Derbyshire Healthcare
NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust
Board of Directors Meeting

The Post Mill Centre, Market Street, South Normanton, Alfreton, Derbyshire DE55 2EJ
4 June 2019 09:30 - 4 June 2019 12:30

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Derbyshire Healthcare
NHS Foundation Trust

NOTICE OF PUBLIC BOARD MEETING – TUESDAY 4 JUNE 2019
TO COMMENCE AT 9:30am at
The Post Mill Centre, Market Street, South Normanton, Alfreton. Derbyshire DE55 2EJ

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks, apologies and Register of Interests	Caroline Maley
2.	9:35	Patient Story	Carolyn Green
3.	10:00	Minutes of Board of Directors meeting held on 7 May 2019	Caroline Maley
4.		Matters arising – Actions Matrix	Caroline Maley
5.		Questions from governors or members of the public	Caroline Maley
6.	10:05	Chair's Update	Caroline Maley
7.	10:15	Chief Executive's Update	Ifti Majid
OPERATIONAL PERFORMANCE, QUALITY, STRATEGY AND GOVERNANCE			
8.	10:30	Integrated Performance and Activity Report	C Wright/A Rawlings/ C Green/M Powell
9.	10:50	Quality Report to focus on CQC essential standard of Caring	Carolyn Green
11:00 B R E A K			
10.	11:15	Derbyshire Joined up Care System Risk Share Agreement	Claire Wright
11.	11:25	Guardian of Safe Working Report	John Sykes
12.	11:35	Business Plan Proposal for 2020/21	Gareth Harry
13.	11:45	Fit and Proper Person Declaration	Caroline Maley
14.	12:55	Workforce Development Delivery Plan 2019/20	Amanda Rawlings
15.	12:05	Board Assurance Framework Second Issue for 2019/20	Justine Fitzjohn
16.	12:15	Board Committee Assurance Summaries and Escalations: Safeguarding Committee 14 May, Quality Committee 14 May, Finance & Performance Committee 21 May, Audit & Risk Committee 23 May 2019 *(minutes of these meetings are available upon request)*	Committee Chairs
CLOSING MATTERS			
17.	12:30	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Forward Plan for 2019/20 - Meeting effectiveness	Caroline Maley
FOR INFORMATION			
Summary of Council of Governors Meeting held 7 May 2019			
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 2 July 2019 in
Conference Rooms A & B, Centre for Research and Development, Kingsway, Derby DE22 3LZ
Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.
Participation in meetings is at the 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
NHS Foundation Trust

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) is Hospital Director, The Priory Group	(e) (a, e)
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 connection 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 7 May 2019

MEETING HELD IN PUBLIC

Commenced: 9.30am Closed: 12:15pm

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
	Justine Fitzjohn	Incoming Trust Secretary
	Sue Turner	Board Secretary (minutes)
	Louise Haywood	MASH Health Advisor
VISITORS	John Morrissey	Lead Governor and Public Governor, Amber Valley
	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
	Rosemary Farkas	Public Governor, Surrounding Areas
	Christine Williamson	Public Governor, Derby City West
	Bob MacDonald	Public Governor, Derby City East
	April Saunders	Staff Governor, Allied Professions
	Al Munnien	Staff Governor, Nursing

DHCFT 2019/057	**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 Louise Haywood, Multi-Agency Safeguarding Hub Health Advisor, who attended the meeting to shadow Chief Executive, Ifti Majid. No declarations of interest in agenda items were raised. The 2019/20 Declarations of Interest Register was noted. Ifti Majid advised that the interest he had disclosed on behalf of his wife should be amended to show that she is now a Hospital Director for the Priory Group. **ACTION: 2019/20 Declarations of Interest Register to be corrected in respect of interest relating to the spouse of the CEO**
DHCFT 2019/058	**MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 2 APRIL 2019** The minutes of the previous meeting, held on 2 April 2019, were accepted as a correct record of the meeting.
DHCFT 2018/059	**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 2019/060	**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 2019/061	**CHAIR'S UPDATE** This report provided the Board with the Trust Chair's summary of activity undertaken since the previous Board meeting held on 2 April. Caroline reflected on her involvement in the undergraduate training induction day and the insight this gave her into the training of the Trust's workforce of the future. She also visited the Crisis Team North and was encouraged by the person centred and calm manner in which they assessed their patients. Lisa-Anne Mack, Senior Nurse on the team will shadow Caroline at the next Board meeting in June which will continue the connection between the Trust's services and the Board. Caroline also joined the BME Network for their regular meeting where she gained a good understanding of the issues that they are facing. The Board discussed and acknowledged the value of having a forum for reinforcing equality and inclusion and supported the BME Network in their aims and objectives. The Board Development Programme for 2019/20 appended to the report was referred to. Caroline was pleased that input from Board members had produced a balanced programme that will focus on the development of all Board members. Updates on system collaboration and key messages arising from the JUCD (Joined Up Care Derbyshire) Board meeting held on 18 April were also appended to the

	Chair's report and was noted. **RESOLVED: The Board of Directors noted the activities of the Trust Chair since the last meeting held on 2 April 2019**
DHCFT 2019/062	**<u>CHIEF EXECUTIVE'S UPDATE</u>** Ifti Majid's report reflected on a wider view of the Trust's operating environment and served to highlight risks that may affect the organisation. His report provided an update on national developments which included the formation of a new arms-length body called NHSX that will lead the NHS in optimising the use of digital technology to enhance productivity, efficiency and patient outcomes. Ifti highlighted the need for the Board to think about how the Trust Strategy links in with the responsibilities of NHSX as this is one of the Health Secretary's top priorities. The report also included details on the membership of the new NHS Assembly that will bring people together from across the health and care sectors to advice on delivery of the NHS Long Term Plan. From a local context Ifti referred to outcomes from the Joined up Care Derbyshire (JUCD) Board which met on 18 April and the key messages that were appended to the Chair's report. He was pleased to report that the four CCGs in Derbyshire have now completed their planned merger into a single organisation. He saw this as a positive move that will develop the new organisation known as NHS Derby and Derbyshire in its role as the strategic commissioner for Derbyshire. This was the second JUCD meeting as part of the 'system organisational development programme' which focussed on system Chairs and Non-Executive Directors (NEDs). He was pleased that NEDs Geoff Lewins and Richard Wright are involved in this programme and are committed to creating a culture in the system that enables open and transparent operating that will ensure that all NEDs in the system are kept up to date with developments within the Sustainability and Transformation Partnership (STP) which will result in increased joint reporting into Boards. The Trust's Clinical NED Anne Wright already attends one of the STP mental health work streams. To ensure the Board can be better sighted on the work streams Ifti undertook to raise at the next JUCD meeting the potential for more NEDs to attend further work stream meetings and proposed that regular reporting on the STP work streams be factored into the Board Forward Plan. Ifti drew attention to the event held by the Trust to mark the 100th anniversary of Learning Disability (LD) Nursing. He felt privileged to join colleagues in the Trust to celebrate how 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. The Staff Forum has grown in pace over the last year and has become extremely influential. This month's forum focussed on developing a compassionate culture within Team Derbyshire Healthcare. It is hoped that this new staff support model will raise awareness of staff wellbeing and develop a culture of self-compassion to support staff resilience. Director of Finance and Deputy Chief Executive, Claire Wright emphasised the importance of the Staff Forum being fully represented by all areas within the Trust. Through Ifti's visits to clinical services he has seen the pressures that are driven by increasing demand which has resulted in a lack of effective connectivity between services. He is keen to ensure that the work in developing the Trust's clinical

	strategy will link services together going forward. Deputy Trust Chair, Julia Tabreham agreed that the Trust's services need to be more connected as she had seen evidence of silo working between some service teams. Chief Operating Officer, Mark Powell informed the Board that he was looking at the success achieved by another trust with internal collaboration which will help balance internal integration of the Trust's services. The clinically led strategy work being led by Director of Business Improvement and Transformation, Gareth Harry is looking to expand partnerships as it is clear there is a real desire by teams to work more inclusively. **ACTION: The potential for NEDs to attend STP work stream meetings is to be raised at the next JUCD meeting by the Chief Executive** **ACTION: Cycle of STP work stream reporting to the Board to be captured in the forward plan to include Urgent Care, Children's Services and PLACE** **RESOLVED: The Board of Directors scrutinised the Chief Executive's update, noting the risks and actions being taken.**
DHCFT 2019/063	**<u>INTEGRATED PERFORMANCE AND ACTIVITY REPORT</u>** The Integrated Performance Report (IPR) provided the Board with an integrated overview of performance as at the end of March. The focus of the report is on workforce, finance, operational delivery and quality performance. The Trust continues to perform well against many of its key indicators with maintenance or improvements continuing across many of the Trust's services. Director of Finance and Deputy Chief Executive, Claire Wright summarised the Trust's end of year financial position. 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 the Trust's surplus to £3.8m at the end of the financial year. The main area of concern for Claire is the Cost Improvement Programme (CIP). She reported that the CIP programme for 2019/20 is under development and will require non-recurrent costs to become recurrent. Mark Powell reported that performance remains broadly the same across most key indicators. Ongoing concerns include out of area placements which have increased slightly over the last couple of months which is consistent with the national picture. The Finance and Performance Committee will receive a detailed report on the plans to improve performance in this area on 21 May. Ifti Majid expressed concern that the safeguarding workload remains high with Health Visitors and that it has caused a national shortage. Director of Nursing and Patient Experience, Carolyn Green referred to the high number of Health Visitor caseloads and proposed that the innovative use of technology will help ease the pressure on Health Visitors. The Board agreed that this should be further explored in order to reduce caseloads and increase efficiency. This will be supported through the Trust's refreshed digital strategy and will be linked in with the responsibilities of NHSX by the Information Management and Technology Team (IM&T). Director of People Services and Organisational Effectiveness, Amanda Rawlings reflected on how complex and difficult the role of the Health Visitor is and advised that she would be working to towards improving the role Health Visitors in order to improve the recruitment rate to this role.

	The Board received limited assurance due to the lack of progress made in several areas. It was noted that there are various plans of action in place that will be considered by the Quality Committee and Finance and Performance Committee as well as Board Development over the coming months. **RESOLVED: The Board of Directors** **1) Confirmed that limited assurance was obtained on current performance across the areas presented** **2) Further assurance will be provided through detailed reporting to the Quality Committee and Finance and Performance Committee**
DHCFT 2019/064	**<u>QUALITY REPORT - RESPONSIVENESS</u>** This paper presented by Mark Powell provided the Board with a focused report on 'responsiveness' as part of wider reporting relating to Care Quality Commission (CQC) domains. The report included an overview of performance in this domain and prompted a strategic discussion about the Trust's approach to service delivery, skills and staffing requirements for the future and helped identify whether further development or focus may be needed. The report also included further detail on requirements and commitments set out in the NHS Long Term Plan and recent clinical review of national access standards in areas of urgent care and community services. The Board discussed the operational delivery, skills and staffing that will be required and how performance would be measured against the national access standards. It was recognised that the NHS Long Term Plan requires the Trust to deliver a different perspective on skills requirements and with current staffing the Trust would not be able to deliver its services to the required standard. Mark Powell advised that new access standards are already being embedded in the work the Trust is doing which will demonstrate how better access can be provided to service users. He will also look at how work with voluntary services and other partners can expand the Trust's services into other arenas. Margaret Gildea reflected on the challenges contained in the report and observed that the clinical strategy work will support the work taking place on workforce planning. She considered that having an understanding of the funding the Trust would receive would help establish the level of risk that the Board would be willing to tolerate with respect to services that are not yet delivering the national 'responsiveness' requirement. The Board understood that solutions to the challenges raised in the report and the impact this will have on patient safety will be looked at in more detail by the Finance and Performance Committee on 21 May which will provide a better understanding of the new standards that the Trust will be required to achieve. **ACTION: Finance and Performance Committee to address the service delivery, skills and resources that are required to achieve the new national access standards in areas of urgent care and community services** **RESOLVED: The Board of Directors:** **1) Considered the key strategic questions set out in the Executive summary, particularly in respect of the level of risk it is willing to tolerate** **2) Agreed to progress further action through the Finance and Performance Committee**

	3) Agreed to update the 2019/20 Board Assurance Framework accordingly
DHCFT 2019/065	**<u>TRUST STRATEGY REVIEW AND UPDATE</u>** Gareth Harry presented his report and outlined the progress made in 2018/19 against the key strategic actions within the Trust Strategy for 2018-21 that was refreshed in February 2018. Progress achieved against the key priorities was noted. The Board discussed the proposed strategy refresh for 2018-22 and was pleased to see that it has been designed to make the Trust's strategic objectives more accessible and relevant through the use of building blocks that outline what is required to achieve the three simple Strategic Objectives for delivering the Trust's vision for great care, the Trust being a great place to work and the best use of money. It was recognised that this updated version takes account of the challenges of the next three years. It also reflects the progress made since the strategy was last refreshed and is cross-referenced with the organisational risks. Ifti Majid confirmed that the draft strategy had received a positive response at recent leadership development sessions and it has been used as a framework for the 2019/20 Board Assurance Framework (BAF). The programme objectives contained in the strategy will provide the Executive Leadership Team (ELT) with a clear steer on how to respond to outcomes and will be used as a response measure. It was agreed that the strategy will now go forward for consultation with the Council of Governors, the Staff Forum and other staff networks for a period of 60 days and will be finalised by August. The Board Committees will monitor and manage the risks contained in the BAF that are aligned with the new strategy. **RESOLVED: The Board of Directors:** **1) Noted the progress made against the short-term priority actions outlined in the Refreshed Trust Strategy agreed in February 2018** **2) Noted that those areas that have not seen significant progress are included as key actions within the updated Trust Strategy for 2018-22** **3) Received and discussed the updated Trust Strategy for 2018-22** **4) Agreed that this updated version will go forward for consultation and engagement with stakeholders and partners.**
DHCFT 2019/066	**<u>BUSINESS PLAN MONITORING CLOSE DOWN OF 2018/19</u>** Gareth Harry presented the Board with the Trust's Business Planning Process for 2018/19 which included a 'plan on a page' summary for each clinical division, corporate areas and clinical support services. The Board reviewed the progress against the Trust's business planning process for 2018/19 alongside a summary of the position at the end of the financial year. Business plans. Assurance was received that that where areas are not completed or meeting the trajectory for completion, these are addressed through the operational route and challenged in performance reviews through the Trust Management Team (TMT) or via escalation to ELT. It was noted that priority actions for 2019/20 are being aligned to the new, developing Trust Strategy and will be provided in detail at the June meeting.

	RESOLVED: The Board of Directors **1) Noted the content of the paper.** **2) Received significant assurance with the performance management mechanisms that have been put in place**
DHCFT 2019/067	**NHS IMPROVEMENT YEAR-END SELF-CERTIFICATION** The aim of self-certification is for the Trust to assure itself it is in compliance with NHS Provider conditions. Incoming Trust Secretary, Justine Fitzjohn presented the proposed relevant declarations to the Trust Board. The Board noted the declarations regarding its NHS provider conditions as outlined and confirmed it was satisfied that the Trust is compliant with its licence conditions was satisfied that governance systems are in place to achieve the objectives set out in the licence condition and received assurance from the feedback received from governors that they have undergone training and support to carry out their roles. Additional external assurance was noted from the work undertaken through the Deloitte Well-led assessment. **RESOLVED: The Board of Directors:** **1) Confirmed its agreement with the proposed declarations for signature by the Chair and Chief Executive** **2) Agreed to the publication of the self-declarations on the Trust's website.**
DHCFT 2019/068	**SUMMARY OF YEAR-END GOVERNANCE REPORTING FROM BOARD COMMITTEES AND APPROVAL OF TERMS OF REFERENCE** Justine Fitzjohn presented a summary of the year end reports from the Board Committees, together with a full set of the Committees' Terms of Reference (TOR). The Board was advised that on 30 April the Audit and Risk Committee had received assurance from the full year-end reports that the Committees have effectively carried out their role and responsibilities as defined by their TOR during 2018/19. The Committee recommended at the meeting that all Board Committees should include an objective for 2019/20 relating to equality, diversity and inclusion. However this objective had been included in all the Terms of Reference as a permanent objective. It was also agreed that the TOR would be updated to include a paragraph relating to Speaking Up to ensure that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. These additions were highlighted in the TORs and were duly approved by the Board. **RESOLVED: The Board of Directors:** **1) Considered and noted 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** **2) Considered and approve the revised TOR for all Board Committees as appended to the report**
DHCFT 2019/069	**BOARD COMMITTEE ASSURANCE SUMMARIES AND ESCALATIONS** Assurance summaries were received from the Board Committees and highlights were provided by the respective Non-Executive Chair.

	Quality Committee 9 April: Acting Chair, Margaret Gildea escalated to the Board the lack of progress that is being made on supervision and the need to develop alternative ideas to increase performance. The Board observed that the ability to achieve delivery outcomes is linked to the priority actions contained in the new strategy. This will measure the Trust's ability to deliver its services and meet physical healthcare standards. **People and Culture Committee 23 April:** Chair, Margaret Gildea reported that the Committee was monitoring the link between the workforce plan and integrated workforce planning. She highlighted the success of maximising opportunities through utilising the Apprenticeship Levy and was pleased to report that the Trust is developing its own apprenticeship programmes and designing bespoke training resources. The Committee had proposed operating a pilot scheme within the Trust that will ensure high quality apprenticeships and the ability to grow its own workforce. The Board supported this prospect and saw it as an opportunity to introduce much needed younger people into its workforce. **Audit and Risk Committee 30 April:** Chair, Geoff Lewins advised that the Committee had thoroughly reviewed the draft Annual Report and Accounts and the Annual Governance Statement. Significant assurance was obtained that the 2018/19 Annual Report has been prepared in line with the requirements set out in the External Auditors' benchmarking report. The Committee is due to receive the final audited version for approval at its next meeting on 23 May **RESOLVED: The Board of Directors received and noted the Board Committee Assurance Summaries**
DHCFT 2019/070	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK** It was agreed that Mark Powell and Carolyn Green will work together to include in the BAF the level of risk that the Board would be willing to tolerate with respect to services that are not yet delivering the national 'responsiveness' requirement and the impact this will have on patient safety. **ACTION: BAF to be updated to include risks associated with delivery the national responsiveness requirement**
DHCFT 2019/071	**2019/20 BOARD FORWARD PLAN** The 2019/20 forward plan was noted by the Board and would be updated as noted above in line with today's discussions.
DHCFT 2019/072	**MEETING EFFECTIVENESS** Attendees and visitors were thanked for their attendance at today's meeting. The Board considered that good debate had taken place on most items. Louise Haywood who shadowed Ifti Majid had found it reassuring that the Board had covered a number of issues that are regularly discussed by members of her team, particularly the discussion concerning Health Visitor caseloads. Louise explained that as her background is in LD nursing she was pleased to hear how LD services were discussed by the Board.

The next meeting of the Board to be held in public session will take place at 9.30am on Tuesday 4 June 2019 at The Postmill Centre, Market Street, South Normanton, Alfreton, Derbyshire DE55 2EJ.	

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - JUNE 2019			
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
7.5.2019	DHCFT 2019/057	Declarations of Interest	Sue Turner	2019/20 Declarations of Interest Register to be corrected in respect of interest relating to the spouse of the CEO	4.6.2019	Declarations of Interest Register updated in respect of entry relating to the CEO	Green
7.5.2019	DHCFT 2019/062	CEO Update	Ifti Majid	The potential for NEDs to attend STP work stream meetings is to be raised at the next JUCD meeting by the CEO	4.6.2019	CEO has sent email raising this with Paul Wood Chair of JUCD and Vikki Taylor STP Director	Amber
7.5.2019	DHCFT 2019/062	CEO Update	Ifti Majid Mark Powell	Cycle of STP work stream reporting to the Board to be captured in the forward plan to include Urgent Care, Children's Services and PLACE	4.6.2019	CEO and COO are to agree cycle of work stream reporting to the Board for inclusion in forward plan	Yellow
7.5.2019	DHCFT 2019/064	Quality Report on Responsiveness	Mark Powell Claire Wright	Finance and Performance Committee to address the service delivery, skills and resources that are required to achieve the new national access standards in areas of urgent care and community services	4.6.2019	This is on the agenda for the July meeting of the Finance and Performance Committee	Yellow
7.5.2019	DHCFT 2019/064	Issues Arising for Inclusion/Updating in the BAF	Carolyn Green Mark Powell	BAF to be updated to include risks associated with delivering the national responsiveness requirement	4.6.2019	BAF will be reviewed and updated when proposed standards are formally agreed by NHSE and NHSI	Amber

Resolved	**GREEN**	**1**	**20%**
Action Ongoing/Update Required	**AMBER**	**2**	**40%**
Action Overdue	**RED**	**0**	**0%**
Agenda item for future meeting	**YELLOW**	**2**	**40%**
		5	**100%**

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 4 June 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 7 May 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. On 21 May I visited the Kedleston Unit with Suzanne Overton-Edwards. It is good to hear that occupancy for the unit is up and in fact at capacity. Rebecca Mace, Senior Nurse on the unit demonstrated the way that best use is made of resources in delivering accommodation which meets CQC requirements, as well as being good for patients. It was also good to see the OxeHealth vital signs monitors which have just been installed.

3. On 22 May I joined Dr Sentil Mahalingham of our substance Misuse team at St Andrew's House. I was able to experience the parking challenges that our staff face there, as well as the need for investment in fans or air conditioning in the large meeting room. I attended a multi-disciplinary meeting of the alcohol team, and then joined a clinic with drug users. It was evident the positive difference that the team makes to those living with addiction, and it was good to see the positive interactions in the team meeting, with both caring and patient centred care being evidenced.

Council of Governors

4. On 14 May I met with a number of the staff governors. I plan to do this three or four times a year as a way of understanding the issues that they are picking up from their constituents, and also to engage them on any topics which I feel are important. Four of the six staff governors were able to attend the meeting and we covered a range of topics, including the Trust wellbeing offer; the new Freedom to Speak Up Guardian (and they met Tamara Howard who has just taken up the role) and the "Grab a Governor" sessions that they have been holding. I am grateful to the staff who take on this role with passion and commitment to the Trust.

5. On 22 May the Nominations and Remuneration Committee met to consider the process for the appointment of a clinical Non-Executive Director (NED) and also the extension of terms of office for three of our existing NEDs.

Recommendations will be made to the Council of Governors on 2 July. The terms of reference for the Committee have been reconsidered and should be represented to the July meeting of the Council of Governors for approval.

6. Our Lead Governor, John Morrissey, has resigned as Lead Governor after serving for some three years. He will hand over to a new lead governor in July. I would like to thank John for his support and contribution to the Council of Governors over this period. We will also be recruiting a new Deputy Lead Governor to replace Carole Riley who was not re-elected as a governor in March.

7. The next meeting of the Council of Governors will be on 2 July 2019 after the public Board meeting. The next Governance Committee takes place on 12 June.

Board of Directors

8. On 30 April I attended the Audit and Risk Committee to see an early draft of the annual report and financial statements and associated reports. It is pleasing to see again the usual high standard of preparation by so many teams in ensuring that we can deliver our reporting requirements in good time. I also met with external auditor Mark Stocks of Grant Thornton as part of the end of year processes. On 23 May I again joined the Audit and Risk Committee for the final review and approval of the annual report and accounts and signing on behalf of the Board. My thanks go out to the Finance team, the Communications team and others from the Nursing and Patient Experience team who have contributed so well to this annual process.

9. The Board met on 7 May in Derby and once again I was pleased with the attendance by governors and members of the public.

10. Board Development on 15 May addressed the following lenses of development: “strategy”, considering the clinical strategy work and also our digital readiness; “beyond our borders” with a briefing on the wider NHS strategic view from Saffron Cordery of NHS Providers; and “interpersonal” through consideration of our skills as a board and where there were gaps or opportunities to use skills differently We also completed our mandatory fire training. This was valuable time for the Board to spend considering a number of issues which are important in terms of the Trust’s priorities.

11. In May I met with Anne Wright, Geoff Lewis and Suzanne Overton-Edwards for their regular NED development meetings. 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.

12. In May I also completed the appraisal of Ifti Majid and the reports to the Remuneration and Appointments Committee will be made in June.

13. I am currently working with NHS Improvement (NHSI) on the recruitment of a new NExT Director to join us for placement for a year, starting in July, when Suzanne’s secondment comes to an end. I will be meeting a prospective candidate on 13 June who has an HR background and meets my request to host

someone from a BME background.

System Collaboration

14. I attended the JUCD (Joined Up Care Derbyshire) Board on 16 May 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 system at the end of the financial year, and looking forward to the financial gap and the savings plans that are required to close this. Importantly there was consideration given to the Risk Sharing Agreement which is on the agenda for our Board meeting this month. Whilst it may feel uncomfortable to be faced with a possible share of part of the system financial gap, we acknowledge that this is right for the system and we need to adopt a positive approach to closing the gap rather than debating how to share the residual costs. There is some exciting work being undertaken to understand from a system perspective our high users of resource, as well as more about the prevention agenda and what the local authorities can offer in terms of understanding the opportunities of working with their prevention approaches. This will be covered in more detail in the CEO report.

    Attached as Appendix 1 are the key messages noted from the meeting.

15. On 29 May I will be attending a system wide ICS (Integrated Care System) development session in Stafford.

Regulators; NHS Providers and NHS Confederation and others

16. On 1 May I attended the NHSI Chairs meeting held in Birmingham. This was the first meeting since the announcement of the Regional Director appointments of NHSI/NHSE (NHS England). We heard from Dale Bywater, the Midlands Regional Director about the way that the new structures are being set up, and also how he wants to work across the systems in his region. We also received a presentation from Aidan Fowler, National Director of Patient Safety, Crishni Waring, Chair of Northamptonshire Healthcare NHS Foundation Trust, who have been rated as outstanding as a mental health and community services trust; and from John Macdonald and Eric Morton, two chairs of Nottinghamshire trusts about the Nottinghamshire Integrated Care System.

17. On 15 May we hosted a visit by Saffron Cordery, Deputy Chief Executive of NHS Providers. We are pleased that she requested a visit to our Trust, and was able to make a good contribution to our Board Development day with a national overview of the sector. My thanks also go to teams who hosted her visits to our services to help her understanding of the work that we do.

18. Also on 15 May we were visited by Simon Stephens, CEO of NHSI/E and he met a number of staff and experts by experience from our Learning Disability Strategic Health Facilitation Team.

19. Also on 15 May, I attended with Ifti Majid a meeting of Chairs and Chief Executive Officers with Simon Stephens and Dido Harding, Chair of NHSI. It was good to hear the emphasis being placed on the workforce and making the NHS a

great place to work.

Beyond our Boundaries

20. 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. 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

Joined Up Care Derbyshire Board – 16 May 2018

Key Messages

Review of Derbyshire STP

The refresh of the Derbyshire STP has now commenced in earnest. Taking our original submission from October 2016 and applying the new directives contained within the NHS Long Term Plan, we will test out again the models of care are plans we developed for all our areas of care. Each Joined Up Care Derbyshire work stream will conduct a refresh of its plans during May and June and these will be used to refresh the overall plan, with a renewed focus on 'people' rather than patients and also factoring in the wider determinants of health, including housing, education and air quality.

The overall aim of the plan will be to ensure local people are able to:

- Have the best start in life
- Stay healthy
- Age Well
- Die Well

The summer will also see a period of significant stakeholder engagement in our planning to ensure that the public voice is heard in how we plan to improve health and care in Derbyshire.

In addition to the review, we start from the position of having a single, system financial plan, which is a huge step forward in understanding our starting position through an 'open book' approach across all partners, where the financial risk and also the planning process is shared across the system rather than separately in either the commissioner or provider organisations.

Local Health Indicators and a new Prevention Strategy

As part of the STP review, colleagues in public health have reviewed the current position regarding health indicators in Derbyshire. This work has shown again that Derbyshire has a wide variation of levels of deprivation, alongside a wide variation health outcomes for various reasons. As a City and County we are often average when compared to national statistics, but when this is reviewed at a district level we are outliers in many areas, including tobacco use, alcohol consumption and other measures. Much of our work within JUCD – incorporating both traditional health and care services and those services linked to education, housing and others – must be driven to make a difference to these outlying areas to ensure local people live longer lives, in better health.

Additionally, the JUCD prevention work stream has sets out the ambition for prevention. The vision and actions within this strategy aim to complement those of

the health and wellbeing board strategies, which have a broader focus on the wider determinants of health. These strategies are interdependent and taken together; provide a whole system approach to prevention across Derbyshire.

The 4 priorities of the prevention strategy are:

- Enabling people in Derbyshire to live healthy lives
- Building mental health, wellbeing and resilience across the life course
- Empowering the Derbyshire population to make healthy lifestyle choices
- Building strong and resilient communities where people are supported to maintain & improve their own wellbeing

Workforce

In a number of discussions during the Board meeting, the issue of workforce was a recurring theme, ensuring we have the planning in place to ensure our workforce plans are geared up to support the systems to deliver our local priorities. Setting a shared culture and supporting staff in their delivery of high quality local care is crucial and one of the main priorities of JUCD. Added to this, Sir Simon Stevens, NHS Chief Executive, visited Derbyshire on 15 May and a key theme of the discussion with staff was the importance of solving the workforce challenges we face, and ensuring our staff are supported in delivery and making the NHS a better place to work.

The national people plan is to be published shortly and the Joined Up Care Derbyshire Board agreed to spending some dedicated time to focus on organisational and system culture and what we can do to ensure Derbyshire remains an attractive place to live and to work.

Chief Executive's Report to the Public 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. NHS Improvement / England has released a guide around how we develop and nurture our next generation of leaders as set out as an expectation in the Long Term Plan.

   We as a Board recognise that at the most senior levels of healthcare organisations, leaders face increasingly complex strategic and operational problems arising from the demands of an ageing population, shortages in key workforce groups and ongoing financial constraint.

   These challenges demand:

   - Effective team-based working within and across traditional organisational and sector boundaries
   - Innovation and experimentation to find new ways of delivering care
   - Collaborative and compassionate leadership to enable health and care staff to do their best work.

   Evidence suggests that professionally diverse teams and clinicians at board level increase the likelihood of meeting these challenges. Drawing on this, the NHS Long Term Plan highlights the importance of visible senior clinical leadership in enabling and assuring the delivery of high quality care, both within organisations and in the new system architecture

   Building on clinical leadership work by professional and national NHS bodies, NHS England, NHS Improvement, NHS Leadership Academy and NHS Providers are working together to respond to the 2018 recommendations. Our particular focus is increasing the number of people with clinical backgrounds involved in strategic leadership. Traditionally, doctors and nurses have a seat at the provider board table. However, there are a host of other clinicians – allied health professionals (AHPs), pharmacists, healthcare scientists, midwives, psychologists – who also have great leadership contributions to make but, because of career structures or expectations, may be less able to find their way to strategic roles that maximise their contribution. I

think this is a key toolkit for us as a Board as we are spending time and investing resources thinking about the leadership culture we are developing. The report highlights a number of key questions in five domains that we should consider when thinking about our senior leadership and our governance approaches and given the priority we are placing on creating the right leadership culture I have included the full set below:

Building Confidence

- How are you helping build clinicians' confidence in their ability to manage and lead?
- How are you helping clinicians to gain leadership and management skills?
- How are you helping clinicians to gain 'low risk' leadership experience?
- How are you preparing clinicians as they take on new roles?
- How are you developing clinicians to develop as leaders 'on the job'?

Widening Perspectives

- How are you helping clinicians to understand the breadth of available career options?
- How is your How is your senior leadership team creating or identifying opportunities for clinicians to develop leadership careers?
- How are you supporting clinicians to network outside your organisation?

Talent management

- How are your senior leaders spotting and nurturing clinicians who show interest or ability in management and leadership?
- How are you making sure that clinicians get high quality line management?
- How are clinicians' part of your talent management and succession planning systems for leadership roles?

Practical levers

- How are you encouraging and rewarding clinicians who take on and excel in leadership roles?
- How are you helping clinicians to continue their clinical practice as they take on leadership roles?
- How are you making sure that human resources and recruitment processes aren't biased against clinicians?

Organisational Culture

- How are you creating a flexible, supportive and trusting culture?
- Who is championing the involvement of clinicians in organisational leadership?
- How are you developing teams who value professional diversity?

I think there is merit in us as a Board requesting assurance on how we as a Trust are moving forward against these key questions and I would recommend we ask our People and Culture Committee to set up a process to gain the necessary assurance.

2. As a Board we have often discussed our influence in other sectors within the NHS and the importance of ensuring people with mental health difficulties receive the appropriate treatment in different sectors. NHS England have released data looking at the identification of older patients with dementia and delirium, monitoring of appropriate assessment and prompt appropriate referral and follow up after they

leave an acute hospital. Three measures are reported:

The number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours:

- Have a diagnosis of dementia or delirium or to whom case finding is applied
- Identified as potentially having dementia or delirium and are appropriately assessed
- Where the outcome was positive or inconclusive, are referred on to specialist services.

The data finds that:

- 84.6% of patients aged 75 and over *admitted as an emergency* for more than 72 hours were initially identified or given case finding for potential dementia
- Of the patients initially identified or found as potentially having dementia, 92.6% were further appropriately assessed
- Of the patients whose outcome was positive or inconclusive, 94.0% were referred for specialist services

For us this triangulates with information we receive from our psychiatric liaison services with respect to increasing activity levels of patients admitted in to acute hospitals

Local Context

3. The Joined up Care Derbyshire (JUCD) Board met on 16 May. The formal communications following the meeting is an appendix to the Chair's report however I also think it is important to share those issues I think are particularly relevant to our Trust:

    - The JUCD STP Leadership advert for the independent system Chair which will be hosted by our Organisation closed on 28 May and formal interviews including stakeholder panels will take place week commencing 3 June.
    - Something we have noted at our Board around the importance of building system capacity and resilience to manage the cross system change programmes is now being developed within the system. All responsible Officers have been contacted to understand the needs of each workstream and plans to develop a central PMO to support the shared savings plan are well under way.
    - Really importantly we agreed that the focus of the Learning Disability workstream will broaden out to include other Long Term Plan expectations such as medication management, meaningful activity and so on rather than just the repatriation agenda under transforming care. It was confirmed that I am the SRO (Senior Responsible Owner).
    - A really valuable discussion around workforce/people and system culture and an agreement this would become a standing agenda item at JUCD Board moving forward and would require and change in emphasis of the Local Workforce Action Board (LWAB).
    - Subject to internal audit opinion of accounts three out of four organisations in Derbyshire were reporting meeting their control total in 2018/19.
    - As reported last month we now have an agreed single savings plan over the

system and the systems savings group has been formalised as the mechanism for ongoing assurance against this shared plan

- Approved the risk share agreement that we discussed in confidential Board last month with myself and Caroline Maley sharing the feedback from our Board. The agreement is on the agenda of our meeting today for formal agreement by our Board in public session.
- Importantly for our Trust the JUCD Board agreed the request by the strategic commissioner for a review of psychological services in Derbyshire. It was agreed this review would include all types of psychological interventions not just those for people with mental health difficulties (so including services for people with long term conditions such as pain management). We agreed a phased approach however and that we would start with psychological services for people of all ages with mental health difficulties excluding IAPT (Improving Access to Psychological Therapies). This would include services provided by all four provider Organisations in Derbyshire.

Within our Trust

4. On 3 May I was privileged to speak to our doctors in training and to be involved in the first ever Derbyshire Healthcare Trainee awards. We were able to use The Kingsfund report into Junior Doctor morale as a benchmark to understand more about how junior doctors were treated in our organisation. It was good to hear that from a rest perspective our trainees felt they did have opportunities for on shift rest, provision of hot food and so on. In addition they reported being well supported when they were on call and that they felt they had a good level of influence of the rotas which is a big area of concern nationally. They spoke about struggling with our electronic patient record system and its lack of intuitiveness, important because they are not with us for long enough to become very familiar. Discussing what would persuade senior trainees to take up a permanent role with us the absolute key requirement is around role flexibility to allow for those with divided interests in different speciality areas and also to support employment of those trainees who were looking to take a break between core and speciality training.

5. I was delighted to try out some innovative new equipment we are using at the Hub at the Hartington Unit. Following an innovation bid by Martin Revis who works in reception at the Hartington Unit we purchased some state of the art virtual reality equipment to support patients on the Unit in relaxation and de-escalation. The equipment provides an incredible experience that can be tailored to an individual's interest, I heard about a patient who was very interested in archery, who clearly couldn't use that pastime to relax on the unit but the VR equipment gave her the opportunity to do that. My personal experience was around being under water and being able to reach out and touch sea creatures and flora in such a realistic way – incredible! Our next stage is to see how we can make the experience more mobile to enable people who are not allowed to leave our wards a similar experience.

6. On 15 May we were delighted to welcome Simon Stevens, Chief Executive of NHS England/Improvement to our Trust accompanied by Dale Bywater, Regional Director for the East Midlands. At his request Simon met with colleagues from our Learning Disability Strategic Health Facilitation Service and Jackie, Rachel, Daniel, Adam and Debbie did a superb job in describing to Simon the role of the team and some of the challenges in supporting people with a learning disability to access health screening. It was rewarding to hear Simon reference some of the statistics our team shared with him when he was presenting to East Midlands Chairs and Chief Executives at an event later that day.

7. I have mentioned in passing to the Board previously that as part of the pillar in our people plan about supporting and developing leaders and managers, we are currently engaged in rolling out a series of group conversations with all of our leaders/managers in the Trust. These sessions are led by myself supported by Amanda and Claire and we are focussing on the culture of leadership and management we want to create within the Trust, the barriers and enablers to that development, the benefits evidence, their role and importantly the support they can expect.

   The sessions are held at different venues up and down the county with the first session being held on the 7 February. To date we have held eleven sessions and they have been attended by approximately 50% of our leaders and managers.

   Feedback has been universally positive, participants are encouraged to share their reflections on the session with me afterwards, a very small selection of comments include:

   "I just wanted to say how inspired I was by the session this morning. I felt a little taller walking away from the event"

   "The overall event was very interesting and informative and it a very good idea that it is mandatory to attend if you are Management/Leaders"

   "Thanking you Ifti for facilitating the 'leading Team Derbyshire' event this morning. A lot of what you said resonated with me and I totally agree with collaborative leadership and needing new ways of working"

"Huge thanks to you and your team presenting the forum to day. It was really interesting and hugely inspiring. Something you said about the changing face of management and leadership really resonated with me".

