out in our contract with Commissioners
- Delivering the performance requirements associated with the Five Year Forward View

- We will continue to work with our commissioners to deliver the 5 Year Forward View for Mental Health and Children
- We will implement the Transforming Care agenda in Learning Disability Services
- We expect to develop a new Community Forensic Service
- We will enhance our Community Perinatal service in line with national expectations set in the 5 year forward view
- We will work with Public Health to deliver enhanced joined-up pathways for people who require support from our substance misuse services

How will we measure our achievements?

In delivering our strategy we need to be able to show that we have achieved our priorities. With our focus on people, we want to measure how colleagues and patients will know that things have changed. Below we have added the high level changes that we want to see. Our monthly Board Reports will have more detailed measures to help us monitor progress.

Strategic Objective	What will it mean for colleagues in the Trust?	What will it mean for patients?
Quality		
• Delivering a quality, people focused service through regulatory compliance	• Everyone will understand what is required to deliver services that comply with core standards • Work in an environment that helps deliver core standards	• We will give greater public assurance to the community of Derbyshire that we have received and acted on feedback following external assessments of our quality.
• Delivering improvements in physical healthcare	• We will have the skills and tools, within teams to deliver improved physical healthcare.	• We will implement the evidence, and focus upon the public health concerns that individuals with specific conditions have worse outcomes. • We will contribute to the public health knowledge gap, on the outcomes of smoking, high alcohol consumption, substance misuse, (prescribed and illegal) lack of effective exercise, occupation and diet.

How will we measure our achievements?

Strategic Objective	What will it mean for colleagues in the Trust?	What will it mean for patients?
Engagement		
• Developing empowered, compassionate and inclusive leaders	• Leaders who create an environment where people can experience the values • A positive and engaging work environment for all colleagues making the Trust a place where people choose to work. • Developing inclusive and compassionate leadership • A caring and progressive organisation that promotes equality, values and celebrates diversity and has created an inclusive and compassionate environment for receiving care and for employment	• Less bank and agency colleagues ensuring greater continuity of care • Inclusive services that are delivered with kindness, dignity and respect and meet the needs of service users and patients
• Enhancing colleague voice through action	• A well-developed colleagues engagement programme with a focus on two-way communication. • Vibrant and connected networked colleague to help everyone make a difference	• A happy, motivated and well supported workforce who give good patient care.

How will we measure our achievements?

Strategic Objective	What will it mean for colleagues in the Trust?	What will it mean for patients?
Operational Delivery		
• Transform our services	• Working in more joined-up pathways of care which are easy to understand • Ability to develop new skills and work in new roles for example Advanced Clinical Practitioners and Nurse Associates	• Easier access to care – 'I tell my story once' • New Pathways developed as part of the Five Year Forward View • Services will be developed using evidence and feedback from a variety of sources to ensure we meet peoples diverse needs and considered impact
• Meet Operational Targets	• Expectations about performance are clearly articulated at all levels of the organisation.	• Access to care in a timely way
Financial Sustainability		
• Create and deliver a recurrent cost improvement plan (CIP)	Recurrent CIP delivery through continuous cost and quality improvement helps us get things right first time which means less waste of resources and time	Continuous cost and quality improvement means CIPs are well planned and effective which help services to become more efficient for patients and better value for money for the public purse
• Achieve agency 'ceiling' through reduced temporary colleague using usage	Less use of temporary colleagues means more substantive colleagues. Reducing the expensive agency costs means better quality of care, better team cohesion and better overall workforce planning. It also reduces the need to find savings from substantive roles	Less use of temporary colleagues means more substantive colleagues and that enables better patient experience through improved consistency of clinical contacts as well as better value for money

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 7 May 2019

Business Plans on a Page 2018/19
Quarter 4 Final position

Purpose of Report

The Trust's Business Planning Process for 2018/19 includes a 'plan on a page' summary for each clinical division, corporate areas and clinical support services. Each plan on a page was turned into an action matrix, which could be monitored through the Trust Management Team (TMT) as part of the divisional performance reviews and summarised to the Trust Board on a six monthly basis to provide an update of delivery against plans, and ultimately delivery of the Trust's strategy. This report includes the Quarter 4 performance summary and the action matrix updated for Quarter 4 presented as a balanced scorecard.

Executive Summary

The report demonstrates the final Quarter 4 position against the 2018/19 Plans on a page.

To give assurance, where areas are red, these are being picked up via the operational route and challenged in performance reviews through TMT or via escalation to the Executive Leadership Team (ELT). For information, where areas are seen as amber this indicates that work is ongoing and has not yet been completed, the detail of which is being discussed within performance meetings.

We are continuing to review the plan on a page reporting process to ensure that it is embedded within the Trusts performance reporting framework. The plan on a page is seen as a key output from the business planning process, and is fully embedded operationally.

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

Assurances

To give assurance, where areas are red, these are being picked up via the operational route and challenged in performance reviews through TMT or via escalation to ELT. For information, where areas are seen as amber this indicates that work is ongoing and has not yet been completed, the detail of which is being discussed within performance meetings.

Consultation

This report will routinely be reviewed at Trust Management Team meetings, and as part of Divisional performance review meetings.

Governance or Legal Issues

There are no immediate governance or legal issues to note.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

There are no adverse effects on people with protected characteristics (REGARDS).	
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	X

Actions to Mitigate/Minimise Identified Risks

Some developments or service changes may impact on people with protected characteristics. These will be reviewed as and when they arise.

Recommendations

The Board of Directors is requested to:

1) Note the content of the paper.
2) Be assured by the performance management mechanisms that have been put in place

Report presented by: **Gareth Harry, Director of Business Improvement and Transformation**

Report prepared by: **Jenny Sutcliffe, Head of Contracting and Business Development**

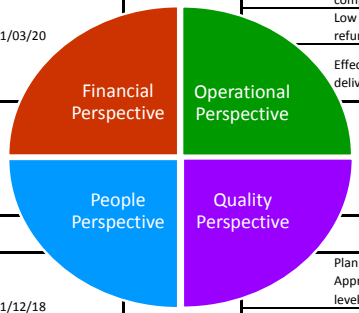
Business Plans on a Page 2018/19
Quarter 4 Update

Department	Q4 Performance		
	Red	Amber	Green
Campus	1	9	13
Central	0	4	20
Children's Services	4	21	21
Neighbourhoods	1	12	9
Pharmacy	0	3	10
Information Management, Technology and Patient Records	0	1	14
Estates	0	0	7
Communications	0	2	5
Legal Affairs	0	2	2
Governance	0	0	4
Contracting and Business Development	1	4	3
Procurement	1	0	3
Programme Assurance	0	0	7
Nursing and Quality	0	3	21
People and Engagement	0	3	10
Finance	0	2	4
Total	**8**	**66**	**153**

Red = not completed or meeting trajectory for completion
Amber = not yet delivered but work in progress
Green = completed or assured of delivery

Campus Services
Plan on a Page Scorecard

Milestone	RAG	Update	Owner	Target
Create and deliver a recurrent Cost Improvement Plan		Plan not delivered, revised programme for 19/20	M.H.	31/03/19
Minimse agency usage to contribute towards the Trust achieving agency ceiling		Agency spend reducing	M.H.	31/03/19
Provide information on expenditure and accurate forecast information		0	R.L	31/03/19
Contribute and support the Costing Transformation Programme - ongoing development of PLICS		0	K.P	31/03/20



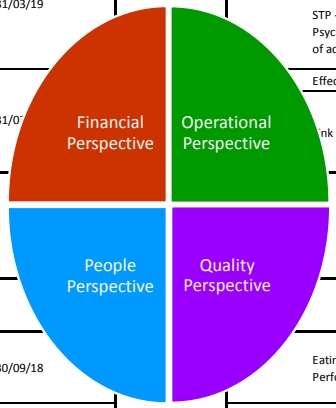
Milestone	RAG	Update	Owner	Target
Urgent care clinical model review		Work ongoing	M.H.	31/12/18
Stepdown - Review current model and address any governance concerns		Work ongoing - still operspent	M.H.	31/12/18
High Intensity Network (HIN) - Develop work programme to address pathway issues for this cohort, establishing exactly who the term applies to and conducting a case review for the last financial year		Work programme commenced, networks and funding in place	F.W	31/12/18
Delivery of bed optimisation programme, including repatriation of out of area patients		Still overspent. BOP inlcuded in Urgent Care Action Plan and reduction in OOA	K.L	31/03/19
Review of rehab pathway, identifying a pathway to pursue and competing an options appraisal		Now under a new division	K.L	31/03/19
Low secure - Ensure full bed occupancy at Kedleston following refurbishment		Bed occupancy significantly improved	T.H.	31/03/19
Effective and timely rostering processes in place to support operational delivery		full roster cleanse completed on Radbourne and Kingsway. Reviewing rota system and shift pattern work still to be undertaken	C.S	31/03/19

Milestone	RAG	Update	Owner	Target
Build a sustainable workforce by reviewing skill mix, plans for recruitment and retention and training opportunities		Reviewed workforce and plans for recruitment and retention under review.	M.H.	31/12/18
Reduce vacancies to maximum of 5%		Work ongoing	C.S	31/03/19
Develop empowered and compassionate leaders through the Leadership Development Programme (Team Derbyshire Healthcare), talent management and succession planning		0	C.S	31/03/19
Amplify colleague voice through pulse check feedback and staff survey results		0	C.S	31/03/19

Milestone	RAG	Update	Owner	Target
Plan created for implementation of improved audit of Care Programme Approach (CPA) and discharge summaries, with approval sought at Trust level		0	M.H.	30/06/18
Complete CQC Action Plan		2016 action plan completed, 2018 action plan ongoing	M.H.	30/06/18
Complete Green Light Toolkit		0	M.H.	31/03/19
Meeting Physical healthcare Strategy standards and the CQUIN requirements for health checks		0	D.Th	31/03/19
For all staff to have access to and undertake autism awareness training		0	D.Th	31/03/19
Improve physical healthcare for people who use our services		0	D.Th	31/03/19
Improve services for people with mental health needs who present to Accident and Emergency		0	D.Th	31/03/19
Increase staff uptake of flu vaccine in support of the Physical Healthcare CQUIN		0	C.S	31/03/19

Central Services
Plan on a Page update

Milestone	RAG	Update	Owner	Target
Create and deliver a recurrent cost improvement plan		Plan in place	DH	31/03/19
Minimise agency usage to contribute towards the Trust achieving agency ceiling		Plans in place	DH	31/03/19
Provide information on expenditure and accurate forecast information		0	RL	31/03/19
Contribute and support the Costing Transformation Programme - on-going development of PLICS		Q4 2019-20	KP	31/0



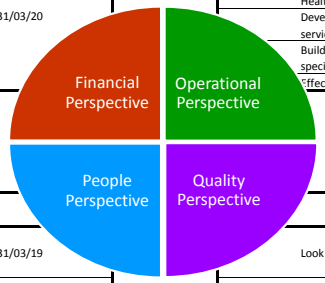
Milestone	RAG	Update	Owner	Target
Service Models: Ongoing developments of models within services; review Service Models based on feedback within Perinatal; Learning Disabilities (LD) to complete clinical pathways work; - LD to develop operational model in line with Transforming Care		Service progressed but not fully delivered	DH	31/03/19
Business Case: Improving Access to Psychological Therapies (IAPT) business case to expand into Serious Mental Illness (SMI) 3+ services; complete to ensure that new models are viable		0	JW	30/06/18
Service Specification: develop Cognitive Behavioural Therapy (CBT) specification for Specialist Psychological Therapies; IAPT to develop treatment options by exploring electronic/remote options		IAPT completed. Further work to be done on wider psychological therapy review.	DH	30/06/18
Service Evaluation: Substance Misuse service to evaluate new services, new ways of working and lessons learnt after 6 months		0	HP	30/09/18
Linking with other services and teams to develop integrated ways of working; exploration of internal requirements across services;, explore LD and Mental Health (MH) teams working closely together with formal definitions of roles		Linked to wider LD consultation	DH	30/06/18
STP - Work with Commissioners and providers to highlight client need after diagnosis; Health Psychology to work with the wider physical healthcare teams and review work undertaken and level of activity Perinatal to undertake 3 methods of working with patients and partners		0	DH	31/03/19
Effective and timely rostering processes in place to support operational delivery		Service issues in Perinatal	CS	31/03/19
nk CBT with improved neighbourhood pathway review and redesign		Incomplete due to pending CCG psychological therapies review potential to lead to changes in CBT delivery model.	DH	31/03/19

Milestone	RAG	Update	Owner	Target
LD service to review skill mix as part of service specification and consultation		Consultation ongoing	LR	30/09/18
Deliver basic Autism Spectrum Disorder (ASD) training and more advanced skill based training		ASD training delivered. Advanced E-Learning and bespoke training on track.	DH	30/06/18
Retraining of substance abuse staff in physical healthcare interventions		0	DH	30/06/18
Reduce vacancies to maximum of 5%		Incomplete/ongoing - due to service changes across Central Services, stabilisation once changes completed in 19/20	CS	31/03/19
Develop empowered and compassionate leaders through the Leadership Development Programme (Team Derbyshire Healthcare), talent management and succession planning		0	CS	31/03/19
Amplify colleague voice through pulse check feedback and staff survey results		Create a better link between People Services and the teams	CS	31/03/19

Milestone	RAG	Update	Owner	Target
Eating disorders to agree new outcome tool with clinicians and joint development of Key Performance Indicators (KPIs)		To be part of updated operational policy review for 19/20 and KPI agreed with CCG	DH	30/09/18
Meeting Physical Healthcare Strategy standards and the CQUIN requirements for health checks		0	DTh	31/03/19
In central services, delivering compliance with Annual Health checks and Lead the Greenlight toolkit		0	DTh	31/03/19
In central services, develop a well-rounded personal health plan that identifies, prevention and reduction of avoidable admission		0	CG	31/03/19
Progress and work on the High Need Support Group (157) offering interventions		0	DTh	31/03/19
For all staff to have access to and undertake autism awareness training		0	DTh	31/03/19

Children's Services
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
Create and deliver a recurrent Cost Improvement Plan		Delivering above target at M5 but difficult to identify recurrent savings.	HD	31/03/19
Minimise agency usage to contribute towards the Trust achieving agency ceiling		Agency in use in CAMHS (medical), CAMHS (Dietetics) & paediatrics.	HD	31/03/19
Provide information on expenditure and accurate forecast information		x	RL	31/03/19
Contribute and support the Costing Transformation Programme - on-going development of PLICS		x	KP	31/03/20



