Derbyshire Healthcare
NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust
Board of Directors Meeting

Conference Rooms A and B, Centre for Research and Development, Kingsway Hospital, Derby
3 September 2019 09:30 - 3 September 2019 12:30

INDEX

NHS
Derbyshire Healthcare
NHS Foundation Trust

NOTICE OF PUBLIC BOARD MEETING – TUESDAY 3 SEPTEMBER 2019
TO COMMENCE AT 9:30am
CONFERENCE ROOMS A & B, CENTRE FOR RESEARCH AND DEVELOPMENT, KINGSWAY, DERBY

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks, apologies and Register of Interests	Caroline Maley
2.		Patient Story - cancelled	Carolyn Green
3.	9:35	Minutes of Board of Directors meeting held on 2 July 2019	Caroline Maley
4.		Matters arising – Actions Matrix	Caroline Maley
5.		Questions from governors or members of the public	Caroline Maley
6.	9:40	Chair's Update including Board Joined Up Care Derbyshire Board update	Caroline Maley
7.	9:50	Chief Executive's Update	Ifti Majid
OPERATIONAL PERFORMANCE, QUALITY, STRATEGY AND GOVERNANCE			
8.	10:05	Integrated Performance and Activity Report	C Wright/A Rawlings/ C Green/M Powell
9.	10:25	Quality Report on Use of Resources	Claire Wright
10.	10:40	Freedom to Speak Up Guardian Report	Tamera Howard
10:55 B R E A K			
11.	11:10	Board Assurance Framework Update – Version 3.2	Rachel Kempster
12.	11:30	Pulse Check Results and Staff Survey Plan	Amanda Rawlings
13.	11:40	Workforce Race Equality Standard (WRES) Report and Action Plan Workforce Disability Equality Standard (WDES) and Action Plan	Amanda Rawlings
14.	12:00	Learning from Deaths Mortality Report	John Sykes
15.	12:10	Control of Infection Report	Carolyn Green
16.	12:20	Board Committee Assurance Summaries and Escalations: Quality Committee 9 July, Audit & Risk Committee 11 July, Extraordinary Meeting of the Finance & Performance Committee 12 July, Finance & Performance Committee 15 August, Safeguarding Committee 16 July, 2019 *(minutes of these meetings 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 2 July and 6 August 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 1 October 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.

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.

Our Trust values are:

People first – We focus on our colleagues, in the knowledge that a well-supported, engaged and empowered workforce results in good patient care.
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.

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DECLARATION OF INTERESTS REGISTER 2019/20		
NAME	**INTEREST DISCLOSED**	**TYPE**
Margaret Gildea Non-Executive Director	• Director, Organisation Change Solutions Limited • Non-Executive Director, Derwent Living	(a, b) (a)
Carolyn Green Director of Nursing & Patient Experience	• Husband employed by Derbyshire Probation Service	(d)
Gareth Harry Director of Director of Business Improvement & Transformation	• Chairman, Marehay Cricket Club • Member of the Labour Party	(d) (e)
Geoff Lewins Non-Executive Director	• Director, Arkwright Society Ltd	(a)
Ifti Majid Chief Executive	• Board Member NHS Confederation Mental Health Network • Kate Majid (spouse) 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 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 Deputy Trust Chair and 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 2 July 2019

MEETING HELD IN PUBLIC

Commenced: 9.30am Closed: 12:25pm

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
IN ATTENDANCE	Anna Shaw	Deputy Director of Communications & Involvement
	Justine Fitzjohn	Trust Secretary
	Sue Turner	Board Secretary (minutes)
For DHCFT2019/094	Max	Service Receiver
For DHCFT2019/094	Nicola Fletcher	Assistant Director of Clinical Professional Practice
VISITORS	John Morrissey	Lead Governor and Public Governor, Amber Valley
	Lynda Langley	Public Governor, Chesterfield
	Kelly Sims	Staff Governor, Administration and Allied Support
	Jo Foster	Staff Governor, Nursing
	Christine Williams	Public Governor, Derby City West
	Christopher Williams	Public Governor, Erewash
	Julie Lowe	Public Governor, Derby City East
	Andrew Beaumont	Trust Member