We are now developing our Leadership and Management Touchpoint sessions that will happen twice a year with the purpose of bringing all leaders together again to review progress, challenges and opportunities for further development.

8. Saturday 11 May was the highlight of the Trust social calendar to date with our Trust five a side football tournament. Teams from a range of clinical and support services entered the competition which was played in a great spirit with some really good skills on show (not all relevant to football perhaps!). Congratulations to the Estates Team who beat the Radbourne Unit in a thrilling final.

9. By way of a communications update this month coverage of the visits to our Trust mentioned earlier were included in local media for Derby and Derbyshire. It also then featured in the NHS Providers electronic bulletin, shared with all provider trusts.

   This last month has also seen Mental Health Awareness Week and International Nurses Day. Both events and the work done by the Trust to promote and champion these initiatives received significant coverage, particularly through social media channels.

10. During May engagement visits have continued. I have held *Ifti on the Road* engagement events at Killamarsh Clinic and Century House. I also attended the Dales North adult mental health MDT (Multi-Disciplinary Team) Meeting and the operations meeting at the Hartington Unit.

    In addition I met with two patients at the Hartington Unit who had just been discharged who were keen to share some of their experience of our services

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

    Patient feedback

    - We could perhaps focus more on healthy food options and how much patients are encouraged to drink water when on the wards
    - The importance of engendering hope when talking to people who were

admitted on our wards
- Privacy and dignity, single sex ward areas great but need to think about male staff entering female areas at night
- Getting fresh air and exercise when an inpatient

On the Road feedback
- The impact in morale of person centred leadership
- Psychological therapies for older adults – are we discriminating?
- Dementia rapid response teams and the positive impact being seen in community teams
- Consultant vacancies causing pressures related to access times and the pressure this can then put on colleagues having difficult conversations with families

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, people who use our services 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 use of innovative equipment such as VR detailed above provides a great opportunity to support access to interventions to a much wider more inclusive group of individuals.

As part of our leading Team Derbyshire Healthcare events we have a strong focus on inclusion and the leadership responsibility in creating a culture that actively seeks out difference. We share up to date data where it exists as an aid to helping leaders and managers understand the impact decisions they make have.

The feedback from patients I reference in my report challenges our thinking about how for the right reasons we sometimes can exacerbate a sense of exclusion and this is something we are working on as part of our ongoing acute care improvement work.

When I was at Killamarsh clinic I had some really interesting conversations about older adult access to therapies and was it discriminating that this was not as available as it was to younger adults. This is a challenge we need to address through some of our clinically led strategy work.

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 – 4 June 2019

Integrated Performance Report (IPR) 2019/20 - Month 1

Purpose of Report

This paper provides the Board of Directors with an integrated overview of performance at the end of April 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.

There are a number of challenging areas where performance is persistently below the required standard in the month. 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

The report also includes Trust benchmarking information for the recording of service user and patient ethnicity and Care Programme Approach (CPA) reviews to give Board members further information to help inform decisions about how the Trust is performing compared to others.

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	2.87%	2.36%	G	→		
			Forecast	2.87%	2.80%	G	→		
		NHS I Segment	YTD		2		→		
Quality and Operations	KPIs	CPA 7 Day Follow-up (M)	Apr, 2019	95.00%	95.00%	G	↓		
			Mar, 2019		98.36%	G			
		Data Quality Maturity Index (DQMI) - MHSDS Data Score (Q)	Apr, 2019	95.00%	96.50%	G	→		
			Mar, 2019		96.52%	G			
		IAPT RTT within 18 weeks (Q)	Apr, 2019	95.00%	100.00%	G	→		
			Mar, 2019		100.00%	G			
		IAPT RTT within 6 weeks (Q)	Apr, 2019	75.00%	96.97%	G	→		
			Mar, 2019		96.71%	G			
		Early Intervention in Psychosis RTT Within 14 Days - Complete (Q)	Apr, 2019	56.00%	79.17%	G	↓		
			Mar, 2019		100.00%	G			
		Early Intervention in Psychosis RTT Within 14 Days - Incomplete (Q)	Apr, 2019	56.00%	93.75%	G	↑		
			Mar, 2019		92.31%	G			
		Patients Open to Trust In Employment (M)	Apr, 2019		10.06%	G	→		
			Mar, 2019		10.22%	G			
		Patients Open to Trust In Settled Accommodation (M)	Apr, 2019		58.78%	G	→		
			Mar, 2019		59.57%	G			
		Under 16 Admissions To Adult Inpatient Facilities (M)	Apr, 2019	0	0	G	→		
			Mar, 2019		0	G			
		IAPT People Completing Treatment Who Move To Recovery (Q)	Apr, 2019	50.00%	53.81%	G	↓		
			Mar, 2019		55.41%	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)	Apr, 2019		23		↑		
			Mar, 2019		21				
		Out of Area - Number of Patients PICU (M)	Apr, 2019		31		↑		
			Mar, 2019		27				
		Out of Area - Average Per Day Non PICU (M)	Apr, 2019		12.3		↑		
			Mar, 2019		9.7				
		Out of Area - Average Per Day PICU (M)	Apr, 2019		15.1		↓		
			Mar, 2019		15.3				
		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)	Apr, 2019	0	0	G	→		
			Mar, 2019		0	G			
		Patient Safety Alerts not completed by deadline (M)	Apr, 2019		1		→		
			Mar, 2019		1				
		CQC community mental health survey (A)	1905		6.9/10		↑		
			2017		7.3/10				
		Mental health scores from Friends and Family Test – % positive (M)	Apr, 2019	81%	96%	G	↓		
			Mar, 2019		97%	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)	Apr, 2019	10.00%	10.32%	G	↑		
			Mar, 2019		10.31%	G			
		Sickness Absence (monthly)	Apr, 2019	5.00%	6.52%	R	↓		
			Mar, 2019		6.11%	R			
		Sickness Absence (annual)	Apr, 2019	5.00%	5.99%	R	↑		
			Mar, 2019		5.90%	R			
		Vacancies (funded fte)	Apr, 2019		10.15%		↑		
			Mar, 2019		8.87%				
		Appraisals All Staff (number of employees who have received an appraisal in the previous 12 months)	Apr, 2019	90.00%	74.43%	R	↓		
			Mar, 2019		75.30%	R			
		Medical Appraisals (number of medical employees who have received an appraisal in the previous 12 months)	Apr, 2019	90.00%	98.00%	G	↑		
			Mar, 2019		85.00%	A			
		Compulsory Training (staff in-date)	Apr, 2019	85.00%	85.48%	G	↓		
			Mar, 2019		85.59%	G			
		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 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 £34k at the end of April. This generates '1' on this metric within the finance score. The agency expenditure is forecast to be below the ceiling at the end of the financial year by £17k. The forecast also includes a level contingency spend for any unforeseen agency posts.

The agency expenditure equates 2.4% of the pay budgets at the end of April and 2.8% at the end of the financial year. 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 April increased slightly to an average of around 12 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 has been prepared for Trust Management Team and commissioners which includes an overarching programme of work for eliminating out of area placements and a work plan reflecting key deliverables for the next 2 years.

This programme of work includes 5 specific projects;

- Development of a service offer for patients diagnosed with a Personality Disorder
- Development of service offer aligned to Crisis pathway set out in the NHS Long Term plan, to include alternatives to admission and more resilient in-reach from community services
- Enhanced pharmacy provision in Community teams to support admission avoidance for specific groups of service users, including Clozaril initiation
- Operational flow including Red2Green
- Development of options for PICU provision

A detailed assurance report on the overall programme will be provided at July's Committee meeting.

In addition, the Trust is currently advertising for a senior Programme Manager to lead this programme of transformation.

1.3 People position

Improvement in attendance has slipped back this month from 6.11% in March 2019 to 6.52% in April 2019. Compared to the previous month long term sickness absence has increased by 0.15% and short term sickness absence has increased by 0.25%**.**

A focussed level of support is now in place to scrutinise long term cases in inpatient areas particularly and how these can be moved forwards and resolved with either return to work or options for redeployment or termination of employment if this is appropriate.

The Leadership Development programme is now delivering "Managing Health and Attendance" to support all line managers, this course is mandatory and sessions are available throughout 2019.

Compulsory training compliance has also dipped with a compliance rate of 85.48% from 85.59% in March 2019. Recruitment into the Workforce Development team will address the trainer's capacity which in turn should help to increase compliance levels where courses have been cancelled. We are also looking at solutions to increase attendance at face to face training and how staff can be released particularly in inpatient areas.

Appraisal completion has fallen again this month at 74.43% from 75.30% in March 2019. Appraisal training is now being delivered to managers and completion rates should increase. Again there is a focus on

inpatient areas where staff need to have time to meet with their line manager and have a quality conversation. This is also a mandatory course module, 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 10.15% which is an increase from March 2019 at 8.87%.

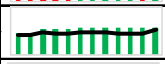
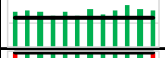
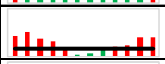
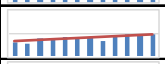
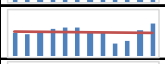
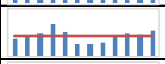
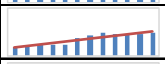
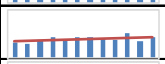
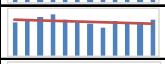
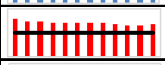
Recruitment activity across the Trust continues to move at a fast pace and remains a key focus for inpatient areas in particular. During April 2019, 30 employees left the Trust which included 7 retirements (the average number of retirements each month is 6).

- Annual Turnover KPI	10.4%	- Appraisal Completion KPI	74%
- Corporate Services	7.5%	- Corporate Services	71%
Business Improvement + Transformation	25.0%	Business Improvement + Transformation	14%
Corporate Central	13.0%	Corporate Central	86%
Estates + Facilities	6.7%	Estates + Facilities	80%
Finance Services	0.0%	Finance Services	91%
Med Education & CRD	2.2%	Med Education & CRD	33%
Nursing + Quality	3.8%	Nursing + Quality	41%
- Ops Support	12.4%	- Ops Support	88%
IT, Information Management + Patient Records	10.0%	IT, Information Management + Patient Records	98%
Ops Management	16.7%	Ops Management	50%
Pharmacy	14.3%	Pharmacy	82%
- Operational Services	10.9%	- Operational Services	75%
Campus	9.8%	Campus	74%
Central Services	11.6%	Central Services	73%
Children's Services	17.2%	Children's Services	76%
Clinical Serv Management	3.1%	Clinical Serv Management	84%
Complex Care	0.0%	Complex Care	25%
Neighbourhood	8.0%	Neighbourhood	76%

- Bank Usage KPI	6.2%	- Agency Usage KPI	0.9%
- Corporate Services	2.1%	- Corporate Services	0.8%
Business Improvement + Transformation	0.0%	Business Improvement + Transformation	0.0%
Corporate Central	0.0%	Corporate Central	3.3%
Estates + Facilities	2.9%	Estates + Facilities	1.7%
Finance Services	0.0%	Finance Services	0.0%
Med Education & CRD	0.0%	Med Education & CRD	0.0%
Nursing + Quality	2.8%	Nursing + Quality	0.0%
- Ops Support	1.4%	- Ops Support	0.0%
IT, Information Management + Patient Records	0.0%	IT, Information Management + Patient Records	0.0%
Ops Management	0.0%	Ops Management	0.0%
Pharmacy	3.2%	Pharmacy	0.0%
- Operational Services	7.1%	- Operational Services	0.9%
Campus	16.2%	Campus	0.8%
Central Services	2.2%	Central Services	0.0%
Children's Services	2.0%	Children's Services	1.0%
Clinical Serv Management	0.0%	Clinical Serv Management	0.0%
Complex Care	0.0%	Complex Care	7.9%
Neighbourhood	1.6%	Neighbourhood	1.5%

- Sickness Absence KPI	6.5%	- Compulsory Training KPI	85%
- Corporate Services	5.0%	- Corporate Services	87%
Business Improvement + Transformation	0.8%	Business Improvement + Transformation	85%
Corporate Central	0.9%	Corporate Central	78%
Estates + Facilities	7.4%	Estates + Facilities	86%
Finance Services	9.7%	Finance Services	97%
Med Education & CRD	1.6%	Med Education & CRD	79%
Nursing + Quality	6.5%	Nursing + Quality	85%
- Ops Support	2.8%	- Ops Support	94%
IT, Information Management + Patient Records	1.2%	IT, Information Management + Patient Records	99%
Ops Management	12.8%	Ops Management	87%
Pharmacy	1.9%	Pharmacy	89%
- Operational Services	6.8%	- Operational Services	85%
Campus	7.9%	Campus	84%
Central Services	5.8%	Central Services	88%
Children's Services	6.4%	Children's Services	83%
Clinical Serv Management	8.5%	Clinical Serv Management	77%
Neighbourhood	6.3%	Neighbourhood	87%

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	204	155	R			
		Forecast	1400	1400	G			
	CIP achievement £m	YTD	0.461	0.335	R			
		Forecast	4.598	4.598	G			
		Recurrent	4.598	2.538	R			
	Agency £m	YTD	0.253	0.219	G	↓		
		Forecast	3.030	3.013	G			
	Cash £m	YTD	25.408	27.394	G	↓		
		Forecast	25.728	27.158	G	↓		
Quality and Operations Scorecard	RTT Incomplete Within 18 Weeks (%)	Apr, 2019	92%	94.9%	G	→		
		Mar, 2019		95.7%	G			
	CPA Review in last 12 Months (on CPA > 12 Months)	Apr, 2019	95%	93.9%	R	↓		
		Mar, 2019		95.4%	G			
	Delayed Transfers of Care (%)	Apr, 2019	0.8%	2.02%	R	→		
		Mar, 2019		2.02%	R			
	North Neighbourhood Average Wait (weeks)	Apr, 2019		8.0		↑		
		Mar, 2019		7.5				
	North Neighbourhood Current Waits (number)	Apr, 2019		1737		↓		
		Mar, 2019		1785				
	City Neighbourhood Average Wait (weeks)	Apr, 2019		8.6		↑		
		Mar, 2019		8.3				
	City Neighbourhood Current Waits (number)	Apr, 2019		1466		↑		
		Mar, 2019		1461				
	South Neighbourhood Average Wait (weeks)	Apr, 2019		8.5		↓		
		Mar, 2019		8.7				
	South Neighbourhood Current Waits (number)	Apr, 2019		1842		↑		
		Mar, 2019		1781				
	CAMHS Average Wait (weeks)	Apr, 2019		10.7		↑		
		Mar, 2019		9.2				
	CAMHS Current Waits (number)	Apr, 2019		941		↑		
		Mar, 2019		873				
	Community Paediatrics Average Wait (weeks)	Apr, 2019		20.4		↑		
		Mar, 2019		16.9				
	Community Paediatrics Current Waits (number)	Apr, 2019		872		↓		
		Mar, 2019		884				
	Number of Adult Acute Inpatients (Hartington and Radbourne) LoS > 50 Days	Apr, 2019		74		↑		
		Mar, 2019		70				
	Health Visiting 0-19 Caseload (based on 50.8 WTE)	Apr, 2019	250	328	R	↑		
		Mar, 2019		327	R			
	Distinct LD Caseload	Apr, 2019		1052		↓		
		Mar, 2019		1062				
	Distinct Substance Misuse Caseload	Apr, 2019		5546		↑		
		Mar, 2019		5433				
	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 Control Total

At the end of April the surplus is behind plan by £49k with the forecast assuming delivery of the control total surplus of £1.4m. The Trust has resubmitted its financial plan on 15 May as requested by NHS Improvement in light of additional income to fund Agenda for Change cost pressures. The control total surplus has increased to £1.8m.

2.2 Cost Improvement Programme (CIP)

As per the plan submission there are identified schemes for £4.1m against a target of £4.6m, leaving an unidentified gap of £478k. This remains the case as at month 1.

During month 1 CIP has been transacted in the ledger totalling £3.4m for the full year, leaving a balance in the ledger of £1.16m. The forecast assumes that the identified schemes will deliver and that the current gap of £0.5m will be closed.

2.3 CPA Reviews

From the most recently published data (see 3.2) we can see that nationally many Trusts are also finding this standard challenging to achieve. It is expected that performance will return above 95%.

2.4 Delayed Transfers of Care

Currently there are 3 patients whose discharges are being delayed. All 3 patients have been escalated to ensure that their discharge is progressed as quickly as possible. We continue to work with relevant partners to address and minimise delays to avoid unnecessary waits in beds.

2.5 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.

2.6 CAMHS (Child and Adolescent Mental Health Service) Waiting List

A planned review of CAMHS was commenced by the CCG but placed on hold. We await their engagement to commence this process again. Meanwhile, we have submitted an investment proposal as requested by the CCG to add resource to the CAMHS supported care service. We await a decision on this. A weekly trajectory has been devised to monitor progress to reduce the external waits for first assessment.

CAMHS ASIST is currently offering 20 assessments per week to manage the external referrals. This has increased to circa 27 assessments per week from May 2019 which we anticipate will have a positive impact on the waiting list. Staff wellbeing and workload is an important consideration here and is being monitored by local management. Internal waits for therapy such as CBT (Cognitive Behavioural Therapy) have improved, however pressure remains in the neurodevelopmental assessment and support services in CAMHS. Any investment will help supplement this. Waiting well standards are being developed for CAMHS.

Finance and Performance Committee will receive a detailed report setting out the actions that are being taken to address this risk. This report will be provided at the July meeting.

2.7 Paediatric Waiting List

Finance and Performance Committee received a report and associated action plan on the current waiting time challenges within the Community Paediatric service.

The report provided an overview of current challenges, the actions being undertaken to address these issues and ongoing residual risks that the Committee need to be aware of.

The action plan was discussed in some detail, along with the ongoing residual risks of providing a Consultant led service when it is difficult to recruit Paediatricians. It was agreed that an update on the delivery of the action plan would be provided in 6 months.

In addition, the Trust has written again to the CCG to ask for a joint working group to be set up to discuss and agree the service specification for this service as this has not been updated for as number of years. This is a key action to help understand, and resolve, the continued rise in demand for this service.

2.8 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 is being explored with commissioners. Recruitment to vacancies is underway, and confirmation of 3 Health Visitor training places, commencing in September 2019, has recently been received and recruitment for trainees is also underway.

Quality Committee will receive a detailed report setting out the actions that are being taken to address this risk. This report will be provided at the July meeting.

3. Benchmarking

3.1 Ethnicity recording (MHS-DQM05 ethnic category code)

Reporting Period	Provider	DQ Result	DQ Number of Records	Valid %
Jan-19	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	Valid	30	100
Jan-19	SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	Valid	2605	98
Jan-19	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	Valid	25	96
Jan-19	NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	Valid	35075	95
Jan-19	NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	Valid	3565	95
Jan-19	TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	Valid	55210	94
Jan-19	ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	Valid	30555	94
Jan-19	BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	Valid	35995	93
Jan-19	WEST LONDON NHS TRUST	Valid	17765	93
Jan-19	CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	Valid	27685	92
Jan-19	SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST	Valid	18860	92
Jan-19	BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	Valid	18645	91
Jan-19	DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST	Valid	13890	91
Jan-19	SOMERSET PARTNERSHIP NHS FOUNDATION TRUST	Valid	10075	91
Jan-19	COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	Valid	35705	90
Jan-19	DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	Valid	21750	90
Jan-19	ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	Valid	2265	90
Jan-19	EAST LONDON NHS FOUNDATION TRUST	Valid	34775	89
Jan-19	NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	Valid	14260	89
Jan-19	LEEDS COMMUNITY HEALTHCARE NHS TRUST	Valid	2110	89
Jan-19	NORTH WEST BOROUGHS HEALTHCARE NHS FOUNDATION TRUST	Valid	21575	88
Jan-19	BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST	Valid	17200	88
Jan-19	GATESHEAD HEALTH NHS FOUNDATION TRUST	Valid	2075	88
Jan-19	NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	Valid	19460	87
Jan-19	LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	Valid	16035	87
Jan-19	2GETHER NHS FOUNDATION TRUST	Valid	15650	87
Jan-19	BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	Valid	12925	87
Jan-19	SHEFFIELD HEALTH & SOCIAL CARE NHS FOUNDATION TRUST	Valid	11790	87
Jan-19	CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	Valid	11490	87
Jan-19	WORCESTERSHIRE HEALTH AND CARE NHS TRUST	Valid	9990	87
Jan-19	UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	Valid	140	87
Jan-19	SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	Valid	27395	86
Jan-19	KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	Valid	22480	86
Jan-19	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	Valid	15235	86
Jan-19	GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST	Valid	28770	85
Jan-19	ROYAL FREE LONDON NHS FOUNDATION TRUST	Valid	925	84
Jan-19	HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	Valid	825	84
Jan-19	AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	Valid	24640	83
Jan-19	NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	Valid	22735	83
Jan-19	OXLEAS NHS FOUNDATION TRUST	Valid	17160	83
Jan-19	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	Valid	11685	83
Jan-19	CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST	Valid	10620	83
Jan-19	HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	Valid	19510	82
Jan-19	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	Valid	19500	82
Jan-19	ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST	Valid	15800	82
Jan-19	HUMBER TEACHING NHS FOUNDATION TRUST	Valid	10845	82
Jan-19	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	Valid	1335	81
Jan-19	PENNINE CARE NHS FOUNDATION TRUST	Valid	28790	80
Jan-19	CAMDEN AND ISLINGTON NHS FOUNDATION TRUST	Valid	9470	80
Jan-19	MERSEY CARE NHS FOUNDATION TRUST	Valid	25195	78
Jan-19	WHITTINGTON HEALTH NHS TRUST	Valid	1880	78
Jan-19	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	Valid	535	78
Jan-19	LANCASHIRE CARE NHS FOUNDATION TRUST	Valid	49450	76
Jan-19	DEVON PARTNERSHIP NHS TRUST	Valid	15270	76
Jan-19	SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	Valid	39755	75
Jan-19	CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	Valid	20560	75
Jan-19	NORTH EAST LONDON NHS FOUNDATION TRUST	Valid	31425	74
Jan-19	NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	Valid	21170	74
Jan-19	LEICESTERSHIRE PARTNERSHIP NHS TRUST	Valid	20875	74
Jan-19	SOUTHERN HEALTH NHS FOUNDATION TRUST	Valid	15740	74
Jan-19	OXFORD HEALTH NHS FOUNDATION TRUST	Valid	21200	73
Jan-19	SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST	Valid	22050	72
Jan-19	BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	Valid	45	71
Jan-19	TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST	Valid	12310	70
Jan-19	SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	Valid	27440	68
Jan-19	MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST	Valid	18985	68
Jan-19	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	Valid	12010	68
Jan-19	SOUTH TYNESIDE NHS FOUNDATION TRUST	Valid	1380	66
Jan-19	GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	Valid	610	66
Jan-19	HERTFORDSHIRE COMMUNITY NHS TRUST	Valid	1255	65
Jan-19	CHILDREN'S HOSPICE NHS FOUNDATION TRUST	Valid	615	64

Reporting Period	Provider	DQ Result	DQ Number of Records	Valid %
Jan-19	ISLE OF WIGHT NHS TRUST	Valid	2880	64
Jan-19	KENT COMMUNITY HEALTH NHS FOUNDATION TRUST	Valid	3520	61
Jan-19	DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST	Valid	470	58
Jan-19	NORFOLK COMMUNITY HEALTH AND CARE NHS TRUST	Valid	1555	57
Jan-19	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	Valid	650	57
Jan-19	BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	Valid	765	56
Jan-19	CAMBRIDGESHIRE COMMUNITY SERVICES NHS TRUST	Valid	2380	53
Jan-19	BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	Valid	4350	50
Jan-19	SOLENT NHS TRUST	Valid	3840	50
Jan-19	EAST LANCASHIRE HOSPITALS NHS TRUST	Valid	1415	33
Jan-19	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	Valid	1025	27

Data source – NHS Digital

3.2 CPA reviews

PERIOD	PRIMARY_LEVEL_DESCRIPTION	AMH01 - People in contact with adult mental health services at the end of RP	AMH02 - People in contact with adult mental health services on CPA at the end of RP	Proportion of patients on CPA	AMH05 - People in contact with adult mental health services on CPA for 12 months at the end of RP	AMH06 - People in contact with adult mental health services on CPA for 12 months with review at the end of RP	CPA review %
Jan-19	2GETHER NHS FOUNDATION TRUST	11690	1360	12%	905	885	98%
Jan-19	ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	2425	70	3%	40	15	38%
Jan-19	AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	22650	5840	26%	3200	3000	94%
Jan-19	BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	13550	3215	24%	2050	1990	97%
Jan-19	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	16140	1035	6%	615	505	82%
Jan-19	BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	34525	5095	15%	2980	2865	96%
Jan-19	BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	6970	680	10%	370	*	
Jan-19	BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST	12615	700	6%	700	*	
Jan-19	BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	13910	3210	23%	1870	1610	86%
Jan-19	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	7345	1535	21%	835	780	93%
Jan-19	CAMDEN AND ISLINGTON NHS FOUNDATION TRUST	10625	1970	19%	1590	1470	92%
Jan-19	CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	21200	3350	16%	2575	2385	93%
Jan-19	CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	21865	2855	13%	1925	1205	63%
Jan-19	CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	8275	3395	41%	1365	1110	81%
Jan-19	COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	26880	1810	7%	885	845	95%
Jan-19	CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST	8155	1005	12%	570	490	86%
Jan-19	DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	18735	2525	13%	1850	1745	94%
Jan-19	DEVON PARTNERSHIP NHS TRUST	15815	795	5%	555	*	
Jan-19	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	10645	2240	21%	1105	975	88%
Jan-19	DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST	9760	1375	14%	1060	*	
Jan-19	EAST LONDON NHS FOUNDATION TRUST	28455	4810	17%	2885	2780	96%
Jan-19	ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	28940	4670	16%	3045	2670	88%
Jan-19	GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST	28145	8320	30%	5860	3840	66%
Jan-19	HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	14360	2595	18%	1430	1320	92%
Jan-19	HUMBER TEACHING NHS FOUNDATION TRUST	6275	2480	40%	1450	1330	92%
Jan-19	ISLE OF WIGHT NHS TRUST	3495	480	14%	335	*	
Jan-19	KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	21235	3000	14%	1810	1615	89%
Jan-19	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	14305	2135	15%	1225	1040	85%
Jan-19	LEICESTERSHIRE PARTNERSHIP NHS TRUST	21745	1635	8%	970	510	53%
Jan-19	LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	14955	1175	8%	430	260	60%
Jan-19	MERSEY CARE NHS FOUNDATION TRUST	27730	3930	14%	2920	1105	38%
Jan-19	MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST	18955	4050	21%	2230	2080	93%
Jan-19	NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	19455	4290	22%	2310	255	11%
Jan-19	NORTH EAST LONDON NHS FOUNDATION TRUST	33640	3435	10%	2535	2370	93%
Jan-19	NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	11300	1550	14%	990	925	93%
Jan-19	NORTH WEST BOROUGHS HEALTHCARE NHS FOUNDATION TRUST	15315	2655	17%	1720	*	
Jan-19	NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	14030	1325	9%	700	555	79%
Jan-19	NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	21820	3595	16%	1750	1435	82%
Jan-19	NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	3455	75	2%	40	40	100%
Jan-19	NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	18925	1875	10%	925	890	96%
Jan-19	OXFORD HEALTH NHS FOUNDATION TRUST	13145	4780	36%	3415	1945	57%
Jan-19	OXLEAS NHS FOUNDATION TRUST	15360	2120	14%	1385	1360	98%
Jan-19	PENNINE CARE NHS FOUNDATION TRUST	22360	3455	15%	2710	2280	84%
Jan-19	ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST	13300	1905	14%	1515	885	58%
Jan-19	SHEFFIELD HEALTH & SOCIAL CARE NHS FOUNDATION TRUST	11295	1330	12%	835	695	83%
Jan-19	SOLENT NHS TRUST	3185	565	18%	335	310	93%
Jan-19	SOMERSET PARTNERSHIP NHS FOUNDATION TRUST	8740	1780	20%	665	565	85%
Jan-19	SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	30465	4880	16%	3545	2710	76%
Jan-19	SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST	15580	3145	20%	1940	1900	98%
Jan-19	SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	20540	4150	20%	2555	2410	94%
Jan-19	SOUTHERN HEALTH NHS FOUNDATION TRUST	16790	1980	12%	1050	835	80%

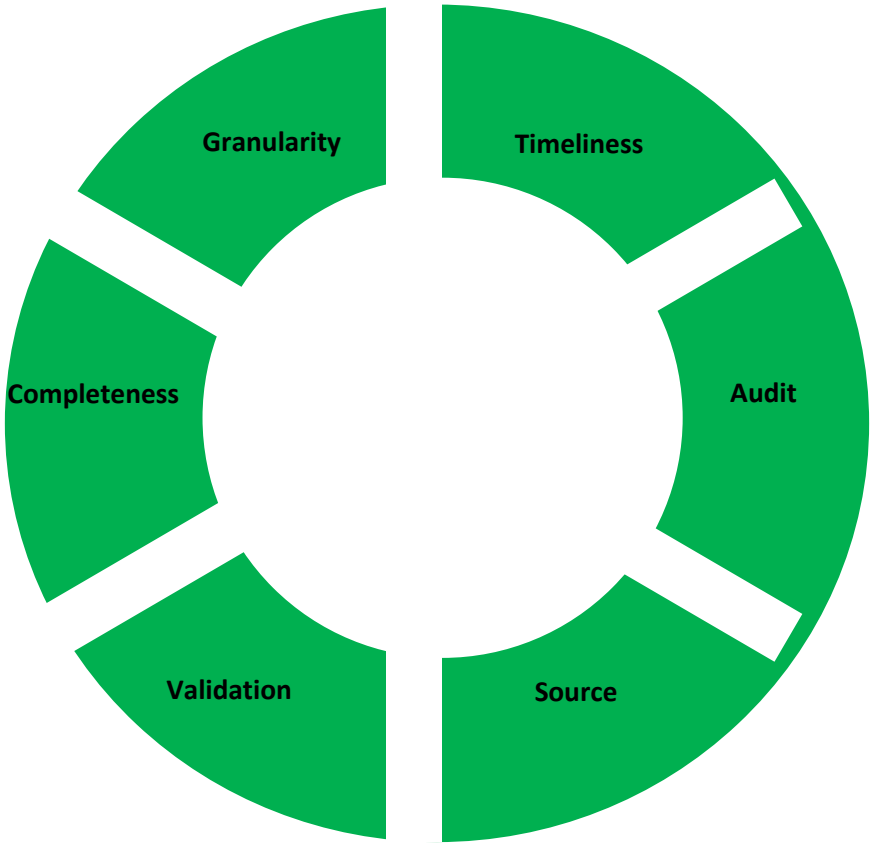
PERIOD	PRIMARY_LEVEL_DESCRIPTION	AMH01 - People in contact with adult mental health services at the end of RP	AMH02 - People in contact with adult mental health services on CPA at the end of RP	Proportion of patients on CPA	AMH05 - People in contact with adult mental health services on CPA for 12 months at the end of RP	AMH06 - People in contact with adult mental health services on CPA for 12 months with review at the end of RP	CPA review %
Jan-19	SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST	19595	2765	14%	1460	895	61%
Jan-19	SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	33465	4170	12%	2735	2320	85%
Jan-19	TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	35365	8825	25%	4675	4035	86%
Jan-19	WEST LONDON NHS TRUST	13555	2655	20%	1895	1825	96%
Jan-19	WORCESTERSHIRE HEALTH AND CARE NHS TRUST	7485	925	12%	580	560	97%

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.

Data Quality Indicator	Definition	Not yet assessed	Sufficient	Insufficient
Validation	Prior to publication, is the data subject to validation, e.g. spot checks, random sample checks, involvement of a clinician, the associated service or approval by Executive Director?	Not yet assessed	The data is validated against a secondary source. The indicator owner can assure the data is a true reflection of performance, supported by a sign off process and underlying information.	No validation has taken place. The 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 – 4 June 2019

Quality Report – 'Caring'

Purpose of Report

This paper provides the Trust Board with a focused report on 'Caring' as part of the wider expanded quality reporting relating to CQC (Care Quality Commission) domains and NHS Improvement requirements. It is written to aid strategic discussion on how best to improve our outcomes for those who use our services.

Executive Summary

Caring covers a wide range of measures. This is a summary of the areas and the Trust's current levels of performance and the future direction of travel per section.

The key lines of enquiry for caring are presented with benchmarking evidence, independent evidence from surveys or externally verified information from the CQC.

The report shows evidence that the Trust has achieved strong compliance and internal and external assurance. This is demonstrated by the retention of the Trust's wide overall 'good' rating in this area.

The Trust has reached a strong performance in benchmarking, in responsiveness and in acceptance of feedback at above the national average. This has been maintained this year and the organisation has additionally made significant headway in the Family and Friends Test Trust-wide feedback.

The Trust has achieved solid community survey benchmark information and feedback on all of its services. All community services are rated as good or outstanding in this domain. However there are significant areas of quality improvement that can be made in one inpatient setting and within the Trust's strategy relating to a new course in this area of clinical governance which is shown in the report.

New mental health model data has been developed and triangulated with other indicators provided solid performance in this area.

Since the last caring report was submitted to the Board in December 2018 the Trust's strategy has been revisited and now includes more specific focus on patient experience and the introduction of a shared governance model for patients with the Carers Forum as a mirror image to the Staff Forum which has been very well received. The draft Terms of Reference for 'Equal' forum and newly released best practice guidelines on involvement and engagement released by the Royal College of Psychiatrists are included as an addendum to this report to enable a sense check with Board colleagues on whether we are close or some distance from implementing the best practice evidence in co-production and emerging models of shared governance.

In the same manner that the Trust assessed organisational readiness for electronic records are we ready to co-pilot with our patients and carers and listen to their voice?

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 consideration of the use of caring has positive assurances which are well evidenced

The quality improvements and or quality improvement strategy areas for further growth are outlined in the paper.

Consultation

This paper has not been formally considered by other meetings, but has been shared with Executive colleagues. The content has been reviewed within the Trust's internal structure meetings.

Governance or Legal Issues

There are no other legal or governance issues impacted on by this paper other than the regulatory requirements of CQC and NHSI as described.

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 paper explores the domain of caring at a whole Trust level rather than by patient or staff groups who may have protected characteristics.

However the Board will be aware that there are known equality, diversity and inclusion issues that will adversely affect some of the measures. For example, the ability to access services and have them adapted to fit your needs will directly impact upon these groups.

The Trust is working hard to improve these factors but there is work still to do to ensure services are able to meet current or emerging national access targets.

Recommendations

The Board of Directors is requested to;

1. Consider and confirm the levels of assurance as rated by the CQC as good. Furthermore consider the current priorities for quality improvement in the domain of Caring.

2. Consider whether any additional information is to be included in the Integrated Performance Report, either regularly or periodically.

3. Confirm the level of assurance obtained on the areas presented. It is suggested that there is significant assurance.

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

Quality Report – Caring

1. Policy and regulatory context

The formal legal duties under this domain are as follows:

Caring covers a wide range of measures.

The key lines of enquiry (KLOE) for Caring are:

KLOE C1- Kindness, respect and compassion

The measures for this area are the Trust's training in equality and diversity and patient feedback on caring as per our community and in-patient survey and any questionnaires or service visits in our comprehensive inspection. In addition CQC (2018) patients and carers said "staff were compassionate, caring and kind. Staff listened and treated patients with dignity and respect. Staff knew their patients and patients gave positive feedback on the quality of care."

This correlates with the National Benchmarking information on the Trust's services, which at this time remain unchanged.

Benchmarking Network

Quality

While productivity and cost are important considerations, the safety and quality of services remains of central importance as a benchmarking theme. A wide range of quality metrics are available in the mental health benchmarking toolkit, and providers may find it useful to consider the findings in this section of the tool.

The score for community patient satisfaction comes from the National CQC survey, results of which are published on its website. The question asks *"Overall view of mental health services - feeling that overall they had a good experience"*. This metric has ranged from 69% to 73% in recent years. This year's position is 70.1%.

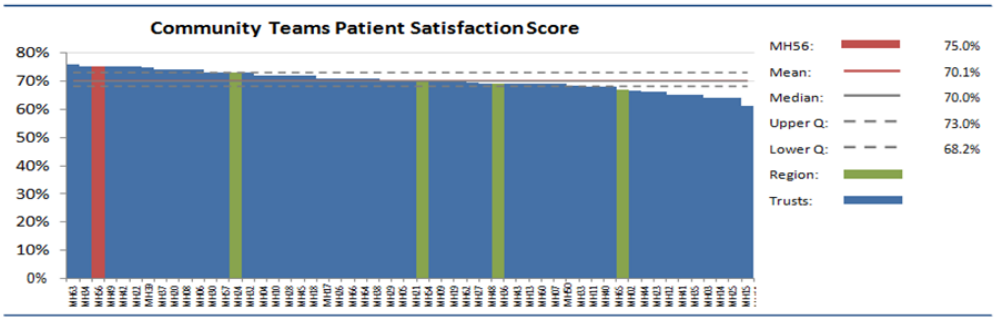


Figure 106

An alternative measure newly introduced to mental health providers is the NHS Friends and Family Test. This question asks *"How likely are you to recommend to friends and family if they needed similar care or treatment?"*

The average position this year was 85.3% would be likely or extremely likely to recommend.

Overall the Trust is rated as "good." The feedback from the CQC (2018) was very positive "there was good management of complaints and there was an increase in compliments." "There were clear responsibilities at every level in the Trust for the management, investigation and response to complaints."

New national data on the Trust's Friends and Family Test has been received.