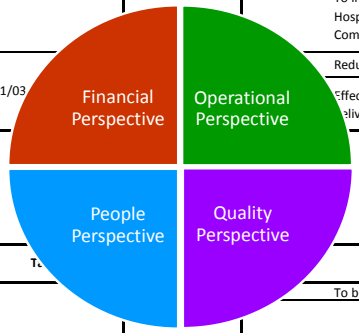
Milestone	RAG	Update	Owner	Target
Continued development and evaluation of home treatment and support in Child and Adolescent Mental Health Services (CAMHS)		Recruitment of B7 and B6 complete. Further recruitment undertaken in April 2019.	HD	31/03/19
Scope services along with commissioners around services in CAMHS becoming 0-25		Not progressed as CCG wish to undertake a review of CAMHS.	HD	31/03/19
Continue workforce development of Future in Mind (FiM) – and interdependencies with 'place' based care		Further FIM funded training in CBT, EMDR and RO-DBT underway.	HD	31/03/19
0-19 services – scope alignment to localities and school clusters re future provision		x	HD	31/03/19
Provision of a clearer service delivery model for specialist paediatric services		Await CCG confirmation of working group to achieve 18 week RRT with revised speciation.	HD	31/03/19
Ongoing participation in workstream 7 led by CCG – out of area placement (CAMHS & Special Educational Needs and Disability (SEND))		x	HD	31/03/19
Participation in scoping of 'place of safety' discussions in Southern Derbyshire CCG (SDCCG) – and developing our response and role in development		No further discussions underway at present.	HD	31/03/19
Development of a crisis response in line with FiM		First meeting held on 29 April 2019 with CCG.	HD	31/03/19
Develop an integrated Neurodevelopment pathway across services within DHcFT and with wider service providers		New pathway commencing Sept'18. Website has been launched.	HD	31/03/19
To work with partners on delivery of a regional Sexual Assault Referral Centre (SARC) service – mobilisation and delivery of specification		Contract commenced Sept '18.	HD	31/03/19
Future in mind developments – alignment with 0-19 services – develop shared pathways to increase community resilience		EWP service not longer provided by DHcFT due to CCG tender process.	HD	31/03/19
Alignment to trauma based services		Trauma pathway in CAMHS established.	HD	31/03/19
Review of all outstanding service specifications, providing clarity on current identified gaps		About to commence review of 2 Paed specifications. 2 CAMHS specs under review.	HD	31/03/19
Focus on future tenders – 0-19		2nd year extension granted.	HD	31/03/19
Lifespan service review – eg eating disorders services		Initial discussions with Commissioners, await further meetings.	HD	31/03/19
To work with commissioners on clarifying role and subsequent service delivery of Primary mental Health Workers (PMHW) within CAMHs services		Work underway.	HD	31/03/19
Develop an integrated Neurodevelopment pathway across services within DHCFT and with wider service providers		as above.	HD	31/03/19
Building stakeholder relationships in a changing education provision around complex health – eg special schools health provision		Work with SEND and Special Schools.	HD	31/03/19
Effective and timely rostering processes in place to support operational delivery		x	CS	31/03/19

Milestone	RAG	Update	Owner	Target
Continue workforce development of Future in Mind – and interdependencies with 'place' based care		Represented at STP	HD	31/03/19
Develop a framework of development opportunities across Division		methods being tried, eg attendance at COAT, TMT.	HD	31/03/19
Succession and progression plan for Division – including resilience of staff		x	HD	31/03/19
Ongoing review of skill mix across the services – alignment with workforce strategy		x	HD	31/03/19
Scoping and alignment of all of the roles across those who interface across age range 0-19		x	HD	31/03/19
Explore joint training / development opportunities		x	HD	31/03/19
Sharing expertise of roles across the care pathway		x	HD	31/03/19
Review of tools for the 'job' – IT systems, IT infrastructure & equipment		Trial of voice recognition software to commence.	HD	31/03/19
Work to identify flexible working and agile working opportunities and create explicit expectations around this for the service		x	HD	31/03/19
Develop 'you said we did' feedback mechanism with clinical leads, focussing on staff wellbeing		x	HD	31/03/19
Reduce vacancies to maximum of 5%		x	CS	31/03/19
Build a sustainable workforce by reviewing skill mix, plans for recruitment and retention and training opportunities		x	HD	31/03/19
Develop empowered and compassionate leaders through the Leadership Development Programme (Team Derbyshire Healthcare), talent management and succession planning		x	CS	31/03/19
Amplify colleague voice through pulse check feedback and staff survey results		x	CS	31/03/19

Milestone	RAG	Update	Owner	Target
Look for opportunity to reduce duplication of clinical intervention		x	HD	31/03/19
Further Develop transitions process for Children and Young People (C&YP) from CAMHS – CQUIN		x	HD	31/03/19
Ongoing dialogue with Commissioners re services aged 16-18 – prescribing agreements, stepdown provision,		x	HD	31/03/19
Pathways – across providers – underpinned by SEND, among others – End of Life Care (EOLC)		EOLC - we provide sessional input and participate in research. Recent changes in commissioning in acute providers is now having an impact.	HD	31/03/19
Transitions between providers – need to review and agree in distinct areas		About to participate in MAPPA transitions work.	HD	31/03/19
~~Meeting Physical Healthcare Strategy standards and the CQUIN requirements for health checks~~	~~N/A~~	~~Division not part of CQUIN.~~	~~DTh~~	~~31/03/19~~
In children's services, contribute to one of the following: Achieving Baby Friendly status / A personal health or family support plan / A plan to reduce deterioration which results in avoidable admission		Baby Friendly status achieved 2018.	CG	31/03/19
A well rounded health and psychological plan that identifies, relapse signature and prevention reduction of avoidable admission		x	CG	31/03/19
~~Progress and work on the High Need Support Group (157) offering interventions~~	~~N/A~~	~~Not applicable to Divison~~	~~DTh~~	~~31/03/19~~
For all staff to have access to and undertake autism awareness training		x	DTh	31/03/19
Developing EPR and technological solutions to help our teams care plan well		x	CG	31/03/19

Neighbourhood Services
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
Create and deliver a recurrent cost improvement plan		Recurrent CIP not identified. But full non recurrent CIP target met.	DT	31/03/19
Minimise agency usage to contribute towards the Trust achieving agency ceiling		Achieved. Spending on agency in 18/19 was much less than previous year.	DT	31/03/19
Provide information on expenditure and accurate forecast information		x	RL	31/03/19
Contribute and support the Costing Transformation Programme - on-going development of PLICS		x	KP	31/03



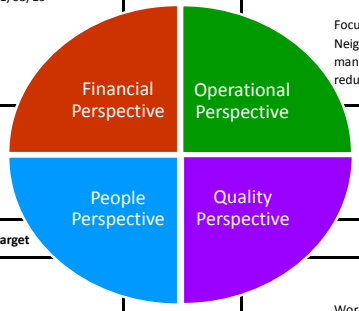
Milestone	RAG	Update	Owner	Target
To complete Neighbourhood Review		The Neighbourhood review is ongoing. We have established the vision and what we want	DT	31/03/19
To implement recommendations from Neighbourhood Review		Work on recommendations from review ongoing and will need to carry over in to 2019/20	DT	31/03/19
To recruit and operationalise the North Dementia Rapid Response Services (DRRT)		this is completed. The remaining recruitment of the team is considered usual team business.	AH	31/12/18
To establish STP plans for the following services: Older Peoples Day Hospital; Community Rehab Services; Community Personality Disorders (PD) Services; Community Forensic Services		The STP plan was not developed.	TBC	31/03/20
To implement STP plans for the following services: Older Peoples Day Hospital; Community Rehab Services; Community PD Services; Community Forensic Services		The STP plan was not developed.	DT	31/03/20
Reduce vacancies to minimum of 5%		x	CS	31/03/19
Effective and timely rostering processes in place to support operational delivery		x	CS	31/03/19

Milestone	RAG	Update	Owner	Target
Reduce vacancies to maximum of 5%		x	CS	31/03/19
Develop empowered and compassionate leaders through the Leadership Development Programme (Team Derbyshire Healthcare), talent management and succession planning		x	CS	31/03/19
Amplify colleague voice through pulse check feedback and staff survey results		x	CS	31/03/19

Milestone	RAG	Update	Owner	Target
To benchmark services against NICE Guidelines		x	PB	30/09/18
To complete Comprehensive Case File Audit and implement associated Action Plan		This was completed. The audit took place in every cmht. Each CMHT was provided with conclusions and each developed their own action plan. We are currently undertaking the audit for 19/20.	KW	31/12/18
To hold bi monthly meetings to embed effective Neighbourhood Dementia Lead network		This is established.	SW	31/03/19
To implement a county wide service monitoring physical health needs of people prescribed anti psychotic medication		This service has commenced with the limited resources available. Funding for further posts has been agree (March 2019) and the recruitment for the additioanl posts has commenced. Expected to be fully operational around July 19.	DTh	30/06/18
Meeting Physical Healthcare Strategy standards and the CQUIN requirements for health checks		x	DTh	31/03/19
A well rounded health and psychological plan that identifies, relapse signature and prevention reduction of avoidable admission		x	CG	31/03/19
Progress and work on the High Need Support Group (157) offering interventions		x	DTh	31/03/19
For all staff to have access to and undertake autism awareness training		x	DTh	31/03/19
Developing EPR and technological solutions to help our teams care plan well		x	CG	31/03/19

Milestone	RAG	Update	Owner	Target
Provide Associate Clinical Director (ACDs) and prescribers with information on prescribing costs, volume and patterns to allow benchmarking between colleagues		Currently proveded every 6 months. In future will be shared with MMC, TMT and QC	SJ	31/03/19
Provide information on trends and changes in medicines expenditure to the Drug and Therapeutics Committee and the Trust management Team		6-monthly presentation to TMT and MMC (formerly D&T)	SJ	31/03/19
Review the current model for purchasing and distributing pharmaceuticals in-line with anticipatd publication of Lord Carter's report into proactivity of Mental Health and Community Health Services NHS Trusts in England		Review superseded by introduction of Falsified Medicines Directive across EU	SJ	31/03/19

Milestone	RAG	Update	Owner	Target
Provide pharmacist and pharmacy technician support to the Dementia Rapid Response Teams to improve access to medication for service users and to support clinical teams in the pharmacological management of complex cases		Technician and pharmacist time funded as part of the model in north. Technician time now provided to both DRRTs in the north and pharmacist time to DRRT High Peak, with other advice ad-hoc. Technician post funded by DRRT south and being delivered. Pharmacist support will be provided as ber business case during 2019/20, currently providing pharmacist advice ad-hoc via technician requests.	SJ	30/06/18
Provide pharmacist and pharmacy technician support to the Crisis Resolution and Home Treatment teams to improve access to medication for service users and to support clinical teams in the pharmacological management of complex cases		Technician commenced in role supporting CRHT north 0.6WTE. Technician role created in CRHT south and support is currently commencing. Pharmacist support provided ad-hoc at present and is factored into business case approved for pharmacy team development in 2019/20	SJ	31/03/19
Focus a greater proportion of specialist mental health pharmacist resource towards the Neighbourhoods to support work through clinical advice and contact with service users to reduce frequency of admission to inpatient care		Business case approved in Dec 2018 and currently recruiting additional pharmacy professionals to deliver a service from July 2019.	SJ	30/09/18
Focus a greater proportion of Pharmacy Technician resource towards the Neighbourhoods to support the development of systems to better manage medicines, particularly depot injections in the first instance, to reduce the risk of treatment breakdown		Business case approved in Dec 2018 and currently recruiting additional pharmacy professionals to deliver a service from July 2019.	SJ	30/09/18

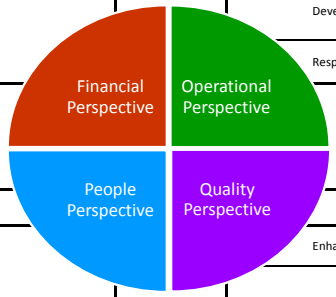


Milestone	RAG	Update	Owner	Target
Introduce a new role of Chief Pharmacy Technician – team Manager to provide management support for and lead development of Pharmacy Technicians and Pharmacy Support Workers in the department		Role now substantively appointed	SJ	30/06/18
Continue to generate revenue from pharmacy staff developing and / or delivering resourced training		Revenue generated from training activities including pre-registration pharmacist placements from the University of Nottingham and the provision of training to medical students.	SJ	31/03/19
Support pharmacy staff to study for advanced qualifications relevant to their specialist role, to enable them to support Trust teams with this expertise and to facilitate recruitment and retention in a challenging environment		Three pharmacists currently undertaking courses (1 certificate, 2 diploma)	SJ	31/03/19

Milestone	RAG	Update	Owner	Target
Work with Senior Management to develop an implementation strategy for Electronic Prescribing and Medicines Administration		Work now progressing at pace determined by the organisation	SJ	31/03/19
Continue to work with Derbyshire Community Health Services (DCHS) and East Midlands Ambulance Service (EMAS) to provide high-quality medicines supply services		DCHS fully supported until the end of their contract on 31/10/18. DBTH supported untile the end of their contract in Feb 2019. Continue to provide service to EMAS.	SJ	31/03/19
Continue to work with DCHS to provide clinical services		Continue to work with DCHS until the end of their contract on 31/10/18. Contract now ended	SJ	31/03/19

Information Management, Technology and Patient Records
Plan on a Page Update

Milestone	RAG	Update	Owner	Target	
Deliver required Cost Improvement Plan (CIP)		Budget costs all identified and budget removed	PC	31/03/19	31/03/19



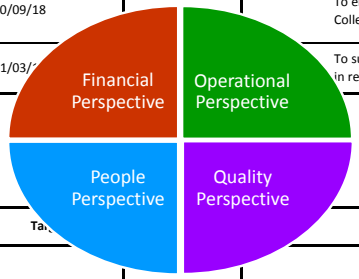
Milestone	RAG	Update	Owner	Target
Investigate Electronic Prescribing and Medicines Administration (EPMA) system functionality		EPR project established including EPMA	PC	30/09/18
Explore the capabilities of Voice Recognition		Not currently a priority as resources are working on eRostering	PC	31/03/19
Continue to enhance integration within the Trust and with other organisations to make the Trust more efficient		Working on the EPR based on CRG direction	PC	31/03/19
Ensure patients have appropriate access to their records		processes in place to redcat and deliver patients records when requested	PC	31/03/19
Development of apps to support clinicians and patients		delivered Obs App. Second handheld solution under development due for deleivery Q1 2019/20	PC	31/03/19
Respond efficiently and affectively to any issues or enhancements raised by the Trust		continual improvement based on Trust requests	PC	31/03/19

Milestone	RAG	Update	Owner	Target	
Enhance network to support Agile working		HSCN contract signed and project established	PC	31/03/19	31/03/19

Milestone	RAG	Update	Owner	Target
Enhance Electronic Patient Record to reflect required clinical processes		Working on the EPR based on CRG direction	PC	31/03/19
Provide reliable technical environments and support services		ATP fully delpoyed, c300 Windows 10 devices deployed and EPR platform upgrade underway however proving more complex than imagined	PC	31/03/19
Maintain appropriate Cyber Security measures to protect the Trust		ATP fully deployed, windows updates, rigor processes ongoing	PC	31/03/19
Deliver all NHS England or Clinical Commissioning Group (CCG) mandated information on time and of the required quality		All information provided on time	PC	31/03/19
Maintain our Information Governance (IG) excellence and implement General Data Protection Regulation (GDPR) by end of May 2018		GDPR delivered. All criteria met. Externally assured.	PC	31/03/19
Ensure patients paper records are efficiently processed and stored		Reduction in on site storage of paper records now supporting other teams to undertake the process	PC	31/03/19
Provide access to SystmOne or PARIS to ensure clinicians can access records when appropriate		All those who ask for access have been provide with it	PC	31/03/19

Estates
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
Create and deliver a recurrent cost improvement plan		Complete	LB	30/09/18
Work within budget constraints make sure break even at year end		On track	SD	31/03/



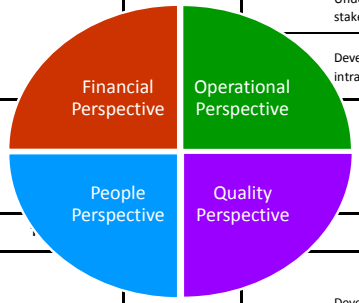
Milestone	RAG	Update	Owner	Target
To ensure completion of annual returns Estates Return Information Collection (ERIC) and Project Assurance Model (PAM)		ERIC completed and PAM ongoing	SD	31/03/19
To support through capital and the Trust Estate Strategy, clinical services in redesigning their services		Ongoing	SD	31/03/19

Milestone	RAG	Update	Owner	Ta
To work with the wider Healthcare community in compiling a Derbyshire Wide Estate Strategy and ensuring best use is made of all premises		Completed through the STP	LW	31/03/19
Amplifying colleague voice through action		Local staff engagement events planned	SD	31/03/19