DHCFT 2019/093	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** The Trust Chair, Caroline Maley, welcomed all to the meeting. No declarations of interest in agenda items were raised.
DHCFT 2019/094	**PATIENT STORY** Assistant Director of Clinical Professional Practice, Nicola Fletcher introduced service receiver Max to the Board who described her mixed experiences and the negative impact of receiving a late diagnosis of autism as an adult and her disappointments with the delays in treatment and lack of support post diagnosis for her autism care needs. Max explained how she and other people with autism have complex needs and described how this feels unbalanced with support on one side for mental health conditions but not on the other side because of the lack of commissioned support for adults with autism. She felt that change is needed so that person centred care can be provided to adults with autism. Chief Executive, Ifti Majid was struck by how Max had described the two components of herself and the need to have support for them both. Max realises now that the psychological therapy that she receives in the Psychodynamic Therapy service is helping her live her life. She added that she does not view her diagnosis of autism as being something that is wrong with her, autism is just something she needs assistance with and was concerned that people from the lower end of the autism spectrum are not able to access services for themselves. Deputy Trust Chair, Julia Tabreham agreed that it was unacceptable that Max had to wait so long for treatment and asked her what difference it would have made to her life if she had received an earlier diagnosis. Max believed her referral was lost in the system which resulted in her experiencing extended waiting times. If she had received therapy and specialist support for autism a lot earlier she would be a lot healthier. It is well known the gastrointestinal problems are associated with autism and she was later diagnosed with these issues and never understood why she had these symptoms. Max felt that the service support that she received was not centred on the entirety of what she was struggling with and explained the events in life that she felt were impacted and delayed through not getting the right help. Non-Executive Director, Anne Wright apologised for the Trust's lack of a commissioned service for autism support post assessment. She asked Director of Business Improvement and Transformation, Gareth Harry what plans the Trust had for the provision of a service in Derbyshire. He advised that ongoing discussions are taking place with Derbyshire commissioners to explore resource within the current diagnostic ASD (Autism Spectrum Disorder) team to see what can be offered for people who need post diagnostic support. Senior Independent Director, Margaret Gildea struggled to understand how the Clinical Commissioning Group could allow diagnosis to be made without providing treatment and was interested to know what treatment is available. Medical Director, John Sykes explained that treatment is generally supported through a number of options including education and coaching, it is not a highly medicalised form of treatment. Director of Nursing and Patient Experience, Carolyn Green informed the Board that