FFT	Number of organisations submitting	Total responses to date	Responses		Score (% recommend)		Score (% not recommend)	
	Mar 19	Mar 19	Mar 19	Feb 19	Mar 19	Feb 19	Mar 19	Feb 19
Mental Health Overall	**75**	**953,825**	**22,766**	**21,897**	**90%**	**89%**	**3%**	**4%**
Primary Care	42	164,599	4,184	4,026	94%	94%	2%	3%
Secondary Care Community Services	56	353,926	8,795	7,868	91%	90%	3%	3%
Acute Services	51	153,295	3,087	2,959	83%	84%	6%	7%
Specialist Services	44	75,085	2,074	1,955	93%	92%	2%	2%
Secure and Forensic Services	21	35,142	650	633	83%	81%	8%	9%
Child and Adolescent Mental Health Services	47	113,024	2,743	3,053	85%	87%	3%	4%
Mental Health Other	33	58,754	1,233	1,403	90%	91%	3%	2%

The Trust's performance has been rated as follows:

- Eighth highest out of 75 submitting organisations' percentage of people recommending our services of all mental health trusts

- The Trust submitted the 22nd most number of completed returns - therefore this ranking is representative of strong data return. The Patient Experience Team is the central point of contact for people to provide feedback and raise concerns about the services provided by the Trust. The team sits within the Nursing and Patient Experience Directorate. The team's aim is to provide a swift response to concerns or queries raised and to ensure a thorough investigation takes place when required, with complainants receiving comprehensive written responses including any actions taken.

The previous report showed there have been issues providing timely responses to some complaints during the year. The Patient Experience Team has worked hard with operational staff to reduce the time taken for investigations. Progress has improved with newly recruited staff to the Patient Experience Team. This has resulted in a substantial reduction in sickness rate to below average since this change. Informal feedback received from patients has shown that the telephone support has demonstrably improved. Comments also included a noticeable positive attitude of the new team and that the staff change had transformed the service to one which felt responsive, helpful and 'can do'.

During the year the following contact has been made:

	2018/19	2017/18	2016/17	2015/16
Compliments	1684 ↑	1222	1,215	1,016
Concerns	475 ↑	451	420	352
Complaints	197 ↑	191	146	115

Complaints are issues that need investigating and require a formal response from the Trust. Investigations are coordinated through the Patient Experience Team. Concerns can be resolved locally and require a less formal response; this can be through the patient experience team or directly by staff at ward or team level within our services and the desired outcome is to achieve an open culture where we talk about concerns and resolve issues. A service with fewer complaints is not always a positive sign. High performing trusts are open cultures that accept where they have areas to improve and model and improvement culture.

Complaints Upheld	Upheld in part	Not upheld	Closed with investigation	Still being investigated	Total
22	62	50	8	55	197

There has been a significant increase in compliments, which is to be applauded and recognised. Themes from compliments received reflect general gratitude and appreciation for support provided. A high number comments relate to the care, kindness and compassion of Trust staff.

During the year, the Trust discussed five cases with the Parliamentary and Health Service Ombudsman. Two investigations are being undertaken and three are being assessed to see if they will proceed.

Comparison of concerns and complaints by top subjects 2017-18 and 2018-19:

There is a change:

The constant theme for the past three years has been service availability. This year this has changed to appointment delays and cancellations. Although service availability is still present, this is not the highest area of concern. This is a known issue and transformational work being carried out to reconsider our clinical community service including put-patients will need to draw upon this evidence.

However the Trust's website on NHS choices continues to receive some difficult messages and very mixed feedback about the experience of waiting, accessing the services and some quality issues.

The Trust has deteriorated from two stars to one star, in online feedback. However, there has only been one additional entry since 2018. This was received in April 2019.

> *If you're reading this you are probably as desperate as I feel now about the care provision, or lack of, for my daughter. I have just tried to ring the PALS complaints/comments number but there is an out of date voicemail message from mid-March 2019. it is now mid-April 2019.*
>
> *I am an OT myself and understand fully what the pressures are like regarding volume of clients / service users that need to be seen / bed availability and the inevitability of waiting lists, but when someone, like my daughter is now, in need of acute, intensive intervention and it is not there, it is totally devastating for her primarily and the extended family. I feel totally let down for her by where she has been placed, when she is getting worse, and we are told that there is no bed for her. She is at increasing risk and no one from the Crisis Team seems to be listening! Safeguarding is clearly 'not' everyone's concern as I learnt when I tried to contact the Crisis Team - who told me to contact Call Derbyshire. In my job I have to be proficient in dynamic risk assessment of my service users on my caseload , so what makes it different for the Crisis Team when they are being presented with increasing risks around my daughter's ability to 'keep herself safe'???*

I want to speak to someone and I am currently awaiting a call back from a service manager at my behest. I am totally dismayed at the manner in which my daughter's care is being conducted. If you are going to read this and leave me a comment saying I can now contact the PALS line or the hospital direct then please do so; but note, please do change your voicemail message and please do have someone at the end of the phone when I ring that will listen and act as appropriate to the situation. Many thanks.

We need to ensure our communities are continually seeing that their feedback is improving our service and we far more robustly connect this feedback to our trust intelligence and our improvement agenda.

2. Accessible information

Previously our implementation of the Accessible information standards had been an area of improvement in our 2016 feedback. This was assessed as fully complaint in 2018 and an adaptation to communication aids was noted as an example of outstanding practice. CQC (2018) Staff collaborated with a national charity, the Anne Craft Trust, to create a simplified and pictorial form to help patients and their families to recognise and understand what constitutes abuse. We saw this was an area of innovative practice to support the patient group and tackle abuse. This remains unchanged at the time of writing the report.

KLOE C2 - Involving people in decisions about their care

We rated it as good because:

- There was good carer's involvement and carers assessment in place
- Staff knew their patients and patients gave positive feedback on the quality of care

However, we continued to find that not all patients were involved in their care plans or given copies of their care plans. Not all patients had crisis plans. There was variability in the use of advance decisions. These are plans that patients make to enable staff to carry out their wishes when situations arise.

We continue to have inconsistent and variable levels of care planning, person centred care and involvement. This remains a quality priority and in the newly designed Trust strategy is a core area of focus.

Key improvement areas

1. Re-design and focus of clinical compliance staff in Nursing and Quality to have redesigned job description to include clinical practice improvement facilitation and key outcomes for care planning. This will be using the same methodology that we have successfully used in the Mental Capacity Act development and using coaching principles practice improvement facilitators (Q2 2019).
2. Dashboard developments for care planning for all services on whether a care plan was co-produced and whether a copy has been shared (Q2/3 2019). This will be recommended as a core objective for all acute senior Nurses and their Consultant Psychiatry colleagues.
3. Final review of the East London Foundation Trust core model of a CPA / care plan including relapse prevention and fast roll out of this recommended good practice (Q2 2019).

4. Developing a model of EQUAL self-assessment of good practice in involvement and care planning and all acute ward senior nurses having coaching from an expert by experience of the lived experience of their ward.(Q3 2019)
5. Evaluation of the expert by experience Borderline arts training and impact upon staff and individuals when focusing upon positive approaches to borderline personality issues and understanding Trauma (Q3/4 2019/20).

KLOE C3 - Privacy and dignity

We have no changes to our Community Mental Health survey published on the 22 November 2018, responses were received from 267 people at Derbyshire Healthcare NHS Foundation Trust. Respect and dignity for feeling that they were treated with respect and dignity by NHS Mental Health services 8.4/10 - about the same, as previous measures (comparator Trust's Nottinghamshire Healthcare - 8.7).

The specific measures in this area are listed as an appraisal of whether there is strong evidence in place to confirm compliance. Incidents of breaches of confidentiality (strong evidence), Compliance with data protection requirements - Staff training in IG (Information Governance) (strong evidence). Healthwatch feedback (strong evidence and noted as a responsive organisation, number of complaints and compliments (strong evidence and patient privacy and confidentiality (strong evidence).

One learning from the survey was to improve our service to assist individuals back into employment and since this survey we have been successful in securing a national bid to invest in an Individual Placement Support service which enables individual to recover through occupation and to employment,

We do, however, also have improvement areas to work on with regard to our acute services which include privacy and dignity screens, ensuring our staff are always courteous in safety checks and the significant improvement areas of our dormitory bed stock.

Key improvement areas

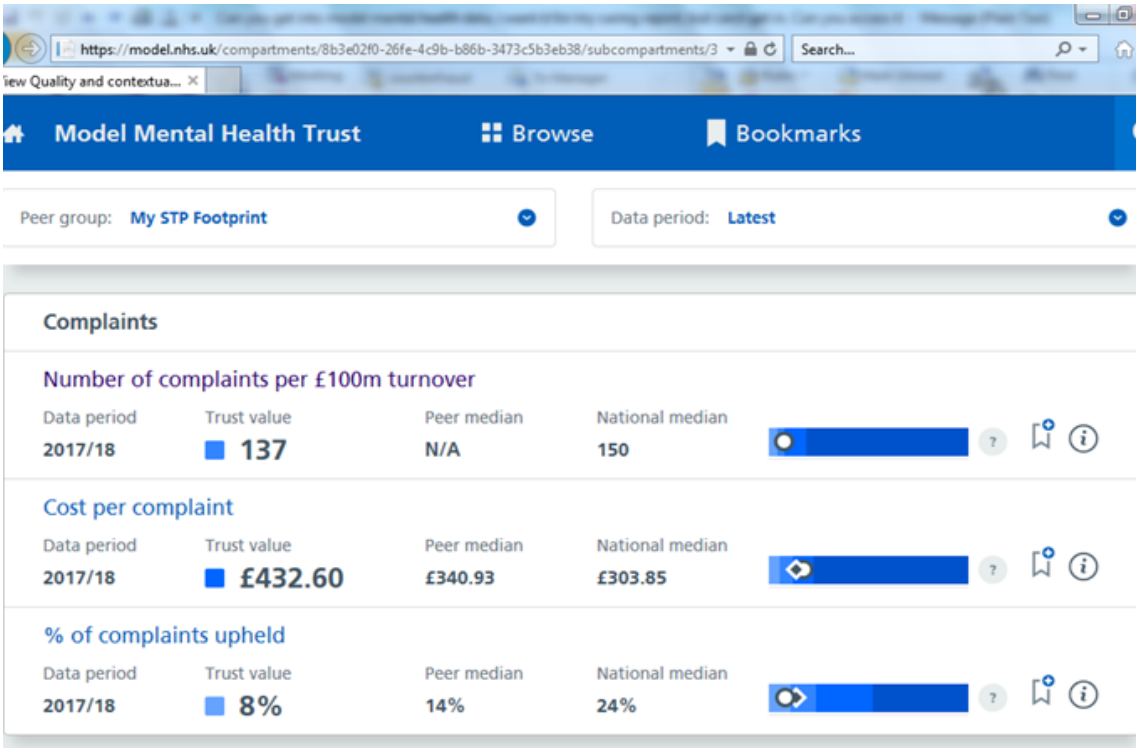
1. Redesign and re-focus of the Safeguarding and Trust strategy on eradication of dormitory bed stock. Immediate in year solutions which are already in design for Older Adults, Acute care on the removal of curtains to hard wood dividers, further increases to single rooms in the North of the Trust acute bedstock and exploration of single gender wards (Q1 and Q2 2019).

2. Briefing to the Derbyshire wide Clinical Professional Reference group on the long term plan, revisions to the Mental Health Act and large scale hospital redevelopment of the acute mental health bed stock was completed on 23 May. This follows tours of our estate with the CCG and NHS England in February 2019 to explore solutions.

3. Model Hospital

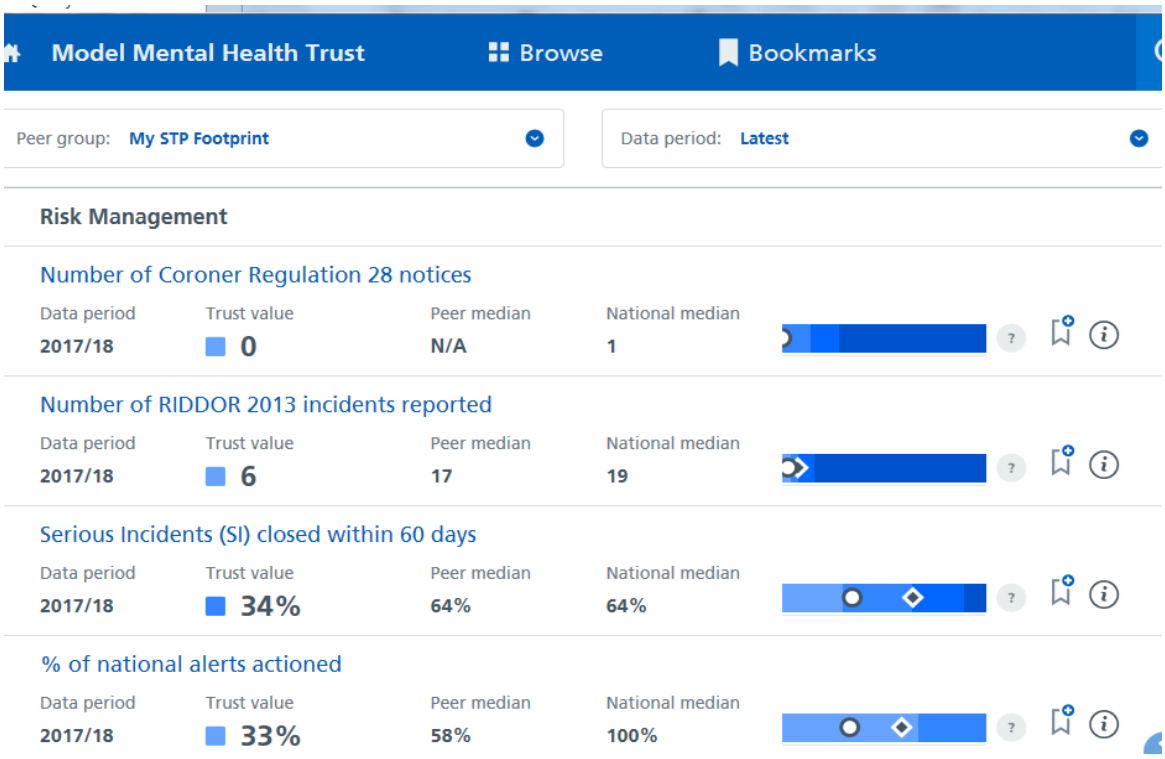
The 'Model Hospital' is a digital information service provided by NHS Improvement to support the NHS to identify and realise productivity opportunities.

This section looks at the actual metrics which have been identified and reports the monthly position for 2018/19 including, where applicable, historic information and any benchmarking information reported on the 'Model Hospital.'



This is a strong performance. The best value of the service includes the nationally recommended Family liaison model

The next slide is solid performance. As executive lead I am not unduly concerned re the serious incidents closed with 60 days, as we are complying with family liaison models of practice,



Overall, this is a solid area of performance across the organisation, with key improvement areas presented to consider further strategy priorities and improvements.

In my last report:

I confirmed that we would be developing a Patient and Carer Experience Strategy that develops a systematic quality improvement and feedback improvement loop. This is in final draft and the feedback model into services is incorporated into the Trust's IT development plan. We have struggled to convert the idea of a 'Trip Advisor' model into a reality and I will continue to explore how we can realise that aim.

A key theme has been the family and carer involvement in care decisions and their active participation and involvement. We are redeveloping the Carers Strategy in 2019 and this work has not commenced, but remains on target for the completion by year end. The EQUAL model is growing and new people are stepping forward to get involved.

As an addition to this document, I include a very draft terms of reference and a newly released best practice guidelines on involvement and engagement which has been released by the Royal College of Psychiatrists to sense check with Board colleagues on whether we are close or some distance from implementing the best practice evidence in co-production and emerging models of shared governance.

In the same manner that we assessed organisational readiness for electronic records are we ready to co-pilot with our patients and carers and listen to their voice?

Carolyn Green
Director of Nursing and Patient Experience

Appendix 1
EQUAL TOR

Derbyshire Heal
NHS Founda

EQUAL PATIENTS AND CARERS FORUM

TERMS OF REFERENCE

What	The EQUAL Forum brings together patients, carers and nominated staff from across the Trust. It is an opportunity to create change in the Trust and shape the culture of our organisation through engagement. The EQUAL Forum works in partnership with leaders, including Executive Directors, and is in place to ensure that patients and carers feel able to raise issues, and can work together to plan ways to deliver improved services.
Who	• Patient representatives • Carer representatives • Experts by Experience (staff) • Peer Support Workers (staff) • Executive Directors • Chair All members of the EQUAL Forum make attendence a high priority.
Quoracy	• 2 Patient representatives • 2 Carer representatives • 2 Staff members/peer support workers • 1 Executive Director
When	Meetings will take place every other month, in May, July, September, November, January and March each year.

Where	Meetings will be held on the Kingsway Site but may rotate.

Why	As a Trust, we are doing this because we know that it's the right thing to do – To give people a voice to be able to influence and improve the way things are done. EQUAL Forum members will be able to ask for more information and question the Trust's strategy and performance on behalf of those they represent, ensuring that the Trust continues to work in the best interests of patients, carers, families, staff, and the whole organization. We want to make sure that patients and carers have an opportunity to feedback, to contribute to solutions, and to be able to influence decisions; making improvements in service delivery by raising issues and problem-solving together.
How	Standard agenda items will be based on the work plan as agreed by the EQUAL Forum at the first meeting. The work plan will be included in every agenda pack and may be reviewed by the forum as necessary (at least annually). Members will discuss the agenda items with those they represent before each meeting and then feedback to them after each meeting. The agenda will be circulated to Executive Directors and others who may be asked to attend to allow them to prepare for the items. Executive Directors and any other invited attendees will attend the EQUAL Forum to work through the agenda with members. At the end of each meeting the agenda will be agreed for the next meeting. This is an opportunity for members to submit agenda items that are outside of the work plan. The group, as a whole, will prioritise the issues and decide which should be included on the agenda of the next meeting. Any items raised that are not included on the agenda will be logged for consideration for future agendas. Honest dialogue and straightforward exchanges between the all attendees is vital. Members will feedback to those they represent following each meeting.

Communications	Minutes and action plans from the meetings will be available to all members via email. Paper copies will be made available upon request. Trust-wide updates on the EQUAL Forum, the work it has undertaken and the outcomes will be regularly produced.
Reporting To	The EQUAL Forum will share information with the Patient Experience Group. Also, feedback will be provided to the Quality Committee and directly to the Trust Board.
How will we know how it's working?	Good attendance levels at the EQUAL Forum meetings will be a measure of success of the forum. Active contribution and engagement in the agenda setting and meetings will indicate members' appetite for the forum. Completion of actions set within the EQUAL Forum will provide a measure of effectiveness of the forum.
Review Date	June 2020

Appendix 2
https://www.rcpsych.ac.uk/improving-care/nccmh/other-work/coproduction

Evidence and tools to enable co-production in mental health commissioning

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Online PDF version

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National Collaborating Centre for Mental Health, 2019

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Contents

1 Introduction

1.1 Background

One of the key recommendations of The Five Year Forward View for Mental Health[1] called for the development of evidence-based approaches to co-production in commissioning (see Box 1).

Since then, the NHS Long Term Plan[2] has also committed to 'doing things differently' throughout the healthcare system, backed up by increased funding for mental health care. It encourages collaboration among people, primary care and community services, commissioners and clinical commissioning groups (CCGs), and between services and trusts. The NHS also promotes co-production in mental health care through personalised care plans, which give people more control over their health and care. Overall, the NHS Long Term Plan's pledge to 'do more to develop and embed cultures of compassion, inclusion and collaboration across the NHS' means that co-production in mental health care commissioning is vital and achievable.

The National Collaborating Centre for Mental Health (NCCMH) was commissioned by NHS England to build an evidence base for co-production in mental health commissioning using both documented and undocumented case studies.

Box 1: The Five Year Forward View for Mental Health – recommendation 8

'NHS England should work with NHS Improvement to run pilots to develop evidence-based approaches to co-production in commissioning.'

1.2 Purpose and scope of this document

By setting out the evidence, including examples of positive practice, this document aims to improve local strategic decisions about, and the provision of, current and future mental health services for children, young people, adults and older adults. This includes people who are not in contact with mental health services, because of existing barriers to access or for other reasons. This document also talks about co-production with people who are in at-risk populations, including those who have an increased risk of being detained under the Mental Health Act 1983[3] (amended 2007[4] and by the Policing and Crime

Positive practice examples are accompanied by the positive practice star. See Section 5 for full information on the positive practice examples in mental health commissioning.

Act 2017[5]) and people who may face discrimination because of their protected characteristics (see Section 1.5 for more information on protected characteristics and inequalities).

The recommendations from this document are aimed at commissioners of mental health services, and will also be relevant for the following in mental health:

- drug and alcohol (addiction) services
- health professionals and other staff in contact with people with mental health problems within healthcare settings
- physical health services including acute, primary and secondary care
- people who need mental health support, and their families, friends and carers[a]
- service providers
- voluntary, community and social enterprise (VCSE) organisations.

This document will support commissioners in end-to-end co-production, providing guidance and tools for co-produced commissioning, practical recommendations for each step and ways of measuring the effectiveness of the process. It includes key co-production principles for creating measurable standards, describes the existing evidence gaps and identifies examples of positive practice.

1.3 Current context for co-production

Public involvement has been central to NHS ambitions for many years.[6] The NHS Constitution for England holds public ownership in high esteem, declaring that the NHS is accountable to the public and that those who may need to use NHS services should be involved in their development and improvement.[7] In addition, the Children Act 2004,[8] Health and Social Care Act 2012,[9] Care Act 2014[10] and NHS England's Patient and Public Participation Policy[11] all require CCGs, local authorities and NHS England to embed public involvement and

Helpful resources

Bite Size Guides to Participation

NHS England

What is Co-production – The Policy and Legal Context

Social Care Institute for Excellence

[a] Any person who cares for a partner, family member, friend or other person in need of support and assistance with activities of daily living. Carers may be paid or unpaid, and includes those who care for people with mental health problems, long-term physical health conditions and disabilities.

consultation in the commissioning of health services. Section 3.2 discusses levels of participation in co-production in England; although these efforts rarely reach the level of genuine co-production, they provide a strong foundation and tradition on which to build.

1.3.1 Current levels of public engagement

A review of patient and public involvement showed that many clinicians consider patient satisfaction questionnaires part of co-production,[12] and that these kinds of consultation exercises are the most commonly reported method of engagement.[12,13] However, such consultation represents a low level of involvement and does not constitute a co-production partnership (see Section 3.2). Also, this method does not allow organisations or commissioning bodies to explore ways to modify their practice. Using this method alone also excludes people with unmet needs, especially those who are not in contact with mental health services. These different understandings of engagement and co-production may have contributed to the development of different co-production models (see the helpful resources in Section 6), which in turn may have caused confusion around what constitutes best practice. This document uses existing models and available literature to clarify the key aspects of best practice and to provide the basis for a common understanding.

Helpful resource

Ladder of Co-production

Think Local Act Personal

1.4 Co-production: terminology and language

1.4.1 The importance of language

Language is the first step to creating the potential for a transformative co-production journey. Using terms that are not understood can be off-putting and limiting for many participants and some terms may even unintentionally exclude people, so the language used during the process is crucially important to successful co-production.

People's contributions add up to be like a jigsaw. Each person is like an equal-sized piece but they all have to come together to form a whole and meaningful picture.

Expert by Experience

1.4.2 Agreeing on preferred terminology

It is a valuable exercise to explore preferred terminology at the beginning of any co-production process and develop a shared understanding among the group.

Although using jargon and acronyms is often discouraged, it must also be recognised that there may be a breadth of experience within the group you engage with. Some people may already be familiar with many commissioning terms, so it is important to identify terms that are understood by everyone. Use of commonly understood language in the group can empower people and help everyone feel like they have the same platform to share, be heard and make valuable contributions. See Box 2 for more about preferred terminology.

Box 2: Talking with people

People may have different feelings about being called 'service users', 'survivors', 'experts by experience', 'citizens', 'people with lived experience' and so on – all of these terms can make some people or groups feel excluded. Using 'person' or 'people' is more inclusive but does not distinguish what makes their contribution important and unique.

Any co-production process should therefore include discussion of labels and agreement around the terms that participants prefer.

1.4.3 Definition of co-production in mental health commissioning

For the purposes of this guidance, the Co-production Working Group (see Appendix A for members), which included people who have used mental health services, carers, and commissioners and providers of mental health services, co-produced the following definition:

Co-production is an **ongoing partnership** between people who design, deliver and commission services, people who use the services and people who need them.

The Co-production Working Group also agreed on the following wider definition of co-production:

Wider definition of co-production

Co-production should **flatten hierarchies** and **promote respect**, while acknowledging and **making the most of the experiences and skills** of people with mental health problems, and of their families, friends and carers.

Everyone should have an **equal opportunity** to contribute value to **decision-making** throughout the co-production process. Positive outcomes in co-production need a **culture change** in which people no longer perceive each other as 'us and them', but as **us together**. Everyone involved should have the **same level of control and choice**, throughout the process, where appropriate and required.

Co-production should be a **continuous journey** over which the successes and mistakes of individuals and the whole group lead to **learning**. Co-production needs to **take a flexible approach** when **engaging people** and **working together as a team**.

Everyone involved in the co-production project should continue to be involved in its **evaluation**. Ongoing **improvements and adaptations** can then be made based on the feedback. All of the people involved should have access to **support**, **training**, **resources**, and **recognition and reward**.

1.5 Advancing mental health equality

There are inequalities in access to and outcomes of mental health support, care and treatment, particularly for people who have one or more protected characteristic (see Box 3).

Tackling and reducing mental health inequalities should always be at the heart of service planning, including explicit strategies to learn about local communities, engage with them and encourage their participation. Any strategy should be regularly revisited and reviewed, then updated, to ensure there are no gaps.

Helpful resource

Advancing Mental Health Equality: Steps and Guidance on Commissioning and Delivering Equality in Mental Health Care

NCCMH

Box 3: Some characteristics that may increase the risk of experiencing inequalities

The nine protected characteristics (Equality Act 2010)

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- gender
- sexual orientation

Other characteristics

- socioeconomic status, including social exclusion and deprivation
- refugees and asylum seekers
- migrants
- looked-after children
- homeless people
- prisoners and young offenders
- traveller communities
- veterans.

1.6 How this document was developed

1.6.1 Background

NHS England asked the NCCMH to co-produce this document with a Co-production Working Group. This included national advisers from around England with a breadth of personal and professional experiences in mental health care, healthcare, mental health commissioning and co-production.

1.6.2 Gathering the evidence

The Co-production Working Group reviewed the existing evidence on co-production in statutory and VCSE organisations, and contributed to the writing of this document. They developed a survey (survey questions can be found in Appendix B) to gather examples of positive practice. The survey responses included international entries as well as responses from around England. Responses were screened for relevance and applicability against the principles of genuine co-production. They were then used to generate the solutions to challenges in co-produced commissioning, and describe what those solutions are intended to achieve (see Section 2). From all responses, eight positive practice examples were identified and asked to provide more detail (the additional survey questions can also be found in Appendix B). Four commissioners responded with more information, and Section 5 contains information on those positive practice examples.

1.7 The key principles of co-production

The six principles in Table 1 were developed by the Co-production Working Group, including experts by experience, carers, commissioners and providers. These principles were selected as fundamental to supporting co-production in mental health commissioning, based on people's views and experiences.

Table 1: The six key principles of co-produced commissioning

C	**Celebrate involvement** – All types of involvement are important and fundamental to the process, and should be celebrated at each stage and be received with an open and fair approach. Co-production is a continuous process rather than an aim or event and there should be ownership, understanding and support of the process from everyone involved throughout.
A	**Adaptable** – The approach to co-produced commissioning should be adapted to ensure that the community of interest's* voice is heard at every level, ensuring that inequalities are identified and addressed throughout.
R	**Resources** – Co-production should be built into every level of work programmes and business plans and resourced as a fundamental integrated part of the whole commissioning process. There should be a dedicated member of staff to champion co-production in practice.
I	**Influence of power** – There should be a collective understanding that acknowledges the power of individuals and organisations, the influence it can have and the perceptions it can lead to. A culture of honesty, value and respect should be fostered, with each person being committed to sharing power and taking responsibility for the decision-making they take part in.
N	**Needs-led** – Accessibility is fundamental to co-production, so people's needs should be considered and any barriers minimised. This includes consideration of the location of meetings and events, travel to and from venues, and preferred methods of communication. Terminology should be discussed and agreed at the start, and communication should always be clear and available in agreed formats. The environment and space must also be accessible, inviting and supportive of the overall values of co-production. The environment needs to foster creativity, courage and curiosity, so that everyone present has an equal opportunity to be involved.
G	**Growth** – Quality assurance needs to take place to maintain, improve and grow the co-produced commissioning process as well as the quality of services. This should be evidenced through outcome measures.

* A community of interest is a network or group of people who share the same interest and aim – in this case, to create good quality mental health provision. This shared interest may not extend into other areas of their lives, but they will be focused on working together towards the commissioning of mental health services.

2 Solutions to the challenges of co-production

The journey of genuine co-production requires **effort, planning and resources**. At the start, co-production can be perceived as a risk, which may overshadow the potential of its positive impact. Therefore, it is essential to map out internal and external challenges and barriers, and to talk about overcoming them together. For example, co-production in rural areas will likely require people to travel greater distances to participate. Therefore, travel, hotels and other relevant expenses should be paid where possible – this requires planning, communication and action.[14,15]

Before exploring how to do co-production in mental health commissioning, Table 2 outlines solutions to challenges that everyone involved in co-production may face. It then describes the outcomes that are expected to result from acting on the solutions. The 11 solutions in the table are referenced at relevant points throughout this document.

The content of Table 2 was derived from the feedback of 39 commissioners who had responded to this project's survey (as described in Section 1.6.2). The commissioners described challenges they had encountered, the solutions they had used to overcome them and what happened as a result. The Co-production Working Group analysed this information alongside existing research and generated the following table. The items in the table are numbered for reference purposes and are not in order of importance or the time point at which they would occur.

Helpful resources

The Fifteen Steps Challenge: Quality from a Patient's Perspective – A Guide for Commissioners

NHS England

How to Estimate the Costs of Public Involvement

East Midlands Academic Health Science Network

Commissioning for Outcomes and Co-production

New Economics Foundation

Table 2: Solutions to challenges and barriers in co-produced mental health commissioning

	Challenge	Possible solution	What will this achieve?
1	Lack of sign-up at system-level for genuine co-production and working together	Discuss co-production widely and encourage the whole system to adopt a recognised co-production approach that best meets the needs of the task at hand. Use the chosen approach to develop a shared message and goal that all people can subscribe to.	The organisation will have a clear and consistent message about what co-production is and will have core co-production development processes in place.
2	There is not enough time to dedicate to co-production	Encourage all stakeholders to recognise the value of co-production, particularly in saving time later down the line. If something is commissioned properly the first time and truly meets the needs of the community, it will prevent all stakeholders having to go back to the drawing board.	Even if more time could have been dedicated to co-production, starting early and continuing throughout will ensure that some value is derived from the process and that it is not tokenistic.
3	Difficulty in making the case for co-production to staff in environments that haven't embedded it yet or are resistant to change	Educate people on the value and benefits of co-production using the evidence and tools available. If co-production is not embedded, a first step in the right direction would be to obtain commitment from all parties, particularly from senior leaders.	All people who enter the co-production process will come with an open mind, ready to welcome ideas and innovations from all members. The culture will begin to move towards one that embraces co-production and values partnerships and equality of opinion.
4	Confusion about what contributions are expected of people	Be clear from the outset about the parameters of co-production (and the reasons for them), what type of co-production is being practised, and how you would like people to engage with the project. Engage in some preparatory work with people, if appropriate, to ensure that everyone comes to the meeting feeling informed and able to contribute.	People will have a clear idea of how best to voice their opinions and how these views might be used and taken forward. This will contribute to a greater feeling of being heard.

Table 2: Continued

5	Difficulty encouraging people with different complexities of mental health need to participate together	Support various methods for contributing, such as one-to-one feedback sessions, providing interpreters or advocates, or allowing for submissions in writing. Encourage several methods of contribution at every meeting and embed these into the group principles. In one-to-one sessions, be prepared and willing to openly discuss individual wellbeing and any barriers.	Everyone will be given the opportunity to contribute in the way that feels most comfortable to them, ensuring that the process has been inclusive.
6	The same people are involved every time, meaning that new voices might be seldom heard, or newcomers may find it difficult to contribute	Have an open recruitment process that has been co-produced and is advertised across as many channels as possible, including local community groups and voluntary and community sector services to broaden the range of people involved. Collaboratively review the recruitment process to identify ways to widen the reach of recruitment. Celebrating every stage of co-production widely and openly, especially using social media, can help to encourage those who might be seldom heard to engage.	Provides an opportunity to those who may never have been involved in co-production before but would like to be. Encourages new ways of thinking for each project and ensures a freshness of approach.
7	The lines of accountability for co-production and commissioning are not clear	Ensure that governance is co-produced at every level, from board to service level, with representation from every stakeholder within each governance structure. All individuals need a role description and will be treated in the same way as other members of staff or trustees.	Will allow people to develop an accountability structure they feel comfortable with, encouraging them to take positive risks and contribute more freely.
8	Feelings of unequal power, or inability to share power within meeting spaces	Recognise the power imbalances that currently exist and encourage all people who are involved in the co-production process to acknowledge the power they have. Promote open discussions about power and encourage all people to enter the room with differing views and experiences, rather than with views of differing weight. Embed this into the group principles.	Builds trust, respect and openness within the group and fosters a comfortable atmosphere in which people can express views, knowing they will be valued and heard.

Table 2: Continued

9 Previous experiences of feeling unheard or ignored when voicing opinions can prevent people from engaging	Demonstrate real commitment and desire to getting co-production right this time around. Admit where things are not working perfectly and be open and honest with the group. Create time and space for people to acknowledge their previous experiences and listen to them, demonstrating a commitment to learn from them. Commissioners should be prepared to accommodate negative emotions to build trust. Commissioners should also be committed to ensuring there are clear lines of communication and that every outcome is communicated to all stakeholders.	Builds trust with the group, promotes openness and inclusion, and helps people to feel that you are dedicated to learning and changing historical processes, and to embedding co-production into future commissioning structures.
10 Meeting locations that are difficult to access (because of the physical structure, the safety of the area, accessibility to public transport and so on)	Consider moving meetings into the community, in spaces that are safe and accessible for all people. Consider providing transport for people or remuneration for transport if geography poses problems.	Better engagement with the community and more opportunity to engage with people who might not typically engage in co-production.
11 Lack of financial resources to be able to co-produce properly (for example, remuneration for time, travel and other areas for support and so on)	The improvements that co-production brings are becoming increasingly evident for both the community and commissioners. Commissioners could consider taking a top slice of their budgets to cover the relatively small costs related to establishing and sustaining co-production.	All participants will feel that their presence and contributions are valued. This builds more trust and respect among all members.

3 Approaching and planning co-produced commissioning

3.1 Benefits of co-production

A service that has been commissioned based on the principles of co-production is more likely to be cost effective, responsive and have high satisfaction and health outcome rates from the people who use it. This section will concentrate on the available evidence to outline key potential benefits of co-production. As part of the process, we looked for relevant NICE guidance and identified nine NICE guidelines, two NICE quality standards and six quality statements (see Appendix C).

3.1.1 Benefits for the service and commissioning process

Co-production is based on the idea that people who use services and those who work in them are the best people to suggest better ways of working.[16,17] In a review of different levels of NHS patient and public engagement,[18] it was found that co-produced commissioning leads to new and improved services, as described in Box 4.

Box 4: Benefits for services designed with co-produced commissioning

- Development and delivery of additional resources[19]
- Development of holistic approaches[19]
- Development of peer support groups[19]
- Improved access to care, including adapting services to better meet the needs of the community[20]
- Improved outcomes for the service or project[21]
- Improved communication and connection between staff and the community[21]
- Increased responsiveness and efficiency in delivery of care[22]
- Long-term sustainability of services and programmes[18,19]
- Mobilisation of community resources and energy
- More efficient use of resources[22]
- Reduced inequalities in care[22]
- Prioritisation and re-organisation of existing services[19]
- Quality assurance of commissioned services[19]
- Utilisation of local intelligence to create better services[19]

A literature review by the New Economics Foundation identified key themes related to co-production outcomes, including wellbeing, prevention, social connectedness, stigma, inclusion and personal competences and skills. They found wellbeing to be the strongest theme, including physical and mental health.[17]

3.1.2 Benefits for those involved in co-production

There is strong evidence that taking part in co-production, as well as being part of a community of peers, is a positive experience both for people with experience of mental health problems and those involved in mental health commissioning and provision. Co-production contributes to a sense of shared identity and purpose among all involved,[21] as well as other benefits described in Box 5.

Box 5: Benefits for people involved in co-production

- Confidence to develop new peer relationships[23]
- Development and enhancement of skills and employability[24]
- Empowered professionals in frontline practice who are confident in positive risk-taking and have more empathy[25]
- Improved confidence and self-esteem[26]
- Improvement in own individual health and wellbeing[26,27]
- Improved recognition of working group members' expertise, leading to an exchange of skills[14,28]
- Improved relationships, understanding and power balance between people who use the service and service providers[29]
- Increased social connectedness[24] and new peer relationships[30]

3.1.3 Cost and time efficiencies

In many instances, co-production has been found to improve the efficiency of mental health services and demonstrated potential reductions of long-term costs.[24] Cost and time efficiencies are outlined in Box 6.

Box 6: Cost and time efficiencies from co-produced commissioning:

- In the initial stages of co-production in commissioning, the costs attached to practising co-production (time, effort, resource) can increase, but **significant cost savings can be made in the long run**[14,17,25,32]
- Reductions in avoidable costs and other **long-term financial benefits have been found to be sustained when the co-production process continues and is embedded** into the commissioning working strategy, for example in evaluation and assurance processes[16,33]
- Other evidence focusing on improving practice (through peer support, joint design and delivery of services with people with long-term health conditions) indicated a **7% financial savings and predicted future growth of up to 20%**[23,34]

Cambridge and Peterborough CCG reported positive outcomes from the co-produced commissioning of two services for time efficiency, positive patient outcomes and financial gains, as can be seen in Box 7. For more information about this positive practice example, see Section 5.