Milestone	RAG	Update	Owner	Target
Ensuring preparedness for the next Care Quality Commission (CQC) visit. Estates to ensure compliance files are current		Complete	SD	31/03/19

Communications and Involvement
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
To determine best value options for graphic design support into the organisation.		To be reviewed by ELT	AS	31/03/19



Milestone	RAG	Update	Owner	Target
To develop a comprehensive understanding and record of the Trust's stakeholder engagement activities.		Stakeholder mapping activity completed with Exec Directors. Paper being considered at ELT for next steps.	AS	31/12/18
To identify key stakeholders and prioritisation in order to deliver the Trust strategy.		Identification taken place - prioritisation continues	AS	31/12/18
Undertake a brand audit to asses the Trust's current reputation amongst stakeholders		Workprogramme delayed.	AS	31/12/18
Development of a new extranet, to replace the existing Trust website and intranet.		New website launched in April. Work underway on developing new intranet.	AS	31/03/19

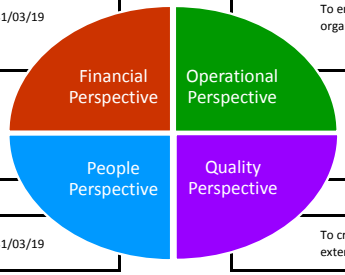
Milestone	RAG	Update	Owner	Target
Develop and implement a new programme of staff engagement. Implement system to capture staff engagement feedback. Identify key themes from staff engagement and ensure appropriate response		New programme developed and in implementation. Key themes being captured and due for future analysis at People and Culture Committee	AS	31/10/18

Milestone	RAG	Update	Owner	Target
Development of a new Trust-wide Communications Strategy and associated policies		Communication strategy being submitted to People and Culture Committee in October for sign off. Policies have already been approved.	AS	31/10/18

Legal Affairs
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
To optimise external legal use to achieve value for money by rationalising legal services to one provider wherever possible [or to rationalise legal services to one framework thus ensuring consistent costs across the various departments that access legal services].		Completed	AC	31/03/19

Milestone	RAG	Update	Owner	Target
To ensure that the Accessing Legal Advice Policy is fully embedded in the organisation		Well embedded	AC	31/03/19

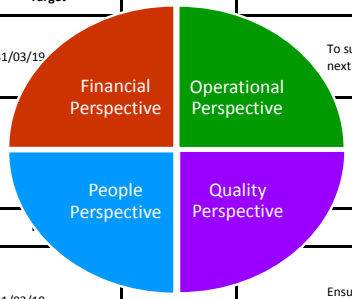


Milestone	RAG	Update	Owner	Target
To create a self-sustaining internal system of knowledge to minimalize external legal expenditure.		Some gaps where areas for improvement has been identified	AC	31/03/19

Milestone	RAG	Update	Owner	Target
To create a self-sustaining internal system of knowledge to minimalize external legal expenditure.		Some gaps where areas for improvement has been identified	AC	31/03/19

Governance
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
Maintain an effective and streamlined governance structure, which releases indirect savings and ensures financial sustainability		Governance calendar for 18/19 reflects a streamlined governance arrangements. Frequency of meetings reviewed and reduced	SH	31/03/19



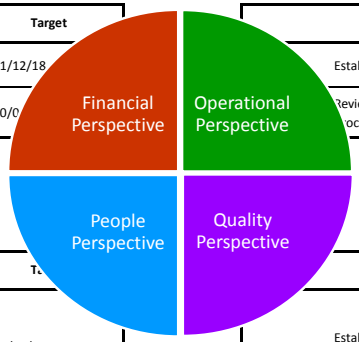
Milestone	RAG	Update	Owner	Target
To sustain and embed governance improvements in preparation for the next external well-led framework review		Reports to Board in November and March on actions arising from the latest well-led review.	SH	31/12/18

Milestone	RAG	Update	Owner	Target
Ensure that there is good governance practice embedded throughout the organisation		Internal audit to review divisional governance/accountability arrangements completed with opinion of significant assurance with minor improvement opportunities.	SH	31/03/19

Milestone	RAG	Update	Owner	Target
Ensure continued improving effectiveness of Board and Board Committees		Year end effectiveness reviews and surveys undertaken by each Board Committe and reported on to Audit and Risk Committee.	SH	31/03/19

Contracting and Business Development
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
Implement revised governance processes for 2019/20 contract negotiations		Currently testing IT solution before rolling out	L.W-S	31/12/18
Quarterly reconciliation of contracts with invoices and increased rigour of uplift		Monthly contract meeting with finance and review of income	JS	30/0



Milestone	RAG	Update	Owner	Target
Establish permanent second Business Development Manager Post		Business case for additional permanent BDM case not approved	JS	30/06/18
Review the Contract Negotiation Protocol and contractual governance processes		Currently under review as CCG structures now confirmed.	JS	30/06/18

Milestone	RAG	Update	Owner	Ta
Continue development of Business Bytes programme to support organisational development – roll out specific programmes to certain staff groups, expand topics, market internally to improve uptake		Business bytes included as part of the leadership and development masterclasses	JS	31/03/19
Develop a suite of best practise guides and templates for the intranet (i.e. business case development)		Team capacity reduced	JS	30/09/18

Milestone	RAG	Update	Owner	Target
Establish internal web based contract systems – finalise roll out of online contract database and initiate development of reporting module		Team capacity reduced	JS	31/03/19
Options developed for alternative contractual governance frameworks in Sustainability and Transformation Plan (STP) environment		No STP direction on contract frameworks	JS	30/09/18

Procurement
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
Procurement re-org. plan proposed and under consideration		Not approved by Execs	RH	31/03/19
3 year Procurement Work Plan completed and continuous monitoring of cost reduction opportunities through use of Purchase Price Index and Benchmarking (PPIB) and emerging Future Operating Model (FOM)		0	RH	31/03/19

Milestone	RAG		Update	Owner	Target
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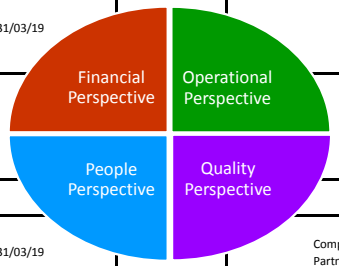


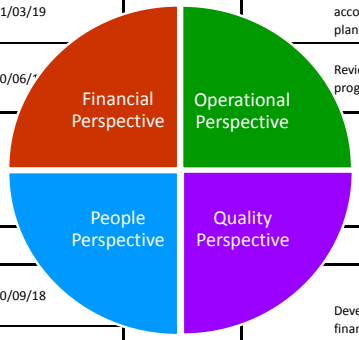
Milestone	RAG	Update	Owner	Target
Continued development of Purchasing Team to provide greater support to the organisation		0	RH	31/03/19

Milestone	RAG	Update	Owner	Target
Completing the CQC action plan and the preparedness plan for next year – Partnership section completed and kept up to date as required		0	RH	31/03/19

Programme Assurance
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
Work across the Trust to create and deliver a re-current cost-improvement-plan		Delivered recognising some reliance on non-recurrent schemes.	JW	31/03/19
Further development of Programme Assurance process generating leadership and accountability		Process has been improved with further improvements planned.	JW	30/06/1

Milestone	RAG	Update	Owner	Target
Relocate team to Kingsway House base following series of moves to accommodate wider estate strategy. Including Contracts and STP in the plan		Office reloaction completed.	JW	30/06/18
Review team structure and job descriptions to ensure fit for purpose programme office delivery and assurance function		Review completed. Recruited against revised role.	JW	30/09/18

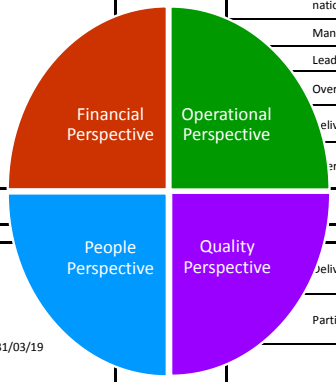


Milestone	RAG	Update	Owner	Target
Develop co-production approach to continuous improvement process		Approach developed and incorporated into the Quality Strategy, CQI and annual planning cycle.	JW	30/09/18
Team development for sustainable capability relating to CQI		CPD plans are progressing and on track.	JW	30/09/18

Milestone	RAG	Update	Owner	Target
Develop Continuous Quality Improvement (CQI) methodology to support financial sustainability		CQI approach evolving within Trust.	JW	30/09/18

Nursing and Quality
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
Support the achievement of CQUINs		Q1, Q2 and Q3 main contract CQUINs submitted as required, Q4 currently being submitted. High level of achievement aside from expected challenge around physical health and flu vaccinations	DTh	31/03/19



Milestone	RAG	Update	Owner	Target
Support Area Service Managers (ASMs) in their understanding of and delivery of Commissioning for Quality and Innovation National Goals (CQUINs)		In partnership with Heads of Nursing and individual CQUIN leads	DTh	31/03/19
Engage operational colleagues in the delivery of the Schedule 4 Quality Contract		Support offered as and when required	DTh	31/03/19
Provide training on the reporting of incidents, including serious incidents, ensuring they are accurate and promoting a culture of candour		Training is ongoing, including in Team bases	DTh	31/03/19

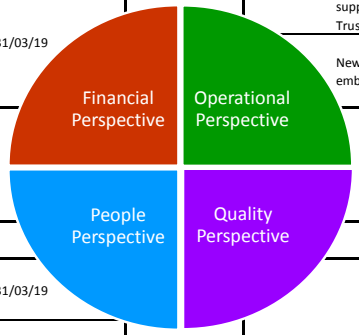
Milestone	RAG	Update	Owner	Target
Ensure the Trust meets its legal duties around Safeguarding Children & Adults		New "Working Together 2018" document has been reviewed by Safeguarding Children's Board from a multi-agency perspective.	TN	31/03/19
Ensure the Trust meets its legal duties around Infection Prevention & Control		Reported to Quality Committee as required. No significant changes.	RM	31/03/19
Ensure the Trust meets its legal duties around the Mental Health Act and Mental Capacity Act		Undertaken throughout the year	KB	31/03/19
Ensure the Trust meets its legal duties around Health & Safety		Undertaken throughout the year	CG	31/03/19
Report on the Schedule 4 Quality Contract to the Clinical Commissioning Groups (CCGs)		All submitted as required at the current time, no concerns raised by commissioners	DTh	31/03/19
Oversee the reporting process and submit CQUIN evidence to the CCG and NHS Improvement (NHSI)		Undertaken throughout the year	DTh	31/03/19
Oversee the Trust position on Patient Safety and Mortality, submitting committee reports and national data as appropriate		Completed throughout the year with positive feedback from external partners	RW	31/03/19
Manage, respond and report appropriately to all complaints that come to the Trust		Undertaken throughout the year	AR	31/03/19
Lead on our carer involvement work		Triangle of Care work has continued	WS	31/03/19
Oversee and manage the Datix incident reporting system		Undertaken throughout the year	RK	31/03/19
eliver the annual Quality Report		Quality Report written, currently out for public consultation	DTh	31/03/19
ersee the annual Quality Visit programme		Season 9 complete, teams shortlisted, about to go out to for Trust wide votes.	DTh	31/03/19

Milestone	RAG	Update	Owner	Target
eliver the Quality Improvement Strategy for the Trust		Implementation plan in place, strategy guided the approach to Clinically Led Strategy Development	DTh	31/03/19
Participate in the national patient safety campaign 'Sign up to Safety'		Work is ongoing. All required progress updates submitted to commissioners.	RW	31/03/19
Develop a structure to demonstrate our position around NICE Guidelines and promote their use		NICE Steering Group is established, baseline assessments being undertaken, contributions to national reviews. Working with NICE to ensure consisency of expectation going forward.	DTh	31/03/19
Improve level of Datix reporting		Reviewed NRLS data in September for comparison with other similar MH trusts. Findings were that although we are in the lower quartile in comparison to this cohort, the feedback from the CQC Intelligence Report is that we are not an outlier.	RK	31/03/19
Engage with the NHS Staff Health and Wellbeing agenda for the Nursing & Quality Team		Staff sickness has been approached in line with the Trust commitment. Sickness levels have reduced as the year has progressed.	DTh	31/03/19
Offer leads for each CQUIN and enable teams to succeed		All CQUINs have an operational lead and an aligned Head of Nursing	DTh	31/03/19
Revise the Quality Visit programme – to a new model		New model is established and delivered	CG	31/03/19
Design a new Quality Improvement strategy and define agreed methodology toolkit that can be used		QI Strategy signed off by Quality Committee	CG	31/03/19

People Services
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
Create and deliver a recurrent cost improvement plan		No CIP applied to People Services	CS	31/03/19
Achieve agency ceiling		Achieved against agency ceiling making an underspend of £130k (4.3%)	CS	31/03/19

Milestone	RAG	Update	Owner	Target
Joined up recruitment processes that reduce time to recruit		101 days reduced to 60 to 65 days on track and continue to monitor	CS	Ongoing
Dedicated Bank for Derbyshire Healthcare NHS Foundation Trust supported by Derbyshire Community Health Services NHS Foundation Trust		Complete	CS	31/03/19
New structure to provide HR support to divisions e.g. Business partners embedded in services providing strategic advice and support		New Divisional People Leads (DPL) in place with defined portfolios as of 1st Sept 18 Complete	CS	01/09/18



Milestone	RAG	Update	Owner	Target
Amplifying colleague voice through pulse check feedback and staff survey results		Staff survey 17/18 results in February 2019 and pulse checks complete	CS	31/03/19
Promote Staff Forum and attendance across DHCFT, feedback and outcomes published		Complete	CS	31/03/19
Promote Equalities Forum		Complete but continue to promote within the Trust	CS	31/03/19
Effective Appraisal process		New appraisal process in place as at 1 April 2019	CS	31/03/19
Attract, develop and retrain strategy		Complete	CS	31/03/19
Flexible career pathways		Ongoing work developing alongside Trust workforce plans	CS	To continue into 2019

Milestone	RAG	Update	Owner	Target
Strengthened employee relations team, reducing length of investigations and improving outcomes		As of March 2019 31 live cases under investigation. Continued work between Employee Relations and Staffside to review policies and procedures.	CS	To continue business as usual
Developing empowered and compassionate leaders through Leadership Development Programme. Team Derbyshire Healthcare, Talent Management and succession planning		Leadership Development Programme launched as at 1 April 2019, Team Derbyshire events from 2019, ongoing work on Talent Management and succession process.	CS	To continue into 2019

Finance
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
To support the delivery of the short term and long term financial plans		Financial plans submitted to NHSI of which are being managed in year. Forecasting to deliver those plans. Will be completed with the conclusion of year ends. On track to deliver.	RL	31/03/19
Provide information on expenditure and accurate forecast information		Information is being provided to budget holders, ELT, TMT, F&P and Trust Board	RL	31/03/19
Contribute and support the Costing Transformation Programme - on-going development of Patient Level Information and Costing Systems (PLICS)		This is on-going working towards the mandatory deadline	KP	31/03/20

Milestone	RAG	Update	Owner	Target
Continue to provide a responsive service to budget holders and senior managers across the Trust to enable them to effectively manage their budgets		Information is being provided to budget holders, ELT, TMT, F&P and Trust Board	RL	31/03/19

Milestone	RAG	Update	Owner	Target
Provide information and support to managers to support the delivery of the 2018/19 efficiency programme		Information is being provided to managers. Cost avoidance schemes are being reported to PAB	RL	31/03/19

Milestone	RAG	Update	Owner	Target
Involvement in the National Costing Transformation Programme groups		This is on-going working towards the mandatory deadline	KP	Ongoing

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 7 May 2019

NHS Improvement Year-End Self-Certification

Purpose of Report

The aim of self-certification is for the Trust to assure itself it is in compliance with NHS Provider foundation trust licence conditions. The report presents the proposed relevant declarations to the Trust Board.