	Max is a member of the Trust's expert by experience EQUAL Forum and asked the Board to respond formally to her story and commit to making improvements to person-centred care and reduce waiting times for people with autism. In addition Carolyn Green advised of the national policy review and the review of the statutory guidance and asked Board colleagues to commit to discussing and escalating these issues so that a service can be explored and the benefits of a national service change, delivered locally could be provided that meets an individual's needs after diagnosis. Carolyn Green also drew attention to the Treat Me Well campaign that would be discussed later during the meeting as this is closely connected to Max's story. She described how with the EQUAL Forum that Max belongs to can help advise on physical healthcare issues associated with autism. Carolyn proposed sharing Max's experience with commissioners so they can understand the impact that a lack of person centred care after diagnosis has on people with autism and the impact this has on their life. Gareth Harry set out the strategic objectives that the Trust is trying to deliver with commissioners around ASD. The focus over the last three years is about discharging people from hospital and providing them with support in the community. The intention moving forward is to deliver an improved package of care for people with ASD and make mainstream services provide reasonable adjustments to improve people's needs aligned with autism legislation. This is the start of the work the Trust is doing with commissioners to address the very issues Max has talked about today. Anne Wright was keen to know if there was a process for reporting on follow up action taken from patient stories and was assured that an update on patient story outcomes is scheduled to be reported to the Board in October. Ifti Majid reflected on how Max's story gave a very graphic picture of her needs and proposed using her story to further explore person cantered care and improve waiting list management so that people can be diagnosed earlier as this will prevent them experiencing anxiety and depression which often goes hand in hand with autism. The letter that Max read out to the Board will be shared with commissioners to demonstrate the impact of the current gaps in this service area. On behalf of the Board, Caroline Maley thanked Max for bringing her story to the attention of the Board **ACTION: Letter from an EQUAL member Max to be shared with commissioners.** **RESOLVED: The Board of Directors thanked Max for sharing her story which enabled the Board to focus on delivering an improved package of care for people with ASD.**
DHCFT 2019/095	**MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 7 MAY 2019** The minutes of the previous meeting, held on 4 June 2019, were accepted as a correct record of the meeting.
DHCFT 2018/096	**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 2019/097	**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 2019/098	**CHAIR'S UPDATE** Caroline Maley's report provided the Board with the Trust Chair's summary of activity and visits to the Trust's services undertaken since the previous Board meeting held on 4 June. A particular highlight for Caroline during June was the visit made by Peter Wyman, Chair of the Care Quality Commission (CQC) who met colleagues and patients at the Kedleston Unit, the Hub at the Radbourne Unit and The Beeches perinatal team who shared their experience of receiving care and working for the Trust. Caroline referred to the training undertaken by governors on 12 June that focussed on how governors engage with members of the community. She acknowledged that this is a particularly difficult part of a governor's role and was pleased to see that governors discussed how they feed back the work of the Trust throughout their constituency. Caroline congratulated Linda Langley on her appointment as Lead Governor. Linda will take up this role when John Morrissey steps down from this role in September. The NHS Confederation conference was held from 19 to 20 June where Caroline was pleased to see issues including mental health, workforce and inclusion having an increased focus. Caroline's report also detailed the Joined Up Care Derbyshire Board (JUCD) meeting held on 20 June with the key messages noted from the meeting outlined in the appendix attached to her report. **RESOLVED: The Board of Directors noted the activities of the Trust Chair since the last meeting held on 4 June 2019.**
DHCFT 2019/099	**CHIEF EXECUTIVE'S UPDATE** 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 the national health and social care sector as well as developments within the local Derbyshire health and social care community. Ifti made reference to the interim NHS People Plan that would be covered in more detail by Director of People Services & Organisational Effectiveness, Amanda Rawlings later in the agenda. The final plan will be published soon after the publication of the 2019 spending review in the autumn. The Trust has now received the final report from the CQC following their visit to the acute inpatient wards in March. The overall rating remains inadequate although it

	was noted that key significant improvements have been made in some areas. There remains a significant level of improvement needed to the Trust's acute mental health wards in order to meet the requirements outlined by the CQC. Ifti was pleased to report that he has been impressed with the way that the acute teams are working closely with Executive Directors on an action plan to address the issues raised in the report and are looking at new and innovative ways to make necessary changes. The Annual Staff Conference took place on 10 June when two guest speakers gave an insight into their unique inspiring experiences of the importance of effective teamwork. This was particularly true with the second speaker who spoke about the importance of having a clear organisational branding which Ifti felt was similar to the Trust's vision and values and open and transparent culture. The guest speakers had inspired some creative discussions with colleagues that day and these will be progressed through the Trust's strategy. Ifti's report also highlighted the success of second NHS Confederation Conference. Matters discussed that day around mental health, workforce and inclusion will also be taken forwards as part of the Trust's strategy development. Discussion took place on the potential funding reductions to 0–19s children's services in the county to establish what could be done to influence reconsideration by central government. Although this national policy is disappointing it was thought that the formation of a constructive relationship with public health would show how the Trust's caseloads are growing and helps provide an understanding of the impact that a change in landscape has on this service. The Board discussed how the school nursing service and health visitor service is performing an increasing safeguarding role dealing with children who have early adverse childhood experiences and the difficulties associated with budgeting and commissioning for school nurses. The Quality Committee will be briefed on projects that have developed through escalations from the patient story that featured the voice of a child told through a school nurse made at the April Board meeting. Individual work streams associated with this area of safeguarding were discussed at the June JUCD Board meeting. The Board acknowledged that the JUCD must uphold the ethos of early intervention and prevention as this is the vision of joined up care which must be driven alongside the wider determinants of housing and social care. **RESOLVED: The Board of Directors scrutinised the Chief Executive's update, noting the risks and actions being taken.**
DHCFT 2019/100	**<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 May. This review commenced with an explanation of the Trust's financial challenges that were outlined by Director of Finance and Deputy Chief Executive, Claire Wright. The Trust is forecasting to meet its adjusted plan but there are a significant number of risks to achieving that plan due to ongoing and new cost pressures. These continue to be appraised and plans are being developed to mitigate these pressures as far as possible. Some of these risks include extra costs relating to improvements to our urgent care services, recruiting additional staff and for the cost of moving to different shift patterns. There are also gaps in the Cost