Box 7: Positive practice example: outcomes of co-produced commissioning

Cambridge and Peterborough CCG

- **First response services**: the community-based 24/7 first response crisis mental health service has had positive outcomes, including financial gains that enabled recurrent funding of the service and:
  - 19% reduction in mental health hospital admissions
  - 26% reduction in mental health A&E attendances
  - overall reduction in A&E presentation for self-harm.
- **Patient outcomes and experience**: feedback on the experience of the PRISM service was 100% positive.
- **Improved time effectiveness** – establishing the **first response** and **PRISM services** have proved highly effective, saving time on further commissioning and transformation initiatives.
- **Cost** – the **first response** and **PRISM services** have proven to be highly effective, and are currently both **saving money**:
  - First response service saved about £4 million
  - PRISM service cost was £3.2 million and shows savings of £650,000.

3.2 Levels of co-production

Broadly speaking, services can be designed while working together in three ways, two of which involve participation while the third does not. When planning a commissioning project, it's important to consider what level of co-production can be used and aim for as much collaboration and co-production as possible. The following series of steps lead from 'doing to' to co-production's 'doing with'. Sometimes services and commissioners find themselves stuck at a certain level of the ladder, but the aim will be towards 'doing with'.

The three levels shown here can be read alongside the National Co-production Advisory Group's ladder of co-production, which shows seven levels of involvement from coercion at the lowest to co-production at the top of the ladder.

Helpful resource

Practical Things that You Can Do to Get Better at Co-production (Moving Up the Spectrum of Practice)

Think Local Act Personal

Start on the ladder of co-production. Don't be put off by not getting it right straight away.

Co-production in Mental Health: Not Just Another Guide

‘Doing with’ means everyone involved is equal and has the same decision-making power, where people’s voices are heard, valued, debated and then acted on. In reality this will take many forms, but what matters is that people share equal roles and responsibilities, and that everyone’s unique experiences and contributions are valued.

‘Doing for’ requires participation. The involvement includes some engagement and consultation with people, but it will take place within boundaries and the decision-making will not be shared by citizens and providers/commissioners. While these service designers have people’s best interests in mind, in truth people’s ideas and opinions are heard but will only be part of the decision-making process, not fully shape it.

‘Doing to’ does not seek participation or input from people but aims to educate them and have them conform to norms and standards. The resulting service ‘happens to them’.

3.2.1 Current co-production in England

Mental health commissioning in England is generally in the middle – ‘doing for’[24] – and may entail focus groups, consultation around topics, community feedback and so on.

One of the biggest barriers to effective co-production is people feeling they cannot do co-production well enough, and they cannot reach the top of the ladder straight away. This can lead to people not even trying.[24]

Helpful resource

Co-production in Mental Health: Not Just Another Guide

Skills for Care

3.2.2 Choosing the level of co-production that is most appropriate

Commissioners should always ensure that the level of co-production that is chosen is appropriate and necessary for the task at hand. It is not always necessary for every aspect of the commissioning process to be co-produced, but the decision to not co-produce a task needs to be collaborative and shared with those who would normally be involved. Otherwise the mental health service that is being commissioned is unlikely to reach its full potential.[17,35]

3.3 Co-production: 'It's messy'

Co-production at the NCCMH

At the NCCMH, we have worked hard to improve our approach to co-production over the last 3 years. Now, people consistently tell us they feel welcomed as equal partners in our work, and we have adapted several processes to make it work even better.

However, we are also aware of the remaining barriers to some people's involvement: the application process we ask people to complete, the location of most of our meetings (geographically, and the cultural associations that come with our offices), and the forms we ask people to complete in order to be paid. All of these are likely to be factors that exclude people from the process. This particularly applies to people most excluded from society, whom mental health services most need to serve.

Once in the room, the fast pace of some meetings, the language and jargon occasionally used (despite our best efforts), and the unfamiliarity of the environment are further barriers to people feeling equal partners.

Co-production can be difficult, and sometimes feels a little bit messy, but we always try to adapt. It is a continual process of examining how we could do it better. As a result, it helps us to improve the quality of our work, our understanding and our enjoyment of the process beyond measure.

Co-production can add enormous value to mental health provision, but the process will take different paths and will not be linear. But this is not to be feared. When it's done right, it will involve spontaneity and creativity, and it is likely to feel messy at times because of the amount of communication and negotiation involved, and the need to 'rock the boat without getting rocked out of it'.[b] To harness this, commissioners should welcome the different approach to working and encourage system-level sign-up to co-production. Commissioners will need to ensure that their processes give sufficient time and flexibility to plan the project and allow for this way of working. There is significant expertise that can be accessed by working in this way, particularly in the VCSE sector, as well as in local authorities and CCGs, which should be utilised.

See **item 1** in Table 2 for solutions to challenges around **sign-up to co-production**, and potential outcomes.

See **item 2** in Table 2 for solutions to challenges around the **time needed to carry out co-production**, and potential outcomes.

3.3.1 Taking positive risks

Working co-productively can take unexpected turns, involve positive risk-taking and bring everyone involved together in the pursuit of shared aims and goals. Each person will be faced with different obstacles on their journey but will also celebrate different, and at times unexpected, successes.

[b] McGrath J, Co-production: an inconvenient truth? [blog], The King's Fund, 31 October 2016.

3.4 Culture change

Changing the culture in mental health provision may not be easy. Reportedly, and from positive practice examples, commissioners said they often struggle to implement changes at service level. When the new approach of co-production is being put into place, the professionals are often asked to take a 'risk' or step out of their comfort zone. This might happen when they are asked to deliver services based on different methods or while involving people who use mental health services. Professionals should be supported and prepared (for example with training and supervision) to learn and feel confident about changes and new approaches, to help them be more enthusiastic about the result of co-production and new changes. Staff should have a clear understanding of the aims and potential outcomes of the project, and how the new approach can improve their services in the short and long term.

See **item 3** in Table 2 for solutions to challenges to **staff engagement**, and potential outcomes.

Following the principles of co-production may also require a change in the balance of power and a broader culture shift.[36] This means genuine partnership supported by strong and decisive leadership to better overcome barriers.[28,37] It involves viewing interactions as reciprocal, by shifting the focus away from solely delivering services and towards facilitating and enabling people to access services and resources.[21,38] It also will involve acknowledging risks and creating a plan to manage them. Having a risk-management strategy makes it easier for partners to experiment, and to test and pilot new elements of service provision.

3.4.1 The skills needed to facilitate co-production

Some of the skills that could be required to facilitate co-production in commissioning include:

- ability to communicate clearly throughout the co-production process, including when giving feedback
- ability to make reasonable adjustments for people
- ability to support others to develop their own skills and be open to developing your own skills
- co-chairing skills, including the ability to keep conversations clear and honest
- knowledge and skills in planning, delivering and evaluating services collaboratively
- willingness and ability to share power, knowledge, skills and expertise.

The King's Fund report, Patients as Partners, recommends adapting styles, focusing on what works, knowing what questions to ask and being aware of assumptions so that they can be addressed.[39]

3.4.2 Prompts for thinking about the activity you want to co-produce

These 'Think about' and 'Suggested solutions' prompts, adapted from the National Development Team for Inclusion,[42] are useful for everyone involved in co-production to enable you to design services together by understanding and addressing practical issues that are likely to come up during the co-production process. You will find them at relevant points throughout this document.

Think about:

- How will you as a group define the changes that are needed (what research methods are going to be used?) and agree on the process of achieving these changes?
- If a problem or an issue arises between people, how will you make sure that there is a shared understanding and agreement of how it should be resolved?
- How will the process of finding solutions to any conflicts and finding common ground be managed? Everyone involved needs to feel safe and empowered to tackle and resolve disagreements.
- How will everyone be supported to express their professional and personal stories when developing a shared understanding of how conflict should be resolved?

Suggested solutions

- Collate and understand the changes to be made and break them down into smaller elements. Discuss together how each can be resolved, what difficulties there may be, and how long it will take for the change to take place.
- Discussion about processes should include common agreement and expectations about the timeframes, the issues that need to be addressed (including predicted and unforeseen issues) and how any issues will be managed. Discuss the framework or method that will be used (the groups should have an in-depth understanding of the pros and cons of each framework).
- As a group, agree on a set of shared values, aims and ground rules, including how any disagreements will be worked through.
- Build in time (whenever the group works together) and create a feeling of safety so that everyone feels able to talk about their experience of using and providing mental health services – this information can be used to increase understanding about what needs to change and why, and how it can be done.

4 Practising co-produced commissioning

4.1 The commissioning process

4.1.1 Before the project

Before starting recruitment for each project, the following questions could be considered:

1. At what stage of the commissioning process should co-production take place?
2. Is co-production the best strategy with this commissioning process?
3. How many people should be involved?
4. How will the people involved be recruited?
5. How do we ensure that everyone's contributions are included and actioned?
6. How will decisions be made?

Some co-production methods and models might be effective and applicable at one commissioning level, but not work at another. The approach to co-production in commissioning may need to be adjusted at:

- the individual level for specific population groups
- the team, service or practice level, or
- the whole community level.[40]

4.1.2 Planning co-production processes

Co-production processes should be planned in advance and reflected on throughout, to ensure that they continue to meet the aims of the group. This includes establishing whether there will be a need for any focus or special interest groups within the team, to work on certain aspects of the project.[32] It should be made clear to all group members what kind of co-production is being practised, how much time will be required and what input and outcome is expected.

See **item 4** in Table 2 for solutions to challenges around **expected contributions from people**, and potential outcomes.

4.1.3 Dedicated co-production roles and champions

To ensure that co-production is embedded into commissioning processes at every level, there should be a dedicated member of staff who champions co-production in practice, and encourages it and promotes it to all members. For example, the Bristol North Somerset and South Gloucestershire CCG have a dedicated post in commissioning (see Box 8). In addition, at least one board-level role should have a responsibility to ensure co-production happens.

Box 8: Positive practice example, in their own words: 'Designing together'

Bristol North Somerset and South Gloucestershire CCG

'We have a dedicated commissioning post, to ensure that co-production is embedded in all areas of the mental health commissioning cycle including transformation. This involvement supports the programme of quality assurance for all mental health contracts with a user-led independent mental health network which has been involved in several procurement processes and the monitoring of mental health providers.'

4.1.4 Identifying gaps while doing co-production

Working together will help identify existing assets and gaps that health and wellbeing initiatives can build on, for example:

- skills, knowledge, social competence and commitment of individual community members
- friendships, intergenerational solidarity, community cohesion and neighbourliness within a community
- local groups and community and VCSE associations, ranging from formal organisations to informal, mutual aid networks such as babysitting circles
- physical, environmental and economic resources within a community
- assets provided by all public and private external agencies.

4.1.5 Improving co-production processes

The evaluations and outcomes of working together should be evaluated and evidenced wherever possible to understand the successes and challenges and destination of any future work and how it can be improved.[41] This information should be reported back to the community in accessible formats and languages.

4.1.6 The co-production commissioning cycle

This commissioning cycle and its principles were developed by the Co-production Working Group (see Figure 1 and Figure 2). It was agreed that the co-produced commissioning cycle should start with collaboration, to conceive and research ideas. However, it was acknowledged that this could be constrained by scope, budget and mandate.

Helpful resource

Commissioning Cycle

NHS England

Figure 1: Outline of the co-production commissioning cycle

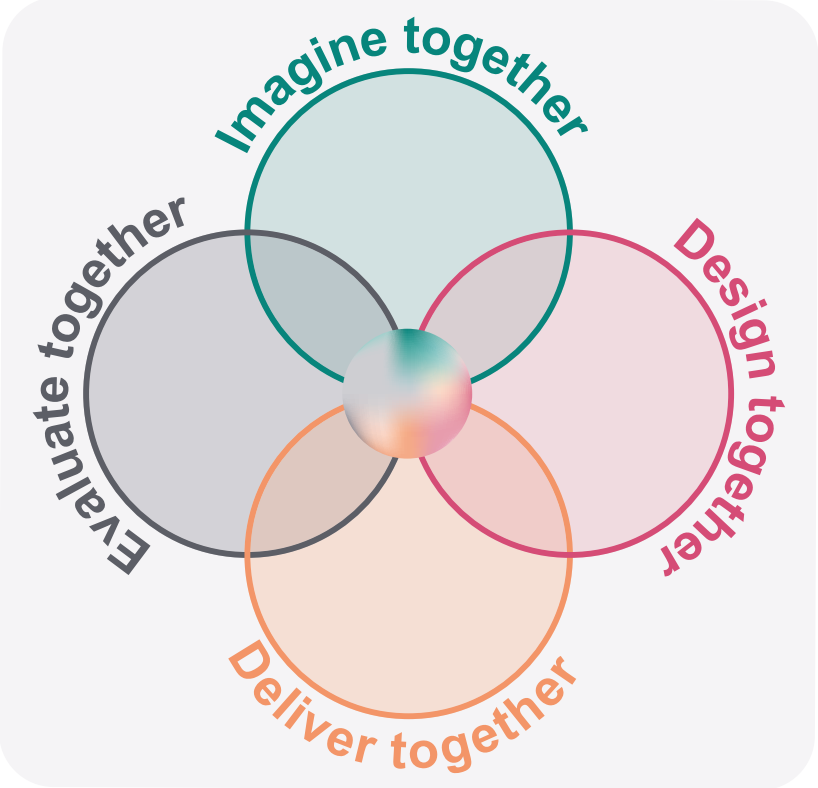

Figure 2: What happens in the co-production commissioning cycle?

The co-production commissioning cycle should **promote equality, diversity, accessibility, courage, curiosity and encourage joint ownership** by the people and partners involved to find solutions as a team. Co-production is a series of actions and a journey rather than an event, and for that reason co-production should embrace creativity.

Notwithstanding any unavoidable constraints or barriers, co-production will still be a key opportunity to identify local needs and inequalities as part of the Joint Strategic Needs Assessment process to select providers of services and evaluate existing contracts. See Box 9 for Cambridge and Peterborough CCG's own description of how they 'imagined' the first response service.

Helpful resource

Better Mental Health: JSNA Toolkit

Public Health England

Box 9: Positive practice example, in their own words: 'Imagining together'

Cambridge and Peterborough CCG

'We have worked with people before the idea has been even conceived and then through every step of the project including ongoing reviews, and evaluations.

When the community-based 24/7 first response crisis mental health service was set up, the service user network and a person with lived experience were represented on the delivery board, which developed and implemented this service. The service users' network has developed a "5 values framework" against which the service was then evaluated and then improved.'

Think about:

- What are the problems that need to be defined and addressed within commissioned mental health provision?
- Who is going to be the champion of co-production during your commissioning cycle/this co-production commissioning project?
- What approach/model/framework are you going to propose for this co-production commissioning project and why? Have you used that approach/model/framework before? Can you reflect on previous approaches and think about what could have been improved?
- What do you hope to achieved by using this approach/method/framework, in terms of goals and outcomes for your working group and mental health provision that you are commissioning?
- What will be done to ensure that all the right people come together from the outset of the commissioning cycle and how can this be decided?

Suggested solutions

- Define the problems and come up with solutions with everyone involved in co-production.
- There should be a dedicated member of staff to champion co-production throughout the commissioning cycle – ideally at a senior level.
- Discuss what can change as a result of co-production, based on previous experience and knowledge of all involved, and reflect on what has and has not worked before; try to identify case studies to help with that, too.
- To help identify who needs to be involved, think about the short-term, long-term and overall goals of the project. For example, depending on the context, you may need:
  - people with a range of experiences and different levels of professional and personal expertise
  - people with a range of relevant backgrounds, to inform the project aims and outcomes.
- Network and collaborate with voluntary and statutory sector services to identify and engage people for the project.
- Always take time to build positive and trusting relationships among all involved, especially if people have had negative experiences of co-production in the past or do not have experience.

4.2 Recruitment and engagement of people in co-production

Throughout the commissioning cycle, engagement with people with whom the project is being co-produced needs to be considered and maintained. Monitoring engagement should be ongoing, to ensure that the community is adequately represented. Co-production should not only involve a range of people who have experienced mental health problems, but people from across the whole of the community, including families, friends and carers of those who need mental health care, as well as staff, clinicians and anyone else who will be affected by the outcome of the project.[33]

See **item 5** in Table 2 for solutions to challenges in **recruiting people with different complexities of mental health need**, and potential outcomes.

See **item 6** in Table 2 for solutions to challenges in **recruiting new people to projects**, and potential outcomes.

4.2.1 Reflecting the population

Co-production working groups should not only reflect the population receiving care within mental health services, but also people in the community who are currently unable to receive help for their mental health needs due to barriers to access or other related barriers (see Section 1.5 on inequalities, and the positive practice example in Box 10 below).

Helpful resources

Engaging Local People

Engaging with Communities

NHS England

4.2.2 Addressing barriers to engagement

To successfully engage a wide group of individuals, barriers to engagement should be reviewed and addressed as much as possible with the levels of planning, engagement and skills adjusted as needed by the relevant population groups (see Section 1.5 on inequalities and where such barriers exist). Wherever possible, co-production should be used during engagement as well. Six Practices for Creative Engagement outlines six steps to consider to help ensure that people with diverse interests and perspectives are identified and engaged.[43] *The Framework for Community Mental Health Support, Care and Treatment for Adults* and Older Adults (forthcoming) provides more detail on community assets mapping. For more engagement tools, see Section 6.4.

Acknowledging limitations of engagement

Commissioners should pay attention to local factors that may affect co-production or the engagement process. Some people may not wish to engage with co-production processes in their own local areas because of the likelihood of being identified by someone they know. These feelings and opinions must be respected, and no one should be forced to engage.

In Box 10, the Surrey-based Adult Social Care-led commissioning process describe how they involve people and engage with them.

Helpful resources

Advancing Mental Health Equality: Steps and Guidance on Commissioning and Delivering Equality in Mental Health Care

NCCMH

Patient and Public Participation Equality and Health Inequalities

NHS England

4.2.3 Recruitment

Commissioners can recruit people to the co-produced commissioning process in several ways, including:

- working with existing local VCSE and local authority groups to ensure they build on existing participation
- advertise creatively, using social media and the community – for example, community centres, sports clubs and town halls
- commission VCSE groups to recruit from within their communities.

To support this, clear role descriptions and training and support packages should be in place before starting recruitment.

Box 10: Positive practice example, in their own words: 'Designing together'

Adult Social Care-led commissioning process in the South of England: Surrey County Council working with the Surrey mental health CCG collaboratives

'We are working with independent user-led mental health network and service providers, to involve people who use their services and support access for people with additional or multiple inequalities.

Engagement approaches include directly asking and talking to people who are using or in touch with mental health services, including on specific issues, and through other means, for example digital technologies such as Twitter, websites or blogs.'

Think about:

- Who are your local population?
- What are the mental health needs in this population?
- What mental health services are available and what is missing?
- Who is and who is not accessing mental health services?
- What kinds of interventions are people receiving?
- What kinds of experiences are people having?
- What do the outcomes of mental health care look like for the local population?
- How do our mental health and social care services work together?
- How do our mental health services work with other public services (schools, universities, police and criminal justice system, young offender institutions and so on)?
- Are there delays in accessing services and in receiving care and treatment?

4.3 Power dynamics when working together

4.3.1 Acknowledging power differences

Power and empowerment are key concepts in co-production, as outlined in 'Influence of power' in Table 1. Community empowerment is about 'shifting power, influence and responsibility away from existing centres of power and into the hands of communities and individual citizens'.[44] This means that power relationships should be acknowledged and addressed transparently, which can be a key factor that contributes to people feeling more confident and in control of services and communities, and of their own health and lives. Open acknowledgement of the power balance and how it is perceived it is not always comfortable, but it is important and should be made a priority (there is more on communication and building trust, in Section 4.4). Co-production strives for equality in decision-making, and intends to distribute power evenly among everybody involved. There should then be regular reminders that the people involved will be given support, respect, and appropriate ways to contribute based on need and preference. This can be achieved by actively encouraging and creating opportunities for everyone to contribute,[33] and by co-producing all levels of governance structure, making sure that they include a structure for accountability.

4.3.2 Marginalised groups

Some communities are more structurally marginalised and may not be in the room at all (see Box 3 in Section 1.5). This means that power can be transferred to the people who find it most easy to access the co-production process, but others may find themselves even more marginalised and disempowered by not being involved, meaning that co-production can increase the marginalisation of some groups if done in a less inclusive way. This may include people from Black, Asian and Ethnic Minority communities, people with lower socioeconomic status and people with more severe and disabling mental health problems. It can also include people based on their geographical location, such as those in rural versus urban areas of England. Commissioners should pay particular attention to ensuring that all communities are empowered through co-production.

See **item 7** in Table 2 for solutions to challenges around **accountability**, and potential outcomes.

4.4 Communication and relationships in co-production

Getting co-production right depends on the relationships between all the people involved. They will come from many different walks of life, have had different experiences, and have different perspectives and approaches. Because of this, some people may start their working relationship from a point of conflict, so consideration should be given to re-building trust from the very beginning of the process.

Everyone involved in the co-production process should be treated as equal partners. To achieve this, there are a number of things that can be done to support people's participation in and engagement with the process, and these are outlined in the sections below.

4.4.1 Building trust

Time and space are needed for people to discuss their experiences and emotions openly, using effective communication to build trust between people. It is important that everyone taking part makes an effort to be receptive to people's experiences, both positive and negative. Group members' positions, and any previous mistakes or problems, need to be heard and acknowledged. Such open, honest discussion can bring mutual understanding, an atmosphere of trust and pave the way to positive collaborative relationships.

To maintain trust and positive relationships it is important to communicate about contributions and decisions that are not ultimately actioned, explaining why the decision has been made. Listening to and acknowledging the views and feelings of everyone involved needs to also be maintained throughout the process.

See **item 8** in Table 2 for solutions to challenges around **power issues in co-produced commissioning**, and potential outcomes.

4.4.2 Communicating clearly

Communication should be clear and accessible to everyone, adapted according to need and available in different formats (see Table 3). Communication methods should be planned, and then reviewed throughout the process. There should be ground rules for everyone, covering issues such as confidentiality, respect and what will happen if those rules are not honoured.

See **item 9** in Table 2 for solutions to challenges around **previous experiences of being ignored or not being heard**, and potential outcomes.

4.4.3 Accessibility

As well as communication, accessibility is one of the most crucial elements of facilitating co-production. The physical space as well as the process itself should be accessible to everyone,[42,46,47] allowing all participants to participate and contribute fully.[14]

The following elements should be considered:

- Providing training to people so that they are prepared to engage fully in all meetings.
- Ensuring that all individuals have timely access to all the relevant resources and support to prepare for meetings,[47] tasks and discussions.
- Ensuring that all people can access buildings, receptions, rooms, toilets and other facilities easily. This includes ensuring there is disabled access, accommodation for guide dogs, induction loops for the hearing impaired, and other adjustments.

Helpful resource

Making Events Accessible

Social Care Institute for Excellence

- Meetings should be scheduled to account for the needs of the people involved. Meeting agendas should allow time for people to build relationships and for dynamics to develop.

In addition to the resources referred to above, see Box 11 on Pathfinder's practice of making projects accessible.

4.4.4 Recognition and reward

All people taking part in co-production should be valued and rewarded. Often the simplest ways of recognising and acknowledging people's input and contributions have the greatest impact, so expressing appreciation can positively improve confidence and self-esteem.[17] At a minimum, every person's contribution should be openly recognised; however, people should also be remunerated for their contributions. Case studies show that remuneration can be the most difficult part of the co-production process, mainly due to lack of additional resources within the commissioning budget or uncertainties around how to pay people, particularly those who might also be receiving benefit payments.[14,49] Nevertheless, all participants should be treated and financially rewarded in the same way as any other employees involved in the process.

Helpful resource

Paying People who Receive Benefits – Co-production and Participation for Further Guidance

Social Care Institute for Excellence

The following items are examples of what could be remunerated, where appropriate; for example, time, travel, childcare expenses, replacement carer, support worker, interpreter, accommodation, subsistence, stationery and telephone use. This list is not exhaustive, and expenses will depend on each person's circumstances.

Table 3: Examples of communication formats and platforms

Formats
• easy read • Braille • flash cards • different languages (including sign language) • interpreters
Platforms
• meeting venues • telephone conversations • online interactions • digital technologies

4.5 Measuring, monitoring and evaluating co-production

4.5.1 Quality assurance

Quality assurance of the co-production process and its effectiveness needs to be ongoing, taking on board positive and negative feedback, as well as understanding the dynamics of all involved. This will ensure that there is ongoing reflection and learning on how to improve co-production processes.

See **item 10** in Table 2 for solutions to challenges around **physical accessibility of meetings**, and potential outcomes.

Box 11: Positive practice example, in their own words: Planning ahead

Pathfinder West Sussex Co-production

'When working with people we plan ahead to ensure we work within agreed framework, so people are informed well in advance about the timelines of the project including **meetings**, **activities** and **tasks**.'

4.5.2 Measuring progress

Progress should be measured to monitor, evaluate and reflect (as a team) on everybody's involvement. There are various frameworks that can be used to facilitate that process (see Section 6.9 for further resources). The choice of method or evaluation tool should be decided on by the working group, as different tools will suit different groups. Some of what is learned will lead to solutions that can be implemented immediately to improve the processes or the way the group is working on a task. However, some challenges may require more discussion and planning, and might be more difficult to overcome – sometimes not at all. As part of the evaluation the groups should consider different aspects, including:

- changes in relationships
- the need to develop additional skills to continue with co-production
- openness and capacity for challenge
- people's skills
- recognition of individual assets and expertise
- trust and confidence.

See **item 11** in Table 2 for solutions to challenges around **lack of financial resources to co-produce**, and potential outcomes.

Helpful resource

Budgeting for Participation

NHS England

4.5.3 Evaluating outcomes

When evaluating the outcomes of co-production, they should be communicated to all those involved after the project is finished. This ensures that everyone involved knows the impact of their contributions and feels that they are a valued and integral part of the decision-making process.

Think about:

- How will the knowledge, expertise, assets, strengths and contributions of everyone involved be fully utilised throughout the process to generate a better understanding of mental health provision?
- How will challenges, including people's emotional expressions, be integrated into learning about what needs to change and how?
- How will everyone be supported and encouraged to be honest about their own personal and frontline experiences?
- Will people be expected to conform to formal meeting rules and use a particular language to be heard?
- How will other practical issues including access, payment and expense be addressed?

Suggested solutions

- Ensure that everyone has an equal opportunity to express their thoughts and experiences around topics, including in different languages, written and spoken formats, by digital technologies, and so on. Consider taking minutes during meetings and activities to record everyone's views accurately and check that everything is captured.
- Establish rules of confidentiality and respect, and continually remind people that it is a non-judgmental and safe space. Outline and keep on reminding people how decisions based on their experiences can positively influence mental health provision.
- Always use plain language and agree on the preferred language and terminology with everybody involved.
- Always prioritise budgets to pay people for their time and expertise.

4.5.4 Evidence that commissioners can show

Commissioners should be able to show evidence of how they have involved members of the local community when they were setting priorities for mental health provision, to demonstrate how they have reflected on what has and has not worked. The quality measures should include evidence about monitoring and evaluation, which should have been agreed by everyone involved in the co-production process. Mental health provision should be evaluated using the measures that were derived from agreed priorities, and their outcomes and impact, both positive and negative, should be fed back to the working group.

4.5.5 Community involvement in evaluation frameworks

As part of the co-production commissioning cycle, members of the community should be involved in planning, designing and implementing the evaluation frameworks for community engagement approaches. They should also be involved in deciding on the outcomes that have been derived from co-production.

As part of this, commissioners should regularly evaluate community engagement approaches to advance mental health equalities. The evaluation should also include evidence of what has been done to develop the local community, such as skills, knowledge, networks, relationships, facilities and community assets. Reporting changes, including acknowledging improvements and gaps, is likely to be appreciated by everyone involved in co-production and is a way of recognising everyone's efforts.

4.6 Research recommendations

There is a lack of formal published evidence focusing on the impact of co-production specifically in mental health commissioning, or even in wider health and social care commissioning. Most of the available evidence looks at co-production at a service level. However, there is a wealth of literature based on experiences of co-production.[14,24]

The available evidence focuses on the improvements that a service has made as a result of co-production and the individual experiences of those involved. While much of the evidence indicates that savings have been likely, there is a need for more published economic evaluations to support this case.[17,21,50,51]

Key research areas for future development are the **outcomes** and **benefits** of co-production, particularly in commissioning.

5 Positive practice examples

Positive practice example: Coastal West Sussex CCG – Pathfinder

Overview

Co-production is central to everything we commission, from the outset to the ongoing development of mental health services, including planning, procurement and mobilisation. We use models recommended to us by people who use our services and their carers, including those produced by third sector providers such as Rethink and Mind. We complete an equality impact assessment for every service we commission and identify other groups of people who may be at risk of being underrepresented.

Process and quality assurance

In our recruitment process, we ensure that we concentrate on diversity so that we represent everyone from our local community and get an accurate view of what is needed. We work in partnership with Capital to help us facilitate those roles throughout the co-production process. People with lived experience are members of all key **Pathfinder** boards and workstreams; their title is 'Independent Non-Executive Director'.

When working together, we work within an agreed framework and make sure that people are informed well in advance about the timelines of the project including meetings, activities and tasks. Minutes are taken throughout the process and shared within workstreams. As an alliance, we develop regular updates on our work and processes, and look at what works and what could be improved, including feedback to the Pathfinder Strategic Board. We then make changes accordingly.

Outcomes (what people have found effective)

Because co-production is central to the work of Pathfinder, we have a workstream in place to facilitate this process and agreed terms of reference. The terms of reference have enabled us to have an agreed definition of co-production, develop then review recommendations and structures (including on how to measure and evaluate the effectiveness of co-production), and recommend how we can share and learn from each other. Overall, we act as champions by facilitating the implementation of co-production across the Pathfinder Alliance.

Reflections

We have faced some barriers when seeking to improve mental health services, because some of our statutory providers do not automatically engage service users and carers from the outset. This has caused a number of problems further down the line, and there is still plenty room for improvement in that area.

Find out more

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Positive practice example: Bristol North Somerset and South Gloucestershire CCG

Overview

We have a dedicated commissioning post, to ensure that co-production is embedded in all areas of the mental health commissioning cycle, including transformation. This involvement supports the programme of quality assurance for all mental health contracts with a user-led independent mental health network, which has been involved in several procurement processes and the monitoring of mental health providers.

We have **two CCG-funded mental health crisis houses and a Sanctuary service** (with another similar service planned for North Somerset). Local people who use or have used services had been asking for these services, and they continue to be involved in service specifications and procurement.

Process and quality assurance

People from the community are also trained to be involved in managing the service contracts, including quality assurance visits to all services including inpatient services. For example, we did a user-led review of the crisis houses recently to inform our future plans. This gave us a detailed independent assessment. It also showed that service quality had improved (our main aim), and that our services are more effective.

We also have a wider partnership, engagement and communications team that are working with wider population and community groups to ensure it reflects the local community we strive to serve. In our process there are successes and challenges: in our monitoring of services, we try to engage with people (for example, using National Involvement Standards and other frameworks that we have co-produced within our networks), but there are ongoing challenges, such as engaging excluded people and communities. In the past, we commissioned a community access service to help address equalities issues, but we also know we need to do more to follow up on and demonstrate the value of contributions.

Outcomes (what people have found effective)

As part of the co-production process, we continue to train staff to build their confidence in embracing new approaches. We also make sure that we build trust and relationships with the people we work with who are using the services. We advocate buy-in and support at all levels of the organisation, along with resources, but we also want to be honest and manage expectations of all involved.

Reflections

We have noted improvements in the quality of services by seeking more detailed and independent views on how the services are doing. We have found that co-production in commissioning has certainly helped us to do things differently and more efficiently, which has been cost effective.

Find out more

Glenn Townsend Mental health and learning disabilities, Commissioning, Patient Monitoring and User Development, BNSSG CCG
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Positive practice example: Adult social care-led commissioning process in the South of England: Surrey County Council and Surrey mental health CCG collaborative

Overview

People have long played a critical role in our commissioning processes, to help us understand how the services could be best delivered and to aim for the right outcomes. As a result, we set up **Community Connections Surrey** to bridge the gap between primary and secondary care mental health, and to support people to stay well in their communities. Community Connections Surrey comprises three lead voluntary sector providers (Mary Frances Trust, Richmond Fellowship and The Welcome Project) covering the six CCGs and 11 districts and boroughs in Surrey.

For our engagement processes, we work with an independent user-led mental health network and service providers, to involve people who use their services. Their approaches to engagement broaden our reach and help to support access for people with additional or multiple inequalities. Both are very good with directly approaching people, more generally and on specific issues, through Facebook, Twitter, websites, blogs and other means.

Support during the process and quality assurance

When engaging with people, we always ensure provision of an accessible environment for people to be able to contribute in a meaningful way. This includes providing hearing loops, speech-to-text typing, large-font text and wheelchair-accessible venues. We aim to work with people in ways that suit them through formal and informal events, and to communicate in ways that they choose such as by email, teleconference, phone call or text message if they find it difficult to attend a meeting or workshop in person. We continually feed back outcomes to people working with us and let them know what changes have been made. The performance of all services is monitored on a quarterly basis, and the data is shared with the independent mental health network so that they can comment, challenge and have a say in how the services are going.

Outcomes (what people have found effective)

In a survey of the five sites covered by Community Connections Surrey, 89% to 100% of respondents said that the services have very much or moderately improved their life. The survey revealed that people have been enabled to maintain a network of support, to help themselves and to maintain their recovery. This has been through accessing appropriate courses, groups and activities, which give them a reason to get out and about. Respondents also reported that they received the help and advice they needed.

Community Connections Surrey were also found to contribute to the improved management of crises and a reduced dependence on statutory services. Overall, Community Connections Surrey demonstrate positive impact and are cost effective, meaning they are of key strategic importance in the mental health pathway and are valued by stakeholders.

Reflections

We have committed time, resources and organisational commitment to co-production in commissioning. However, during the process our main barriers and challenges involved challenges with resources, because co-production can be time intensive and expensive. Despite this, we have always used our work as a platform to encourage and inform other senior leaders by illustrating the value and benefits – and therefore the necessity – of involving people in commissioning.

Find out more

Jane Bremner Senior Commissioning Manager, Adult Social Care
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Positive practice example: Cambridge and Peterborough CCG

Overview

When we were setting up a new community-based 24/7 first response crisis mental health service, **The Sun Network**, we had worked with people before the idea was even conceived. We started by getting to know the local population using public health data and by setting up a service user network that included people with lived experience.

Process and quality assurance

Getting people 'into the room' was the first challenge – when we advertised for participants we made it clear that no one would be refused, and that we would provide individualised support. Whenever we needed to hear from certain groups, we would specify, so no one felt like they had been turned away.

We offered as many choices around participation and platforms as possible, so that people could join in in the way that best suited them. For example, the premises were always accessible for in-person events like meetings, workshops and forums, and we utilised IT to include people in co-production via emails, social media, a website, online polls, text messages and training videos. Everyone was always provided with suitable training, which was delivered in different forms such as Braille, larger print, audio support, language translation and so on.

We ensured that everyone had the opportunity to contribute fully and started with a group contract – a 'respect agreement', to address power imbalances so no one felt unimportant. People could engage in ways comfortable for them, such as table discussions, writing ideas on Post-it notes, voting on yes/no questions, holding up cards that said yes/no/speak up, working in smaller groups, Skype, teleconferences, working in pairs, and so on. As a result, the group has put together a '5 values framework' that informed the new service. The '5 values framework' was subsequently used to evaluate the service and to drive needed changes.

To ensure that people knew how valuable their work was, we paid them an hourly rate and offered a shopping gift card, free lunch and provided training on 'attending meetings' and 'confidence and assertiveness'. We also continually encouraged, reassured and provided emotional support to them.

Outcomes (what people have found effective)

As a part of our ongoing improvement, we asked everyone involved a number of questions. We asked how the experience worked for them, if they felt valued, if they felt like an equal part of the process, if the service user network helped them being part of the process, and more.

Our work contributed to our local community's improvement: we noted a 19% reduction in hospital admissions for mental health reasons, a 26% reduction in mental health-related A&E visits, a reduction in A&E presentations for self-harm, and cost savings of around £4 million as well as time savings that could be used for further commissioning and transformation initiatives.

Reflections

Challenges and barriers were part of the process. They included having restrictive timescales, which imposed a feeling of pressure, and limiting the use of jargon in services where culture change and the attitude towards new approaches had to change.

Find out more

Lois Sidney Executive Director, The Sun Network
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6 Helpful resources and tools for co-production in mental health commissioning

The following resources can be referred to when taking part in co-production of all levels and variations. For older resources, please bear in mind that their age may add some limitations to their applicability today, but each resource included below includes information of value.

6.1 Commissioning

Commissioning Cycle [web page] – NHS England, 2016.

Commissioning Independent Advocacy [web page] – Social Care Institute for Excellence, 2014.

Delivering Public Services [web page] – NCVO Knowhow, updated 2017. Includes these useful web pages:

- Social Values in Commissioning and Procurement – in 'Procurement' section
- Co-production and User Involvement in Commissioning – in 'Commissioning' section.

The Fifteen Steps Challenge: Quality from a Patient's Perspective – A Guide for Commissioners [PDF document] – NHS England, 2017.

Patient and Public Participation in Commissioning Health and Care: Statutory Guidance for CCGs and NHS England [PDF document] – NHS England, 2017.

People not Process – Co-production in Commissioning – Think Local Act Personal, 2015. Includes these useful web pages:

- Commissioning Co-production – 'Stories and resources' section
- Co-production in Commissioning and Market Shaping
  - 'In more detail': Practical Things that You can do to Get Better at Co-production (Moving up the Spectrum of Practice).

Values-based Commissioning [web page] – National Survivor User Network, 2017.

6.2 Methods, models and frameworks

Commissioning for Better Health Outcomes [PDF document] – Local Government Association, 2016. Includes this useful web page, which requires login:

- Commissioning for Better Outcomes: a route map (updated edition) [PDF document].

Commissioning for Outcomes and Co-production [web page] – New Economics Foundation, 2014.

Coproduction in Mental Health Commissioning [web page] – Rethink Mental Illness, 2016.