Executive Summary

NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements. This follows on from similar requirements in previous years to submit self-declarations to NHS Improvement (NHSI) on these areas.

The Trust must publish the declarations within one month of declaration by the Trust Board. Boards must sign off conditions G6(3) and CoS7 (3) by 31 May and conditions G6(4) and FT4(8) by 30 June 2019. As in previous years, the Trust is presenting all required conditions together for single sign off.

The template supplied by NHSI to assist with recording the self-certifications is appended to this report.

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

Assurances

The Trust is in compliance with the conditions set by NHS Improvement, as outlined in the report.

Consultation

This report has been scrutinised by the Trust Chair and Chief Executive.

Governance or Legal Issues

The Trust has met the requirements of the self-certification.

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people).

There are no adverse effects on people with protected characteristics (REGARDS).	x
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	

Actions to Mitigate/Minimise Identified Risks – there is no direct impact on those with protected characteristics arising from this report. However, governance of the Trust includes broad consideration of equality and diversity issues for example as a key part of Board Committee business, and as an important element of governor training and development to ensure that decision making encompasses equality impact considerations.

Recommendations

The Board of Directors is requested to:

1. Confirm agreement with the proposed declarations for signature by the Chair and Chief Executive.
2. To agree to publication of the self-declarations on the Trust's website.

Report presented by: **Justine Fitzjohn, Trust Secretary**

Report prepared by **Sam Harrison, Governance Advisor**

NHS Improvement Year-end Self-Certification

NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements. This follows on from similar requirements in previous years to submit self-declarations to NHSI on these areas.

Providers need to self-certify the following after the financial year end:

NHS provider licence conditions

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution; Condition G6(3)
- The provider has complied with required governance arrangements; Condition FT4(8)
- If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service Condition CoS7(3)
- Publication of condition G6(3) self certification by 30 June; condition G6(4)

The aim of self-certification is for providers to carry out assurance that they are in compliance with the conditions and providers may carry out this process as they see fit. DHCFT proposes to present the proposed relevant declarations to the Trust Board highlighting key evidence and narrative to support the declarations.

1. General Condition G6

Condition G6(2) requires NHS foundation trusts to have processes and systems that:

- identify risks to compliance
- take reasonable mitigating actions to prevent those risks and a failure to comply from occurring

Providers must annually review whether these processes and systems are effective must publish their G6 self-certification within one month following the deadline for sign-off (as set out in Condition G6(4)).

Proposed declaration:

The Board declares that the Licensee continues to meet the criteria for holding a licence (Condition G6)

This declaration is supported by evidence as outlined in the Trust's Annual Governance Statement, Board Assurance Framework and through the work of the Board assurance Committees in ensuring management of risks and ongoing compliance. This has been supported through an internal audit carried out in year which provided significant assurance of our risk management processes and positive feedback from the CQC 2018 inspection relating to corporate aspects of Well Led. We have sustained and further improved governance processes which were scrutinised through external independent assurance carried out in quarter 4 of 2017/18.

2. Continuation of Services Condition 7

Commissioner requested services (CRS) are services commissioners consider should continue to be provided locally even if a provider is at risk of failing financially and which will be subject to regulation by NHSI. Providers can be designated as providing CRS because:

- there is no alternative provider close enough
- removing the services would increase health inequalities
- removing the services would make other related services unviable.

Primary evidence is contained in the Going Concern assessment which has been considered by the Audit and Risk Committee. In addition the significantly improved liquidity and cash reserves evidences high short term financial resilience. Successful delivery of control total is managed through the ongoing contract management process and project management office arrangements, overseen by Finance and Performance Committee. This is described in full along with mitigating actions in the 2019/20 Board Assurance Framework (Delivery of financial plans risk 3a).

Proposed Declaration:

The Board declares that the licensee has a reasonable expectation that the licensee will have the required resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

3. Condition FT4 Declaration

NHS foundation trusts must self-certify under Condition FT4 (8) whether the governance systems achieve the objectives set out in the licence condition.

The Trust has during the year sustained, embedded and continuously improved upon work undertaken to improve governance areas following the completion of the external well-led review (undertaken in quarter 4 20171/8) which provided assurance on satisfactory policies and practices in place. This has involved ensuring effective Board and committee structures, reporting lines and performance and risk management systems. See attached NHSI template for further information against each item. All actions arising from the quarter 4 20171/8 external well-led framework review have been completed and overseen by the Trust Board.

Proposed declaration:

The Board confirms that it complies with all elements of the Corporate Governance Statement (condition FT4)

4. Certification on Training of governors

Providers must review whether their governors have received enough training and guidance to carry out their roles.

Governor training has been carried out on a regular basis throughout the year and includes sessions led by Trust Directors, senior staff, external parties and structured training programmes. This has been monitored, evaluated and reviewed by the Council of Governors. Governors have confirmed that they are satisfied with the training provided, through their governor effectiveness survey, and through their input to the on-going training and development programme via the governor Governance Committee.

Proposed declaration:

The Board is satisfied that during the financial year most recently ended the Licensee 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.

Declaration process

The Trust must publish the declarations within one month of the declaration by the Trust Board. Boards must sign off GS 6(3) and CoS7(3) by 31 May and FT4(8) by 30 June 2019.

From July 2019, NHSI will contact a select number of NHS trusts and foundation trusts to ask for evidence that they have self-certified. This can either be through providing the templates if they have used them, or by providing relevant Board minutes and papers recording sign-off.

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Derbyshire Healthcare NHS Foundation Trust

Insert name of organisation

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration"

Financial Year to which self-certification relates 2018/19 Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Trust has sustained and embedded governance improvements arising from the external independent well-led assessment which was concluded in quarter 4 2018/19. The Board has received reports of progress with actions arising from phase 3 of the review in November 2018 and March 2019. Board Committees continue to review effectiveness with year end reviews undertaken by each Committee during February/March 2019 for onwards scrutiny and oversight by the Audit and Risk Committee and then Trust Board.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Trust has continued to embed good practice developed through self assessment and external independent assessment of the of the NHSI well-led framework. The Trust had several areas of positive feedback on corporate governance elements of well-led following the CQC comprehensive inspection report received in September 2018.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The Trust corporate governance framework has been implemented successfully in terms of Board and Board Committee responsibilities, delegation and escalation. There is a process for review of all Board Committees to reflect on their effectivenesss. Divisional governance has been the subject of internal audit during the year (with signficant assurance with minor improvements opinion)
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The Board, via its Committees where relevant, oversees the Trust duties as listed. Items are escalated to the Trust Board from Committees to ensure key risks are addressed.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		Quality Leadership is overseen by the Trust Board and assurance on quality of care is provided through the Quality Committee. Issues and risks are escalated to the Board as required. We have continued to progress and complete actions arising following the CQC inspection report received in September 2018. Quality is led on the Trust Board jointly by the Medical Director and Director of Nursing and Patient Experience. We have continued to review and improve our integrated performance report to Trust Board to ensure robust oversight of operational performance, workforce, financial and quality issues.
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Remuneration and Appointments Committee consider the composition of the Board to ensure that this is appropriate in terms of skill mix and qualifications. Fit and propoer persons test policy has been fully implemented, embedded and updated in May 2018. Wider workforce issues are considered by the People and Culture Committee with risks and issues escalated to the Board as required and routinely through assurance summaries.

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Name** Caroline Maley

Signature _____ **Name** Ifti Majid

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Please Respond

Worksheet "Training of governors" | **Financial Year to which self-certification relates** | 2018/19 | Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee 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.	Confirmed	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Caroline Maley	**Name**	Ifti Majid
Capacity	Trust Chair	**Capacity**	Chief Executive
Date	07 May 2019	**Date**	07 May 2019

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

Derbyshire Healthcare NHS Foundation Trust *Insert name of organisation*

NHS Improvement

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7" | **Financial Year to which self-certification relates** | 2018/19 | Please complete the explanatory information in cell

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed	Please fill details in cell E22

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

Primary evidence is contained in the Going Concern assessment which has been considered by the Audit and Risk Committee. In addition the significantly improved liquidity and cash reserves evidences high short term financial resilience. Successful delivery of control total is managed through the ongoing contract management process and project management office arrangements, overseen by Finance and Performance Committee. This is described in full along with mitigating actions in the 2019/20 Board Assurance Framework (Delivery of financial plans risk 3a).

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Caroline Maley	**Name**	Ifti Majid
Capacity	Trust Chair	**Capacity**	Chief Executive
Date	07 May 2019	**Date**	07 May 2019

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 7 May 2019

Year-end Governance Reporting - Board Committees and Terms of Reference

Purpose of Report

To present a summary of the year end reports from Board Committees for noting, together with a full set of Terms of Reference for approval.

Executive Summary

At its meeting on 30 April 2019, the Audit and Risk Committee (ARC) received the full year end reports for the following Committees as well as their Terms of Reference (TOR):

- Remuneration & Appointments Committee
- Finance & Performance Committee
- Audit & Risk Committee
- Quality Committee
- People & Culture Committee
- Mental Health Act Committee
- Safeguarding Committee

The Committee Chair and Executive Lead for each Committee have worked together to complete the end of year governance arrangements that are established good governance practice. There are several elements of work associated with each Board Committee that are required to be carried out at the end of each financial year, namely:

- Completion of a year-end review of effectiveness of the Committee – reporting against all elements of Committees' terms of reference (TOR)
- Review of the Committees' TOR
- Summary qualitative feedback from Committees
- Outline of objectives for 2019/20
- Development of a forward plan for 2019/20

ARC received assurance from the reports that the Committees have effectively carried out their role and responsibilities as defined by their ToR during 2018/19.

2019/20 Objectives

ARC agreed that all Board Committees should have an objective for 2019/20 relating to equality, diversity and inclusion as detailed below;

- *To actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion*

Terms of Reference

ARC also recommended that the following paragraph be included in the TORs of all Board Committees relating to Speaking Up.

- *The Committee is committed to ensuring that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise the Committee will undertake to challenge robustly and fairly in order to develop a culture of continuous improvement, openness and honesty.*

Copies of the TORs for all Board Committees are appended to this report for the Board's approval.

Wider review of Governance/Committee Structure

As part of ongoing discussions at the Executive Leadership Team (ELT) and Board to refresh the Trust Strategy it is proposed that the Committee structure be reviewed to ensure it aligns to provide assurance on meeting the Trust's strategic objectives. Following agreement of a new governance structure new terms of reference will be required for agreed committees and these will be presented to a future Board for approval.

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

Assurances

Each Committee or Committee Chair has been assured through delivery of the Year-End Report that the Committees are working effectively and meeting the requirements of the Terms of Reference, as required per the Corporate Governance Framework.

Consultation

Through all of the Board Committees February and March.

Governance or Legal Issues

Satisfactory governance performance underpins many aspects of statutory, regulatory and legal compliance for Foundation Trusts. The Audit & Risk Committee forms part of the Trust's Corporate Governance Framework as a Committee of the Board. The NHS Audit Committee Handbook advises that an Audit Committee, in line with best practice in other sectors, should prepare a report to the Board that sets out how the Committee has met its Terms of Reference. It is good governance practice to review effectiveness and provide assurance that Committees are fulfilling their purpose as defined by their TOR.

Public Sector Equality Duty & Equality Impact Risk Analysis The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).	
There are no adverse effects on people with protected characteristics (REGARDS).	x
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential gaps/inequalities are outlined below, with the appropriate action to mitigate or minimise those risks.	
Actions to Mitigate/Minimise Identified Risks – there is no direct impact on those with protected characteristics arising from this report.	

Recommendations

The Board of Directors is requested to:

1) Consider and note the assurance received by the Audit and Risk Committee that all Board Committees have effectively carried out their role and responsibilities as defined by their ToR during 2018/19 and
2) Consider and approve the ToR for all Board Committees as appended to this report.

Report presented by: **Justine Fitzjohn, Trust Secretary**

Report prepared by: **Sam Harrison, Director of Corporate Affairs**
Sue Turner, Board Secretary

Remuneration and Appointments Committee Terms of Reference

Purpose

The Committee is responsible for identifying and appointing candidates to fill Director positions on the Board including the Chief Executive, voting and non-voting Executive Directors. The Committee is also responsible for establishing and keeping under review a remuneration policy in respect of Executive Directors and to advise upon and oversee contractual arrangements for Executive Directors.

1. Authority

1.1 The Remuneration and Appointments Committee (the Committee) is constituted as a standing Committee of the Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings.

1.2 The Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee.

1.3 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

1.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

1.5 As a Committee of the Board, the Remuneration & Appointments Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit.

1.6 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.7 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Remuneration & Appointments Committee will ensure consideration has been given to equality impact related risks.

1.9 To actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion

1.10 As a designated policy ratification group, (see 'Policy on Policy Documents) the Remuneration & Appointments Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

2. Membership

2.1 The membership of the Committee shall consist of:

- Trust Chair
- All Non-Executive Directors on the Board of Directors.

2.2 The Trust Chair will chair the Committee.

2.3 When appointing or removing the Chief Executive, the Committee shall be the committee described in Schedule 7, 17(3) of the National Health Service Act 2006 as amended by the Health and Social care Act 2012 (the Act) (that is all the non-executive directors). When appointing or removing the other executive directors the Committee shall be the committee described in Schedule 7, 17(4) of the Act (that is the Trust chair, the chief executive and the non-executive directors).

3. Attendance

3.1 Meetings of the Committee may be attended by:

- Chief Executive
- Director of People and Organisational Effectiveness
- Trust Secretary
- Any other person who has been invited to attend the meeting by the Committee so as to assist in deliberations.

4. Quorum

4.1 A quorum shall be three members.

4.2 Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.

5. Frequency of Meetings

Meetings shall be held quarterly or as required.

6. Duties & Responsibilities

Monitor's Code of Governance (July 2014) - these terms of reference are based in part, on best practice as set out in that code and have been drafted referring to the provision in the code. The code states as two of its principles that;

"There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration."

"There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. Directors of NHS foundation trusts must be "fit and proper" to meet the requirements of the general conditions of the provider licence."

To be responsible for identifying and appointing candidates to fill all the executive director positions on the Board and for determining their remuneration and other conditions of service.

The Committee will ensure that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise the Committee will undertake to challenge robustly and fairly in order to develop a culture of continuous improvement, openness and honesty.

To consider the Board Assurance Framework and high level risks, in particular as they relate to the remit of the Committee; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

These terms of reference are intended to ensure that the Trust's procedure for the appointment of the chief executive and other directors (excluding Non-Executive Directors) to the Board of Directors reflect these principles.

6.1 Appointments role

6.1.1 To be responsible for identifying and appointing candidates to fill all the executive director positions on the board including the Chief Executive, voting and non-voting Directors. Non-executive Directors are appointed through the Nominations and Remuneration Committee of the Council of Governors.

6.1.2 Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations to the board, and nomination committee of the Council of Governors, as applicable, with regard to any changes.

6.1.3 Give full consideration to and make plans for succession planning for the Chief Executive and other executive board director roles taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the Board in the future.

6.1.4 To advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments.

6.1.5 Ensure that a proposed executive director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise.

6.1.6 Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

6.1.7 Consider any matter relating to the continuation in office of any board executive director including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract. The Committee will oversee ongoing compliance with the Fit and Proper Person requirements of Directors.

6.2 Remuneration Role

6.2.1 Establish and keep under review a remuneration policy in respect of executive board directors.

6.2.2 Consult the Chief Executive about proposals relating to the remuneration of the other executive directors.

6.2.3 In accordance with all relevant laws, regulations and Trust policies, decide and keep under review the terms and conditions of office of the Trust's executive directors (voting and non-voting) on locally-determined pay in accordance with all relevant Foundation Trust policies, including:

- salary, including any performance-related pay or bonus
- provisions for other benefits, including pensions and cars
- allowances.