	Improvement Programme (CIP) as well as concern with the level of non-recurrent compared to recurrent cost reduction schemes. An additional Finance and Performance Meeting is taking place on 12 July when additional scrutiny will take place on the progress with mitigating risks in the financial position and the progress with CIP. Claire Wright also highlighted the need to gain a response from NHS Improvement (NHSI) to the need to use the £0.4m income for agenda for change pay awards in local authority contracts in reaching the planned outturn. Gareth Harry added that a significant amount of work is being undertaken to identify recurrent longer term cost improvements and quality improvement schemes. There are a number of projects under the 'plan, do, study, act' (PDSA) cycles that will be rolled out later in the year as well as additional schemes being developed to achieve savings. Caroline Maley reflected on the potential difficulty of the Trust not being able to meet its control total if all the required improvements to our urgent care services are delivered. Claire confirmed that this will be part of the discussions at Finance and Performance Committee. She reminded the Board that there continue to be a number of challenges that need to be overcome to meet the planned surplus, in doing so she clarified the NHSI definitions of the control total compared to the adjusted plan surplus. Given the level of risk she reiterated the fact that the Board Assurance Framework (BAF) risk 3a "*There is a risk that the Trust fails to deliver its financial plans"* is rated as extreme. Ifti Majid was conscious that it will be seriously viewed if the Trust fails to meet its control total and emphasised the need for the Board to continue to make very careful decisions. Julia Tabreham recognised the sustained pressure that the Trust is under to make these very careful decisions and asked how supportive the system could be in terms of alleviating cost pressures. Claire Wright responded that she felt that transparency in the system is a positive aspect but reminded the Board that none of the system's shared risks were Derbyshire Healthcare's financial risks. Wider key risks and issues are being discussed at the Director of Finance and Chief Executives meetings. She added that the Trust is not alone in feeling this amount of pressure. The effectiveness of system transformation plans should be improved by working differently as the Sustainability and Transformation Partnership (STP) moves towards being an Integrated Care System. Non-Executive Director, Richard Wright recognised the immediate financial challenges that the Trust is facing this year and that this will continue into next year. The immediate task is to work on remedial and recovering action this year that will have an impact on plans for next year. The biggest focus is to close the gap for this year and make the right decisions about future work. Chief Operating Officer, Mark Powell built on this point. The next Finance and Performance meeting taking place on 12 July will be looking to receive assurance of the immediate action that is being taken to close the financial gap. The Committee will also oversee outcomes from the clinically led strategy work that will manifest within quality plans for transformation. Claire Wright referred to the Derbyshire JUCD Risk Share Agreement and made the point that if the risk share is deployed, the Trust will not meet its control total. Discussion turned to delayed transfers of care (DTOC). Mark Powell outlined that there are three patients whose discharges are being delayed. Work is continuing