A Co-production Model: Five Values and Seven Steps to Make this Happen in Reality [web page] – Coalition for Collaborative Care, 2016.

Co-production in Social Care: What it is and How to do it [web page and PDF document] – Social Care Institute for Excellence, 2015.

A Guide to Co-production with Older People. Personalisation – Don't just do it – Co-produce and Live it! [PDF document] – National Development Team for Inclusion, 2010.

Integrated Commissioning for Better Outcomes: A Commissioning Framework 2018 [web page and PDF document] – Local Government Association, 2018.

Joint Commissioning Panel for Mental Health: Guidance for Commissioners [web page and PDF documents] – Joint Commissioning Panel for Mental Health, 2017.

Ladder of Co-production [web page, PDF document and video] – Think Local Act Personal, 2016.

Model Collaborative Commissioning Agreement: Multiple Contract Option [PDF document] – NHS England, 2017.

What is Commissioning and How is it Changing? [web page] – The King's Fund, 2017.

6.3 Tools

Better Mental Health: JSNA Toolkit [PDF documents] – Public Health England, 2017.

Budgeting for Participation [PDF document] – NHS England, 2015.

Co-production Training Courses [web page] – in house training for 25 or more – Social Care Institute for Excellence, 2017.

Documents to Support Participation [web page and PDF documents] – NHS England, 2017.

EBCD: Experience-based Co-design Toolkit [web page] – The Point of Care Foundation, 2018.

How to Estimate the Costs of Public Involvement [PDF document] – East Midlands Academic Health Science Network, 2015.

The Influence and Participation Toolkit [web pages] – Mind, 2013.

Stakeholder Mapping Tool [web page] – The Health Foundation, 2013.

6.4 Engagement

Bite size Guides to Participation [PDF documents] – NHS England, 2014–17. Includes:

- Engaging with Communities, 2017
- Planning for Participation, 2015.

Engaging Local People – A Guide for Local Areas Developing Sustainability and Transformation Plans [PDF document] – NHS England, 2016.

Social Care Institute for Excellence [web pages] on co-production with different groups:

- Co-production with Black And Minority Ethnic People, 2016
- Co-production with Different Groups Of People, 2016
- Co-production and LGBTQI+, 2017
- Co-production and Participation: Older People with High Support Needs, 2012
- Co-production with Seldom Heard Groups, 2016
- Co-production with Young People, 2016.

Independent Mental Health Advocacy [web page] – Social Care Institute for Excellence, 2015.

The NHS Youth Forum's Top Tips to Involve Young People in Healthcare Planning [PDF document] – British Youth Council and NHS England Youth forum, 2016.

Participation in Development of Dementia Care [video] – Social Care Institute for Excellence, 2012.

Patient and Public Participation Equality and Health Inequalities [PDF document] – NHS England, 2017.

Patient and Public Participation Policy [PDF document] – NHS England, 2017.

Six Practices for Creative Engagement [PDF document] – Think Local Act Personal, 2011.

Top Tips for Good CCG Engagement with Patient Participation Groups (PPG) [PDF document] – National Association for Patient Participation, 2017.

6.5 Recruitment

Recruiting New Staff [web page] – Think Local Act Personal, undated.

6.6 Accessibility

Making Events Accessible [web page] – Social Care Institute for Excellence, 2012.

6.7 Payments

Paying People who Receive Benefits – Co-production and Participation [web page] – Social Care Institute for Excellence, 2019.

Working with our Patient and Public Voice (PPV) Partners – Reimbursing expenses and paying involvement payments (v2) [PDF document] – NHS England, 2017.

6.8 Collaboration

The Compact: The Coalition Government and Civil Society Organisations Working Effectively in Partnership for the Benefit of Communities and Citizens in England [PDF document] – HM Government, 2010.

What is Collaborative Practice? [web page] – Altogether Better, 2018.

Altogether Better Working Together to Create Healthier People and Communities: Bringing Citizens and Services Together in New Conversations [PDF document] – Altogether Better, 2018.

6.9 Monitoring, evaluation and outcomes

4Pi National Involvement Standards [web page] – National Survivor User Network, 2013.

Co-production: How are You Doing? [PDF document] – Think Local Act Personal, 2015.

A Guide to: Annual Reporting on the Legal Duty to Involve Patients and the Public in Commissioning [PDF document] – NHS England, 2016.

The Point of Care Foundation [website] – The Point of Care Foundation's 'Evidence and Resources' library (2006–19) is a library with links to various evidence and practical resources.

7 Abbreviations

Abbreviation	Definition
CCG	Clinical commissioning group
FRS	First Response Service
GP	General practitioner
IAPT	Improving Access to Psychological Therapies
JSNA	Joint Strategic Needs Assessment
NCCMH	National Collaborating Centre for Mental Health
NICE	National Institute for Health and Care Excellence
PHE	Public Health England
QS	Quality statement
STP	Sustainability and Transformation Partnership

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Appendix B: Positive practice examples: survey for mental health commissioners

Q1. In practical terms, what does co-production mean to you in the context of your own mental health commissioning? Do you follow any particular guidance or framework? If so, please describe

Q1a. Give an example of working alongside people to commission mental health care provision for your population

Q2. How have you involved people, service users, carers and others with direct experience of mental health problems in commissioning mental health provision?

Q3. How do you ensure you work with people who reflect the population you are trying to serve?

Q4. Tell us what you have done to engage with people who experience additional inequalities?[c] How do you know you are doing this well?

Q5. In the context of commissioning local mental health provision, please give examples of the different approaches you have used when working with people (for example, consultation, co-development, co-design and co-delivery)

Q6. How have you found out whether the people you work with feel that their contributions have been valued and heard? What do you do to communicate that they are valued and heard?

Q6a. What do you see as barriers to everyone involved being heard and acknowledged? What steps do you take to help remove these?

Q7. How have you enabled people to have an active role in the co-produced commissioning of services? Do you have arrangements for remuneration, training, supervision and support that you can describe?

Q8. What language do you use to describe the people involved in co-production?

Q9. What barriers and challenges do you face in making co-production a mainstream approach in commissioning?

Q10. Did you feel, or can you evidence, the benefits[d] of co-production in mental health commissioning?

Additional questions:

Q1. How does the post promote co-production more widely in the CCG

Q2. How does this process fit into the overall governance framework?

Q3. How did you identify the people who were involved? (For example, in a citizen's panel)

Q5. How did you meet the more excluded communities/people?

Q6. How is your commissioning process quality assured?

[c] This refers to any inequalities in access to and experience of mental health care that exist in addition to having a mental health problem.

[d] Benefits to include: (1) improvements in patient outcomes; (2) improvements in patient experience from involvement; (3) time effectiveness; and (4) cost.

Appendix C: NICE quality statements and recommendations

Nine NICE guidelines were identified (listed in Section C.2) as being relevant to working with local communities to improve mental health services and advance mental health equality. Searches of those guidelines focused on the involvement of people in service design and redesign rather than in the delivery of care.

C.1 NICE quality statements

Of the relevant NICE guidance, Community Engagement: Improving Health and Wellbeing and Reducing Health Inequalities (NICE guideline 44) was found to be the most relevant, and from this guideline two quality standards were derived:

- Community Engagement: Improving Health and Wellbeing (NICE quality standard 148)
- Promoting Health and Preventing Premature Mortality in Black, Asian and Other Minority Ethnic Groups (NICE quality standard 167).

From these quality standards, the following quality statements (QS) were found to be the most relevant to co-production in the commissioning of mental health services.

These quality statements will mean different things to people approaching them from different perspectives. For example **health, public health and social care practitioners** in health and wellbeing initiatives should ensure that **from the start of the process, they involve members of local communities as equal partners** in all discussions so that the initiative reflects the priorities identified by those members.

Community Engagement: Improving Health and Wellbeing (quality standard 148)

QS1. Members of the local community are involved in setting priorities for health and wellbeing initiatives.

QS2. Members of the local community are involved in monitoring and evaluating health and wellbeing initiatives as soon as the priorities are agreed.

QS3. Members of the local community are involved in identifying the skills, knowledge, networks, relationships and facilities available to health and wellbeing initiatives.

QS4. Members of the local community are actively recruited to take on peer and lay roles for health and wellbeing initiatives.

Promoting Health and Preventing Premature Mortality in Black, Asian and Other Minority Ethnic Groups (quality standard 167)

QS1. People from black, Asian and other minority ethnic groups have their views represented in setting priorities and designing local health and wellbeing programmes.

QS2. People from black, Asian and other minority ethnic groups are represented in peer and lay roles within local health and wellbeing programmes.

C.2 NICE guidelines

The following nine NICE guidelines contain recommendations relevant to co-production in the commissioning of mental health services in England:

- Care and Support of People Growing Older with Learning Disabilities (NICE guideline 96)
- Coexisting Severe Mental Illness and Substance Misuse: Community Health and Social Care Services (NICE guideline 58)
- Community Engagement: Improving Health and Wellbeing and Reducing Health Inequalities (NICE guideline 44)
- Decision-making and Mental Capacity (NICE guideline 108)
- Mental Health Problems in People with Learning Disabilities: Prevention, Assessment and Management (NICE guideline 54)
- Older People: Independence and Mental Wellbeing (NICE guideline 32)
- Preventing Suicide in Community and Custodial Settings (NICE guideline 105)
- Service User Experience in Adult Mental Health: Improving the Experience of Care for People Using Adult NHS Mental Health Services (NICE guideline 136)
- Transition from Children's to Adults' Services for Young People Using Health or Social Care Services (NICE guideline 43)

Please start your co-production journey with this blank page...

NATIONAL
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Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 June 2019

Joined Up Care Derbyshire (JUCD) - System Risk Share

Purpose of Report

This is a decision paper relating to proposals to share and manage risk differently in 2019/20 across Derbyshire system partners.

Executive Summary

In the last confidential meeting of Trust Board and at the meeting of the Finance and Performance Committee on 21 May discussions have taken place regarding current thinking by the Derbyshire system partners on how to share and manage risk during 2019/20.

The Trust Board will recall that the Derbyshire Healthcare NHSFT Operational Plan submission did not include any detailed or quantified reference to the potential impact of system risk share at that time but did in the supporting narrative reference the system working more closely together. At 'checkpoint' meetings with regulators system partners have discussed the potential to share risk across the system, so regulators are aware and indeed expect the system to work as one to deliver a single system plan.

The appended document went to 16 May Joined Up Care Derbyshire Board. It describes the background, approach and scope of the proposals for risk share. The paper was agreed and the request was made for all partners to consider at their Board meetings.

The paper describes that the type of risks shared will be those associated with delivery of the system-wide transformation. Internal provider and commissioner risks will continue to be managed solely by the respective organisations using their own contingency reserves.

The system risk share is estimated at £36.9m and would be shared on proportional turnover, as described in the JUCD paper but sharing would also take into account the totality of the system picture (and optimisation of receipt of provider and commissioner sustainability funding) before finalising the share transactions.

It will be crucial to consider the principles agreed in light of actual system position as known by quarter one (July 2019).

An important discussion point for the Board to consider therefore is that decisions on the least-worst impact of risk share would be made for the benefit of the system. This is likely to mean that any individual organisation may be worse off than if they had not participated in risk sharing. However there is agreement across all partners in the system that to manage the level of risk and to really deliver the change required, then this change should ensure commitment from all partners. The aim being to mitigate the risks, as opposed to getting to the point of having to enact the sharing of them.

It has been explicitly stated and agreed that if the system needs to transact the risk share then it will be a system failure

In support of this direction of travel described in the paper, it is helpful context for the Board to know that there is a new regular system savings meeting which is co-chaired by commissioner AO (Accountable Officer) and provider CEO. This meeting collates a whole-system, transparent system savings picture.

In addition there are discussions on how best to coordinate and refocus our current teams' skills and resources so that they are directed at supporting the delivery of the transformation and the new way of working rather than at perpetuating old approaches.

A 'learning approach' has been agreed which in effect means that rather than attempting to over-engineer the risk share now, predicting every potential scenario, instead partners agree to the principles. Hence the need to take stock at the end of quarter one to see where we are and what the key issues are at that point. But in the meantime to put all efforts into making the transformations happen.

The paper references the need for all STPs (Sustainability and Transformation Partnerships) to produce a single system operational plan for submission to regulators and this risk share will be a key component that regulators will expect to see.

The Chief Executive and the Director of Finance/Deputy CEO have discussed with system partners the preconditions and clarifications that need to be in place for us to be able to support this approach. For example these include:

- The commitment and unambiguous timeframe to move towards a different set of payment mechanisms in support of risk management/mitigation process i.e. avoidance of perverse incentives of activity sensitive contracts for part of the system
- That the PbR (Payment by Results) activity-related risks associated with acute activity are excluded from any risk share.
- That open-book processes are in place pre-agreement for example sharing of detailed activity planning assumptions for acute activity, shared agreement about priority for bonus PSF and CSF (Provider Sustainability Fund and Commissioner Sustainability Fund) potentially linked to sharing of capital plans including those related to NHS Improvement (NHSI) PSF 'bonus' cash receipts

The Board will be aware that Derbyshire does not have an official 'system control total' therefore individual organisations are still regulated on delivery of their own individual plan and control total. Simon Stevens, Chief Executive of NHS England, recently reiterated the requirement that partners achieve both their own statutory and regulatory requirements, as well as achieving the system ambitions.

At the meeting on 21 May the Finance and Performance Committee discussed the risk share principles and proposals, points discussed are summarised in the 'consultation' section below.

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

- With regard to the 2019/20 Board Assurance Framework (BAF), this discussion paper relates to risks in the wider system and the ability to influence them

Consultation

- On 16 May Joined Up Care Derbyshire Board discussed and agreed the attached paper
- This paper with an earlier draft of the JUCD Board paper was discussed at a confidential board meeting and by the Finance and Performance Committee on 21 May
- Finance and Performance Committee discussions concerned: timing of and progress with alternatives, cultures, trust, system OD progress, seeking clarity on what schemes comprised the risk shared value, system savings oversight and governance and resources, quality impact assessments, capacity to deliver.

The Finance and Performance Committee supported the principles proposed, subject to further discussion on points of clarity to be discussed at public Board today.

Governance or Legal Issues

- The enacting of a risk share will have the impact of non-achievement of the operational plan submission control total(s) which could result in regulatory action for one or more of the partners in the system.

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

All the system savings plans involve quality impact assessments in order to understand and mitigate risks that will include those relevant to the Equalities Act.

There is a risk that in a scenario where Derbyshire Healthcare NHS Foundation Trust is adversely impacted on by the risk share, this could translate into a service impact for service receivers or staff with protected characteristics.

Recommendations

The Board of Directors is requested to:

1) Having considered the Joined Up Care Derbyshire paper, confirm Derbyshire Healthcare's support and participation in the risk share and risk management approach in Derbyshire for 2019/20.

Report presented by: **Claire Wright**
Deputy Chief Executive and Director of Finance

Report prepared by: **Claire Wright**
Deputy Chief Executive and Director of Finance

Joined Up Care Board: System Risk Sharing and Risk Management						
DATE OF MEETING:	16 May 2019		AGENDA ITEM NO:		6.	
DOCUMENT/REPORT TITLE:	Draft System Risk Management and Risk Sharing					
PRESENTER	Chris Sands, Director of Finance & Strategy / Deputy Chief Executive DCHS					
SENIOR RESPONSIBLE OFFICER	N/A					
CONTENTS OF PAPER WERE PREVIOUSLY DISCUSSED BY:	Chiefs / DoFs Group					
AUTHOR/TITLE:	Chris Sands, Director of Finance & Strategy / Deputy Chief Executive, DCHS					
CONTACT EMAIL AND TELEPHONE NUMBER:	Chris.sands@nhs.net					
DOCUMENT IS FOR: (MORE THAN ONE BOX CAN BE TICKED)	INFORMATION		DECISION	✓	ASSURANCE	

PURPOSE

The purpose of the paper is to discuss and agree the risk management and risk sharing arrangements for the shared element of the system efficiency plan in advance of taking through respective Boards and Governing Body.

BACKGROUND

The Derbyshire system has a combined efficiency challenge of £134.5 million in 2019/20. There will need to be a joint approach across organisations to support the delivery of these savings through a cost out integrated efficiency plan.

MATTERS FOR CONSIDERATION

This is a draft paper which has been prepared to move forward the system discussions on risk management and risk sharing across the STP financial plan.

The paper was discussed by Chiefs on 5th and 26th April 2019. It is presented to the JUCD Board for agreement, in advance of further discussions with Boards and Governing Bodies in May / June 2019.

RECOMMENDATIONS

The Joined Up Care Board is asked to:

- Discuss the proposals in the paper

• Approve the proposed approach • Agree that all organisations will take the paper to respective Governing Body and Boards for approval
FINANCIAL IMPACT
The system has an efficiency programme of £134.5m in 2019/20. The paper suggests a joint risk management and risk sharing arrangement over joint efficiency schemes of £36.9m
FURTHER INFORMATION AND APPENDICES
See paper.

MONITORING INFORMATION	
PATIENT, PUBLIC AND STAKEHOLDER INVOLVEMENT	Stakeholder impact will need to be considered through each of the proposed efficiency schemes.
EQUALITY AND DIVERSITY IMPACT	The Equality and Diversity impact will need to be considered through each of the proposed efficiency schemes.
ENVIRONMENTAL IMPACT	The Environmental will need to be considered through each of the proposed efficiency schemes.

1. Background

Through the Derbyshire Sustainability and Transformation Partnership (STP), Derbyshire health bodies have agreed to develop a joined up plan for Derbyshire. As well as submitting individual plans to regulators, the Derbyshire system has for the first time be submitted a STP operational plan, underpinned by a STP financial plan.

The Derbyshire plan is not without its risks. Financial modelling has demonstrated that the efficiency challenge for 2019/20 is £134.5 million, which equates to 8.3% of the commissioner allocation for Derbyshire.

Whilst there continues to be the requirement from regulators for organisations to meet their individual control totals, there is a growing understanding across organisations that the system efficiency gain will be maximised by joint working around transformational schemes.

In addition, by working together, we need to maximise the values of different funding sources into the Derbyshire system so that they can be re-invested in patient care. This includes both the Commissioner and Provider Sustainability Funds.

This paper sets out a proposed way forward to begin joint risk management and risk sharing to support the system operational plan. It is recognised that this will need to evolve as we start our journey to become an Integrated Care System (ICS).

2. Drivers for Change

There are a number of drivers which are encouraging the Derbyshire system to develop a more formalised approach to financial risk management:

- The Long Term Plan sets out a clear expectation that Integrated Care Systems (ICS) will be central in delivery of the Plan, and that individual statutory organisations will take on greater collaborative responsibilities

- The respective regulators, NHS England and NHS Improvement, have now come together under a single leadership structure. They are increasingly starting to have a single conversation with the system, rather than individual organisations

- There is currently a deficit of managerial and clinical resource to implement the transformation required. There is a need to re-focus our collective resource in this area from traditional transaction work to transformation. By agreeing contracts, our approach to risk management and the governance arrangements, it will allow us to work differently, particularly re-focussing resources around contract management.

- The financial risk in the system is significant. The focus needs to be on real cost out efficiency schemes to ensure the system can return to recurrent financial balance and to ensure resources can be invested in the system priorities

3. Risk Management Scope

It is important for all parties to be clear as to the scope of the proposed risk management arrangements. The discussions in the Derbyshire system have focussed upon starting the shared risk management journey for a specific area of risk which requires all parties of the system to work collaboratively to maximise the system financial gain.

The initial discussion between Chiefs has been around getting shared ownership of the formerly known "Commissioner QIPP schemes" which are now known as the "Joint STP Schemes". These are schemes which require collaboration between providers and commissioners to be successful.

It is recognised that there are other areas of financial risk that both commissioners and providers face. It is not proposed that these areas will be included within the risk share at this stage, but it is recognised that our approach needs to evolve and develop so that we have discussions now about how we may operate into 2020/21 as part of our journey to become an Integrated Care System (ICS).

Within organisations, there will continue to be a requirement to deliver traditional efficiency schemes. The additional risk management, and associated risk share, is proposed for the areas of joint work only at this stage.

To facilitate this agreement, discussions have been had between the commissioner and provider as to the arrangement to underpin joint working and joint risk management for this cohort of schemes. These are summarised as:

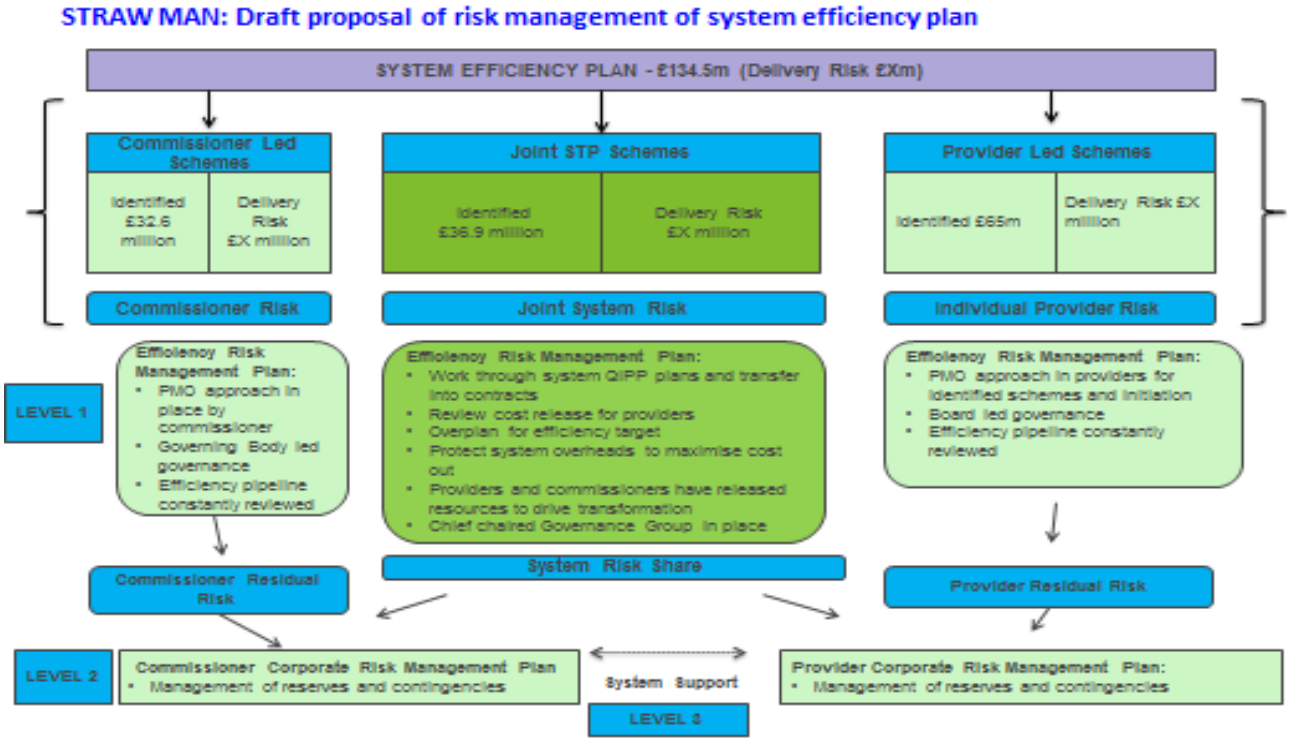
- The commissioner and provider will share financial risk for shared schemes
- The commissioner and provider will share information transparently on an open book basis
- Efficiency schemes will be co-produced
- Savings will be based upon cost, not income
- Over time, there will be a plan to release full cost
- A commitment to maximise local provider overhead recovery (to support more local cost release at full cost)
- Partners to collaborate, accepting the need to comply with procurement laws and regulations
- The commissioner and provider to release people resources to implement the transformation through STP led workstreams

The total value of shared schemes is £36.9m.

4. Risk Management Approach

Individual organisations will already have their own financial risk management arrangements in place. The proposals in this paper are meant to supplement these, not replace.

For organisations efficiency programmes, there will already be a level of risk management over the delivery of these schemes (Level 1). There will then be risk management for the overall financial position to address risks and opportunities (Level 2). As we begin to work better as a system, we will also start to see more supportive risk management across organisations to help achieve collective financial targets (Level 3).



The proposal in this paper brings in an additional layer of risk management at Level 1. So in addition to the organisational risk management of efficiency schemes, there will be additional risk management of joint schemes. This is where the commissioner and providers will work collaboratively to manage and mitigate the risks around delivery of a cost out joint efficiency plan.

5. Risk / Benefit Sharing Approach and Exposure

The risk management processes in place will mitigate the financial risk over joint efficiency schemes to a point. Partners need to plan for how any residual risk or residual benefit will be managed, and have clear agreement around risk exposure.

The risk management scope sets out the efficiency schemes that the risk management arrangements will cover, which gives a worst case risk exposure of £36.9m.

Schemes have been developed to address the £36.9m gap, and these are now being validated jointly by commissioners and providers to understand the likely achievement in year, and the level of residual risk which will require mitigation.

At a scheme level, it has been agreed that the efficiencies to be released will be based upon cost. Work is required to understand the realistic level of cost to be released, and what will require mitigation through the risk management plan.

At an organisational level, the residual risk (or benefit) will be apportioned to partners of the risk share based upon an agreed proportional share split.

Whilst the risk share is limited to these schemes, the system is developing one efficiency plan for Derbyshire to ensure plans are transparent, focus upon cost out, and are integrated across provider and commissioners.

6. Governance

The STP has established a system wide efficiency planning group. This group has initially been reviewing the commissioner, provider and joint efficiency schemes to develop a mutually owned Derbyshire efficiency plan.

It is expected that this group will evolve into a System Wide Governance Group for efficiencies, and will take on the role of monitoring progress, escalating and problem solving issues / barriers and developing / implementing the system risk management plan.

Through the STP Finance Director, this group will then report into the monthly finance report prepared to Joined Up Care Board. As the risk share will have implications for each individual organisation, it will also need reporting to respective Boards. To support timely decisions against both risk mitigation opportunities and residual unmitigated risk, the STP Finance Director will work with colleagues to speed up financial reporting.

Once approved, the risk management and risk sharing approach will be transacted with providers through respective contracts. Any dispute will be dealt with through existing contract resolution processes. It is proposed that this is transacted in month 12 to avoid risk sharing being transacted prematurely, but the residual risk be reported to all Boards monthly so the forecast exposure is highlighted transparently.

Directors of Finance have agreed to include some internal audit time in respective plans for 2019/20. A review of these arrangements may be sensible to provide individual organisations with assurance, and to inform learning for future risk management plans.

As these arrangements also start to connect risk across organisations, Governing Body / Boards may wish to consider the role of lay members /non- executives, and how they support the system governance arrangements. This could be considered further through the ICS development programme, and specifically, the governance workshop.

7. Learning from Approach

It is recognised that this is a new approach to the Derbyshire system. It will be important for system leaders to reflect upon the approach being proposed, and to understand any unintended consequences that may influence how we modify or adapt our approach going forward.

We have also had discussions with regulators to understand what other systems are doing in this area, and how we can learn from them.

8. Next Steps

The practical next steps are:

- Finalise latest assessment of risk to delivery against joint schemes based upon cost out. It is proposed to do this as part of the Quarter 1 financial position review
- Agree how we release the capacity through alternative behaviours throughout management tiers to focus upon the joint schemes. Discussions are progressing with Chief Executives on this.
- Agree a methodology for validating the planned activity changes and thus determining whether the savings have been delivered
- Agree the apportionment methodology for allocation of residual risk as set out in Appendix 1
- Transact the risk sharing agreement through contracts
- Specifically exclude Derbyshire Health United from the risk share although they remain a contributor to STP costs
- Consider how we engage with primary care, Derby City Council, Derbyshire County Council and East Midlands Ambulance in supporting delivery of the joint schemes as key partners, but not parties to the risk share
- Consider how we engage with regulators around our approach to risk management and risk sharing, including how we allocate PSF / CSF, as well as consider locally scenarios to maximise PSF / CSF drawdown
- Through the ICS development programme, agree how we develop our approach to risk management and risk sharing for implementation in 2020/21

9. Recommendation

The Joined Up Care Board is asked to:

- Discuss the proposals in the paper
- Approve the proposed approach
- Agree that all organisations will take the paper to respective Governing Body and Boards for approval in May / June 2019

APPENDIX 1: Apportionment method for residual risk across Derbyshire organisations

Apportionment of Costs	Income £m's	Share	Income £m's	Share
Erewash CCG	142.00	5.5%	142.00	5.6%
Hardwick CCG	160.00	6.2%	160.00	6.3%
North Derbyshire CCG	440.00	17.0%	440.00	17.2%
Southern Derbyshire CCG	751.00	28.9%	751.00	29.4%
Chesterfield FT	217.00	8.4%	217.00	8.5%
Derby Hospitals FT	521.00	20.1%	521.00	20.4%
DCHS FT	187.00	7.2%	187.00	7.3%
Derbyshire Healthcare FT	137.00	5.3%	137.00	5.4%
DHU	40.00	1.5%	0	0.0%
Total	**2,595.00**	**100%**	**2,555.00**	**100.0%**
Commissioner		**57.5%**		**58.4%**
Provider		**42.5%**		**41.6%**

NOTE: Apportionment based upon agreed method for 18/19. For transition purposes, 4 CCGs shown.

APPENDIX 2: Illustrative allocation of residual risk to organisations

Apportionment of Risk	Income	Share	Risk Share of STP Schemes £10m Shortfall	Risk Share of STP Schemes £20m Shortfall	Risk Share of STP Schemes £30m Shortfall
	£m	%	£m	£m	£m
Erewash CCG	142.00	5.6%	0.56	1.11	1.67
Hardwick CCG	160.00	6.3%	0.63	1.25	1.88
North Derbyshire CCG	440.00	17.2%	1.72	3.44	5.17
Southern Derbyshire CCG	751.00	29.4%	2.94	5.88	8.82
Chesterfield Royal FT	217.00	8.5%	0.85	1.70	2.55
UHDB FT	521.00	20.4%	2.04	4.08	6.12
DCHS FT	187.00	7.3%	0.73	1.46	2.20
Derbyshire Healthcare FT	137.00	5.4%	0.54	1.07	1.61
DHU	0	0.0%	0.00	0.00	0.00
Total	**2,555.00**	**100%**	**10.00**	**20.00**	**30.00**
Commissioner		**58.4%**	5.84	11.69	17.53
Provider		**41.6%**	4.16	8.31	12.47
		100.0%	**10.00**	**20.00**	**30.00**

NOTE: Apportionment based upon agreed method for 18/19. For transition purposes, 4 CCGs shown.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 June 2019

Guardian of Safe Working Report

Purpose of Report

This is an extended report from the Trust's Guardian of Safe Working which provides data about the number of junior doctors in training in the Trust, full transition to the 2016 Junior Doctor contract and any issues arising therefrom. The report details arrangements made to ensure Safe Working within the new contract and arrangements in place to identify, quantify and remedy any risks to the organisation.

Executive Summary

This is the quarterly report of the Guardian of Safe Working for the period December 2018 – March 2019 and covers the following:

- Changes have been made to higher trainee rotas which aim to ensure compliance with safe working. Details of exception reports received to date are outlined in this report.
- Issues identified through the Junior Doctors Forum meeting were addressed by the Guardian of Safe Working and Local Negotiating Committee (LNC)
- The Quality Committee received this on 14 May and the Board of Directors is asked to note the information contained in the report including risks associated with vacant trainee posts and associated rota gaps.

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

- Smooth Transition to the 2016 Junior Doctor Contract for all doctors in training in the Trust
- Adherence to previous changes that have been made to higher trainee rotas which aim to ensure compliance with safe working
- The exception reports received to date are outlined in this report
- Any issues identified through the Junior Doctors Forum meeting were addressed by the Guardian of Safe Working and LNC
- There were no equality or diversity or gender related issues noted with regards to the process of Exception Reporting

Consultation

At the Junior Doctor Forum about relevant issues discussed in the report

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).	-
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

1. The junior doctors are encouraged at the induction to complete exception reports to help with the delivery of the new contract.
2. We are currently setting up a survey for all the juniors in the Trust regarding the feasibility of equality risk analysis based on exception reporting.

Recommendations

The Board of Directors is requested to:

1) Note that there are vacancies in trainee posts that reflect the national issue with recruitment in psychiatry. A fall-back position has been agreed with Derbyshire Health United. They will supply medical cover for physical health care urgent referrals in the event of a junior doctor not being available after hours. This is a fail-safe contingency plan. Psychiatric emergencies would be responded to by the Consultant and/or higher trainee on call.
2) Note that the trainees are being supported with exception reporting and to ensure that these have been resolved in a timely fashion.
3) Note that there have been very few exception reports in this period.
4) Note the delay in resolution ER is mainly due to Allocate related issues – logging issues or supervisors unable to read the exception report despite it having been logged in. Allocate were invited to attend the last Junior Doctors Forum (in January) at which they gave assurance that they would respond quickly to any such issues.
5) Note the consultant group takes the responsibility to ensure smooth operation of consultant on call rota with prompt resolution of any issues arising due to sickness or any other reasons for a gap so that it does not impact the HSTs during their on call shifts

Report presented by: **John Sykes**
Medical Director

Report prepared by: **Consultant Psychiatrist**
Dr Smita Saxena
Guardian of Safe Working

Guardian of Safe Working Quarterly Report – December 2018 – March 2019

1. Trainee data

Information supplied from 1 December 2018 to 31 March 2019

Number of posts for doctors in training: Exception reports (with regard to working hours) - there was one report relating to having worked difference in hours, during the above period. No fines were levied and the report has been closed.

Exception reports				
Location	**Number of exceptions carried over from last report**	**Number of exceptions raised**	**Number of exceptions closed**	**Number of exceptions outstanding**
North	0	1	1	0
South	0	0	0	0
Total	0	0	0	0

Exception reports by Grade				
Location	**Number of exceptions carried over from last report**	**Number of exceptions raised**	**Number of exceptions closed**	**Number of exceptions outstanding**
CT1-3	0	1	1	0
ST4-7	0	0	0	0
GPVTS	0	0	0	0
Foundation	0	0	0	0
Total	0	1	1	0

Exception reports by action				
	Payment	**TOIL**	**Not agreed**	**No action required**
North	0	1	0	0
South	0	0	0	0
Total	0	1	0	0

The exception report in the north has been raised by the CT1 trainee. This was about the differences in hours worked. The trainee stayed back on the ward to complete the discharge summaries. It took him 5 hours to finish the pending summaries (3 hours normal working time plus 2 hours premium hours).

There were no other exception reports in this period.

Response time				
Grade	**48hrs**	**7 days**	**Longer than 7 days**	**open**
CT1-3	0	0	1	0
Foundation	0	0	0	0
ST4-6		0	0	0

The delay in resolving this exception report was due to technical issues with the consultant unable to log in to allocate and although on allocate is still showing as pending, although it has been closed.

The exception report was submitted within seven days as all trainees are provided with log in details at induction.

2. Work schedule reviews

No formal work schedule reviews needed during this period

3. Fines

No fines imposed

4. Locum/Bank Bookings

North 21 shifts totalling £7343.93
South 49 shifts totalling £14,657.43

5. Agency

North 13 shifts totalling £7904.00
South 20 shifts totalling £12370.00

The total number of bank or agency shifts is high compared to the vacancy rate and this is due to pregnancy risk assessment recommendations.

6. Vacancies

	North Dec 2018 – Mar 2019	**South Dec 2018 – Mar 2019**
CT1-CT3	1.4	1.5
GP Trainees	0	0
Foundation	0	1

7. Qualitative information

The Junior Doctor Forum has met quarterly over the period reported. Active representation sought with each changeover of new doctors in accordance to the Forum constitution. At the last junior doctors forum, we had representation from Allocate to discuss the software issues.

8. Issues arising

- There has been on going issue about timely completion of discharge summaries on the wards. Currently discussions are ongoing with ADME and in- patient consultants and the junior doctors that should help to resolve this issue.

- SPACE FOR JUNIOR DOCTORS ON HARTINGTON UNIT – Currently we are in discussion with Area Service Manager about appropriate office space for junior doctors. In the meantime alterations to desks in the junior doctor s office have helped to make the space a little less congested.
- There has been a discussion at the Junior Doctors Forum about the mess supplies for junior doctors. The DME has agreed to have a further meeting to discuss this issue in lines with the BMA Fatigue and Facilities Charter but also to maintain the goodwill with the trainee doctors and fulfil any contractual requirements.

9. Ongoing issue

To continue to engage with trainees and to encourage them to understand the purpose and process of exception reporting when this is a valid option.

Consultant Psychiatrist
Dr Smita Saxena
Guardian of Safe Working

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 June 2019

2019/20 Trust Service Delivery Plans (previously Business Plans)

Purpose of Report

This paper is to present the Trust Board with the final 2019/20 Service Delivery Plans (previously Business Plans) for clinical divisions, clinical support services and corporate areas. These are the final plans which have been developed directly with each service area and presented at a market place event for wider consultation.

Executive Summary

The Contracting and Business Development team has spent a significant period of time working with colleagues across all clinical divisions, support services and corporate areas to develop a service delivery 'plan on a page' for each service in line with the process signed off by the Executive Leadership Team (ELT) in September 2018.

This work was facilitated using a suite of tools within an informal workbook in one-to-one meetings with general managers and heads of departments. Following a process of development and scrutiny, each clinical division, support service and corporate area has produced a final draft 'plan on a page'. The plans were open to wider stakeholder engagement through a 'market place' challenge and confirm event, and the final plans reflect all feedback received from the consultation.

This planning process delivers an improvement on the process for 2018/19, as this year's plans build on the consolidated performance and governance delivered in last year's plans, and are more comprehensive and forward focussed.

The plans deliver an overarching vision for the future direction of travel for each service, supported by a number of key objectives in alignment with and supporting each of the Trust's emerging three strategic objectives:

- To deliver great care,
- To be a great place to work, and
- To make good use of our money.

Each plan also includes a summary of key risks that may impede the delivery of each service's objectives aligned with the Trust's three strategic objectives.

The plans developed for clinical services reflect the divisional structure in place at the time of developing and finalising the plans. As the new operational structure is embedded, work will be undertaken with the newly formed division to form their service delivery plan, leaning into the existing service delivery plans which currently encompass those services, and reviewing any plans which have a service portfolio change.