6.2.4 In adhering to all relevant laws, regulations and Trust policies:

- establish levels of remuneration which are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust

- use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors (both voting and non-voting) on locally-determined pay, while ensuring that increases are not made where Trust or individual performance do not justify them

6.2.5 Monitor, and assess the output of the evaluation of the performance of individual executive directors, and consider this output when reviewing changes to remuneration levels.

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded. These will be held confidentially by the Director of Corporate Affairs on behalf of the Trust Chair.

7.2 The Committee will report to the full Board of Directors after each meeting.

7.3 The Committee shall ensure that Board of Directors emoluments are accurately reported in the required format in the Trust's annual report.

7.4 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its terms of reference and give details of any significant issues and how they have been addressed.

7.5 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

7.6 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair.

8. Terms of Reference Review

8.1 The Terms of Reference shall be subject to review at least annually.

Approved by Remuneration & Appointments Committee	20 March 2019
Approved by Audit & Risk Committee	30 April 2019
Approved by Trust Board	

Finance & Performance Committee Terms of Reference

Purpose

The prime purpose of the Committee is to gain assurance on all aspects of financial and operational performance, on behalf of the Board. The Committee also oversees and approves business developments as well as considering progress with commercial and contractual matters. The Committee is responsible for agreeing terms of reference and annual work programmes for its supporting sub-committees. It also receives agreed assurance and escalation reports as defined in the forward plan for the Committee.

1. Authority

1.1 The Committee oversees and approves business developments as well as considering progress with commercial and contractual matters.

The Committee may refer specific issues to the Board, Audit and Risk Committee and other Committees and make recommendations as appropriate. Matters formally delegated to the Finance and Performance Committee by the Board of Directors are:

- Continuous Improvement including CIP plan reporting
- Contractual compliance performance reporting
- Treasury Management – to approve policy, procedures, controls and monitoring of policy implementation
- Working Capital Facility – to approve (if applicable)
- Estate strategy delivery oversight – twice yearly updates
- Indicative 5 year capital plan – approval
- Reference Costs: process - sign-off

1.2 Aside from those specific matters listed, the Committee otherwise gains assurance on matters through reports and exceptions provided to it.

1.3 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.4 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions

1.5 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Finance & Performance Committee will ensure consideration has been given to equality impact related risks.

1.6 The Committee will actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion.

1.7 As a designated policy ratification group, (see 'Policy on Policy Documents) the Finance & Performance Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

1.8 As a Committee of the Board, the Finance & Performance Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit

2. Membership

2.1 The membership of the Committee shall comprise:

Chair of Committee – Non Executive Director
Two other Non-Executive Directors
Executive Director of Finance
Chief Operating Officer
Director of Business Improvement and Transformation

2.2 If the Chair is not present, one of the Non-Executive Directors will chair the meeting. Other staff may be required to attend, at the invitation of the Committee.

2.3 Members of the Committee must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings.

2.4 Executive Director members should aim to attend all scheduled meetings with fully briefed deputies attending no more than one third of meetings on an exception basis.

3. Attendance

3.1 Other staff may be required to attend at the invitation of the Committee.

4. Quorum

4.1 A quorum shall be four members, including at least two Executive Directors and two Non-Executive Directors; noting that as a minimum the executive attendance must include both the Director of Finance and the Chief Operating Officer or their deputies acting as their direct representative.

4.2 Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.

5. Frequency

5.1 Meetings should be held bi-monthly with additional meetings if required.

6. Duties and Responsibilities

6.1 To monitor the development and delivery of financial and operational aspects of the Trust strategy through:

- Detailed oversight of current and future financial performance including financial risks
- Detailed oversight of current and future operational performance

6.2 To monitor delivery of the continuous improvement programme including CIP.

6.3 To oversee progress on contractual negotiations.

6.4 To receive reports on business and commercial matters.

6.5 To consider outline business cases and proposals and to approve or make recommendations to Board accordingly.

6.6 To receive reports or referrals from committees and other meetings, relevant to the work of this Committee.

6.7 The agenda for the Committee will be informed by a forward plan of regular items but will also receive reports on relevant issues requiring additional scrutiny and assurance pertaining to actual and anticipated performance and/or when required by Trust Board or Audit and Risk Committee.

6.8 To consider the Board Assurance Framework and high level risks, in particular as they relate to the remit of the Committee; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

6.9 To conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

6.10 To ensuring that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise the Committee will undertake to challenge robustly and fairly in order to develop a culture of continuous improvement, openness and honesty.

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded and made available to the Board of Directors.

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

7.3 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its Terms of Reference and give details of any significant issues and how they have been addressed.

7.4 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

7.5 Agenda and papers will be distributed in accordance with deadlines agreed with the Committee Chair.

8. Terms of Reference Review

8.1 The Terms of Reference shall be subject to review at least annually.

Revised version approved by Finance & Performance Committee	19 March 2019 (as part of year-end report)
Approved by Audit & Risk Committee	30 April 2019
Approved by Trust Board	

Audit & Risk Committee Terms of Reference

Purpose

This is the principal Committee for seeking independent assurance on the general effectiveness of the Trust's internal control and risk management systems and for reviewing the structures and processes for identifying and managing key risks. It is responsible for reviewing the adequacy of all risk and control related statements prior to approval by the Board and for seeking assurances on these controls. In discharging its responsibilities the Committee takes independent advice from the Internal Auditor or seeks any other legal or professional advice as required to discharge its responsibilities.

1. Authority

1.1 The Audit and Risk Committee (the Committee) is constituted as a Committee of the Trust's Board of Directors. Its constitution and Terms of Reference are set out below, and are subject to amendment at future Board of Directors meetings. The Committee shall not have executive powers in addition to those delegated in these Terms of Reference.

1.2 As a Committee of the Board, the Audit and Risk Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit. This includes identification, review and scrutiny of all relevant risks on the Board Assurance Framework.

1.3 The Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.4 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

1.5 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Audit and Risk Committee will ensure consideration has been given to equality impact related risks.

1.6 The Committee will actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion

1.7 As a designated policy ratification group, (see 'Policy on Policy' document) the Audit and Risk Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring

that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

2. Membership

2.1 The Committee shall be composed of at least three independent non-executive directors, at least one of whom should have recent and relevant financial experience.

2.2 One of the members shall be appointed Chair of the Committee by the Board of Directors.

2.3 The Trust Chair shall not be a member of the Committee (but may attend by invitation as appropriate).

2.4 Members of the Committee must attend at least 80% of all meetings each financial year but should aim to attend all scheduled meetings.

3. Attendance

3.1 Only members of the Committee have the right to attend meetings, but the Deputy Chief Executive & Director of Finance and Trust Secretary shall generally be invited to attend routine meetings of the Committee. Other Executive Directors and/or staff and executives shall be invited to attend those meetings in which the Committee will consider areas of risk or operation that are their responsibility and will be expected to attend as requested.

3.2 The Chief Executive, as accountable officer, may be invited to attend meetings and should discuss at least annually with the Committee the process for assurance that supports the governance statement. He/she should attend when the Committee considers the Annual Governance Statement and the annual report and accounts.

3.3 The External Auditor or his representative should normally attend meetings.

3.4 The Head of Internal Audit should also attend routine meetings.

3.5 A representative of the local Counter Fraud Service will attend at least two meetings of the Committee per year.

3.6 A governor representative may be invited to attend meetings of the Committee as an observer when the Committee considers the Annual Governance Statement and the annual report and accounts.

3.7 The Trust Secretary shall be the secretary to the Committee and will provide appropriate support and advice to the Chair and the Committee members.

3.8 At least once per year the Committee should meet privately with the external and Internal Auditors.

Access

3.9 The Head of Internal Audit, representatives of External Audit and Counter Fraud Specialist have a right of direct access to the Chair of the Committee.

4. Quorum

4.1 A quorum shall be two Non-Executive Directors.

4.2 Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.

5. Frequency of meetings

5.1 Meetings shall be held at least four times per year, the total number of meetings being determined by the assurance required by the Committee to discharge its responsibilities. The Board of Directors, Chief Executive, External Auditors or Head of Internal Audit may request an additional meeting if they consider that one is necessary.

6. Duties and Responsibilities

6.1 The Committee's duties and responsibilities can be categorised as follows:

Integrated governance, risk management and internal control

6.2 To review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities, clinical and non-clinical, that supports the achievement of the Trust's objectives.

6.3 To consider the Board Assurance Framework and high level risks, including Deep Dives of risks as appropriate.

6.4 In particular to review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances

- the underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

- arrangements for the effective management of clinical and corporate risk to underpin the delivery of the Trust's strategic objectives

- arrangements in place for preventing and countering fraud, bribery and corruption and managing security in compliance with the related NHS Protect Standards

- The Committee shall maintain an oversight of the Trust's general material control and risk management systems, including processes and responsibilities, the production and issue of any risk and control-related disclosure statements. The

key record to guide the Committee's work will be the Board Assurance Framework (BAF).

6.5 As part of its integrated approach, the Committee will ensure appropriate information flows, to the Committee from executive management and from and between other Board Committees, in relation to the Trust's overall internal control and risk management position.

6.6 To monitor corporate governance (e.g. compliance with terms of the licence, constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests).

6.7 To develop and use an effective assurance framework to guide the Committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as fulfil its functions in connection with these Terms of Reference.

Internal audit

6.8 To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.

6.9 To oversee on an ongoing basis the effective operation of internal audit in respect of:

- Adequate resourcing
- Co-ordination with external audit
- Meeting the Public Sector Internal Audit standards 2013
- Providing adequate independent assurances
- Having appropriate standing within the Trust
- Reviewing and approving the internal audit plan ensuring that this meets the internal audit needs of the organisation.

6.10 To consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

6.11 To consider the provision of the internal audit service, the cost of the audit.

6.12 To monitor the effectiveness of internal audit and to conduct an annual review of the internal audit function.

External audit

6.13 To make a recommendation to the Council of Governors in respect of the appointment, re-appointment and removal of an External Auditor and related fees as applicable. To the extent that the recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

6.14 To discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy.

6.15 To assess the External Auditor's work and fees each year and based on this assessment, to make the recommendation above to the Council of Governors with respect to the re-appointment or removal of the Auditor. This assessment should include the review and monitoring of the External Auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

6.16 To oversee the conduct of a market testing exercise for the appointment of an auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the Auditor.

6.17 To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

6.18 To develop and implement a policy on the engagement of the External Auditor to supply non-audit services.

6.19 To consider the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal of the auditors.

Annual accounts review

6.20 To approve the Annual Report and Accounts including the Quality Report and Annual Governance Statement on behalf of the Trust Board. In doing so the Committee will determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes
- Changes in, and compliance with the accounting policies, practices and estimation techniques
- Areas where judgment has been exercised
- Explanation of estimates or provisions having material effect
- Explanations for significant variances
- The schedule of losses and special payments
- Significant adjustments in the preparation of the financial statements and any unadjusted statements
- Any reservations and disagreements between the External Auditors and management which have not been satisfactorily resolved
- Changes in and compliance with guidance relating to the preparation of the Quality Report
- Compliance with the Annual Reporting Manual requirements for the content of the annual report as published by NHS Improvement.

6.21 To review all accounting and reporting systems for reporting to the Board of Directors, including in respect of budgetary control.

Raising Concerns (Whistleblowing)

6.22 To review the adequacy of the Trust's arrangements by which Trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

Standing orders, standing financial instructions and standards of business conduct

6.23 To review on behalf of the Board of Directors the operation of, and proposed changes to, the standing orders and standing financial instructions, the constitution, codes of conduct and standards of business conduct; including maintenance of registers.

6.24 To examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension.

6.25 To review the scheme of delegation.

Other

6.26 To review performance indicators relevant to the remit of the Committee.

6.27 To examine any other matter referred to the Committee by the Board of Directors and to initiate investigation as determined by the Committee.

6.28 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health sector and professional bodies with responsibilities that relate to staff performance and functions.

6.29 To review the work of all other Trust committees in connection with the Committee's assurance function.

6.30 The Committee may also request specific reports from individual functions within the Trust (for example, clinical audit).

6.31 The Committee may refer specific issues to the Board, Finance and Performance Committee and other Committees and make recommendations as appropriate.

6.32 The Committee will receive assurance reports on Data Security and Protection arrangements, particularly in respect to compliance with the Data Security and Protection Toolkit and legislative compliance including the Data Protection Act and General Data Protection Regulations.

6.33 Audit and Risk Committee has a specific responsibility for overseeing the management of conflicts of interest and evaluating the Trust's response to implementing the Trust's Conflict of Interest Policy. The Committee is specifically cited in the national guidance in respect of consideration of any breaches.

6.34 Responsibility for the oversight of data quality assurance.

6.35 The Committee is committed to ensuring that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise the Committee will undertake to challenge robustly and fairly in order to develop a culture of continuous improvement, openness and honesty.

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded and made available to the Board of Directors.

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed. This will include details of any evidence of potentially *ultra vires*, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters. To the extent that such matters arise, the Chair of the Committee shall present details to a meeting of the Board of Directors in addition to the assurance summary.

7.3 The Committee will report annually to the Board of Directors and the Council of Governors in respect of its work in support of the Annual Governance Statement, specifically commenting on:

- The assurance framework and its fitness for purpose
- The effectiveness of risk management within the Trust
- The integration of and adherence to governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements relating to its existence as a functioning business
- The robustness of the processes behind the quality accounts
- Any pertinent matters in respect of which the Committee has been engaged.

7.4 The Committee's annual report should also describe how the Committee has fulfilled its Terms of Reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed. The Trust's annual report shall include a section describing the work of the Committee in discharging its responsibilities.

7.5 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

8. Administrative Support

8.1 The Committee shall be supported by the Trust Secretary whose duties in this regard include, but are not limited to:

- Agreement of the agenda with the Chair of the Committee and attendees
- Preparation, collation and circulation of connected papers in good time
- Ensuring that those required to attend are invited to the meeting in good time
- Ensuring that the minutes are taken and keeping a record of matters arising and issues to be carried forward
- Manage the forward plan of the Committee's work
- Arranging meetings for the Chair with directors and advisers as necessary
- Advising the Committee as appropriate on pertinent issues/areas of interest/policy developments
- Enabling training and development of Committee members as appropriate
- Reviewing every decision to suspend the standing orders.

9. Review of Terms of Reference

The Terms of Reference of the Committee shall be reviewed at least annually.

Approved by Audit & Risk Committee	21 March 2019
Approved by Trust Board	

Quality Committee Terms of Reference

Purpose

The prime purpose of the Committee is to enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to promote safety and excellence in patient care, Identify, prioritise and manage risk arising from clinical care, ensure the effective and efficient use of resources through evidence-based clinical practice; and protect the health and safety of Trust employees. The Quality Committee is responsible for agreeing terms of reference and annual work programmes for its supporting sub-committees. It also receives agreed assurance and escalation reports as defined in the forward plan for the Committee.

1. Authority

1.1 The Board of Directors has approved the establishment of a Quality Committee as a Committee of the Board in accordance with standing orders.

1.2 As a Committee of the Board, the Quality Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit

1.3 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.4 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions

1.5 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Quality Committee will ensure consideration has been given to equality impact related risks.

1.6 The Committee will consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion.

1.7 As a designated policy ratification group, (see 'Policy on Policy Documents) the Quality Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

2. Membership

2.1 The membership of the Committee shall comprise:-

- Non-Executive Director – Chair of the Committee
- Non-Executive Director (2)
- Director of Nursing and Patient Experience or a nominated deputy
- Medical Director or a nominated deputy
- Chief Operating Officer or a nominated deputy

3. Attendance

3.1 Attendees for specific agenda items at the request of the Committee:

- Deputy Director of Nursing & Quality Governance
- Lead professional for Patient Safety
- Chief Pharmacist
- Research and Clinical Audit Manager
- Risk and Assurance Manager
- Assistant Director of Clinical Professional Practice
- Health & Safety Manager
- Chairs or Deputy Chairs of COATs (Clinical Operational Assurance Team) will be required to attend specific agenda items at the request of the Committee.

3.2 The following may also attend:

- Chief Executive Officer
- Trust Chair
- Director of People and Organisational Effectiveness
- Director of Business Improvement and Transformation
- Trust Secretary

Any other attendees will be invited upon request.

3.3 If the Committee Chair is not present, the meeting shall be chaired by another Non-Executive Director.

3.4 Members of the Committee must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings.

3.5 Executive Director members should aim to attend all scheduled meetings with fully briefed deputies to attend no more than one third of meetings on an exception basis.

3.6 Nominated deputies for Executive members will contribute to attendance figures but will not contribute to quorum.

3.7 Other staff may be co-opted to attend meetings as considered appropriate by the Committee on an ad hoc basis.

4. Quorum

4.1 A quorum shall be three members, including at least one Executive Director and two Non-Executive Directors.

4.2 Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Board of Directors meeting as an urgent item.

5. Frequency

5.1 Meetings shall be held monthly.

6. Duties and Responsibilities

In respect of general governance arrangements:

6.1 To ensure that all statutory elements of operational risk and quality governance are adhered to within the Trust including the requirements of our regulators, NHS Improvement and the Care Quality Commission (regulations).

6.2 To provide a clear link with the Trust's Strategy and Quality framework when agreeing quality governance priorities and monitor scrutinise these areas to provide assurance and inform the Board on the strategic direction for Quality and monitor the performance of the clinical services.

6.3 To provide direction to the quality governance activities of the Trust's services and divisions. This will include setting strategy, delegating activities and monitoring clinical performance against this strategy or quality priorities.

6.4 To scrutinise, gain assurance and approve the Trust's Quality Position Statements and Quality Governance Annual Reports before submission to the Board.

6.5 To have final sign off of the Trust Quality Account prior to Audit and Risk Committee approval

6.6 To approve the terms of reference and membership of its reporting sub-committees, the primary reporting committee will be the Executive chaired Quality sub group known as Trust Management Team (TMT). This group will scrutinise the clinical performance of the key sub groups known as the Integrated Clinical Operational Assurance Teams at service level; and to oversee the work of those sub-committees and their clinical reference sub groups, receiving reports from them, reviewing their work plans and clinical escalation issues.

6.7 To scrutinise the work of the Trust Management Team and receive assurance from the Chair of the group on quality performance issues and mitigating actions to ensure safe and effective services.

6.8 To agree to refer specific issues to the Board and other Board Committees where required and make recommendations as appropriate.

6.9 To receive and approve the annual Clinical Audit Programme consistent with the audit needs of the Trust and consistent with the Quality priorities.

6.10 To have oversight and gain assurance on the Trust's policies and procedures with respect to the use of clinical data and patient identifiable information to ensure that this is in accordance with all relevant legislation and guidance including the Caldicott Guidelines and the Data Protection Act 1998.

6.11 To make recommendations to the Audit and Risk Committee concerning the annual Internal Audit plan, to the extent that it applies to matters within these terms of reference; and to comply with any request from the Audit & Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register

6.12 To have overview, responsibility and gain assurance for all regulations and standards as described by the Care Quality Commission as part of our responsibilities under the Care Quality Commission (Registration) Regulations 2009 and Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

6.13 To promote within the Trust a culture of open and honest reporting of any situation, including Duty of Candour, that may threaten the quality of patient care in accordance with the Trust's policy on Raising Concerns and monitoring the implementation of that policy. This will include an approach that enables an open patient safety culture and gain assurance on its implementation.

6.14 To ensure that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise the Committee will undertake to challenge robustly and fairly in order to develop a culture of continuous improvement, openness and honesty.

6.15 To oversee the system within the Trust for obtaining and maintaining any licences relevant to clinical activity in the Trust.

6.16 To ensure that risks to patients are minimised through the application of a comprehensive risk management system including clinical risk registers, monitoring and learning from deaths and associated monitoring.

6.17 To oversee the process and gain assurance within the Trust to ensure that appropriate action is taken in response to adverse clinical incidents, mortality, complaints and litigation and those examples of good practice are disseminated within the Trust and beyond if appropriate.

6.18 To ensure a clear link with the Mental Health Act Committee on aspects of quality governance that are cross cutting clinical standards across mental health act or mental capacity act legislation that impacts upon clinical standards.

6.19 To maintain a forward plan of regular agenda items as identified by the scheme of delegation.

6.20 To ensure a clear link and be assured with the Commissioners Quality Assurance Group, and that escalated clinical concerns, gaps in commissioning and patient safety concerns are discussed and monitored through the joint commissioner and provider risk and issues log.

6.21 To gain assurance and monitor the work of the Trust-wide groups which report the Quality Committee, currently the Serious Incident Requiring Investigation (SIRI) group, the Physical Health Care committee, Health and Safety Committee, Drugs and Therapeutics Committee, Patient Experience Group and any short term named task and finish groups established to design or develop Trust Clinical Strategy.

6.22 To co-operate with and assist the work of other Trust-wide groups which report or scrutinise the work of the Quality Committee, e.g. governors' Governance Committee or the Council of Governors.

6.23 To receive assurance on how the Trust has developed and planned for all clinical service re-design with sign off of any associated clinical safety plans to mitigate any significant or material changes in service, which have been designed and developed by the Clinical Operational Assurance Teams.

6.24 To conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

6.25 To oversee the development of an annual review of performance of the Committee against key areas of delegated authority and provide a check that all areas of governance and responsibility have been monitored.

6.26 To consider the Board Assurance Framework and high level risks, in particular as they relate to the remit of the Committee; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded and made available to the Board of Directors.

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

7.3 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its Terms of Reference and give details of any significant issues and how they have been addressed.

7.4 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

7.5 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair.

8. Terms of Reference Review

8.1 The Terms of Reference shall be subject to review at least annually.

Approved by Quality Committee	12 March 2019
Approved by Audit & Risk Committee	30 April 2019
Approved by Trust Board	

People & Culture Committee Terms of Reference

Purpose

The Committee supports the organisation to achieve a well-led values driven positive culture. The Committee is to provide assurance to the Board that the appropriate structures, processes and systems are in place to ensure an effective capable workforce to meet the Trust's current and future needs including workforce engagement and development.

1. Authority

1.1 The People and Culture Committee is constituted as a standing committee of the Foundation Trust's Board of Directors. Its constitution and Terms of Reference shall be as set out below, subject to amendment at future Board of Directors meetings. The People and Culture Committee shall not have executive powers in addition to those delegated in these terms of reference.

1.2 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice and to secure the attendance of both internal and external officers with relevant experiences and expertise it if considers this necessary.

1.3 To consider the Board Assurance Framework and high level risks, in particular as they relate to the remit of the Committee; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

1.4 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.5 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The People & Culture Committee will ensure consideration has been given to equality impact related risks.

1.6 The Committee will actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion.

1.7 As a designated policy ratification group, (see 'Policy on Policy Documents) the People & Culture Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

1.8 As a Committee of the Board, the People & Culture Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit, this includes the delivery and implementation of the Trusts 3 year People Strategy.

2. Membership

2.1 The membership of the Committee will comprise:

- Non-Executive Directors x 3 (one will be appointed as the Chair)
- Director of People and Organisational Effectiveness
- Medical Director
- Chief Operating Officer

The Deputy Medical Director is to attend meetings as the Medical Director's nominated deputy when the Medical Director is unable to attend.

In attendance as core attendees:

- Assistant Director People and Culture Transformation
- The Director of Corporate Affairs is to be included as a core attendee
- Deputy Director of Communications and Involvement will attend only when items to be discussed are relevant

2.2 A quorum shall be three (not less than two non-executive directors and one executive director).

2.3 Members are expected to attend a minimum of four meetings per year.

2.4 Executive Director members should aim to attend all scheduled meetings with fully briefed deputies to attend no more than one third of meetings on an exception basis.

3. Attendance

3.1 Only members of the Committee have the right to attend and vote at Committee meetings. The Committee may require other officers of the Trust, and other individuals may attend all or any part of its meetings as and when is necessary.

3.2 The Board of Directors will appoint the Chair of the Committee

3.3 The Trust Board has delegated authority to any Non-Executive Director of the Trust to act as nominated deputy in the absence of any Non-Executive and this attendance will count towards the quorum.

3.4 The Board Secretary will be in attendance and provide administrative support.

3.5 A register of attendance will be maintained and reviewed by the Committee annually.

4. Quorum

4.1 A quorum shall be three (not less than two non-executive directors and one executive director).

4.2 Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.

5. Frequency

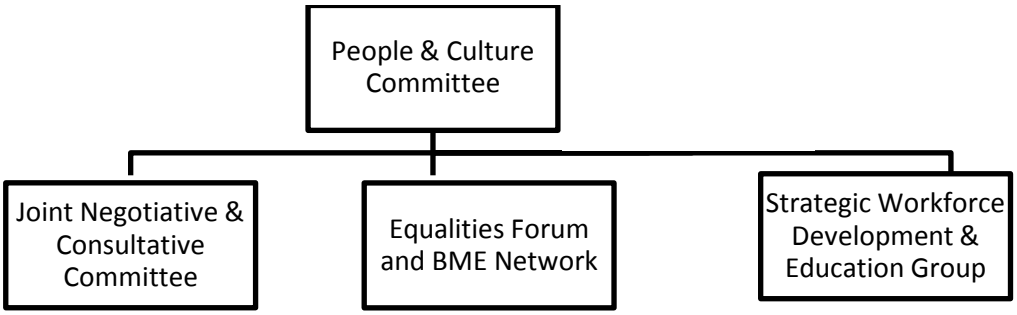
5.1 The Committee will meet on bi-monthly basis with additional meetings being called when necessary.

6. Duties and Responsibilities

6.1 The Committee will support the organisation to achieve a well led, values driven positive culture. The Committee is to provide assurance to the Board that the appropriate structures, processes and systems are in place to ensure an effective capable workforce to meet the Trusts current and future needs.

6.2 The Committee will monitor the implementation of the People Strategy and report progress to the Board by exception

6.3 A number of supporting groups / forums will be accountable to the People and Culture Committee whilst not exhaustive; it is anticipated that the following groups will have a direct or indirect relationship and will be agreed within the Committee



6.4 The Committee will oversee and monitor workforce performance.

6.5 The Committee review and monitor the Workforce metrics and Board Assurance Framework and ensure the Board is kept informed of any significant workforce risks.

6.6 To consider the Board Assurance Framework and high level risks, in particular as they relate to the remit of the Committee; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

6.7 The Committee is to be assured that mechanisms are in place to review and monitor the effectiveness and capability of the workforce across the whole Trust and that appropriate actions are taken to address issues of poor performance and bring about continuous quality improvement.

6.8 The Committee is to be assured that the Trust identifies lessons for improvement and implements these in all relevant areas

6.9 The Committee is to be assured that National standards, guidance and best practice are systematically reviewed and embedded within the Trust

6.10 The Committee is to be assured that the views of staff and appropriate others are systematically and effectively engaged in organisational development activities

6.11 The Committee is committed to ensuring that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise the Committee will undertake to challenge robustly and fairly in order to develop a culture of continuous improvement, openness and honest.

6.12 The Committee will oversee the leadership, training and education framework and monitor progress

6.13 The Committee will monitor the implementation of agreed action plans in relation to organisational interventions and measure the effectiveness of change.

6.14 The Committee will review its effectiveness by self-assessment on an annual basis and at the end of each meeting. The annual review will be presented to the Audit and Risk Committee.

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded and made available to the Board of Directors.

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

7.3 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its Terms of Reference and give details of any significant issues and how they have been addressed.

7.4 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

7.5 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair.

8. Terms of Reference Review

8.1 The Terms of Reference shall be subject to review at least annually.

Approved by People & Culture Committee	19 February 2019
Approved by Audit & Risk Committee	30 April 2019
Approved by Trust Board	

Mental Health Act Committee Terms of Reference

Purpose

The Committee monitors and obtains assurance on behalf of the Hospital Managers and the Trust as the detaining authority that the safeguards of the Mental Health Act are appropriately applied. It also monitors related statute and guidance and reviews the reports following Mental Health Act inspections by the Care Quality Commission.

1. Authority

1.1 The Board of Directors has approved the establishment of a Mental Health Act Committee as a Committee of the Board. The purpose of the Committee is to obtain assurance, on behalf of the "Hospital Managers" and the Trust as the detaining authority, that the safeguards and provisions of the Mental Health Act are appropriately applied; to take account of the provisions of related statute and guidance, such as Mental Capacity Act, Deprivation of Liberty Safeguards (DOLS) and Human Rights Act.

1.2 The Committee will exercise its responsibilities by fulfilling a scrutiny and monitoring role from receipt of regular activity data and inspection reports from an Operational Group; by obtaining assurance that best practice is deployed across the Trust.

1.3 As a Committee of the Board, the Mental Health Act Committee has an important role to provide assurance on the progress and risks arising relating to the delivery of the Trust's Strategic objectives which fall within the Committee's remit. It will consider any exceptions or risks escalating these to the Trust Board or referring to the Executive Leadership Team as necessary.

1.4 The Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.5 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions

1.6 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Mental Health Act Committee will ensure consideration has been given to equality impact related risks.

1.7 The Committee will actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion.

1.8 As a designated policy ratification group, (see 'Policy on Policy Documents) the Mental Health Act Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. These include policies in relation to the Mental Health Act and Code of Practice requirements, and the duties of Associate Hospital Managers, including the protocols for the hearing of appeals and reviews. It also includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

1.9 An operational subgroup will meet approximately one month before the full Committee to prepare assurances and highlight exceptions.

2. Membership

2.1 The membership of the Committee shall comprise:-

- Non-Executive Director – Chair of the Committee
- Non-Executive Director (2)
- Medical Director or a nominated Deputy
- Director of Nursing and Patient Experience or a nominated Deputy
- Director of Corporate Affairs or a nominated Deputy

2.2 Members of the Committee must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings

2.3 If the Committee Chair is not present, the meeting shall be chaired by another Non-Executive Director.

3. Attendance

3.1 Additional attendees shall comprise:-

- Mental Health Act Manager
- Representative of Associate Hospital Managers
- Other senior management/professional leads may be invited at the discretion of the Committee Chair.

4. Quorum

4.1 Quorum is a minimum of three members including at least two Non-Executive Directors.

4.2 Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.

5. Frequency

5.1 Meetings will be held quarterly.

6. Duties and Responsibilities

6.1 To receive compliance and assurance reports from the Operational Group regarding the number of patients subject to detention under each section of the Mental Health Act for the previous quarter as part of a rolling twelve month review to identify any variation or trends (including diversity data) and provide interpretation of data including an outline of actions arising as appropriate.

6.2 To consider matters of recommended good practice, and in particular the requirements of the Code of Practice (Revised): Mental Health Act (1983) and its Code of Practice as amended and approve policy changes to receive assurance on the steps taken to implement and embed recommended good practice relating to the requirements of the Mental Health Act, Mental Capacity Act and related legislation.

6.3 To receive assurance reports and scrutinise, as required, other activity reports from the Operational Group e.g. the use of seclusion, noting any exceptions and escalating concerns as necessary.

6.4 To receive assurance reports relating to the Care Quality Commission Inspection Reports and the implementation of the management response as defined by the Operational Group, providing scrutiny and challenge and noting exceptions and risks escalated by the operational group. With regard to Section 136, to oversee and receive assurance on the use of this section through the multi-agency Section 136 sub-committee.

6.5 To oversee the implications of related legislation, principally the Mental Capacity Act, (including Deprivation of Liberty), Human Rights Act guidance and other related legislation as appropriate, receiving assurance on impact, risk and effective implementation throughout the Trust.