To provide governance and assurance the plans have been triangulated against the emerging Trust Strategy refresh and the Board Assurance Framework. The Strategy refresh is out for consultation and therefore the final approved version was not available at the time of finalising the Service Delivery Plans. The triangulation exercise demonstrated that the plans were in line with the refreshed Strategy and Board Assurance Framework (BAF), with no incongruences to note. Many plans support the delivery of the building blocks from the strategy refresh, but are more focussed around service specific detail.

As the plans reflect the key priorities for each service area for 2019/20, there are areas of the strategy refresh which are not reflected in the plans because of the 'bottom up' process to develop the plans. This may be due to other more pressing local priorities being reflected such as a service already showing good performance against a key objective or identification of a need to challenge to services to reprioritise their focus. The latter will be taken forward in the development of 2020/21 plans and form a key part of the development process, with the finalised Strategy refresh forming an immediate challenge and confirm around emerging priorities for the 2020/21 plans.

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
A significant amount of time and resource has been devoted to developing the Service Delivery Plans to ensure that they are meaningful to services, and reflect the requirements of the wider organisation.

Consultation
Each plan has been developed with individual support to each service area, and wider consultation within their clinical and operational teams. The plans have previously been presented at a market style consultation event for wider Trust feedback. The plans have previously been submitted to ELT and this final submission reflects feedback around the development process and triangulation with other key strategic documents.

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 contents of the plans and be assured over the development process
2) Approve the final Trust Service Delivery Plans

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

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

Campus Division

Our Plan on a Page 2019/20

NHS
Derbyshire Healthcare
NHS Foundation Trust

Our vision: The delivery of services that safely, effectively and efficiently stabilise people with acute mental illness, so that they can receive a suitable package of care in the community

Our key strategic objectives

Provide great care in all our services	Be a great place to work	Make good use of our money

Key strategic aims

• Achieve a unified model across Radbourne and Hartington • Deliver equality of access to services across Derbyshire • Reduce average length of stay to 34 days or less • Deliver single sex accommodation across Derbyshire • Develop links with complex care and rehabilitation, reducing reliance on stepdown • Develop a monitoring and feedback process for KPIs • Develop the Red to Green programme • Review care plan targets • Ensure that data recording systems and IT infrastructure are fit for purpose • Improve links between inpatient and crisis services	• Improve the health and wellbeing of staff • Reduce long-term sickness absence • Develop staff skill mix, including ACPs and non-medical prescribers • Develop new models of supervision • Ensure that strategic workforce policies are fit for purpose • Develop preceptorship and build relationships with nursing schools	• Review estate and ensure that it is fit for purpose • Eliminate reliance on bank/agency staff • Eliminate reliance on staff overtime • Achieve 20-bed inpatient units across Derbyshire (a minimum reduction of 8 beds) • Eliminate out-of-area patients by 2020/21 • Reduce observation spend

Key risks

• Possible negative quality impact of a drive towards reducing the bed base • Possible negative impact of a move away from a medical model towards a therapeutic model • Quality impact of poor relationships between services, especially between community and inpatient services	• Difficulty of recruiting to nursing and psychiatry roles	• Financial pressure of high estate costs • Cost pressures of out-of-area providers

Central Division

Our Plan on a Page 2019/20

NHS
Derbyshire Healthcare
NHS Foundation Trust

Our vision: To provide competitive, high-performing, and responsive specialist services in collaboration with our partners

Our key strategic objectives

Provide great care in all our services	Be a great place to work	Make good use of our money

Key strategic aims

Substance Misuse
- Improve the performance of our partners and sub-contractors by introducing performance management frameworks

Learning Disabilities
- Complete the consultation process with a focus on quality improvement, embed the new model, and develop reflective capabilities

IAPT
- Undertake the re-procurement process, improve performance against specific targets, maintain waiting lists, and formulate transformation plans throughout the mobilisation period

Substance Misuse
- Improve retention rates and resolve recruitment issues with Aquarius

Learning Disabilities
- Develop a culture supportive of adapting to change, improve succession planning and line management, and ensure parity between staff members

IAPT
- Build on the improvements demonstrated in the 2017 staff survey

Substance Misuse
- Bring medication costs under control

Learning Disabilities
- Undertake the consultation process to ensure that the service provides value for money, and fulfil the CIP programme

IAPT
- Ensure continued financial sustainability during the re-procurement period, and plan ahead to ensure that service changes beyond re-procurement are financially sustainable

Key risks

- Inconsistent and underfunded IT infrastructure
- Uncertainty around future service models
- Increasing demand
- Inconsistent performance management
- Lack of clarity on the future IAPT contract and the CCG's capacity for re-procurement
- Estate concerns
- Lack of GP access for IAPT
- Poor working between Sub.Mis. and Mental Health

- Cultural challenges presented by agile working
- Ageing medical workforce
- National lack of psychiatrists
- Low staff morale
- Constant large scale change (in service models and service specifications)

- Uncertainty around future financial envelope/service specification for IAPT
- Increasing medication costs and dominant medical/ prescribing model in Substance Misuse
- Increasing IAPT referrals

Children's Division

Our Plan on a Page 2019/20

Derbyshire Healthcare NHS Foundation Trust

Our vision: To enable children and young people to lead independent, fulfilling lives, maximising their potential; to enable our service users to stay well long term; and, when this isn't possible, to manage complex or life-limiting conditions

Our key strategic objectives

Provide great care in all our services	Be a great place to work	Make good use of our money

Key strategic aims

CAMHS
- Develop pathways with clear operational policies and monitoring, and review clinical assessment and intervention models

Complex Health and Paediatric Therapy
- Develop the ND pathway work, review specifications and clinical and operational structures, consolidate new contracts, and resolve the RTT / capacity gap

0-19
- Review clinical and operational structures and improve caseload management

Divisional
- Review SPOA, develop reflection, meet clinical standards on care and safety planning, and improve clinical standards and clinical strategy delivery

CAMHS
- Review staffing skill mix, medical workforce capacity, roles, and delivery model
- Develop and improve commissioner engagement

Divisional
- Develop and improve staff leadership capabilities
- Improve use of patient feedback and develop and improve outcome measures
- Continue development of the workforce development plan

0-19
- Undertake a value for money review of sub-contracts to create possible capacity improvement opportunities and reduce spend

Key risks

- Capacity in the ND pathway
- Paediatrics RTT
- Uncertain recruitment and training of SCPHN staff
- Forthcoming CCG CAMHS review

- CAMHS medical workforce and recruitment difficulties
- Sufficient workforce and OD capacity needed to support proposed changes

- Tight timescale and difficult process for future of re-tender

Communications

Our Plan on a Page 2019/20

Derbyshire Healthcare NHS Foundation Trust

Our vision: To provide effective internal and external communications, utilising a full range of communications mechanisms to enhance the Trust's internal engagement and external reputation

Our key strategic objectives

Provide great care in all our services	Be a great place to work	Make good use of our money

Key strategic aims

• Develop a new, fully functioning and mobile-read Trust website • Provide communications support to services during the development of their clinically-led strategies • Develop a new Trust intranet, providing colleagues with easy access to frequently accessed tools • Focus communications to support the implementation of the Trust strategy • Focus support to the Radbourne Unit and Campus colleagues using bespoke newsletters and wider communications • Improve relationships with key media outlets • Build the Trust's profile through wider local and national media opportunities	• Review and revise the current programme of staff engagement • 2019 staff conference • Introduce a new programme of stakeholder engagement, comprising of a brand audit, stakeholder mapping, and CRM tool	• Continue to review all outsourced expenditure • Maintain existing mechanisms of financial efficiencies, e.g. in-house staff awards

Key risks

• Involvement is needed from wider staff to embed the new site • Clarification is needed of the proposed new intranet's specifications, and of systems currently 'out of scope' of the project • Clarity is needed regarding the focus needed on the Trust's strategy	• Improved participation of staff in, for example, Team Brief, is needed • Clarity is needed of existing infrastructure, for example how many teams hold team meetings • Stakeholder perception and feedback needs improvement • Executive engagement and participation in CRM is needed • Ongoing negative press coverage needs improvement	• Growing requirements and expectations of Communications Team

Complex Care and Rehabilitation

Our Plan on a Page 2019/20

Derbyshire Healthcare NHS Foundation Trust

Our vision: To rehabilitate those suffering from acute mental illness through evidence-based treatment, while ensuring the safety of patients, staff and the public

Our key strategic objectives

Provide great care in all our services	Be a great place to work	Make good use of our money

Key strategic aims

• Bolster and join up existing services, supporting the whole pathway • Ensure seamless transitions between services • Deliver sustainable alternatives to locked-door rehabilitation • Achieve AIMS accreditation • Achieve 'Outstanding' for Kedleston Unit • Improve outcome and quality measurement • Improve collaborative working between partners • Ensure speedy, streamlined referrals • Develop the forensics service with phase one funding and plan ahead for year two and beyond • Develop a new probation offer • Develop clear plans to implement new care models	• Ensure that service user views are represented across the whole pathway • Develop outstanding peer support capabilities	• Explore the full range of income-generating options for low secure services in Kedlston Unit in conjunction with new models of care • Maximise opportunities for local investment through developing alternatives to locked-door rehabilitation

Key risks

• IPP—Management of risk rather than mental health • Potential impact on quality of reducing beds in Kedleston Unit • Impact of Supreme Court ruling on restrictive care packages in the community • Potential of over-committing to non-statutory work • Impact on quality of the poor interface between CTR, LD, rehabilitation, forensics and mental health	• Impact of expectations around social control rather than managing mental illness • Expectations for rehabilitation, probation and MAPPA • Limited availability of skilled staff	• Uncertainty around availability of future funding • Disparity between level of activity and funding available • Investing more resources than required • Potential of impact on finances of reducing beds in Kedleston Unit

Contracting and Business Development

Our Plan on a Page 2019/20

Derbyshire Healthcare NHS Foundation Trust

Our vision: Internally, to provide a flexible, dynamic, consultancy-based source of specialist knowledge to build organisational capability and resilience, and, externally, to provide a process-driven framework to manage formal relationships with other organisations

Our key strategic objectives

Provide great care in all our services	Be a great place to work	Make good use of our money

Key strategic aims

• Internally develop readily available tools to support core business tasks • Externally, develop clear and open processes for managing relationships • Internally and externally, provide intensive support for only the most complex issues • Provide education and training to improve the resilience and autonomy of our internal partners (e.g. through Business Bytes) • Externally, develop knowledge and improve the use of standard processes to drive relationships • Internally and externally, develop ways to effectively manage the expectations of our partners	• Continue to build the team's reputation • Improve the availability, visibility, and understanding of the team internally and externally • Review skill mix of team in line with needs of service/ organisation • Focus on building capacity and capability within the Trust, through training and development within the team and the wider organisation • Build on the existing strong values of the team, and improve staff well being	• Develop income generation opportunities as an alternative to cost improvement

Key risks

• Difficulty of supporting the whole organisation with a small team • Previous functions of the team setting false expectations within the organisation • A lack of adherence to process on the part of our external partners	• Risks to organisational memory throughout the Trust • Lack of an understanding of purpose and capability of the team • Large scale and continuous organisational change throughout the local health economy	• Supporting sustainable income generation

Corporate Governance and Legal Services

Our Plan on a Page 2019/20

Derbyshire Healthcare NHS Foundation Trust

Our vision: To implement an effective corporate governance framework that supports internal control, reporting, escalation, risk management, and decision making, and to implement a self-sustaining internal legal process to facilitate appropriate and timely access to legal advice where required

Our key strategic objectives

Provide great care in all our services	Be a great place to work	Make good use of our money

Key strategic aims

Corporate Governance
- Ensure continued improvement in the effectiveness of the Board and Board committees, drawing on best practice
- Undertake a developmental review of leadership and governance using the NHSI well-led framework by December 2019
- Support the implementation of the governance and accountability framework throughout the organisation

Legal Services
- Operationalise the Access to Legal Services Policy
- Offer a bespoke, personalised legal service to colleagues
- Enhance the legal knowledge of internal partners through engagement

Corporate Governance
- Continue the programme of Board member visibility and visits
- Promote and encourage governor engagement
- Embed good governance practice throughout the organisation

Legal Services
- Engage local stakeholders, including the Coroner's office, provider partners and social care partners
- Enhance the legal knowledge of key internal partners through engagement

Corporate Governance
- Maintain an effective and streamlined structure which releases indirect savings and ensures financial sustainability

Legal Services
- Continue to utilise a small number of external law firms to maintain value for money
- Continue to use internal legal resources to maintain cost efficiencies

Key risks

Corporate Governance
- Disruption of leadership in corporate governance role
- Lack of engagement on the part of operational teams

Legal Services
- Variable internal legal knowledge
- Increased resource pressure in a single legal area resulting in focus on that area

Corporate Governance
- Time commitment required to implement the Board visits programme

Legal Services
- Current transient nature of Coronial appointments
- Variable internal legal knowledge

Corporate Governance
- Increasing regulatory governance requirements, meaning streamlining and subsequent cost savings can't be realised

Legal Services
- Growing resource demands on the legal team and increasingly complex inquests
- Conflict of interests by external providers

Estates and Facilities

Our Plan on a Page 2019/20

Derbyshire Healthcare NHS Foundation Trust

Our vision: To have an estate that provides clean, well maintained, compliant and efficient buildings that meet the needs of the Trust's clinical services and our patients

Our key strategic objectives

Provide great care in all our services	Be a great place to work	Make good use of our money

Key strategic aims

• Introduce the updated Cleaning and Catering National Specifications • Ensure the ERIC Estates returns are completed • Update the Premises Assurance Model to give assurance around compliance • Implement Year 1 Working in accordance with Health Technical Memorandums to achieve compliance • Update 6 Facet survey • Update procedures around the capital programme • Undertake an estates and facilities gap analysis for the 5-year plan	• Engage with clinical services to ensure that the estate is suited to its use • Ensure Estates and Facilities involvement in clinically led strategic sessions • Establish a training strategy for all E&F staff that promotes succession planning	• Work within operational budgets, ensuring break even at year end • Work on service contracts to ensure value for money • Renegotiate SLA to ensure best value

Key risks

• Risks around HTM compliance • Cost of 6 Facet survey	• Limitations to estate resources	• Risk of increase in service contracts after market testing • Financial implications for SLA and gap analysis

Finance

Our Plan on a Page 2019/20

Derbyshire Healthcare NHS Foundation Trust

Our vision: To support all teams and staff with financial information, assurance and confidence in order to release staff time for direct patient care

Our key strategic objectives

Provide great care in all our services	Be a great place to work	Make good use of our money

Key strategic aims

• Develop involvement in the National Costing Transformation programme • Develop the Patient Level Information Costing System (PLICS) • Continue to provide a responsive service to budget holders and senior managers across the Trust to enable them to effectively manage their budgets	• Provide information to support managers in the delivery of the 2019/20 efficiency programme and overall financial plan • Improve staff leadership development	• Support the delivery of short term and long term financial plans • Support the reduction of agency expenditure to contain within the ceiling, by providing robust information and accurate forecasting

Key risks

• Development of costing system with supplier as supplier is broadening their market • Accuracy of activity reporting on Trust systems • Increases in additional regulatory reporting • Staffing pressures within the department	• Development of leadership training programme • Availability of programmes and staff capacity to attend	• Delivery of CIP to the level required on a recurrent basis • Additional requirements for agency expenditure • CPC income doesn't deliver to plan

Information management, Technology and Patient Records

Our Plan on a Page 2019/20

Derbyshire Healthcare NHS Foundation Trust

Our vision: To build a technology enabled Trust

Our key strategic objectives

Provide great care in all our services	Be a great place to work	Make good use of our money

Key strategic aims

• Upgrade all computers to Windows 10 • Explore alternative solutions to replace Office 2010 • Maintain appropriate cyber security measures • Deliver all NHS England or CCG mandated information on time and at the required level of quality • Maintain IG excellence and implement GDPR by June 2020 • Efficiently process and store paper patient records • Implement a Single Electronic Patient Record based on SystemOne • Develop apps to support patients and clinicians • Explore SystemOne's ability to provide IAPT functionality	• Enhance network to support agile working • Support teams to access GDPR training • Eliminate the use of fax machines within the Trust • Explore scanning at source of recalled paper records to increase the speed of access and carbon footprint of the process • Explore new ways of presenting information • Respond efficiently and effectively to any issues raised by the Trust • Provide reliable technical environments and support services	• Deliver required CIP • Change networks from N3 to Health and Social Care Network (HSCN)

Key risks

• Money • Resources	• Money • Resources	• Money • Resources

Neighbourhoods Division

Our Plan on a Page 2019/20

Derbyshire Healthcare NHS Foundation Trust

Our vision: To deliver proactive, person-centred, evidence-based complex mental health services in a community-based setting

Our key strategic objectives

Provide great care in all our services	Be a great place to work	Make good use of our money

Key strategic aims

• Meet policy expectations regarding transition, supervision, and 'waiting well' • Develop a defined recovery offer • Develop a defined psychological therapy offer • Establish consistent use of outcome measures • Engage effectively with clustering to support a clear and dynamic service offer • Develop an estate strategy that supports clinical services and enables the local offer • Develop a tiered care offer reflective of differing levels of need	• Develop a dashboard for e-learning and mandatory training • Ensure that staff are willing and able to engage with transformation • Develop more effective workforce succession planning • Improve patient involvement in service developments • Develop clear timescales for recruitment • Develop a clear workforce strategy and training plan to tackle skills gaps • Develop informed care for patients and encourage joint ownership of care	• Reduce medical agency usage • Develop electronic patient records that support and enhance clinical care and clinical services • Develop recruitment dashboard • Ensure that the estate strategy supports operational delivery and financial sustainability

Key risks

• Impact of inconsistent clinical use of EPR • Requirement for cost improvement • Impact of a high pace of change, including organisational restructure • Increasing patient demands • Impact of outdated service specifications • Insufficient care co-ordination capacity	• Difficulty in recruiting to key posts • Ageing workforce profile • Obtaining accurate workforce data • Maintaining enthusiasm while establishing consistency	• Cost improvement • Implementation of e-expenses

Nursing and Quality

Our Plan on a Page 2019/20

NHS
Derbyshire Healthcare
NHS Foundation Trust

Our vision: To work in partnership with our front-line colleagues and communities in order to provide assurance for the safety and quality of our services

Our key strategic objectives

Provide great care in all our services	Be a great place to work	Make good use of our money

Key strategic aims

- Help deliver the Quality Improvement Strategy
- Oversee the CQUIN programme
- Deliver improvement to CQC actions, ensuring that the required evidence is submitted
- Promote learning from serious incidents near misses
- Appropriately manage complaints
- Oversee the Quality Visit programme
- Participate in Sign up to Safety
- Lead on systems to implement NICE
- Ensure that the Trust meets its legal duties regarding safeguarding children & adults, infection prevention & control, the Mental Health and Mental Capacity Acts, health & safety, and fire & security
- Lead on the physical health agenda
- Oversee patient safety and mortality, submitting committee reports and national data as appropriate
- Oversee and manage the Datix incident reporting system
- Deliver the annual Quality Report
- Co-ordinate the Quality Priorities

- Set standards for safer staffing
- Engage operational colleagues in CQC actions, the Schedule 4 Quality Contract and CQUINs
- Provide training on the reporting of incidents, including serious incidents, and promote a culture of candour
- Promote staff wellbeing for the division
- Lead on out carer involvement work
- Improve levels of Datix reporting
- Lead on professional standards for nursing / AHPs
- Lead on Core Standards and CPA

- Support the achievement of CQUINs, and support the development of a Quality Improvement Strategy that will include how we approach innovations and waste reduction
- Oversee the reporting process and submit CQUIN evidence to the CCG and NHSI
- Report on the Schedule 4 Quality Contract to the CCG

Key risks

- Challenges from the relative lack of administrative support for the team
- Staffing challenges in the Patient Experience team
- Staffing challenges in the Patient Safety team and elsewhere in the division

- Work planned to clarify the offer from Head of Nursing colleagues, to promote clear and positive engagement with operational colleagues

- Structures are not in place across the Trust for 100% delivery of all the CQUINs

People Services

Our Plan on a Page 2019/20

Derbyshire Healthcare NHS Foundation Trust

Our vision: To provide people management, development and engagement solutions which are business-focused, responsive, innovative, and demonstrate the best value for money

Our key strategic objectives

Provide great care in all our services	Be a great place to work	Make good use of our money

Key strategic aims

• Drive improvement across the Trust using pulse checks and the annual staff survey • Develop a new wellbeing strategy and action plan to support staff and reduce sickness absence levels • Develop policies and procedures that effectively support people to have the skills and knowledge necessary for their role • Develop a meaningful and engaging annual appraisal process that supports personal development • Improve recruitment and retention rates • Implement E-Roster effectively in all inpatient areas • New roles in workforce plans • Review and redesign the People Services specifications in line with operational requirements from services	• Improve colleague engagement and involvement through the annual staff survey and pulse checks • Grow and develop the Staff Forum • Roll out talent management and develop succession planning • Develop and grow staff networks, including colleague network groups for each protected characteristic • Develop innovative and targeted recruitment campaigns to reach a diverse range of applicants, and provide a flexible employment offer at all stages of careers	• Generate income through JVLT • Enable cost avoidance within services through reduction in sickness absence levels • Enable reductions in medical agency spend • Improve rostering in inpatient areas to reduce bank and agency usage • Roll out E-Expenses to reduce travel costs • Scope alternative payroll provider arrangements • Negotiate value for money Occupational Health contract in line with the wellbeing strategy

Key risks

• Cost improvement across all services • High turnover rates in inpatient areas • Difficulty releasing time for training • Delivery of actions from staff survey and pulse checks • Cost Improvement plan against Joint Venture contract • Failure to recruit to realise E-Roster project plan	• Lack of engagement in teams • Insufficient IT infrastructure and capability in some areas • Difficulty releasing time for staff to attend networks • Difficulty recruiting to key posts	• Cost improvement target • IT access • Training capacity to all teams • Unable to meet 'break point' in current payroll provider with an alternative provider

Pharmacy

Our Plan on a Page 2019/20

Derbyshire Healthcare NHS Foundation Trust

Our vision: To reinforce recovery rather than repair relapses, to promote productivity, to remove weak links in the chain, and to provide the right skills in the right place and at the right time

Our key strategic objectives

Provide great care in all our services	Be a great place to work	Make good use of our money

Key strategic aims

• Support the Trust in achieving its medicines optimisation strategic aims • Deliver mental health clinical pharmacy services in the community • Work directly with patients to optimise and maintain their recovery • Maintain the delivery of high-quality pharmacy services to inpatients • Refine our clinical pharmacy standards and measure ourselves against them • Deliver face-to-face clinical pharmacy interventions to patients in the community, prioritising those with a psychotic diagnosis and risk of admission • Record activity to support benchmarking between clinical pharmacy teams and against other providers • Maintain IT systems that are fit for purpose • Contribute to planning for ePMA implementation in 2020/2021	• Provide effective leadership to the organisation with respect to medicines and their usage • Develop empowered and well-led clinical pharmacy teams • Develop the clinical skills of pharmacy professionals • Support professionals working in innovative roles or models • Network with primary care colleagues • Become the mental health pharmacy employer of choice in the Midlands	• Achieve income to offset pharmacy team training and development costs • Utilise national benchmarking data to ensure cost effective medicines procurement • Contribute to a reduction in psychotic relapse requiring inpatient admission • Continue to provide a pharmacy wholesaling service if sustainable • Transform pharmacy operational service to release clinical pharmacist time

Key risks

• Staffing levels—small teams are significantly affected by maternity leave and long-term sickness • Challenge of influencing staff to adhere to agreed standards, possibly mitigated by a refreshed Medicines Code and more relevant e-learning offerings	• Capacity of clinicians and managers to engage with pharmacy • Difficulty recruiting and retaining pharmacy professionals • Lack of availability of education and training • Resistance to change	• Unpredictable increases in medicines costs driven by external factors • Cost of training opportunities, which are essential to developing effective clinical teams

Procurement

Our Plan on a Page 2019/20

Derbyshire Healthcare NHS Foundation Trust

Our vision: To continue to provide value for money for the Trust by balancing costs of goods and services against the best service, quality, and performance

Our key strategic objectives

Provide great care in all our services	Be a great place to work	Make good use of our money

Key strategic aims

• Ensure that a high quality service is delivered by the Procurement department, especially since staff downsizing in 2018/19 • Long term plan for the Procurement department has been developed and agreed	• Work closely with divisions to get early insight into bids and tenders • Continue to offer guidance and advice to all departments within the Trust	• Contribute where possible towards procurement savings with Supply Chain Coordination Limited (SCCL), as referenced within the NHS Long Term Plan • Look at out of area provision

Key risks

• Ensuring value for money whilst not compromising on quality is getting harder due to increasing costs • Recruitment to new positions • Head of Strategic Procurement and Tenders delays departure beyond May 2020		• Increasing costs across the healthcare system

Transformation Team

Our Plan on a Page 2019/20 and 2020/21

Derbyshire Healthcare NHS Foundation Trust

Our vision: ***To develop and maintain an organisational capability and enthusiasm for continuously improving patient care and experience, through engagement, innovation and cost effective use of trust and system resources.***

Our key strategic objectives

Provide great care in all our services	Be a great place to work	Make good use of our money

Key strategic aims

- Effective communication of the Transformation Team offering and value through multiple channels.
- Progress a single approach for continuous improvement with PDSA principles at its core and embed in the trust.
- Work with teams in an engaging co-production style to incorporate a diversity of thinking in the development of effective care systems and processes and that the people who own the change, make the change. Be mindful of CIP language.
- Further develop QIA process ensuring appropriate oversight of small to large and cost out / cost avoidance schemes.

- Develop a Transformation Team identity with a supporting and nurturing approach towards ourselves and the wider organisation.
- Develop training package and support in continuous improvement and transformation.
- Support teams and individuals to explore and develop their ideas with quality improvement techniques and coaching.
- Development of working relationships with key stakeholders through regular informal catch ups and networking as well as formal meetings.

- Identify, explore and support innovative techniques for clinical and support function activities.
- Participate in the work of the Model Mental Health Hospital and incorporate metrics and learning into the Trust continuous improvement programme.
- Further develop process for capturing value of innovation and transformation across multiple cash and non-cash currencies.
- Develop a pipeline of schemes for recurrent CIP.

Key risks

- Capacity to effectively participate in quality improvement programmes of work by the transformation team or staff in general.
- Engagement by operations staff.
- Delay to intranet development (seen as key tool).

- High demand on individuals and teams causing burn out and/or demotivation.
- Disconnect between organisational motivators and individual motivators.

- Due to the configuration of some processes, improved productivity does not always equate to reduced spend or increased income.
- Clinical pressures can result in released budget or reduced expenditure being used elsewhere reducing net financial gain.

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors - 4 June 2019

Fit and Proper Persons Test Chair's Declaration

Purpose of Report

To present the Chair's declaration that all Trust Board Directors meet the fitness test and do not meet any of the 'unfit' criteria as per the Fit and Person's Test regulations (Health and Social Care Act 2008 Regulation 2014).

Executive Summary

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 introduced a 'Fit and Proper Person Test' for NHS bodies. At its meeting on 30 March 2016 the Trust Board approved a Fit and Proper Persons Test policy which outlines how the Trust will meet the requirements placed on NHS providers. An updated policy, to reflect additional Care Quality Commission (CQC) guidance issued in January 2018, was approved by the Board in May 2018.

Under the regulations, all provider organisations must ensure that Director level appointments meet the 'Fit and Proper Persons Test' and the regulations place a duty on NHS providers not to appoint a person or allow a person to continue to be an Executive Director or equivalent or Non-Executive Director under given circumstances. The regulations have been integrated into the CQC registration requirements, and fall within the remit of their regulatory inspection approach.

It is the responsibility of the Chair to discharge the requirement placed on the Trust to ensure that all Directors meet the fitness test and do not meet any of the 'unfit' criteria. The Trust has processes in place to ensure that the appropriate checks are made on appointment of Director level posts, that relevant checks and supporting information relating to existing post holders have been provided and there are proactive processes set in place to ensure the ongoing review and monitoring the filing system for all Directors. These have been carried out at appointment for all Director/Non- Executive Director appointments made during 2018/19. In addition, self-declarations have been made by all Directors as at 31 March 2019. Comprehensive files containing evidence to support the elements of the fitness test are retained and regularly reviewed to ensure contents are updated as required. The CQC commented as part of their report following the comprehensive inspection in June 2018 that we had satisfactory procedures in place relating to applying the Fit and Proper Persons Test for Trust Directors.

This declaration evidences the full embeddedness of processes set in place as part of the Governance Improvement Action Plan (recommendations FF1(4) and FF(5)) relating to compliance with the Fit and Proper Persons Test.

During the year there has been continuing debate within the NHS regarding the requirement to carry out Disclosure and Barring Service (DBS) checks for Directors. Legislation outlines that DBS checks should only be carried out for individuals who meet specified eligibility criteria. Although Non-Executive Director roles, and Executive Director roles (with the exception of the Director of Nursing and Patient Experience and the Medical Director) do not meet the criteria of carrying out eligible roles, it has been noted by the CQC in their inspections that enhanced DBS checks are expected for all

Directors. The Trust's current policy outlines that new appointments should have DBS checks where appropriate to the role. During the year the Trust has carried out checks relating to two new appointments, namely Gareth Harry Director of Transformation and Business Improvement and the hosted STP Director post holder, Vikki Taylor.

We have continued to develop our records to encompass wider social media checks (including Facebook, Twitter, LinkedIn). We also include details reflecting the values based interview and selection process which has included stakeholder evaluation of all candidates for Board member appointments since April 2016 and for appointments prior to this where information is available.

National Developments

In July 2018 Tom Kark, who led the Mid Staffordshire Public Enquiry was commissioned to review the scope, operation and purpose of the Fit and Proper Persons Test. Details of the published report were presented to the Trust Board as part of the Chief Executive's report in March 2019. The review highlighted issues with current implementation of guidance across the NHS and made seven broad recommendations. The first two were immediately accepted by the Secretary of State and five are under review by Baroness Harding:

- All directors must meet specific standards of competence to sit on the Board of any health organisation
- A central database should be developed to hold relevant information about all directors
- Full, honest and accurate employment references must be required for all directors
- The FPPT should be extended to all Arm's Length Bodies and commissioning organisations
- An organisation should be set up with the power to suspend and disbar directors who have committed serious misconduct
- Remove the words 'privy' in the requirement relating to serious misconduct
- Consider how FPPT applies to social care organisations.

The Trust continues to be involved in national debate relating to implementation of the recommendations. There is no timeframe for implementation of any of the recommendations as yet.

DECLARATION:

I hereby declare that appropriate checks have been undertaken in reaching my judgment that I am satisfied that all Directors of the Trust, including Non-Executive Directors, and Executive Directors (including voting, non-voting and Acting) are deemed to be fit and that none meet any of the 'unfit' criteria. Specified information about Board Directors is available to regulators on request.

Strategic considerations

- This declaration confirms that the Trust meets the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 'fit and proper person test' for NHS bodies.
- It is an element of NHS Improvement's Code of Conduct for NHS Trusts (Reference B.2.2) for which the Trust must 'comply or explain' within the Annual Report and Accounts

Board Assurances

- The Board can receive assurance that due process has been followed to ensure that all relevant post holders meet the fitness test and do not meet any of the 'unfit' criteria.
- That comprehensive files have been established and maintained for each relevant post, evidencing compliance and that proactive processes have been set in place to monitor the filing system.

Consultation

This report has not been considered by other groups/committees. However confirmation of Fit and Proper Person Test compliance for Non-Executive roles is reviewed by the governor Nomination and Remuneration Committee, and confirmation of compliance with Fit and Proper Persons Test requirements have been overseen by the Remuneration and Appointments Committee for Executive Director appointments made in year.

Governance or Legal Issues

- It is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that NHS bodies undertake a 'fit and proper person test'
- The regulations have been integrated into the CQC's registration requirements, and falls within the remit of their regulatory inspection approach.

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) and Public Sector Equality Duty & Equality Impact Risk Analysis.

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 - No risks to those with protected characteristics have been identified with the reporting outlined in this paper.

Recommendations

The Board of Directors is requested to receive full assurance from the Chair's declaration that that all Directors meet the fitness test and do not meet any of the 'unfit' criteria.

Report presented by:	**Caroline Maley** **Trust Chair**
Report prepared by:	**Justine Fitzjohn** **Trust Secretary**
	Sam Harrison **Governance Advisor**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 June 2019

Workforce Development Delivery Plan 2019/20

Purpose of the report

To provide the Board of Directors with information and assurance on:

- Workforce training and delivery plan to enable discussion and understanding of the range of work and resources needed to deliver the Trust's future workforce in line with both local and national requirements.
- Identification of the financial implications of workforce development training for the year 2019/20
- Assurance that this plan is in accordance with the Trust's known service, workforce and financial intentions over the year
- Systems alignment and that the plan supports the Joined-up Care vision
- Aligned to the Health Education England (HEE) investment priorities

Executive Summary

This paper has been developed to provide the Trust's 2019/20 workforce development delivery plan which summaries all training and the funding available to fulfil these requirements for the year as they are known currently. It brings together an overarching summary of the Trust's training and development requirements for the next twelve months with an ongoing need to support workforce transformation. It supports the Trust's operational plan and strategic approach which aims make a positive difference in people's lives by improving health and wellbeing.

The report first provides a summary of the financial position for 2019/20 in relation to training and development monies available. We then provide a summary of the Mandatory Training commitment. Next the paper talks through plans for the use of the Apprenticeship Levy in 2019/20. We then provide details of our plans to deliver the training and development offer for staff. This includes available role development opportunities such as Advance Clinical Practice, Nursing Apprentices, Nursing Associates and Continuing Professional Development.

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 financial tables at the end of the plan evidence how our spending decisions align with our strategic direction and ambitions by categorising the spend into areas we are aspiring to develop in as a Trust.

Consultation

The plan has been developed in association with Service Managers and reviewed by the Executive Leadership Team. It was then submitted and discussed at the Strategic Workforce Development Group on 29 May for approval.

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

We know from our staff survey that staff report that their access to training, development and career progression is impacted by their protected characteristics. Therefore we will undertake a review of the Training Needs Analysis to check that any decision making is fair and equitable.

Recommendations

The Board of Directors is requested to:

1) Note the training and development required to attain the workforce transformation that will enable delivery of future service models to continue to provide high quality care to the people of Derbyshire
2) Receive the plan and be aware of the actions and outputs of the Strategic Workforce Development and Education Group.
3) Be assured that a monitoring process is developed
4) Be assured that access to training policy is adhered

Report prepared by: **Nancy Cooke**
Workforce Planning Lead

Report presented by: **Amanda Rawlings**
Director of People Services and Organisational and Effectiveness

Derbyshire Healthcare
NHS Foundation Trust

14.1 DHcFT Workforce Delivery Plan 2019-20

Workforce Development Delivery Plan

2019/20

Workforce Development – Delivery Plan

Introduction

This paper has been developed to provide a 2019/20 workforce development delivery plan which summaries all our training requirements and the funding available to fulfil these requirements for the year as they are known currently. It will also form the basis of a three year workforce plan. Work is underway to finalise this and it will be finalised during summer 2019.

This Delivery Plan brings together an overarching summary of the Trust's training and development requirements for the next twelve months with an ongoing need to support workforce transformation. It supports the trust operational plan and strategic approach which aims make a positive difference in people's lives by improving health and wellbeing.

The report first provides a summary of the financial position for 2019/20 in relation to training and development monies available. We then provide a summary of our Mandatory Training commitment. Next the paper talks through our plans for use of our Apprenticeship Levy in 2019/20. We then provide details of our plans to deliver the training and development offer for staff. This includes available role development opportunities such as Advance Clinical Practice, Nursing Associates and Continuing Professional Development.

The financial tables at the end evidence how our spending decisions align with our strategic direction and ambitions by categorising the spend into areas we are aspiring to develop in as a Trust.

Financial Summary

We know that we need to address the lack of Continuing Professional Development training (CPD) and development which has been available for staff over the past three years as national CPD funding decreased. This position is shown below to provide context as to the improvement we are now able to provide in 2019/20:

- Year 2016/17 - £67,923
- Year 2017/18 - £74,169
- Year 2018/19 - £41,000

However, for 2019/20 this has been increased again to £95,999, this is noted as an initial allocation and there is an expected second allocation of funding for this year.

Specifically, the HEE (Health Education England) funding must be spent on CPD, not mandatory training, be in accordance with identified system priorities and must address one of the seven investment themes:

1. Developing the support worker
2. Extended and advanced roles in priority service areas
3. Supporting patient safety and person centred care
4. Supporting career progression
5. Enabling apprenticeships
6. Promoting prevention
7. Workforce modelling and redesign

Additionally HEE funds are supporting District Nurse, Health Visitor, School Nurse and Advanced Clinical Practice training programmes, and the Trust pays £424,104 per annum into the Apprenticeship Levy and we will be maximising the use of this money in training our current and future staff.

The increase in funds from the previous years is very welcome but still the number of requests for training identified through our training needs analysis is in excess of this and stands at a total of £528,555 A reconciliation exercise therefore had to be undertaken led by the executive team to prioritise the approval for training.

This plan provides the detail on the outcome of that exercise, and how the funds for the Apprenticeship Levy, the funds for CPD and other training programmes will be delivered, focussing predominantly on the internal challenges that are within the gift of the Trust to address, given the good news regarding the increased level of funding from HEE.

Additionally, the Trust has been investing £40,000 per year into leadership and management training which has enabled a comprehensive development offer that is available for all leaders across the Trust.