6.6 To oversee that training needs are satisfactorily met to ensure compliance with legislative and best practice requirements, through assurance reporting and in general help promote awareness of the requirements of the Mental Health Act, Mental Capacity Act and associated legislation.

6.7 When receiving information on Mental Health Act activity and reports, the Committee will pay due regard to the Trust's Equality and Diversity Agenda.

6.8 To ensure that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise the Committee will undertake to challenge robustly and fairly in order to develop a culture of continuous improvement, openness and honesty.

6.9 To consider the Board Assurance Framework and high level risks, in particular as they relate to the remit of the Committee; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

6.10 To conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

6.11 To maintain a forward plan of regular agenda items to encompass the role and remit of the Committee as outlined in the Terms of Reference.

6.12 To oversee the development of an annual review of performance of the Committee against key areas as outlined within the Terms of Reference and confirm that all areas of governance and responsibility have been monitored.

6.13 Receive feedback from Associate Hospital Mangers and review any performance issues arising from mental health tribunals.

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded and made available to the Board of Directors.

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

7.3 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its Terms of Reference and give details of any significant issues and how they have been addressed.

7.4 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

7.5 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair.

8. Terms of Reference Review

8.1 The Terms of Reference shall be subject to review at least annually.

Approved by Mental Health Act Committee	8 March 2019
Approved by Audit & Risk Committee	30 April 2019
Approved by Trust Board	

Safeguarding Committee Terms of Reference

Purpose

The Committee is responsible for setting the Safeguarding Quality Strategy, to provide quality governance and gain assurance on all aspects of the safeguarding agenda. The Committee's purpose is to provide assurance to the Trust Board that the organisation is effectively discharging and fulfilling its statutory responsibility for safeguarding to ensure better outcomes for children and vulnerable adults.

1. Authority

1.1 The Safeguarding Committee (the Committee) is constituted as a standing committee of the Trust's Board of Directors. Its constitution and Terms of Reference are set out below, and are subject to amendment at future Board of Directors meetings. The Committee shall not have executive powers in addition to those delegated in these terms of reference.

1.2 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.3 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions

1.4 As a Committee of the Board the Safeguarding Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit.

1.5 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Safeguarding Committee will ensure consideration has been given to equality impact related risks.

1.6 The Committee will actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion.

1.7 The Committee will ensure that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise the Committee will undertake to challenge robustly and fairly in order to develop a culture of continuous improvement, openness and honesty.

1.8 The Committee has a role during the 2017/18 financial year to oversee implementation of key tasks as outlined in the Trust's Governance Improvement Action Plan. The Committee was assigned as responsible Committee for a range of tasks and is required to provide assurance to the Board that effective governance processes are embedded within the Trust.

1.9 As a designated policy ratification group, (see 'Policy on Policy Documents) the Safeguarding Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

2. Membership

2.1 The membership of the Committee shall comprise:-

Non-Executive Director – Chair of the Committee
Non-Executive Director (2)
Executive Director of Nursing & Patient Experience
Medical Director or nominated deputy
Chief Operating Officer or nominated deputy
Director of People & Organisational Effectiveness or nominated deputy

2.2 At least one the non-executive directors should have recent and relevant safeguarding experience.

2.3 The Trust Chair shall not be a member of the Safeguarding Committee (but may attend by invitation as appropriate).

2.4 If the Committee Chair is not present, the meeting shall be chaired by another Non-Executive Director.

2.5 Executive Director members should aim to attend all scheduled meetings with fully briefed deputies to attend no more than one third of meetings on an exception basis.

3. Attendance

3.1 In attendance at the Committee:

- Assistant Director Safeguarding Children
- Named Nurse – Looked after Children
- Named Doctor – Safeguarding Children
- Opportunities for people with care and support needs and carers to contribute to and inform the Committee's work, to be represented by the Voice of the Child, Voice of the Adult and the Voice of the Carer
- Designated Nurse – Safeguarding Children (CCG)
- Named Safeguarding Adult representative from the CCG
- Assistant Director Safeguarding Adults (Trust lead for MAPPA/MARAC named Trust lead for PREVENT/CHANNEL)
- Named Doctor for Safeguarding Adults

3.2 If the Committee Chair is not present the meeting shall be chaired by another Non-Executive Director.

3.3 Members of the Committee must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings.

3.4 Other staff may be co-opted to attend meetings as considered appropriate by the Committee on an ad hoc basis.

4. Quorum

4.1 A quorum shall be three core members including at least one Executive Director and two Non-Executive Directors.

4.2 Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.

5. Frequency

5.1 Meetings shall be held at least four times per year, the total number of meetings being determined by the assurance required by the Committee to discharge its responsibilities.

6. Duties and Responsibilities

The Committee's duties and responsibilities can be categorised as follows:

6.1 To set the Safeguarding Quality Strategy, to provide quality governance and gain assurance to all aspects of the Safeguarding Agenda.

6.2 To lead the assurance process on behalf of the Trust for the following areas:

6.2.1 **Children's Act** has a statutory duty of care towards children (Children Acts 1989 and 2004) at risk of harm who are resident in Derby city and Derbyshire in our care. The committee will ensure as an organisation we have safeguards in place not only protects and promotes the welfare of vulnerable children, but that we have a significant impact on children in our care's health and well-being.

6.2.2 **The Care Act (2014)** Safeguarding adults at risk of abuse or neglect (Section 42 and named other relevant NHS legislation and NHS Safeguarding Adults policy and procedures.

6.2.3 **Counter Terrorism legislation** The Counter Terrorism and Security Bill, which is currently before Parliament (December 2014) at the time of writing, seeks to place duty on specified authorities (identified in full in Schedule 3 to the bill, and set out in this draft guidance) to have due regard to the need to prevent people from being drawn into terrorism. PREVENT.

6.2.4 **A formal link to the area Safeguarding Children's and Adults Boards** and provide systems leadership to our wider geographical and community safeguarding responsibilities and be the conduit for linking the community Safeguarding Board strategies with the Trust strategy.

6.2.5 **Promote a proactive and preventative approach** to safeguarding

through our Flourishing Families agenda

6.2.6 Ultimately to provide assurance to the Trust Board that the organisation is effectively discharging and fulfilling its statutory responsibility for safeguarding to ensure better outcomes for children and vulnerable adults.

6.2.7 Ensure the Trust workforce is appropriately trained in safeguarding children and adults to their appropriate level depending on their role and responsibility.

6.2.8 To determine strategic and operational development that will enable the Trust to integrate best practice in Safeguarding across the Trust. The Committee has a responsibility to improve and develop Safeguarding practices consistent with national and local legislation, guidance and standards in Safeguarding children and vulnerable people.

6.2.9 To ensure that the Trust embeds Think Family principles within all aspects of care and service developments to enable 'Flourishing Families'.

6.2.10 To provide rigorous and transparent assessment of performance and effectiveness and quality of practice for Safeguarding of Children and Family and Vulnerable Adults Services within the Trust.

6.2.11 To advise the Trust Board of national and local standards and Derby and Derbyshire Safeguarding Board arrangements.

6.2.12 The Committee will oversee Serious Case Reviews, Independent Learning Reviews, Domestic Homicide Reviews and all Safeguarding major incidents and will advise service level Directors and operational managers of recommendations, lessons learnt and compliance requirements.

6.2.13 The Committee will oversee and assure itself that all Safeguarding Boards for Children's and Adults are appropriately represented and feedback from Boards to the Trust Board is in place

6.2.14 The Committee will oversee and assure itself on the PREVENT and Channel: Supporting Individuals Vulnerable to Recruitment by Violent Extremists agenda. Establish or use existing mechanisms for understanding the risk of radicalisation. Communicate and promote the importance of the duty; as outlined in any counter terrorism legislation (2015) and ensure staff implement the duty effectively.

6.2.15 The Committee will oversee and assure itself on the Multi-Agency Public Protection Arrangements (MAPPA) with relevant agencies including the police. These processes ensure that the requirements for offenders in the community needs are met and duties to public safety are met fully.

6.2.16 The Committee will oversee and assure itself on the MARAC agenda, The Multi-Agency Risk Assessment Conference that the trust is discharging its duty The MARAC aims to: share information to increase the safety, health and well-being of victims/survivors - adults and their children; improve agency accountability; and improve support for staff involved in high-risk domestic abuse cases

6.2.17 Have authority in the setting the quality standards, defining and monitoring of clinical practice in safeguarding children and vulnerable adults people

through delegated duties to the Safeguarding operational group.

6.2.18 Provide an annual report and assurances to the Audit & Risk Committee on the compliance to national standards.

6.2.19 Conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

6.2.20 Oversee the development of an annual review of performance against key areas of delegated authority and provide a check that all areas of governance and responsibility have been monitored.

6.2.21 The named link between the Safeguarding committee and the Quality Committee to ensure consistency and cross Board committee discussion is the Executive Director of Nursing.

6.3 Safeguarding Adults Key Responsibilities

6.3.1 Schedule 2 of the Care Act (2014). That Geographical links to the Safeguarding Adults Boards must have a clear, agreed understanding of the roles, responsibilities, authority and accountability of its member agencies, therefore the Trust should annually

- Review suitable governance arrangements an effective infrastructure and adequate resources.
- Deliver operational and strategic requirements
- Provide links to other boards and partnerships
- Provide links to other boards and partnerships
- Provide a person-centred, outcome focused safeguarding policy and procedures
- Ensure that there is awareness training for all health and social care staff and Police who work directly with people with care and support needs
- Ensure that there is a specialist training for all practitioners who have direct responsibilities for safeguarding work
- Develop and publish a Trust strategy specifying each service areas responsibilities
- Link with the wider community to inform its work and learn of the work of the Board
- Sign off the Safeguarding Adult Annual reports, detailing what the Trust and its members have achieved, including how they have contributed to the Board's objectives and what has been learned from and acted upon from the findings of Safeguarding Adults Reviews and Case Reviews and other Domestic Homicide reviews and associated audits
- Arrangements for the quality assurance of the effectiveness of safeguarding work

6.4 Safeguarding Children Key Responsibilities

- Scrutinise the Safeguarding Children's Annual report, oversight of the Section 11 audit work and assurance that the Trust discharges its duty responsibly in line with National requirements.
- Review suitable governance arrangements an effective infrastructure, adequate resources
- Deliver operational and strategic requirements
- Provide links to other boards and partnerships

- Provide a child centred, outcome focused safeguarding policy and procedures
- Ensure that there is training for all health and social care staff and Police who work directly with people with care and support needs
- Develop and publish a Trust strategy specifying each service areas' responsibilities
- Sign off the Children's, Looked After Children Annual Reports, detailing what the Trust and its members have achieved, including how they have contributed to the board's objectives and what has been learned from and acted upon from the findings of Safeguarding Serious Case Reviews

6.5 Groups and Officers reporting schedule

Group/Officer	**Report**	**Frequency**
Internal Safeguarding Children Operational Group	Assistant Director of Safeguarding Children	Bi-monthly
Internal Safeguarding Adults Operational Group	Assistant Director of Safeguarding Adults	Bi-monthly

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded and made available to the Board of Directors.

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

7.3 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its Terms of Reference and give details of any significant issues and how they have been addressed.

7.4 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

7.5 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair.

8. Terms of Reference Review

8.1 The Terms of Reference shall be subject to review at least annually.

Approved by Safeguarding Committee	7 February 2019
Approved by Audit & Risk Committee	30 April 2019
Approved by Trust Board	

Derbyshire Healthcare NHS Foundation Trust

Board Committee Assurance Summary Report to Trust Board
Quality Committee meeting held 9 April 2019

Key items discussed

- BAF Risks for Quality Committee noted and agreed
- Draft Quality Account - process of development and next steps for final publication
- Annual report from the Guardian of Safe Working was not submitted and due to further data requirements. This was deferred to the May meeting. A summary report will be presented to the Board in June.
- Clinical Audit Annual Report and Clinical Audit Plan 2019/20, discussion on the potential impact of clinical audit and how this can be connected to wider quality improvement work. Medical Director to explore potential solutions to interconnect the work with the Director of Business Improvement and Transformation.
- Dementia Strategy Board Annual Review Report. This was presented and reviewed. The Quality Improvement work in older adults wards and waiting list reduction were summarised along with positive impacts and outcomes. There is additional demand management which may present a risk in extended waiting time. Explore a patient and carer story for Board on the impact of MAS (Memory Assessment Service) and DRRT (Dementia Rapid Response Team) and full assurance.
- Implementation of Neighbourhood Delivery Model – verbal update on timeline of report scheduled for July.
- Physical Health Care – Gap Analysis against Strategy Delivery. Report gave a detailed summary of the implementation plan and showed significant improvements overall. Comprehensive report will be submitted to the September meeting August giving detail on areas of improvement, analysis against health regulatory standards (CQC standards), be case examples of patient care improvements, improvement in minimum standards, in acute services, 136 suites, crisis team and further implementation for our community teams with new investments.
- Emergency Incident Response Plan and Procedures agreed and ratified
- Consent to Examination and Treatment Policy agreed and ratified

Assurance/Lack of Assurance Obtained

- Clinical Audit Annual Report and Clinical Audit Plan 2019/20, limited assurance received due to further strategic improvement required on the impact of clinical audit
- Dementia Strategy – full assurance obtained on progress and implementing actions. Some wider tactical and operational risks were noted but these are delivering against their objectives.
- Physical Health Care – Gap Analysis against Strategy Delivery - limited assurance obtained. Comprehensive report is scheduled for September meeting for full analysis.

Meeting Effectiveness

- The agenda is reduced and is therefore more manageable resulting in positive wider impact. No concerns regarding chairing of the meeting, all outcomes were achieved
- Much of the discussion had remained strategic with a positive level of contribution from all members. Effective triumvirate of Director of Nursing and Patient Experience (nursing, allied health professionals and quality), Medical Director (medical and quality), and Chief Operating Officer (operational delivery).
- Improvements are to be made to the equality and diversity reporting which will result on these aspects being addressed during discussion

Decisions made

- Serious Untoward Incident (SUI) bi-monthly reporting to commence from May 2019 and is to be included in the forward plan.
- BAF discussion established the long term implementation plan based on the Board's view, target review dates and how we make an impact.
- Guardian of Safe Working report delayed and will be received at the May meeting with a summary report presented the Trust Board in June

Escalations to Board or other committee

- Escalate to ELT the lack of progress being made on supervision and the need to develop alternative ideas to increase performance
- Highlight to the Board insufficient capacity in terms of time and staff to achieve the required improvements to services

Committee Chair: Margaret Gildea/ Dr Julia Tabreham	**Executive Lead: Carolyn Green, Director of Nursing & Patient Experience**

Derbyshire Healthcare NHS Foundation Trust

Board Committee Assurance Summary Report to Trust Board
People & Culture Committee – Meeting held 23 April 2019

Key items discussed

- **Review of BAF Risks** – 2018/19 risks assigned to the Committee were reviewed and closed off. Key risks relating to recruitment and retention and implementing the staff health and wellbeing plan feature in the 2019/20 BAF. Key measures to work on include retention, making the Trust the best place to work, will be developed along with progression of assurances relating to training and recruitment. Staff recruitment and staff retention is highly focussed on. More pace will be put behind driving the new workforce models. This will be prioritised through the Executive Leadership Team (ELT).

- **Wellbeing and Improving Attendance Presentation** – outlined the launch of the wellbeing offer across DHCFT, improvements to the EAP (Employee Assistance Phone line)

- **Staff Wellbeing Strategy Update** – update to go to Council of Governors, over-arching wellbeing strategy will focus more towards prevention and self-compassion. The wellbeing offer is being communicated throughout the Trust so that staff are aware of the support that is available.