It is also worth being aware that following a discussion at the Derbyshire Workforce Implementation group the Joined Up Care Derbyshire (JUCD) team presented the Derbyshire plan for agreement to the Local Workforce Action Board as requested by HEE. Three areas have been identified where there is opportunity for a collaborative approach, which may reduce course costs, namely:

- Return to Practice
- Non-Medical Prescribing
- Supervision and Assessment

Three other areas have been identified as supporting system priorities, but are not included as part of the Training Needs Analysis (TNA) process and are:

- Cost for maintenance and development of Strategic Workforce Planning (£35k)
- Expanding the Quality Conversations roll out (not yet scoped)
- Scoping of Cognitive Re-enablement training (£50k) – national funding identified

Recognising the agreement to support the system priorities the Trust share for the cost of maintenance and development of Strategic Workforce Planning is £3,426. Therefore, the total allocation for CPD is £93,573

Annual Mandatory Training Programme

Mandatory training is compulsory training that is determined essential by an organisation for the safe and efficient delivery of services. This type of training is designed to reduce organisational risks and comply with local or national policies and government guidelines. During 2019/20 we will be focusing on improving our compliance rates to achieve the Trusts targets. Data security and protection, Fire Safety and Safeguarding (Children - level1) training are at the expected compliance levels and we will be looking at how we ensure all mandatory training meets the expected compliance levels.

We aspire to have an e learning platform for the majority of mandatory training. We are exploring an alternative system to ESR and will be concluding our research during June 2019.

Modules that are mandatory are: Fire, Data Protection and Security (formally known as Information Governance), Conflict Resolution (not for DHCFT), Infection Prevention and Control (Level 1 for all staff and Level 2 for Clinical Staff), Resuscitation for Clinical staff and at a level which is relevant to role, Equality, Diversity and Inclusion, Health, Safety and Welfare, Patient handling (clinical focused staff), inanimate load handling, Safeguarding Adults and Children Level 1, 2 and 3.

The list of Mandatory and Role Specific training modules available and delivered by the People Development Team for the coming year, and are shown in the following table:

Mandatory Learning Module	Number requiring this each year	Delivery Mode
Every year each member of staff is required to undertake Fire and Data Security and Protection	2600	Data Protection and Security is eLearning only. Fire is face to face year one and then by eLearning year
Every three years each staff member is required to undertake Equality, Diversity and Inclusion	900	This is undertaken via eLearning. There will be one essential learning session per month until the additions to ESR (Electronic Staff Record) are undertaken and thereafter one per quarter. Colleagues in IFM teams undertake this learning with their specific key trainer.
Every three years each non-clinical staff member is required to undertake infection prevention and control – level 1	200	This is undertaken via the eLearning route
Annually each clinical staff member is required to undertake infection, Prevention and Control Level 2	2000	This is undertaken via the eLearning route
Moving and Handling Level 1 update every three years	680	This is delivered face to face
Moving and Handling Level 2 update two years	900	
Safeguarding Adults and Children Level 1 is undertaken every three years by non-clinical staff	680	Undertaken via eLearning every 3 years
Safeguarding Adults and Children Level 2 is undertaken every three years by clinical staff	400	Undertaken face to face
Safeguarding Children's Level 3 and 3a, these are annual requirements	400 (level3) 50 (level 3a)	Undertaken face to face
Resuscitation Level 1 is an annual requirement for all relevant staff	260	Undertaken face to face
Resuscitation level 2 is an annual requirement for all relevant staff	860	Undertaken face to face
Resuscitation level 3 is an annual requirement for all relevant staff	100 (ILS) 50 (pLS)	Undertaken face to face
Raising Concerns – level 1 training for all staff	2600	This is undertaken via the eLearning route
Conflict Resolution Training is a requirement every three years for all clinical staff	500	Undertaken face to face
TOTAL Staff contacts for mandatory training	**13,180**	

Management and Leadership Training

The Trust recognises that at organisational level we need to build and develop existing talent and that developing leadership and management is a key priority for our workforce plan. It is also an integral part of improving quality services to enhance patient safety and people's experience of our services. We have developed a range of programmes and activities to support formal and informal development of leaders and managers. Below the key elements of the leadership and management programme are described:

People Management Masterclasses
The following half day masterclasses are currently available for all leaders (or aspiring leaders) to access:

- Dignity at work and grievance
- Disciplinary policy for managers
- Health and attendance
- Performance Management
- Leading through engagement
- Managing Budgets
- Business Bytes

From May we will also have delivering how to conduct an effective appraisal; resilient leadership; and courageous conversations.

We will continue to evaluate and add or adapt the offer to ensure it remains relevant and meet the needs of leaders.

Leading Team Derbyshire Healthcare
Six half day sessions led by Ifti Majid, Claire Wright and Amanda Rawlings have now been delivered with a further sessions planned during the summer. Over 200 leaders have already attended this mandatory session that covers the trust values, leadership expectations and leadership offering. Once these sessions have been completed all new leaders will be expected to attend a half day leadership induction which will cover similar areas and set out expectations on attendance at masterclasses within the first six months of being in post.

Derbyshire Healthcare 360 appraisal
Following the completion of the pilot all Leaders are now being offered the 360. With all programmes there will be an expectation that a 360 is completed prior to commencing the programme.

Senior Leaders Programme
This programme is in development and the outline proposal will include three sessions broadly focussed on Compassionate Leadership; Service Improvement; and Systems Leadership. During the initial three sessions, delegates explore the concept of compassion - what it means to us as an organisation and to our frontline staff. They would also consider real scenarios and how our quality improvement strategy could ensure the most positive outcomes for those scenarios. Following the initial three sessions, an additional three to include Power and Politics; Effective Collaboration; and Living/Learning Systems Leadership may also be included.

Middle Managers Programme – Supporting Transformation
This five day programme will be launching in the summer and will be aimed at supporting the development of middle managers. Initially a cohort of 30 will be available for applications, which will include a request to run a service improvement project alongside the programme. The programme will cover; you as a leader, leading others, change, influencing for change, sustainability. The programme is already run through East Midlands Leadership Academy so is tried and tested and evaluated extremely successfully. EMLA will be bringing this programme in house for us and with support to facilitate from the Leadership Development team. If successful we plan to roll out further cohorts.

The programme is already run through East Midlands Leadership Academy (EMLA) so is tried and tested and evaluated extremely successfully. EMLA will be bringing this programme in house for Derbyshire Healthcare with support to facilitate from the Leadership Development team. If successful we plan to roll out further cohorts.

Aspiring to Be a leader
Summer 2019 also sees the launch of the first Aspiring to Be programme. The programme is aimed at aspiring new leaders and offers a 9 month leadership development programme for 18 individuals who wish to progress their levels of responsibility.

Leaders Forum
The leader's forums run has been run quarterly and will be moving to the requirement for mandatory attendance twice per year.

Coaching Network
We have relaunched our Coaching Network to embed a coaching culture throughout the trust. We will be building coaching into the three in house programmes (senior leadership, middle managers and aspiring to be) a strong recommendation that all delegates have a coach, particularly for the period of the programme and six months post to support ongoing learning and implementation of learning from the programme.

East Midlands Leadership Academy
Whilst the model from EMLA has changed and will allow us to access more in-house bespoke programmes through their consultancy arm such as the middle and senior managers programmes described above, there are still a number of one day masterclasses available which we will promote to leaders to ensure they are aware they can access these for no cost to the trust. Over the next three months the following masterclasses are available: Engaging, Involving and Motivating Masterclass, Influencing Beyond Authority, Crucial Conversations, Relationships and Connectivity and Thinking Creatively.

NHS Elect
We have commissioned NHS Elect to run 2 full day masterclasses on Compassionate Leadership.

Apprenticeships

Apprenticeships are the future and work continues develop our delivery model. The main issue for delivery is rule based and currently there are barriers to get through the regulation. In 2018/19 we spent all of our levy pot. The apprenticeship levy and its delivery plan are pivotal to support the development of our workforce and to overcome the major barrier we are working towards becoming a training provider which will include attainment of the business excellence for training outcomes. The apprenticeship delivery in the future will include:

- Recruiting staff to develop a "grow our own model" by scoping vacancy suitability as an apprenticeship with introductory pay offered in accordance with Agenda for Change Annex 21 – offering a cost saving
- Identifying how apprenticeships can be used to 'Grow our own', by looking at the development of career pathways that start at level 2, intermediate level through to levels 4, 5 and 6 Higher and Degree levels
- Offering opportunities for career progression to existing staff to encourage retention and loyalty.

We have a notional allocation of £424,104 per year from the Apprenticeship Levy. (It is notional as it is based on pay bill and these changes throughout the year.) Based on the allocation the Trust is given a target of training 65 apprentices per year.

Currently, we are training 41 members of staff and further requests are received to support 18 members of the workforce through the apprenticeship training route.

- The total requests for course fees only for the new apprentices is estimated at a cost of £151,500
- This means that our commitment against the Levy for 2019/20 is £361,000
- The balance remaining is approximately £63,000 to support further apprentices

Further work has commenced to explore training roles that can be recruited to, including recruiting to Training Nursing Associate, Trainee Nurses and Trainee Allied Health Professionals. Supporting the development of the "grow our own" staff and talent management strategies.

The following table below summarises the current position using the Apprenticeship Levy:

Apprenticeship title	Cost per Apprenticeship £'s	Length of Progamme in years	Number of Apprentices in training	2018/19 £'s	2019/20 £'s	2020/21 £'s	Total Levy spend £'s	New requests 2019/20	Cost of new requests £'s
Level 5 Assistant Practitioner	£12,000	2	15	90,000	90,000		**180,000**	3	18,000
Health Pharmacy Services, Level: 3	£4,000	2	2	4,000	4,000		**8,000**		0
Digital and technology solutions professional, Level: 6 (Standard)	£27,000	3	1	9,000	9,000	9,000	**27,000**		0
Business and Administration, Level: 3	£2,500	1	3	7,500			**7,500**		0
Health and Social Care: Adult social care, Level: 3	£1,500	1	3	4,500			**4,500**		0
Business and Professional Administration, Level: 4	£4,000	1	2	8,000			**8,000**		0
Nursing Associate, Level: 5 (Standard)	£15,000	2	4	30,000	30,000		**60,000**	1	7,500
Chartered manager degree apprenticeship, Level: 6 (Standard)	£13,500	3	1	4,500	4,500	4,500	**13,500**		0
Registered Nurse, Level: 6 (Standard)	£27,000	3	7	63,000	63,000	63,000	**189,000**	12	108,000
Installation electrician / maintenance electrician, Level: 3 (Standard)	£18,000	2	1	9,000	9,000		**18,000**		0
Occupational Therapists, Level 6 (Standard)	£27,000	3						2	18,000
Team leader / supervisor, Level: 3 (Standard)	£5,000	1	1	5,000			**5,000**		0
Lead adult care worker, Level: 3 (Standard)	£3,000	1	1	3,000			**3,000**		0
TOTAL			**41**	**237,500**	**209,500**	**76,500**	**523,500**	**18**	**151,500**

Functional Skills training

Functional skills form part of all apprenticeship frameworks and all new apprenticeship standards, although learners who already have obtained the level required by the apprenticeship will be exempt from undertaking them. Functional skills are the fundamental, applied skills in English and Mathematics which help people to gain the most from life, learning and work. There is also a requirement to have these skills before entry to the majority of further education training programmes and we have successfully established a programme for staff to gain these skills.

Role Development

The role development programme of work is continually evolving working with service colleagues. Role development and new roles support the modernisation of our services workforce by promoting the use of the established standards for role redesign and encouraging the development of new workforce solutions for areas of staffing under pressure. In turn, the work compliments and supplements the development for flexible and sustainable workforce and supports workforce recruitment and retention.

Included within the new roles and role development portfolio are:

- Advanced Clinical Practitioner
- Nursing Associate
- Clinical Associate Psychologist
- District Nurses
- Health Visitors
- School Nurses

Advanced Clinical Practice (ACP)

Our Advanced Clinical Practice Strategy is being developed; this is reflected in the workforce plan and will be further reflected through future plans leading to the trust 3 year workforce plan. In addition, it needs to be recognised that many of the Specialist Nurses, Occupational Therapists and Physiotherapists within the Trust have undertaken modules and masters degrees which have developed their advanced practice skills. The Trust is in a position to influence the development of the Mental Health ACP Pathway on a national platform and there is a need to ensure that our staff benefit from this work via clearly defined career pathways. Therefore It is recommended that we develop the offer for career development and support for individuals developing their careers in the roles to advance clinical practice level, it is clear that remuneration is not the only factor in retaining these valuable colleagues.

During 2018/19 the Trust supported two members of staff to undertake the ACP training and will support further development of this role over the next three to five years.

Nursing Associate

Nursing associate is a new role within the nursing team. Nursing associates work with healthcare support workers and registered nurses to deliver care for patients. This role is designed to help bridge the gap between health and care assistants and registered nurses. Nursing associate is a stand-alone role that will also provide a progression route into graduate level nursing. The role contributes to the core work of nursing, freeing up registered nurses to focus on more complex clinical care.

The Trust took part in the initial national pilot and supported 2 colleagues to undertake this training in 2018/19; further work is taking place to fully understand the requirement for this role in the mental healthcare setting. We are undertaking some pre-work to ensure the staff have the prerequisite qualifications to join the Nursing Associate Programme. Training places will be made available through the use of our apprentice levy, and a training cohort plan will be developed through a recently established task and finish group.

Health Visiting

We continued to support staff to develop their careers into Health Visiting roles and during 2018/19 three colleagues were supported through the Specialist Public Health Nursing (SPHN) qualification for Health Visiting. For 2019/20 a total of three colleagues have been identified to attend this training, HEE have confirmed that this will be supported in terms of salary support and course fees for each trainee.

School Nursing

We have also continued to support staff to develop their careers into School Nursing roles and during 2018/19 one colleague was supported through the SPHN qualification for School Nursing. For the year 2019/20, one colleague was been identified to attend. HEE have confirmed that this will be supported in terms of salary support and course fees for each student. It is noted that Public Health Nursing services will require a reshaping of the current school nursing offer to meet the new contract budget.

Nursing Apprentices

Over the course of 2019/20 the Trust will be supporting twelve current employees to undertake the Nursing Apprenticeship training. The first cohort has commenced with the second cohort planned for September 2019. We are undertaking some pre-work to ensure the pipeline have the prerequisite qualifications to join the Nursing Apprenticeship Programme.

Continuing Professional Development

The summary of the training needs analysis we have undertaken across the Trust shows that:

- The total requests received for Business Critical training was £160,885 against an initial fund of £93,573, a second round of CPD funding is expected to be announced in the coming months
- Over **400** members of staff requested investment in external continued professional development
- A number of e-learning programmes have been requested.

The training needs analysis was collected from each Division, this has been analysed and costed using the course price list issued by HEE. This was then presented to the Strategic Workforce Development and Education Group for decision and approval of spend on 29 May 2019.

Initially, the Executive team met to discuss the priorities for developing the workforce plan and the use of the Continuing Professional Development (CPD) fund. It was recognised that the requests far exceeded the available funds, but the initial allocation of £95,999 would be used to support the requests that are categorised as business critical with a further review of the requests to be undertaken as additional funds are made available. First and foremost the group agreed that the money would be fully spent and that business critical training is to be supported. But they would need to explore realistic options for supporting the numbers requested and crucially decide what was not to be funded at this time, along with options to maximise the use of our allocation. This includes negotiating contracts across the Derbyshire system were a large requirement for training is needed this includes Non-Medical Prescribing and Mentorship training. The group also agreed that the decision on the monies should be focussed on the organisation's strategic priorities and urgent clinical needs.

The training needs collected was categorised as critical, essential and desirable need for training and aligned to services needs with supporting evidence, the total requests for business Critical training was originally costed at £160,885.

The executive team confirmed that of the training requests categorised as business critical the following would be supported differently to ensure the use of our CPD fund is efficient and makes best use of the monies available:

- Personality Disorder Training for Neighbourhood and Campus services will be purchased separately and delivered in house
- The Strategies for Crisis Intervention and Prevention training (SCIP) will be purchased separately
- Cognitive Behavioural Therapy training for 15 staff in Kedleston to be purchased separately
- The training request for Perinatal mental health to be purchased separately

- Review the need for non-medical prescribing in learning disability services
- The Nursing and Midwifery Council have recently reviewed the standard for mentorship training, and this will be published later in the year. The Trust has been working closely with other Derbyshire Stakeholders and there is an agreement that local Higher Education Providers will deliver the new mentor training at no cost. This reduces our need to utilise our training budget for mentor training

With the above points taken into consideration the revised training requests for business critical training is costed at £119,765 the executive team agreed that these training requests are to be supported with the additional funding requirement of £26,192 to be arranged. The summary is noted below:

Division	Business Critical training to be supported
	£'s
Neighbourhood Services	18,075
Children's Services	8,000
Campus Services	75,990
Central Services	17,700
TOTAL	**119,765**

The HEE fund is to be used to purchase courses at Higher Education Institutes and the National Centre of Rehabilitation Education (NCORE) the detail of this is shown in the financial section of this plan.

The training requests categorised as critical include:
- Non – medical Prescribing
- Mentor Training – to support competence development for all staff
- Behaviour Change Skills
- Cognitive Behavioural Therapy
- Compassion Focussed Therapy

Analysis of the training request demonstrates that all agreed course requests align to the HEE investment themes noted above, the majority being within the "*Extended and advanced roles in priority service areas"*

The table below shows how the requests align to the investment themes:

Investment Theme	Number of courses	£'s	%
Supporting Patient Safety and Person Centred Care (Mandatory Training is funded and delivered separately)	39	**45,515**	38%
Extended and enhanced roles in priority service areas	21	**74,250**	62%
TOTAL	60	**119,765**	100%

Financial Detail

The following table shows the total funding that is available to support and develop the workforce and how the fund has been allocated for the year.

Workforce Delivery Plan 2019/2020					
Workforce Priority	**Apprenticeship Levy £**	**Health Education England CPD £**	**Health Education England (Specific Programmes) £**	**Corporate DHcFT and local budgets £**	**Total £**
Develop extended and Advance Roles		74,250			**74,250**
Developing the Support Workforce	18,000				**18,000**
Supporting Patient Safety and Person Centred Care		19,323		26,192	**45,515**
Leadership and Management Development				40,000	**40,000**
ACPs			20,000		**20,000**
Nursing Associates	7,500				**7,500**
Nurse Apprenticeships	108,000				**108,000**
AHP Apprenticeships	18,000				**18,000**
Health Visitors			127,302		**127,302**
School Nurses			42,434		**42,434**
Supporting JUCD System Priorities		3,426			**3,426**
TOTAL	**151,500**	**96,999**	**189,736**	**66,192**	**504,427**

The following table summarises the number of staff to be trained in the year 2019/20, the outcome of the intervention and the pre-commitment proposed as some of the training programmes require a commitment for longer than one year:

Workforce Priority	Intervention	Headcount Affected	Cost of Intervention 2019/20	Funding Source	Pre-commitment	Outcome / Output of Intervention
Develop Extended and Advance Roles	*Provide training to develop our workforce to extend their skills and competence in specialist clinical areas where workforce pressures are significant*	*65*	£74,250	HEE Budget/DHcFT Budget	*1 year programmes or less*	*Pipeline of qualified staff to fill anticipated vacancies as identified in workforce plan*
Supporting Patient Safety and Person Centred Care		*39*	£45,515			
Developing the Support Workforce		*10*	£18,000	Apprenticeship Levy		
Leadership and Management	*Develop aspiring and future leaders and managers*	*50*	£40,000	DHcFt Budget		*Develop future leaders and managers*
Supporting JUCD System Priorities	*Supporting system wide workforce development for Derbyshire programmes*		£3,426	HEE Budget		*Supporting Derbyshire System development*
ACPs	*Provide training opportunities to increase number of qualified staff to meet needs in 3 years' time*	2	£20,000	HEE Budget		*Pipeline of qualified staff to fill anticipated vacancies as identified in workforce plan*
Nursing Associates		1	£7,500	Apprenticeship Levy	£7,500 year 1 - 2019/20 £7,500 year 2 - 2020/21	
Nurse Apprenticeships		12	£108,000		£9,000 year 1 - 2019/20 £9,000year 2 - 2020/21 £9,000year 2 – 2021/22	
AHP Apprenticeships		2	£18,000		£9,000 year 1 - 2019/20 £9,000 year 2 - 2020/21 £9,000year 2 – 2021/22	
Health Visitors		3	£127,302	HEE Budget	*1 year programmes or less*	
School Nurses		1	£42,434	HEE Budget	*1 year programmes or less*	
Mandatory Training	*Mandatory learning modules*	2,600		DHcFT Budget	To be delivered through 2019/2020	All staff to complete **Compulsory Mandatory** to secure safe and efficient delivery of services, aligned to roles
TOTAL		**2,785**	**£504,427**			

Conclusion

This paper forms the foundation for a robust training plan for the year 2019/20, which has been communicated and supported by all divisions. The training and development team aspire to improve the training, values and education and also to maximise our offer for training and development for all staff. Further to this the Trust's three year workforce plan will be published during the summer of 2019 that will ensure the right levels of staffing and training across the Trust.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 04 June 2019

Board Assurance Framework (BAF)
Second Issue for 2019/20

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the second issue of the BAF for 2019/20.

Executive Summary

The Board Assurance Framework is continuing to be developed in line with the refresh of the 2018 – 2021 Trust Strategy, including a review of gaps in controls and assurances to ensure where appropriate there is a read across to the priority actions identified in the Strategy. As a result, completion dates for some actions are expected to extend beyond the 2019/20 financial year.

No changes have to be made to the current risk ratings of the BAF risks since Issue 1.

As with previous versions of the BAF, changes made between each issue are highlighted in blue text. In this issue an expected completion date for each action has been added alongside the action review date, which is now shown in brackets, to enable Board Committees to focus the reports and reviews required to mitigate the risks identified.

An additional colour rating of blue has been added to the RAG rating of the action, to identify actions which have been completed.

One risk remains removed from formal reporting through the BAF due to commercial sensitivities. It is planned that this will be included from Issue 3.

There was discussion at the Audit and Risk Committee on 23 May 2019 as to if the outstanding gaps in controls and assurances identified against the 2019/20 BAF risk relating to MHA/MCA compliance, had been adequately mitigated. A paper responding to this has been prepared and will be considered by the Mental Health Act Committee at its next meeting on 07 June 2019.

A plan for the BAF deep dive programme is attached.

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 provides an update on all Board Assurance risks and provides assurance on 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.

Consultation

Executive Leadership Team 13 May 2019

Audit and Risk Committee 23 May 2019

Governance or Legal Issues

Governance or legal implications relating to individual risks are referred to in the BAF itself.

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

Specific elements within each BAF risk and associated actions are addressed by the relevant lead Executive Director in taking forward

Recommendations

The Board of Directors is requested to:

1. Agree and approve this second issue of the BAF for 2019/20 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
2. Accept the proposed plan for 'deep dives' for 2019/20
3. Agree to continue receive a quarterly update of the 2019/20 BAF risks as outlined in the forward plan.

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

Report prepared by: **Justine Fitzjohn**
Trust Secretary

Rachel Kempster
Risk and Assurance Manager

Board Assurance Framework
Movement of risks and deep dive programme for
Second Issue of the BAF for 2019/20

The Board Assurance Framework (BAF) is a high level report which enables the Board of Directors to demonstrate how it has identified and met its assurance needs, focused on the delivery of its objectives and subsequent principal risks. The BAF provides a central basis to support the Board's disclosure requirements with regard to the Annual Governance Statement (AGS), which the Chief Executive signs on behalf of the Board of Directors, as part of the statutory accounts and annual report. This is the second formal presentation of the Board Assurance Framework to the Board of Directors for 2019/20

1) Overview and movement of risks 2019/20

A summary of all risks currently identified in the 2019/20 BAF is shown below, together with the movement of the risk rating throughout the year.

BAF ID	Risk title	Director Lead	Risk rating Issue 1	Risk rating Issue 2	Risk rating Issue 3	Risk rating Issue 4	Risk rating Issue 5	Direction of movement
19_20 1a	There is a risk that the Trust will fail to provide standards for safety and effectiveness required by our Board	Director of Nursing and Patient Experience/Medical Director	HIGH (4x4)					
19_20 1b	There is a risk that the Trust estate does not comply with regulatory and legislative requirements	Chief Operating Officer	HIGH (4x4)					
19_20 2a	There is a risk that the Trust will not be able to retain, develop and attract enough staff to protect their wellbeing to deliver high quality care	Director of People and Organisational Effectiveness	EXT (4x5)					
19_20 3a	There is a risk that the Trust fails to deliver its financial plans	Executive Director of Finance	EXT (4x5)					
19_20 3b	There is a risk that the Trust fails to influence external drivers (such as national policy and Brexit) which could impact on its ability to effectively implement its Strategy	Chief Executive Officer	HIGH (4x4)					

2) Deep dives 2019/20

'Deep dives' remain fully embedded in the BAF process and enable review and challenge of the controls and assurances associated with each risk. A timetable for 2019/20, agreed with Executive Directors, is shown below. As before, it is proposed that the deep dives for risks with a residual risk rating of extreme will be undertaken by the Audit and Risk Committee.

The plan for BAF Deep Dives for 2019/20 is shown below. The responsible committee for these risks is also shown (in brackets) in the table below for information.

Risk ID	Subject of risk	Director Lead	Committee
19_20 1a	There is a risk that the Trust will fail to provide standards for safety and effectiveness required by our Board	Carolyn Green/ Dr John Sykes	Quality Committee Sept 2019
19_20 1b	There is a risk that the Trust estate does not comply with regulatory and legislative requirements	Mark Powell	Finance and Performance Committee Nov 2019
19_20 2a	There is a risk that the Trust will not be able to retain, develop and attract enough staff to protect their wellbeing to deliver high quality care	Amanda Rawlings	Audit and Risk Committee July 2019 (People and Culture Committee)
19_20 3a	There is a risk that the Trust fails to deliver its financial plans	Claire Wright	Audit and Risk Committee Jan 2020 (Finance and Performance Committee)
19_20 3b	There is a risk that the Trust fails to influence external drivers (such as national policy and Brexit) which could impact on its ability to effectively implement its Strategy	Ifti Majid	Board Dec 2019

Summary Board Assurance Framework Risks 2019/20. Issue 2.3

Ref	Principal risk	Director Lead	Current rating (Likelihood x Impact)	Responsible Committee
Strategic Objective 1. To provide GREAT care in all services				
19_20 1a	There is a risk that the Trust will fail to provide standards for safety and effectiveness required by our Board	Executive Director of Nursing/Medical Director	HIGH 4x4	Quality Committee
19_20 1b	There is a risk that the Trust estate does not comply with regulatory and legislative requirements	Chief Operating Officer	HIGH 4x4	Finance and Performance Committee
Strategic Objective 2. To be a GREAT place to work				
19_20 2a	There is a risk that the Trust will not be able to retain, develop and attract enough staff to protect their wellbeing to deliver high quality care	Director of People and Organisational Effectiveness	EXTREME 4x5	People and Culture Committee
Strategic Objective 3. To make BEST use of our money				
19_20 3a	There is a risk that the Trust fails to deliver its financial plans	Executive Director of Finance	EXTREME 4x5	Finance and Performance Committee
19_20 3b	There is a risk that the Trust fails to influence external drivers (such as national policy and BREXIT) which could impact on its ability to effectively implement its Strategy	Chief Executive Officer	HIGH 4x4	Board

Note: In line with the review of the BAF against the Trust Strategy 2018 – 2021 (refreshed April 2019), completion dates for some actions are expected to extend beyond the 2019/20 financial year.

Summary Board Assurance Framework Risks 2019/20. Issue 2.3

Strategic Objective 1. To provide GREAT care in all services

Principal risk: There is a risk that the Trust will fail to provide standards for safety and effectiveness required by our Board

Impact: May lead to avoidable harm including: increased morbidity and mortality; delays in recovery; and longer episodes of treatment; affecting patients, their family members, staff, or the public

Root causes:

a) Financial settlement in contracts chronically underfunded
b) Workforce supply and lack of capacity to deliver effective care across all services
c) Substantial increase in clinical demand
d) Increasing patient and family expectations of service
e) Changing demographics of population
f) Lack of stability of clinical leadership at all levels
g) Lack of compliance with CQC standards
h) Lack of embedded outcome measures
i) Known links between SMI and other co-morbidities, and increased risk factors in population
j) Lack of processes for communication between primary and secondary care with respect to physical health monitoring

BAF ref: 1a	**Director Lead**: Executive Director of Nursing/Medical Director	**Responsible Committee**: Quality Committee	Datix ID: tbc

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 4	Impact 4	Rating HIGH	Likelihood 4	Impact 4	Direction ⟺	Rating MODERATE	Likelihood 3	Impact 4	Accepted	Tolerated	Not accepted

Key controls:

Preventative – Quality governance structures, teams and processes to identify quality related issues; Induction and mandatory training; 'Duty of Candour' processes; clinical audits and research, health and safety audits and risk assessments, physical health care screening and monitoring

Detective – Quality dashboard reporting; Quality visit programme; Incident, complaints and risk investigation; Annual Training Needs Analysis; HoNoS clustering; FSR compliance checks; mortality review process; Physical health care monitoring clinics pilots; Daily assurance safety check log

Directive – Quality Improvement Strategy. Physical Health Care Strategy; Recovery Strategy; Policies and procedures available via Connect; CAS alerts; Clinical Sub Committees of the Quality Committee

Corrective – Board committee structures and processes ensuring escalation of quality issues; Annual skill mix review; CQC action plans; Learning from incidents, complaints and risks; Actions following clinical and compliance audits; Workforce issues escalation procedures; Reporting to commissioner led Quality Assurance Group on compliance with quality standards

Assurances on Controls (internal):	**Positive assurances on Controls (external):**
Quality and NHSI dashboard Scrutiny of Quality Account (pre-submission) by committees and governors Programme of physical healthcare and other clinical audits and associated plans	National enquiry into suicide and homicide NHLSA Scorecard demonstrating low levels of claims Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review 2018, 11 services area domains improved, 5 deteriorated;

		Identified Trust fully compliant with NQB Learning from Deaths guidance. 2017/18 BAF and Risk Register Reviews (internal audit) Schedule 4/6 analysis and scrutiny by commissioners			
Key gaps in control:	**Key actions to close gaps in control:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Summary of progress on action:**	**Action on track:**
Effective plan to ensure urgent care is improved to a level that the CQC would assess and rate as at least 'requires improvement' across all domains	Delivery of plan for urgent care to meet CQC rating of least 'requires improvement' delivered by May 2019 [ACTION OWNER DON/MD/COO]	Outcome of acute core service CQC inspection. Due May 2019	31/05/2019	Awaiting outcome of inspection	
Compliance with physical healthcare standards as outlined in the Physical Healthcare Strategy	Develop and agree a Physical Healthcare Strategy Implementation Plan (by June 2019). Completed. [ACTION OWNER MD] Deliver Physical Healthcare Implementation Plan [ACTION OWNER MD]	Implementation of targets as identified within Physical Health Care Strategy/Implementation Plan Physical health care dashboard reporting (specific measurables with respect to % compliance to be identified and added)	31/03/2020 (31/08/2019) 30/09/2019	Gap analysis completed and received by Quality Committee April 2019. Implementation plan to be developed and overseen by PHCC, 6 month progress report planned for QC Sept 2019. Plan to include principles of shared care with primary care.	
Effective plan to ensure ability to achieve quality priorities, CQUIN and Non CQUIN targets	Implement CQUIN action plan for 2018/19 (by March 2020) [ACTION OWNER DON]	Delivery of CQUIN targets for 2019/20 Quarterly submissions to Commissioners on achievements to date	31/03/2020 (30/06/2019)	Suicide prevention CQUIN continues to be on track, The design of pathway specific safety planning tools Plan to be developed to achieve flu vaccination CQUIN for staff	
Care plans and /or relapse prevention plans effectively involve the patient concerned.	Ensure care and/or relapse prevention plans are person centred and made available to the patient involved (by	85% of care and /or relapse prevention plans are assessed as patient centred and are	31/03/2020 (30/06/2019)	New model for care planning including relapse planning is in	

	March 2020) [ACTION OWNER DON]	made available to the patient		design. Progress against target to be added once live on PARIS. Paper on care planning and performance agreed by QC May 2019	
Effective implementation of NICE/best practice guidance	Evidence of individual teams implementation of NICE guidance, evidenced through the Quality Visits (by close of 19/20 Quality Visit programme) [ACTION OWNER DON]	100% of clinical teams can evidence use of NICE guidance	~~30/09/2019~~ 31/12/2019	Completion date revised from 30/09/2019 in line with expected completion of 2019/20 Quality Visit Programme.	
Effectively implemented plan to ensure continuous quality improvement in the Trust in line with NHSI guidance Lack of coherent vision of the purpose of services at pathway level with a clear plan of how services need to adapt to meet changes in the demand	Identify gaps to delivery of quality improvement against NHSI guidance and implement agreed Quality Improvement Plan (by March 2020) [ACTION OWNER DBI&T] Evidence of individual teams development of a quality initiative, evidenced through the Quality Visits (by close of 19/20 Quality Visit programme). [ACTION OWNER DON] Workshop for clinically led strategy development [ACTION OWNER DBI&T] Strategies agreed by Board (by Sept 2019) [ACTION OWNER DBI&T]	Achievement of the 19/20 milestones and any 18/19 milestones that have not yet been delivered of the Quality Improvement Implementation plan 100% of clinical teams can evidence implementation of a quality initiative Delivery of outcomes as defined in implementation plan for clinically led strategy development	30/09/2019 ~~30/09/2019~~ 31/12/2019 31/05/2019	Report on progress against plan considered by QC March 2019. Plan in place for stakeholder engagement sessions before rolling programme of Board decisions on strategies.	
Lack of a co-ordinated approach to collecting and acting on patient feedback across all services	Develop and implement a Patient Experience Strategy (by March 2020) [ACTION OWNER DON]	Agreed Patient Experience Strategy to Board (by July 2019) (specific measurables with	31/03/2020 (31/07/2019)	Draft Patient Experience Strategy completed.	

	Implementation of EQUAL forum (by March 2020) [ACTION OWNER DON]	respect to impact to be identified and added)	31/03/2020	Shadow EQUAL forum to be in place from June 2019	
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Summary of progress on action:**	**Action on track:**
Gaps identified in CQC comprehensive assessment of services June 2018 (reported in September 2018) and Mental Health Act focused inspections undertaken throughout year	Completion of CQC action plan following the 2018 CQC comprehensive inspection (by May 2019) [ACTION OWNER DON/MD/COO] Completion of all actions following MHA focused CQC inspections (by timescales agreed in individual reports) [ACTION OWNER DON/MD/COO	Completion of all actions following CQC comprehensive inspection Completion of all actions following MHA focused CQC inspections	31/07/2019 (31/07/2019)	Completion date revised from 31/05/2019. No of actions still requiring completion reduced from 110 to 21. 55 recommendations in last year, 17 overdue. Monitored by MHA Ops group meeting	
Achievement of Royal College of Psychiatrists (RCP) Standards across Acute Services	Complete RCP self-assessment (by 30/09/2019) Develop and implement plan to achieve RCP standards [ACTION OWNER MD/DON/COO]	Achievement of RCP Standards by Jan 2020	31/01/2020 (30/09/2019)	Draft self-assessment completed, overseen by Campus COAT.	

Summary Board Assurance Framework Risks 2019/20. Issue 2.3

Strategic Objective 1. To provide GREAT care in all services

Principal risk: There is a risk that the Trust estate does not comply with regulatory and legislative requirements

Impact: Low quality care environment
Crowded staff environment
Non-compliance with statutory care environments
Non-compliance with legal requirements for asbestos, legionella and electrical compliance

Root causes:

a. Long term under investment in NHS capital projects and estate
b. Limited opportunity for Trust large scale capital investment
c. Increasing expectations in care and working environments

BAF ref: 19_20 1b	**Director Lead**: Chief Operating Officer	**Responsible Committee**: Finance and Performance Committee	Datix ID: tbc

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 4	Impact 4	Rating HIGH	Likelihood 4	Impact 4	Direction ⟺	Rating MODERATE	Likelihood 3	Impact 4	Accepted	Tolerated	Not accepted

Key controls:

Preventative – Routine environmental assessments for legionella and asbestos; Environmental risk assessments reported through Datix;
Detective – Monthly reporting progress against Premises Assurance Model (PAM) to TMT
Directive – Capital Action Team role in scrutiny of capital projects
Corrective – Short term investment agreed to support key risk areas

Assurances on Controls (internal):	Positive assurances on Controls (external):
- Health and Safety Audits - Premises Assurance Management System (PAMS) reporting to TMT providing updates on key priority areas	- 2018/2019 CQC Inspection feedback regarding PLACE regarding quality of Trust environment

Key gaps in control:	Key actions to close gaps in control:	Impact on risk to be measured by:	Expected completion date./(Action review date):	Progress against action:	Action on track:
Board approved Estates Strategy for 5 years, and implementation of 2019/20 plan	Estates strategy engagement event to finalise strategy (by Sept 2019) [ACTION OWNER COO] Present Estates Strategy to Board (by Nov 2019) [ACTION OWNER COO]	Agreed Estates Strategy (by Nov 2019)	30/11/2019 (31/01/2020)	5 day engagement week planned for Sept 2019.	