- **Flu – Lessons Learnt** – report provided for information at this point and included plan to improve vaccination rates for next year to include advance booking within first three weeks of campaign, using a lead vaccinator. Challenges are being addressed and solutions are on track.

- **E-Rostering Update** - report provided an update on the formal consultation process regarding the change in shift times proposal across all Campus areas to be effective from October 2019. Committee supported the approach being taken and received significant assurance that the project will deliver equitable shift time across campus

- **Workforce Supply** - report showed progress is being made in current recruitment activity

- **Workforce Plan Update** – report demonstrated the work that has been undertaken over the last two years. Report highlighted that the Trust is one of very few trusts to spend apprenticeship levy. Advanced Clinical Practitioners are in place, draft plans are to be finalised in May. Concern was raised that only 3% of workforce is under 25 years – there is a need to grow this part of our workforce. Committee was satisfied that work is well underway and progress is being made in terms of longer term plans

- **Appraisal Process Launch** – new process launched in April 2019 alongside training module for leaders to attend. Process is aligned to the Trust values and has received positive feedback so far from staff who have started to use the new process.

- **Update on Leadership and Management Development Strategy** –- discussed a range of in-house available programmes. Committee suggested that Non-Executive Directors be invited to the Leaders Forum.

- **Workforce Performance Report** – no new areas of concern but actions in place showing improvements with sickness absence, training and appraisals. Outcomes are yet to be seen.

- **Strategic Workforce Report** – included details of the appointment of the new Chief People Officer for NHS, Government response to Nursing Degree Apprenticeships, changes that

impact workforce from 1 April 2019. Report included local level matters which included mileage scheme for staff, e-expenses roll out, bullying and harassment workshops.

- **Policy Review** – Junior Doctors policy and Supervision policy were both ratified. Update report will be received by the Committee on Supervision as assurance was required on the metrics that can be obtained from supervision.

- **2019/20 Forward Plan** is under development to reflect the workforce strategy and the BAF risks that the Committee has oversight for.

Assurance/lack of assurance obtained

- Staff wellbeing strategy update – significantly assured
- Temporary staffing report – significant assurance
- Workforce plan – assurance given
- Appraisal process and paperwork – assurance given
- E-Rostering Update - received significant assurance that the project will deliver equitable shift time across campus
- Workforce performance report – significant assurance
- Review of BAF Risks - assurance given
- Meeting Effectiveness - agenda gave a good balance and was well connected, Papers were appropriate and well written, there was good challenge and of value and good use of time. Committee was focussed and well chaired. Attendance was low due to Easter break.

Key risks identified

- None identified

Decisions made - noted actions above

Escalations to Board or other committee

- Highlight to the Board that the Apprentice Levy spend is ensuring high quality apprenticeships and the ability to grow our own workforce. The Trust currently has 41 members of staff being supported through apprenticeship programmes. There is a desire to operate a pilot scheme that will develop young people to work in clinical roles.
- Suggest holding a Board Development session in September to look at progress and outputs from workforce development plans regarding the clinical pathways and what that means for workforce.

Committee Chair: Margaret Gildea	**Executive Lead: Amanda Rawlings, Director of People Services & Organisational Effectiveness**

Derbyshire Healthcare
NHS Foundation Trust

Board Committee Summary Report to Trust Board
Audit & Risk Committee – Meeting held 30 April 2019

Key items discussed

- Review Draft 2018/19 Annual Accounts
- Updated Draft Annual Report 2018/19
- Review Draft Annual Governance Statement
- Going Concern Assessment
- Receive Year-End Effectiveness Reports from Board Committees
- Impact of Clinical Audit – this item was deferred to the July meeting
- External Audit Plan 2019/20 and Progress Report
- Informing the Audit Risk Assessment
- Internal Audit Progress Report
- Draft 2018/19 Head of Internal Audit Opinion
- Data Quality RTT Review Final Report
- Integrity of the General Ledger & Key Financial Systems Review Final Report
- Risk Management Review Final Report
- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework
- 2019/20 Forward Plan
- Meeting effectiveness

Assurance/lack of assurance obtained

- Page turn of the draft Annual Report and Accounts including the Annual Governance Statement. Several challenges and amendments made but overall the Committee was assured on that the document met with the guidance. The Committee would receive the final audited version for approval at the 23 May meeting
- Significant assurance received on the Going Concern statement, external assurance was given by Grant Thornton
- Significant assurance on robust process carried out in line with good governance practise on Year-End Effectiveness Reports from Board Committees.

- Significant assurance on follow up of actions arising from internal audit and external audit recommendations

- Assurance on External Audit Plan 2019/20 and progress of audit. Grant Thornton stated that there were no significant events to bring to the attention of the Committee.

- The Informing the Audit Risk Assessment was compliant with the Audit Committees understanding.

- Full assurance on Internal Audit Progress Report and on the three final 'significant assurance' reports. Relating to pay controls, next year the internal Auditor will provide benchmarking around the 3rd party.

- 360 Assurance's Draft 2018/19 Head of Internal Audit Opinion indicated significant assurance and assurance was received around the split opinion.

Key risks identified

- No identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework

Decisions made

- Agreed second draft of the 2018/19 Annual Governance Statement

- Confirmed there is sufficient confidence to assess the organisation as a Going Concern and agreed that the financial statements should be prepared on that basis

- Agreed the addition to all Board Committee terms of reference relating to Speaking Up and agreed the addition to all Board Committee objectives for 2019/20 relating to equality, diversity and inclusion

- Agreed that a summary of the year end effectiveness report of Board Committees should be presented to the Trust Board along with updated terms of reference

Escalations to Board or other Committee

- ToR of Board Committees and summary of year end effectiveness

Committee Chair: Geoff Lewins **Non-Executive Director**	**Executive Lead: Justine Fitzjohn** **Trust Secretary**

2019-20 Board Annual Forward Plan

Exec Lead	Item	2 Apr 19	7 May 19	2 Jun 19	2 Jul 19	3 Sep 19	1 Oct 19	5 Nov 19	3 Dec 19	4 Feb 20	3 Mar 20
	Paper deadline	26 Mar	29 Apr	28 May	24 Jun	27 Aug	23 Sep	28 Oct	25 Nov	27 Jan	24 Feb
Trust Sec	Declaration of Interests	X	X	X	X	X	X	X	X	X	X
CG	Patient Story	X	X	X	X	X	X	X	X	X	X
CM	Minutes/Matters arising/Action Matrix	X	X	X	X	X	X	X	X	X	X
CM	Board Forward Plan (for information)	X	X	X	X	X	X	X	X	X	X
CM	Board review of effectiveness of meeting	X	X	X	X	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE											
CM	Chair's Update	X	X	X	X	X	X	X	X	X	X
IM	Chief Executive's Update	X	X	X	X	X	X	X	X	X	X
MP/CW	NHSI Annual Plan - timing to be confirmed							X			
AR	Staff Survey Results										X
AR	Equality Delivery System2 (EDS2)							X			
AR	Workforce Race Equality Standard (WRES)				X						
AR	Workforce Disability Equality Standard (WDES)				X						
AR	Workforce Standards Formal Submission									X	
AR	Gender Pay Gap Report										X
AR	Public Sector Duty Annual Report									X	
AR	Pulse Check Results and Staff Survey Plan					X					
AR	Flu Campaign for 2019/20							X			X
AR	Workforce Plan			X							
Trust Sec	NHS Improvement Year-End Self-Certification		X								
Trust Sec	Year-End Governance Reporting from Board Committees and approval of ToRs		X								
Trust Sec	Corporate Governance Framework							X			
Trust Sec	Trust Sealings (six monthly)	X					X				
Trust Sec	Annual Review of Register of Interests	X									
Trust Sec	Board Assurance Framework Update	X		X		X		X		X	
Trust Sec	Freedom to Speak Up Guardian Report (six monthly)				X						X
Trust Sec	Fit and Proper Person Declaration		X								

Exec Lead	Item	2 Apr 19	7 May 19	2 Jun 19	2 Jul 19	3 Sep 19	1 Oct 19	5 Nov 19	3 Dec 19	4 Feb 20	3 Mar 20
Trust Sec	Board Effectiveness Survey Report Policy for Engagement between the Board and COG	X							X		
Trust Sec	Report from Council of Governors Meeting (for information)	X		X		X	X		X	X	
Committee Chairs	Board Committee Assurance Summaries (following every meeting) - Audit & Risk Committee - Finance & Performance Committee - Mental Health Act Committee - - Quality Committee - People & Culture Committee - Safeguarding Committee	X	X	X	X	X	X	X	X	X	x
MP	Emergency Planning Report (EPPR)							X			
GH	Business Plan Monitoring close down of 2018/19 (May) Proposal for 2020/21 (June)		X	X				X			
GH	Trust Strategy Review		X								
OPERATIONAL PERFORMANCE											
CG/CW/AR/ MP	Integrated performance and activity report to include Finance, Workforce, performance and Quality Dashboard		X	X	X	X	X	X	X	X	X
CG/JS/AR/ MP	Workforce Standards Formal Submission/Safer Staffing										X
QUALITY GOVERNANCE											
CG/CW/MP/ GH/JS/AR	Quality Report - focus on CQC domains		Responsive MP	Caring CG	Use of Resources CW	Safety JS	Quality & Strategy GH	Well-led CQC & NHSI Trust Sec	Effective CG AR		
JS	Learning from Deaths Mortality report (quarterly publication of specified information on death) Apr/Jul/Oct/Feb/Apr	X			X		X			X	
JS	Guardian of Safe Working Report			X							
CG/JS	Safeguarding Children & Adults at Risk Annual Report					X					
JS	NHSE Return on Medical Appraisals sign off					X					
CG	Control of Infection Report				A						
JS	Re-validation of Doctors				A						
CG	Annual Review of Recovery Outcomes								X		
CG	Treat Me Well Campaign Update				X						
CG	Annual Looked After Children Report							X			
CG	Outcome of Patient Stories					X					

Derbyshire Healthcare NHS Foundation Trust

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST TERMS

NHS Term / Abbreviation	Terms in Full
A	
A&E	Accident & Emergency
ACCT	Assessment, Care in Custody & Teamwork
ACE	Adverse Childhood Experiences
ACP	Accountable Care Partnership
ACS	Accountable Care System (now known as ICS)
ADHD	Attention Deficit Hyperactivity Disorder
AfC	Agenda for Change
AHP	Allied Health Professional
ALB	Arms-length body such as NHS Improvement (NHSI) and NHS England (NHSE)
AMHP	Approved Mental Health Professional
ASD	Autism Spectrum Disorder
ASM	Area Service Manager
B	
BAF	Board Assurance Framework
BMA	British Medical Association
BAME	Black, Asian & Minority Ethnic group
C	
CAMHS	Child and Adolescent Mental Health Services
CASSH	Care & Support Specialised Housing
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CCT	Community Care Team
CDMI	Clinical Digital Maturity Index
CEO	Chief Executive Officer
CGA	Comprehensive Geriatric Assessment
CIP	Cost Improvement Programme
CMDG	Contract Management Delivery Group
CMHT	Community Mental Health Team
CNST	Clinical Negligence Scheme for Trusts
COAT	Clinical Operational Assurance Team
COF	Commissioning Outcomes Framework
COG	Council of Governors
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPR	Child Protection Register
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQUIN	Commissioning for Quality Innovation
CRB	Criminal Records Bureau
CRG	Clinical Reference Group
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST TERMS	
NHS Term / Abbreviation	**Terms in Full**
CTO	Community Treatment Order
CTR	Care and Treatment Review
D	
DAT	Drug Action Team
DBS	Disclosure and Barring Service
DfE	Department for Education
DHCFT	Derbyshire Healthcare NHS Foundation Trust
DIT	Dynamic Interpersonal Therapy
DNA	Did Not Attend
DH	Department of Health
DoLS	Deprivation of Liberty Safeguards
DPA	Data Protection Act
DRRT	Dementia Rapid Response Team
DTOC	Delayed Transfer of Care
DVA	Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action)
DWP	Department for Work and Pensions
E	
ECT	Enhanced Care Team
ECW	Enhanced Care Ward
ED	Emergency Department
EDS2	Equality Delivery System 2
EHIC	European Health Insurance Card
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising & Reprocessing Therapy
EMR	Electronic Medical Record
EPR	Electronic Patient Record
ERIC	Estates Return Information Collection
ESR	Electronic Staff Record
EWTD	European Working Time Directive
F	
FBC	Full Business Case
FOI	Freedom of Information
FFT	Friends and Family Test
FSR	Full Service Record
FT	Foundation Trust
FTN	Foundation Trust Network
F&P	Finance and Performance
5YFV	Five Year Forward View
G	
GDPR	General Data Protection Regulation
GGI	Good Governance Institute
GMC	General Medical Council

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST TERMS	
NHS Term / Abbreviation	**Terms in Full**
GP	General Practitioner
GPFV	General Practice Forward View
H	
HEE	Health Education England
HES	Hospital Episode Statistics
HoNOS	Health of the Nation Outcome Scores
HSCIC	Health & Social Care Information Centre
HSE	Health and Safety Executive
HWB	Health and Wellbeing Board
I	
IAPT	Improving Access to Psychological Therapies
ICS	Integrated Care System (formerly ACS)
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDVAs	Independent Domestic Violence Advisors
IG	Information Governance
IM&T	Information Management and Technology
IPP	Imprisonment for Public Protection
IPR	Individual Performance Review
IPT	Interpersonal Psychotherapy
J	
JNCC	Joint Negotiating Consultative Committee
JTAI	Joint Targeted Area Inspections
JUCB	Joined Up Care Board
JUCD	Joined Up Care Derbyshire
K	
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework
L	
LA	Local Authority
LCFS	Local Counter Fraud Specialist
LD	Learning Disablities
LHP	Local Health Plan
LHWB	Local Health and Wellbeing Board
LOS	Length of Stay
M	
MARS	Mutually Agreed Resignation Scheme
MAU	Medical Assessment Unit
MAS	Memory Assessment Service
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST TERMS	
NHS Term / Abbreviation	**Terms in Full**
	from the statutory and voluntary sectors.
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MDA	Medical Device Alert
MDM	Multi-Disciplinary Meeting
MDT	Multi-Disciplinary Team
MFF	Market Forces Factor
MHA	Mental Health Act
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard
MHRT	Mental Health Review Tribunal
MSC	Medical Staff Committee
N	
NCRS	National Cancer Registration Service
NED	Non-Executive Director
NICE	National Institute for Health and Care Excellence
NHS	National Health Service
NHSI	National Health Service Improvement
O	
OBC	Outline Business Case
ODG	Operational Delivery Group
OP	Out Patient
OSC	Overview and Scrutiny Committee
P	
PAB	Programme Assurance Board
PAG	Programme Advisory Group
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PHE	Public Health England
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PLIC	Patient Level Information Costs
PMLD	Profound and Multiple Disability
PPT	Partnership and Pathway Team
PREM	Patient Reported Experience Measure
PROMS	Patient Reported Outcome Measure
Q	
QAG	Quality Assurance Group
QC	Quality Committee
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
R	

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST TERMS	
NHS Term / Abbreviation	**Terms in Full**
RAID	Rapid Assessment, Interface and Discharge
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
RTT	Referral to Treatment
S	
SAAF	Safeguarding Adults Assurance Framework
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SEND	Special Educational Needs and Disabilities
SI	Serious Incidents
SLA	Service Level Agreement
SLR	Service Line Reporting
SOC	Strategic Options Case
SOF	Single Operating Framework
SPOA	Single Point of Access
SPOE	Single Point of Entry
SPOR	Single Point of Referral
STEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Partnership
S(U)I	Serious (Untoward) Incident
T	
TARN	Trauma Audit and Research Network
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TMT	Trust Management Team
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
TMAC	Trust Medical Advisory Committee
W	
WTE	Whole Time Equivalent