	Implement relevant milestones set out in the 5 year Estates Strategy implementation plan [ACTION OWNER COO]				
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Progress against action:**	**Action on track:**
Lack of assurance on full cycle of governance for estate compliance with statutory legislation	Completion of self-assessment of premises assurances model (PAM) and plan for annual reassessment (by April 2019) [ACTION OWNER COO]	Achievement of statutory compliance with legionella, electric, asbestos (by March 2020)	30/09/2019	PAM self-assessment completed	
	Development of a Board approved improvement/ action plan, prioritised by level of risk (by April 2019) [ACTION OWNER COO]			Action plan agreed by TMT and ELT in Feb 2019	
	Associated resource plan agreed (April 2019) [ACTION OWNER COO]			Resource plan agreed by TMT and ELT in Feb 2019	
	Review 2019/20 action plan to identify risks to delivery, including implementation of skilled roles to ensure routine regulatory and legislative checks are completed [ACTION OWNER COO]	Compliance reporting to TMT with specific risks identified as part of PAMS reporting (to continue monthly from March 2019)	(31/07/2019)	Reporting started in March 2019	
Negative feedback from staff regarding their working environment, including buildings, office environments, car parking etc	Develop plans to address immediate estates issues ahead of formalisation of the Trust Estates Strategy [ACTION OWNER COO]	Improvement in feedback from staff via existing engagement routes	31/12/2019	Trust wide Estates and Environmental Group to commence by June 2019	

Summary Board Assurance Framework Risks 2019/20. Issue 2.3

Strategic Objective 2. To be a GREAT place to work

Principal risk: There is a risk that the Trust will not be able to retain, develop and attract enough staff to protect their wellbeing to deliver high quality care

Impact: Risk to the delivery of high quality clinical care including increased waiting times
Exceeding of budgets allocated for temporary staff
Loss of income

Root causes:

a. National shortage of key occupations
b. Future commissions of key posts insufficient for current and expected demand
c. Trust reputation as a place to work
d. Trust seen as small with limited development opportunities
e. Sufficient funding to deliver alterative workforce solutions
f. Retention of staff in some key areas

BAF ref: 19_20 2a	**Director Lead**: Amanda Rawlings, Director of People and Organisational Effectiveness	**Responsible Committee**: People and Culture Committee	Datix ID: tbc

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating EXTREME	Likelihood 4	Impact 5	Rating EXTREME	Likelihood 4	Impact 5	Direction ⟺	Rating HIGH	Likelihood 3	Impact 5	Accepted	Tolerated	Not accepted

Key controls:

Preventative – Resourcing Plan covering wide range of recruitment channels.
Detective – Performance report identifying specific hotspots and interventions to increase recruitment.
Directive – Wellbeing strategy, infrastructure and programmes to support staff health and wellbeing. Workforce plan to grow and develop the workforce.
Corrective – Leadership and Management Strategy and development programmes to build inclusive and engaging leadership and management. Leadership Programme Launch – Core Leaders.

Assurances on Controls (internal):	Positive assurances on Controls (external):
Bi Monthly People Performance Report to Trust Management Team, Executive Leadership Team and People and Culture Committee, includes recruitment tracker Workforce Supply Hot Spot report to Trust Management Team and People and Culture Committee Workforce Plan delivery monitored monthly by the Strategic Workforce Group	Staff survey, high level of participation for 2018 Pulse Checks CQC visits identify caring and engaging staff

Key gaps in control:	Key actions to close gaps in control:	Impact on risk to be measured by:	Expected completion date./(Action review date):	Progress against action:	Action on track:
Effective recruitment and retention plan to fill substantive and bank posts	Monthly tracking of People Performance: turnover and recruitment hot spots, with focused actions	Reduction in vacancies in identified hotspot areas to below 10%	31/03/2020 (30/06/2019)	Focused campaign with active promotion on specific professions. Increased social	

	[ACTION OWNER DP&OE, COO]			media activity. Overall increased recruitment.	
Fully delivered leadership and management development programme	Roll out of the Leadership Launch and masterclasses (by June 2019) and monitor up take. Move from Pilot to scale for 360 feedback leadership tool [ACTION OWNER DP&OE]	90% of Leaders attend the Leadership Launch 50% update of Management Masterclasses	31/03/2020 (30/09/2019) 31/03/2020] (31/01/2020)	Developing range of leadership courses with East Midlands Academy. 360 feedback tool now in place, pilot completed. Tool is being offered to leaders to use	
Gaps in colleagues health and wellbeing provision and infrastructure	Agree investment wellbeing offer by the Executive Leadership Team (Completed March 2019) [ACTION OWNER DP&OE Review Occupational Health contract to include rapid access to musculo-skeletal services (MSK). Roll out access to counselling service [ACTION OWNER DP&OE]	Reduction in sickness absence rates to 5% or below (target date tbc as linked to CIP agreement) Increased uptake of staff flu vaccination to 75%	31/03/2020 (30/09/2019) 01/03/2020 (30/09/2019)	Well-being offer launched, positive uptake. Reduced sickness absence reported in March 2019. MSK services being negotiated through OH contract. Flu campaign to relaunch Oct 2019	
Development of a funded Workforce Plan	Develop and implement Year 1 of the Workforce Plan (by March 2020)	Utilisation of the Apprenticeship Levy Use of CPD, DHCFT Investment decisions (by when and how measured to be determined)	31/03/2020 (30/09/2019)	2019/20 Apprenticeship Levy being used for 10 nursing, 2 ACP and a range of other apprenticeship roles 2019/20 Workforce Plan to be developed by June 2019. Pathway focused (3 year) work plan to be developed by Sept 2019, to support the Clinical Pathway Developments	

Staff reporting being disadvantaged due to their protected characteristics	Action plans to be approved and implemented for staff with protected characteristics (by March 2020). To be monitored by Board	Annual publication of Workforce Race Equality Standard data, identifying an improved position Gender pay gap report action plan Workforce Disability Equality Standard reporting to commence in late 2019	31/03/2020 (30/09/2019)	Actions plans being developed around protected characteristics. Reporting PCC	
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Progress against action:**	
Training compliance in key areas below target set by the Trust	Review and simplify mandatory training requirements to align to an individual's role and contract [ACTION OWNER DP&OE, DON, MD] Improve E-Learning offer, including improvements in terms of ease of use [ACTION OWNER DP&OE]	90% of staff achieve their mandatory training requirements (by March 2020)	31/03/2020 (tracked monthly)	Mandatory training compliance at 78%, as of March 2019. However, Level 3 safeguarding children's training compliance is decreasing, plan to improve to be developed and monitored through PCC. Alternative solution to E Learning being sought	
Evidence of safer staffing levels of suitably qualified staff	Compliance with NHSI Workforce Safeguards requirements (by March 2020) [ACTION OWNER DP&OE, COO/MD/DON]	Full compliance with safer staffing levels in line with the NHSI Workforce Safeguards	30/09/2019	Reporting to PCC Sept 2019. WRES reporting being considered as part of review of integrated performance and strategy reporting	
Trust tracking of retention of staff who could be impacted by the recent changes to pension taxation rules	NHS Employers have set up a national working group to look at this. Trust has briefed the Remunerations and Appointments Committee and is tracking this with medics at LNC.	Tracking of Executives and Medical staff retention rates as this is the group that is impacted at this time	(31/10/2019)	Six monthly review process in place	

Summary Board Assurance Framework Risks 2019/20. Issue 2.3

Strategic Objective 3. To make BEST use of our money

Principal risk: There is a risk that the Trust fails to deliver its financial plans

Impact: Trust becomes financially unsustainable

Root causes:

a) Non-delivery of internal CIP including back office efficiency
b) 'QIPP' disinvestment by commissioners leaves unfunded stranded costs in Trust
c) Other income loss without equivalent cost reduction (e.g. CQUIN, cost per case activity, commissioner clawback)
d) Costs to deliver services exceed the Trust financial resources available, including contingency reserves.
e) Lack of sufficient cash and working capital or loss due to material fraud or criminal activity

BAF ref: 19_20 3a	**Director Lead**: Claire Wright, Executive Director of Finance	**Responsible Committee**: Finance and Performance Committee	Datix ID: tbc

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating EXTREME	Likelihood 4	Impact 5	Rating EXTREME	Likelihood 4	Impact 5	Direction ⟷	Rating MODERATE	Likelihood 2	Impact 5	Accepted	Tolerated	Not accepted

Key controls:

Preventative – Budget training, segregation of duties, contract team to manage with commissioning risk, mandatory counterfraud training and annual counterfraud work programme. Project Vision system controls for CIP/CI

Detective –Audits (internal, external and in-house); Scrutiny of financial delivery, bank reconciliations; Continuous improvement including CIP planning and delivery; Contract performance, Local counterfraud scrutiny

Directive – Standing financial instructions; budget control, delegated limits, 'no-PO no pay' rules; Agency staff approval controls; Approval to appoint process; Business case approval process (e.g. back office); CIP targets issued; Invest to save protocol

Corrective – Corrective management action; Use of contingency reserve; Disaster recovery plan implementation; TMT performance reviews and associated support/ in-reach in ELT and TMT for CIP delivery

Assurances on Controls (internal):	Positive assurances on Controls (external):
Delivery of plan, in-year and forecast outturn for overall Trust financial plan Delivery of Continuous improvement including CIP (through appropriate mix of waste reduction and year-on-year actual cost reduction, productivity improvement and successful budget reduction Delivery of Counterfraud and audit work programme with completed and embedded actions for all recommendations Independent assurance via internal auditors, external auditors and counterfraud specialist that the figures reported are valid and systems and processes for financial governance are adequate Use of Resources report to Trust Board meeting November 2018 evidences strategic approach to effective use of resources	- Internal Audits– significant assurance rating for 2018/19 audit: Integrity of the general ledger and key financial systems - External Audits – strong record of high quality statutory reporting - Grant Thornton audits show good benchmarking for key financial metrics (including liquidity) - NHSI Finance Rating Metrics – shows good performance - National Fraud Initiative – no areas of concern - Local Counterfraud work – Referrals show good counterfraud awareness and reporting in Trust and no material losses have been incurred - Deloitte Well Led review – positive affirmation of the effectiveness of the Finance and Performance Committee

Summary Board Assurance Framework Risks 2019/20. Issue 2.3

Key gaps in control:	Key actions to close gaps in control:	Impact on risk to be measured by:	Expected completion date./(Action review date):	Progress against action:	Action on track:
Delivery of a continuous improvement (CI) plan that will meet requirements for financial sustainability and quality improvement to improve productivity and reduce waste, driven by the Use of Resources top ten	2019/20 plans to be finalised [ACTION OWNER DBI&T] Reporting of future continuous improvement and 19/20 CIP schemes – plan and actual delivery throughout year [ACTION OWNER DBI&T]	Achievement during year of planned 19/20 CIP savings totalling £4.6m. Replacement of non-current 2019/20 CIP with recurrent CIP ahead of 1st April 2020 Size of pipeline for continuous improvement plans for future years	31/03/2020 (30/06/2019)	Full plans not yet finalised	
				Non recurrent CIP still needs replacing with recurrent CIP	
				Finance and Performance Committee May 2019 will scrutinise progress with 2019/20 and future pipeline	
Delivery of specific benefits realisation as described in investment cases, including the Mental Health Investment Standard	CCG Contract sign-off including MHIS investments (by April 2019) [ACTION OWNER DBI&T] Collation of summary of expected benefits to be realised from key investments in 2019/20 [ACTION OWNER DBI&T]	Signed contract Measurement and monitoring of impact of E-Roster, E Job planning, new shift pattern and MH Investment Standard by Finance and Performance Committee and MH Service Delivery Board	31/03/2020 (30/06/2019)	Contract signed	
				Description and quantification of benefits expected has not yet been compiled. To be scrutinised and driven by ELT	
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Progress against action:**	**Action on track:**
Inconsistency of managers' application of appropriate HR policy e.g. secondary employment and working while sick, in order to close practice gaps identified by previous counterfraud referrals	Implementation of group Counterfraud meetings with HR, Finance and LCFS to support targeted training and oversight (meetings in place by end March 2019) [ACTION OWNER DOF]	Reduction in counterfraud findings related to application of relevant HR process Conversion of amber ratings within parts of 2018/19 self-review tool (SRT) to green in next submission	31/03/2020 (30/09/2019)	First meeting undertaken. Self-Review Tool (SRT) for 2018/19 completed and submitted (with green overall rating)	

Summary Board Assurance Framework Risks 2019/20. Issue 2.3

Strategic Objective 3. To make BEST use of our money

Principal risk: There is a risk that the Trust fails to influence external drivers (such as national policy and Brexit) which could impact on its ability to effectively implement its Strategy

Impact: If the Trust Strategy is not delivered, it could lead to a deterioration of services available to patients and a negative impact on the Trusts financial position, which could result in regulatory action

Root causes:

a) Priority in other parts of the system i.e. A&E
b) Financial constraints nationally and locally
c) Lack of system wide leadership
d) Lack of engagement with staff from other organisations
e) Suddenly changing national directives out with control of the Trust
f) Regulatory bodies imposing different rules and boundaries
g) Move to system wide working causes tension between loyalty to the system v's sovereign organisation
h) Unresolved political decision making regarding Brexit
i) Political time spent on Brexit taking time from other priorities

BAF ref: 19_20 3b	**Director Lead**: Ifti Majid. Chief Executive Officer	**Responsible Committee**: Board	Datix ID: tbc

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating	Likelihood	Impact	Rating	Likelihood	Impact	Direction	Rating	Likelihood	Impact	Accepted	Tolerated	Not accepted
HIGH	4	4	HIGH	4	4	⟺	MOD	3	4			

Key controls:

Preventative – Maintenance of strong relationships with commissioners particularly mental health and learning disability SRO (Senior Responsible Officer); Close alignment between emerging CCG QIPP plans and STP workstream objectives; Full involvement with appropriate system wide groups; Maintenance of strong relationships with other providers; service receiver engagement; Working openly and honestly with clear line of sight to impacts on sovereign organisation; CEO representation on national Mental Health Network Board

Detective – Scrutiny of national directives; Translation to local action i.e. are national directives being adhered to?

Directive- Agreed contract with CCG and adherence to Mental Health Investment Standard

Corrective- Ongoing discussions with key stakeholders on proposed changes, progress, establishment of partnerships etc. ; Engagement and consultation with patients, carers, public and staff as appropriate; Interrelationships with other STP workstreams; Active CCG membership and participation in STP Mental Health Delivery Board; Fortnightly CEO and DOF meeting across Derbyshire system

Assurances on Controls (internal):	Positive assurances on Controls (external):
- Reports to Board regarding any system wide changes or risks - Regular progress feedback to F&P on system change - Updates and feedback at TMT and ELT in order to update on system change or 'blockers' - Engagement with Governors in order to get feedback and update them on progress - Engagement with staff though managers, staff side, focus groups etc	NHSE/I agreement of plans Mental Health Delivery Board and checkpoint meetings with central STP team

- CEO's Board Report providing strategic scan of national policy landscape					
Key gaps in control:	**Key actions to close gaps in control:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Progress against action:**	**Action on track:**
National policy and local implementation focuses on organisations in deficit and those that provide urgent care, leading to the Trust not receiving the focus they deserve	Maintain senior open dialogue with commissioners being prepared to escalate through contract mechanisms any failure to deliver national MHIS contract expectations [ACTION OWNER CEO] Have a strong senior leadership presence in system Board and Executive meetings as well as the emerging provider alliance Boards and urgent care strategy forums – this will require re-prioritisation of Executive and next in line capacity [ACTION OWNER CEO] Lead the development of an updated STP mental health system plan ensuring it is approved through Joined Up Care Derbyshire governance [ACTION OWNER CEO]	Maintenance of separate working groups at a system level relating to our core services led by Trust senior leaders Agreed contract in place for 19/20 that does not require external mediation. Delivery of the Mental Health Investment Standard and support to core services within it. Delivery of the STP MH QIPP savings and realise reinvestment of all savings into MH programme spend. Full *Futures in Mind* allocation passed to the Trust by commissioners	31/03/2021 (30/09/2019)	All workstreams currently undertaking review of process in line with STP refresh in Sept 2019	
				Contract in place, without need for external medication	
				Contract includes a full MH Investment Standard monitored through the MH Service Delivery Board	
				No MH QIPP savings identified in CCG plan	
				Futures in Mind allocation agreed as part of contract. To monitor throughout year.	
Lack of full understanding as to the impact to the Trust of leaving the EU in relation to essential supplies, impact on research and development, impact on staffing availability and logistics such as petrol	Maintenance of an up to date EU Exit risk assessment until the risk nationally has deemed to have reduced [ACTION OWNER COO] Ensure colleagues within the Organisation are aware of the key risks and mitigating actions [ACTION OWNER COO]	The lack of major or critical incidents affecting the Trust resulting from risks associated with leaving the EU	31/10/2019 (30/06/2019)	National reporting stood down pending agreement of national decision regarding BREXIT. Trust risk assessment being maintained. Two briefings to Trust staff outlining Trust readiness for BREXIT	

	Link in with Joined Up Care Derbyshire colleagues to ensure that where actions are needed that can be completed at a system level this is carried out [ACTION OWNER COO] Respond to requests for information from the national leadership team as these could inform changes in actions required of our Trust [ACTION OWNER COO]			Monthly reporting to Joined Up Care Derbyshire on system BREXIT readiness All escalation reports delivered on time as required	
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Progress against action:**	**Action on track:**
Lack of assurance with respect to the impact of national policy, in particular in relation to the: Long Term Plan; Integrated Care Systems, Revisions to the Mental Health Act; Fit and Proper Persons which may impact on the governance mechanisms and or clinical service delivery within our organisation	Continue to utilise opportunities to influence and lobby at a national level through attending MHN Board national and regional CEO and Chair meetings [ACTION OWNER CEO] Development of a stakeholder register including local MP's to ensure they are briefed on risks to and opportunities for our local population relating to proposed policy change [ACTION OWNER CEO] Attendance at regional events such as Regional CEOs meeting as these feed into NHSI/E at a national level and provide a conduit for influencing policy changes [ACTION OWNER CEO]	Trust maintenance of full compliance with regulatory standards Plans for policy and or legislation changes are developed in a timely way to enable effective implementation	31/03/2021 (30/09/2019)	Quarterly MH Network in place. CEO met national MH Director regarding important of care services Stakeholder management approach considered by ELT April 2019 Chair and CEO continue to attend events to ensure early notification on planned changes to policy	

Summary Board Assurance Framework Risks 2019/20. Issue 2.3

Risk Rating:

The summary score for determining the risk ratings for each risk is shown below. The full Risk Matrix, including descriptors, is shown in the Trusts Risk Management Strategy

Risk Assessment Matrix						
The Risk Score is simply a multiplication of the Consequence Rating x the Likelihood Rating. The Risk Grade is the colour determined from the Risk Assessment Matrix below.						
LIKELIHOOD		CONSEQUENCE				
		INSIGNIFICANT 1	MINOR 2	MODERATE 3	MAJOR 4	CATASTROPHIC 5
RARE	1	1	2	3	4	5
UNLIKELY	2	2	4	6	8	10
POSSIBLE	3	3	6	9	12	15
LIKELY	4	4	8	12	16	20
ALMOST CERTAIN	5	5	10	15	20	25

Risk Grade/ Incident Potential
Extreme Risk
High Risk
Moderate Risk
Low Risk
Very Low Risk

Action progress:

The previous 'risk to delivery' of the action detailed in the 2018/19 BAF has been changed for 2019/20 to detail if the action is on track to delivery. The colour ratings are based on the following descriptors.

Actions on track for delivery against gaps in controls and assurances:	Colour rating
Action completed	Blue
Action on track to completion within proposed timeframe	Green
Action implemented in part with potential risks to meeting proposed timeframe.	Amber
Action not completed to timeframe. Revised plan of action required.	Red

Action owners:

CEO	Chief Executive Officer
DOF	Executive Director of Finance
MD	Medical Director
DBI&T	Director of Business Improvement and Transformation
COO	Chief Operating Officer
DON	Executive Director of Nursing and Patient Experience
DP&OE	Director of People and Organisational Effectiveness

Derbyshire Healthcare NHS Foundation Trust

Board Committee Assurance Summary Report to Trust Board
Safeguarding Committee – 14 May 2019

Key items discussed

- **Policy Matrix** - compliant

- **Safeguarding Adults and Children Strategy** – the draft strategy was agreed, some improvements to the language were agreed particularly around family inclusive practice. Significant assurance received on discharging duties, and style of the development. Director of Nursing and Patient Experience presented the key domains that the Safeguarding Committee would be achieving in support of the Trust strategy requirements with regard to being a trauma informed organisation. A high level infographic and success criteria will be developed and presented to the next meeting in July and a detailed implementation plan will be submitted to the September meeting. The draft strategy was authorised for further consultation and discussion.

- **Safeguarding Children Position Statement -**. The need to establish solutions to improve safeguarding training compliance was discussed. Limited assurance received due to gaps in training compliance. Discussion is taking place with public health on the monitoring of caseloads and plans to reduce the gap between capacity and demand. Learning from the joint targeted inspection and monitoring will be captured in the action plan and will be reviewed at the next meeting.

- **Markers of Good practice.** Looked after children implementation plan is in progress.

- **Improvements and revisions to DBS checks for Safeguarding Adults and Children's Doctors. Improvements and revisions to DBS checks for Safeguarding Adults and Children's.** A review of systems and processes, and a review of audit checks to ensure, we are complaint and complying with improvement plan. The risk appetite and target for improvement and timescale for completion was given a further 8 weeks with immediate action and completion. To achieve less than twenty staff at any time and then reducing to a proactive plan for no staff to be expired. The governance policies are rectified and escalated to People and Culture Committee to monitor this risk and ensure achievement. If this is not achieved in the required timescale this will be articulated in the BAF (Board Assurance Framework) with a further rapid improvement plan.

- **Joint targeted inspection**. The formal feedback was received and operational improvement plan was reviewed and will be implemented and driven by the operational group. The Committee will be briefed on the improvements made. This was noted as having implications for Children's services and the gaps in control include lack of health visiting and school nursing capacity, this continues to impact upon the service's ability to meet the population needs and additional impact upon the retention of valued colleagues. Further exploration with public health by the operations team is in progress.

- **Safeguarding Adults Position Statement -** Summary given, improvement seen in training, further discussion on revising the training model in line with intercollegiate changes was required will be presented by the Safeguarding adults lead at the next meeting. Escalation to People and Culture Committee to monitor the training trajectory and proposed new model. Significant assurance.

- **Safeguarding Adult Policy** - Ratified further amendments to policy on the flowchart, including the new PARIS referral form and how to access and use this and the Safeguarding App. The executive lead can sign off these amendments and improvements.

- **Meeting Effectiveness** - Well chaired. Some improvement seen with summary reports on the equalities Act.

Assurance/lack of assurance obtained

- **Safeguarding Strategy** – improvements to the text specifically regarding family improvement were suggested and agreed, timeline for improvement and developments of an outline for success criteria, including an infographic of what the changes in practice will be.

- **Improvements and revisions to DBS checks for Safeguarding Adults and Children's Doctors** - limited assurance with a specific improvement plan and an escalation if outcomes are not met.

- **Safeguarding Children Position Statement –** Limited assurance

- **Safeguarding Adults Position Statement -** Significant assurance

- **Safeguarding policy-** ratified

Key risks identified

- Improvements and revisions to DBS checks for Safeguarding Adults and Children's to be mitigated. Scrutiny of plan and People Services statutory standards to be reviewed by executive leads and People and Culture Committee.

Decisions made

- Addition of BAF risk – safeguarding children training to recruit and retain and the development of suitably qualified staff to the People and Culture Operational Group.
- Addition of BAF risk – capacity to manage and maintain quality standards for Health Visitors and School Nurses, learning from the JTAI and the integrated Board reports on caseload size.

Escalations to Board or other committee

- Escalations to other Board Committees

Committee Chair: Anne Wright	**Executive Lead: Carolyn Green. Executive Director of Nursing and Patient Experience**

Derbyshire Healthcare
NHS Foundation Trust

Board Committee Summary Report to Trust Board
Quality Committee - meeting held 14 May 2019

Key items discussed

- **Policy status-** on target and compliant
- **Board Assurance Framework (BAF)** was reviewed along with additional risks escalated from the Safeguarding Committee. Discussion took place on improvement areas and solutions to safeguarding training and Health Visiting and School Nursing. A formal review of the CQC visits to the acute pathway is scheduled for the next meeting in June.
- **Quality Dashboard -** agreed and reviewed with specific scrutiny of supervision levels, improvement in clinical indicators, impact of pressure and the solutions to significantly improve.
- **Quality Impact assessment (QIA) Summary** was scrutinised and reviewed. The paper provided significant assurance on the system and process and showed that policy standards have been implemented. Improvement areas for further development for the next report would be to include an insert from the Medical Director and Director of Nursing (DON) confirming due process and any issues to escalate. DON gave feedback on adaptations and changes that are to be made on one scheme. The need to consider the adverse effects that QIA might have on people with protected characteristics will feature in the next report.
- **Supervision and Training Summary** was scrutinised and reviewed. The executive lead will look at improving the quality improvement areas by exploring whole time equivalent versus headcount for funding and provision of training. The report provided clarity on areas to plan and improve. Limited assurance was received on the report due to the need to resolve hot spots in certain areas.
- **Inquest report -** a full scrutiny of the analysis of Inquest activity was undertaken which showed no deterioration in performance. No Prevention of Future Deaths (PFD) have been received by the Trust. Report showed improved quality and pace the Serious Incident (SI) process. Action taken by the executive lead to explore taking feedback to staff on how they are supported through inquests. Significant assurance was confirmed from the report.
- **Serious Incident report -** the report was reviewed and the structure and process showed evidence of significant scrutiny and improvement. The learning and improving culture is improving and the continual improvement of implementing improvement actions continues. The National Confidential Inquiry into Suicide and Safety in Mental Health Safety Scorecard offered significant assurance. Limited assurance was obtained on the completion of actions.
- **Guardian of Safe working report-** the report was reviewed and confirmed. The Medical Director briefed the Committee on the business continuity model that will be reported on to the next meeting. The CQC will be reviewing the governance arrangements of this structure and will be meeting to discuss improvements. Significant assurance.
- **Care planning -** Six monthly update report provided limited assurance.

Decisions made

- Quality risk highlight reports on risk issues for quarterly reporting.
- Exploration of the impact and allocation for some key monies and reinvestment into key areas to be provided by Executive Leadership Team with assurances that the investment will be targeted to the greatest risk areas as evidenced in BAF risk 1a.
- Further assurance and scrutiny on equalities issues in the accessible information standards.
- Exploring executive membership with the addition of a new director, to review the representation of forward plan.
- Scheduling and amendments to forward plan on clinical strategies to enable completion.
- Recommendations to the Board development session on quality.
- Implementation of Quality Committee evaluation recommendations was confirmed.
- Changes to the forward plan on revised quality priorities.
- Revisions to the BAF were based upon additional risks escalated from the Safeguarding Committee. These included improvements in quality standards, improvements to safeguarding training levels, Health Visitor and School Nurse capacity and issues relating to DBS checks.

Meeting effectiveness

Effective discussion took place on risks and issues to be escalated and articulated in the BAF.

Escalations to Board or other committee

Volume of training and supervision to be escalated to People and Culture Committee and ELT in order to understand and plan how to improve and resolve supervision requirements.

It was suggested that an Urgent Care review takes place at Board Development.

Committee Chair: Margaret Gildea	**Executive Lead: Carolyn Green**

Derbyshire Healthcare
NHS Foundation Trust

Board Committee Assurance Summary Report to Trust Board
Finance & Performance Committee – Meeting held 21 May 2019

Key items discussed

- In light of Board Assurance Framework (BAF) - accessing capital and changing processes in light of future estate requirements.
- Systems Risk Sharing - Discussed Joined Up Care Derbyshire (JUCD) meeting outcomes and the progress to date. Supported in principle, to be discussed at public board.
- Commissioning Interface and Contract Update - Discussed MHIS (Mental Health Investment Standard) and adult out of area, including PICU (Psychiatric Intensive Care Unit). Also discussed recent service changes and new tenders.
- Operational Performance and KPI Achievement including CAMHS (Child and Adolescent Mental Health Service) and Paediatrics waiting times - Overall report: Discussed the metrics outlined in the report, triangulating with discussions elsewhere. Included some discussion on the equalities monitoring BME data compared to census data. Paediatrics RTT (Referral to Treatment) focussed report: Significant reductions over recent years but not able to achieve the overall reductions in waits to deal with demand. Potential for regulatory impact.
- CIP (Cost Improvement Programme) Delivery and Continuous (Quality) Improvement Delivery Programme - Discussed the gap that still exists, additional risks (including non recurrent schemes) and progress to date and governance.
- Improving Access to Psychological Therapies (IAPT) - Reprocurement update provided: Complex market and contractual requirements, due diligence information outstanding and very challenging timeframe.
- 2019/20 Financial Performance - Significant risks in the forecast delivery of the control total at month one. Additional meeting to discuss year to date up to month 3 to allow detailed scrutiny of assumptions and risks.

Assurance/lack of assurance obtained

- Significant assurance from contract outcome
- Limited assurance for operational performance KPIs
- Limited assurance for paediatrics waiting times
- No assurance for CIP progress
- No assurance for financial performance given current risks

Key risks identified

- National capital access routes in relation to future Trust estate requirements
- 2019/20 CIP delivery: gap in programme, high risk schemes, non-recurrent schemes.
- Risk of non-achievement of control total.

Decisions made

- Paediatrics to report again in 6 months (added to forward plan)
- Additional F&P meeting required in July for scrutiny of CIP and financial performance

Escalations to Board or other committee • Additional meeting for further scrutiny of CIP and financial position to then brief the Board • IAPT procurement will require Board sign off	
Committee Chair: Richard Wright	**Executive Lead: Claire Wright, Deputy Chief Executive and Director of Finance**

Derbyshire Healthcare NHS Foundation Trust

Board Committee Summary Report to Trust Board
Audit & Risk Committee – Meeting held 23 May 2019

Key items discussed

- Board Assurance Framework (BAF) - Second Issue for 2019/20
- Data Security & Protection - Quarter 4 report 2018/19
- Third Party Assurance Reports (ISAE3402 reports) on NHS Shared Business Services (SBS)
- Review and approval of audited Annual Report and Accounts 2018/19 and Annual Governance Statement)
- Review and approval of audited Quality Account 2018/19
- Head of Internal Audit Report and associated opinions
- External Audit

  Accounts:
  - Audit Findings Report
  - Proposed Opinion (Enhanced Auditor's Report)
  - Management Letter of Representation

  Quality Report:
  - Auditor's report to the Council of Governors on the Quality Report
  - Proposed Limited Assurance opinion on the Quality Report
  - Management Letter of Representation
- Sign off of Annual Report and Accounts 2018/19 under delegated authority from the Trust Board
- 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

- The Committee approved the second issue of the BAF for 2019/20, receiving significant assurance 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. The plan for 'deep dives' for 2019/20 was also agreed and this Committee receives a quarterly update on the BAF risks.
- Significant assurance was received on the 2018/19 Data Security & Protection Toolkit and progress made with the Data Security work. The Committee acknowledged the positive progress taken around cyber security and the continual need for cyber security.

- The Third Party Assurance Reports (ISAE3402 reports) on NHS Shared Business Services (SBS) were received. The report on Finance and Accounting was unqualified but the report on Employment Services (payroll) was qualified. The Committee received assurance, through the Trust's auditors, that the qualified opinion on employment services does not have any adverse impact on the annual report or accounts of the Trust. The qualification reflected gaps in control over the provision of the payroll service and the committee were assured that the Finance team were aware of these and were taking active measures to mitigate any impact on the Trust's employees/

- The 2018/19 Head of Internal Audit Opinion was one of 'Significant Assurance' that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently. Internal Audit's Annual Report outlined the service delivery by 360 Assurance, including details of responses to their Client Satisfaction Questionnaires as well as an assessment of compliance to the agreed Key Performance Indicators (KPIs). The Committee received assurance that the Internal Audit Plan had been fully completed and KPIs achieved.

- In relation to the Annual Report, Annual Quality Report and Annual Accounts, assurance was received that the documents have been prepared in line with NHSI requirements. The detailed consultation was outlined in the report, this included Governors, Board Committees and Commissioners.

- Grant Thornton (GT), the Trust's External Auditor presented their audit findings for the above three annual documents. Positive feedback was given by GT in terms of the working relationship with the teams at the Trust and it was confirmed that an unqualified audit opinion would be issued. In relation to the Quality Report it was confirmed that it was materially consistent with quality report content guidance. Management Letters of Representation would be signed.

- Grant Thornton drew attention to the longer term risk to the Trust of the deficit in the overall Derbyshire Finances (as reflected in the BAF) but confirmed that this did not impact the validity of the 2018/19 accounts which were properly prepared on the going concern basis.

- Meeting effectiveness – members agreed that the meeting had been effective and the Lead Governor who had attended the meeting as an observer commented that he felt assured by the process undertaken and from comments by both internal and external auditors.

Key risks identified

- A challenge was made around the outstanding gaps in controls and assurances identified against the 2019/20 BAF risk relating to MHA/MCA compliance and whether these had been adequately mitigated. A paper responding to this has been prepared and will be considered by the Mental Health Act Committee at its next meeting on 07 June 2019. The Executive were also asked to consider the broader issue of more general compliance with basic controls and how this can best be assured.

- Potential risks were acknowledged around the Trust failing to meet the requirements of the new Data Security & Protection Toolkit for 2019/20 and the potential reputational and financial risk of data security incidents to the Trust. However assurance was given than robust plans were in place to mitigate these risks.

Decisions made

- Due to the significant progress in the Trust's Data Security & Protection, it was agreed that the Committee would receive the update twice yearly, at year end and mid-year, instead of the current quarterly reports, with any immediate concerns brought up by exception.

- Agreement of the Management Letters of representation which were signed by the Audit and Risk Committee Chair and Chief Executive.

- Approval and Sign off of Annual Report, Quality Report and Accounts 2018/19 under delegated authority from the Trust Board. The documents would now be submitted to NHS Improvement and laying before Parliament to prescribed deadlines. All required documentation was duly signed by the Trust Chair, Chief Executive and Audit and Risk Committee Chair.

Escalations to Board or other Committee

- BAF risk relating to MHA/MCA compliance will be considered by the Mental Health Act Committee.

- The Executive will be asked to consider the broader issue of more general compliance and proposals will be taken through the BAF/Risk Register updates.

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	4 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	
IM	Deep Dive BAF Risk 3b - risk that the Trust fails to influence external drivers								X		
IM	BAF Deep Dive Risk 3b								X		
Trust Sec	Freedom to Speak Up Guardian Report (six monthly)				X						X

Exec Lead	Item	2 Apr 19	7 May 19	4 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	Fit and Proper Person Declaration			X							
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								
GH	Clinical Strategies				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
Report to the Board of Directors – 4 June 2019

Report from the Council of Governors Meeting Held on Tuesday 7 May 2019

The Council of Governors met on Tuesday 7 May 2019 at the Centre for Research and Development, Kingsway Hospital site, Derby. The meeting was attended by 19 governors.

Briefing on NHS Long Term Plan

Ifti Majid provided a briefing on the NHS Long Term Plan. Ifti referred to the full report which is available via the link https://www.longtermplan.nhs.uk/.

Report from Governors' Nominations and Remuneration Committee

Caroline Maley, Trust Chair gave an update from the meeting of the Nominations and Remuneration Committee, which was held on the 13 March 2019. The Committee received confirmation that Julia Tabreham, Anne Wright, Richard Wright and Geoff Lewins had received satisfactory appraisals. A Non-Executive Director Skills Audit had been undertaken in January 2019 and this has been discussed and moderated at the Board Committee Chairs meeting, on 2 April 2019. Succession planning for Non-Executive Directors was considered which included consideration of renewal of appointments. Further discussion will take place at the next committee meeting on 22 May to include planning for replacement of Anne Wright who has confirmed she is to leave the Trust at the end of her term in January 2020. The draft of the year-end report for 2018/19 on the effectiveness of the Committee in the context of it meeting its Terms of Reference was presented to the Committee and amendments were made. A discussion took place on the proposed changes to the Committee's Terms of Reference and it was agreed that a further review of the Terms of Reference would be undertaken, with a view to bringing back a revised proposal to the July Council of Governors meeting..

Non-Executive Director deep dive

Richard Wright, Non-Executive Director and Chair of Finance and Performance gave an update on the work of the Committee, highlighting his role in holding Executive Directors to account.

Integrated Performance Report

The Integrated Performance Report was presented to the Council of Governors to provide an overview of performance as at the end of March 2019. The Non-Executive Director Board Committee Chairs reported on how the report had been used to hold Executive Directors to account in their respective Board Committees for areas with regards to workforce, finance, operational delivery and quality performance.

Escalation Items to the Council of Governors

Three items were escalated to the Council of Governors from the Governance Committee. Richard Wright, Chair of Finance and Performance Committee, responded to a question relating to the Liaison Teams co-located in the acute hospitals. Margaret Gildea, Chair of People and Culture Committee responded to a question seeking assurance that staff have the confidence to 'speak up'. Anne Wright, Chair of Quality Committee responded to a question relating to concern that some care coordinators are producing online care plans for service users without the

involvement of the service user. The Council of Governors received assurance on all three areas.

Governance Committee Report
Kelly Sims, Chair of the Governance Committee presented a report of the meeting held on 9 April 2019. The Committee had approved the content of the governor and membership section of the Annual Report. The draft Quality Report has also been discussed and the draft statement was agreed.

Update on the Annual Members' Meeting
Governors were reminded that the Annual Members' Meeting is taking place on 11 September 2019 and were asked to keep this date free in their calendars and promote the meeting to their constituents and the public.

Review of the Current Processes and Role Description for the Lead/Deputy Lead Governor
Justine Fitzjohn, Trust Secretary, presented a paper, which detailed the summary discussions from a Task and Finish Group, convened to review the current role descriptions and processes around the Lead Governor and Deputy Lead Governor roles. The Council of Governors agreed to the amendments presented and also agreed that the qualifying period for governors to stand as Lead Governor and Deputy Lead Governor would be twelve months and six months in the governor role respectively.

Update on Recent Governor Elections
Denise Baxendale, Membership and Involvement Manager, gave an update to governors on the recent elections for public and staff governors to provide assurance on the process taken. The election process is undertaken by Electoral Reform Service (ERS), an independent company used by the majority of foundation trusts to run their elections. Governors were asked to note the range of activities that took place to promote the vacancies and identify individuals interested in the governor vacancies. All six seats were contested.

Recommendation
The Trust Board is asked to note the summary report from the Council of Governors.

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
AO	Accountable Officer
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST TERMS	
NHS Term / Abbreviation	**Terms in Full**
CRS	Commissioner Requested Services
CSF	Commissioner Sustainability Fund
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
EIP	Early intervention in psychosis
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	

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST TERMS	
NHS Term / Abbreviation	**Terms in Full**
GDPR	General Data Protection Regulation
GGI	Good Governance Institute
GMC	General Medical Council
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST TERMS	
NHS Term / Abbreviation	**Terms in Full**
	cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists 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
PSF	Provider Sustainability Fund
Q	
QAG	Quality Assurance Group
QC	Quality Committee

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST TERMS	
NHS Term / Abbreviation	**Terms in Full**
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
R	
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