	with partners to address and minimise delays to avoid unnecessary waits in beds and improve escalation processes. NHS England has recently advised that the Trust's target threshold for DTOC is 3.5%. This was based on a historic trend which Mark felt was a more reasonable target. The outpatient referrals and rate of non-attendance benchmarking data was referred to which compares the Trust's position with other providers. Carolyn Green felt that benchmarking should be shared around the organisation especially as she is mindful that although there are difficulties in some areas, it is important to show areas where the Trust is doing well. This data shows the Trust in a good position and will look to clinical aspects to help the Trust reach its control total. Non-Executive Director, Geoff Lewins asked how the management of sickness absence was progressing and whether managers were carrying out return to work interviews. Amanda Rawlings clarified that work is ongoing across all divisions in the Trust to tackle increasing levels of sickness absence, particularly in the inpatient areas. The main reason for sickness absence is stress and anxiety, which accounted for 33% of all sickness absence during May 2019. Through Employee Relations and support and from Divisional People Leads, focus is particularly aimed at long term sickness cases to either support employees back to work in a more timely way or to look at alternative solutions. There is also a lot of work being undertaken to support staff wellness and give everyone the opportunity to be at work. Geoff Lewins also asked what the effect would be on consultant workload if DNA (Did Not Attend) rates were halved. Mark Powell confirmed that a reduction in the DNA rate would help to ensure that service users receive regular contact with their doctor. This would mean that doctor time is used more effectively. It will also help with better resource management, for example, support staff would not have to rearrange appointments. After concluding discussions, the Board received limited assurance from the report and noted that the Finance and Performance Committee will have additional oversight of the challenges described above. **RESOLVED: The Board of Directors:** **1) Received limited 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 2019/101	**ANNUAL REPORT ON REVALIDATION OF DOCTORS** This report provided the Board with the necessary assurance that the Trust has fully achieved all the standards with the Statement of Compliance required by NHS England by September 2019. It was noted that 100% of available doctors completed appraisals or had approved postponement. The quality of appraisals is improving and appraiser numbers are satisfactory. John Sykes made reference to the psychiatrist who practiced within the Trust for eleven weeks between 6 March 2016 and 30 June 2016 as a locum Learning Disability consultant without a primary medical qualification. This was due to failures in GMC (General Medical Council) scrutiny when this individual presented fraudulent qualifications to the Regulator. The Trust followed all the correct

	employment checks in place at the time. A full report of this incident was taken to the Serious Incident Group. The Trust has learnt from this event and strengthened its recruitment process and has contacted all affected patients and carers and liaised with the police and GMC. Patients and carers have been supported and full duty of candour discharged. The Board noted that the Quality Committee obtained full assurance from the report on 11 June and that it contained detail of recruitment checks to support the signing of the compliance statement by the Trust Chair to submit to the Higher Responsible Officer at NHS England by 27 September. Thanks were extended to Medical Appraisal Lead, Dr Edward Komocki for his work in reporting on medical appraisal and validation over the years. As Dr Komocki is retiring from the Trust Ifti Majid undertook to write to him on behalf of the Board recognising his valued commitment in ensuring that there are procedures in place to support doctors and protect patients and also for his contribution to improving performance with the Mental Health Act and Mental Capacity Act. **ACTION: Trust Chair to sign the statement of compliance required by NHSE for submission by 27 September** **RESOLVED: The Board of Directors:** **1) Accepted the report** **2) Noted that Statement of Compliance for submission to NHS England in September 2018.**
DHCFT 2019102	**PROPOSALS TO AMEND THE TRUST'S CONSTITUTION RELATING TO THE GOVERNORS NOMINATIONS AND REMUNERATION COMMITTEE** Trust Secretary, Justine Fitzjohn's report informed the Board that the Council of Governors, at its meeting later on 2 July, will be asked to approve an updated version of the Terms of Reference for the Nominations and Remuneration Committee. If approved, this will also require an amendment to the Trust's Constitution. Any changes to the Constitution require approval of both the Trust Board and the Council of Governors. **RESOLVED: The Board of Directors approved the amendment to Annex 5 of the Trust's Constitution as outlined in the report, subject to the Council of Governors approving the revisions to the Governors Nominations and Remuneration Committee's Terms of Reference and the required changes to the Trust Constitution.**
DHCFT 2019/103	**REVISED TRUST STRATEGY** Gareth Harry presented the Board with a revised Trust Strategy. He explained that following initial conversations at the May meeting of the Board of Directors, further engagement had taken place with colleagues and groups across the Trust on the draft revised strategy and their feedback has been captured in the revised strategy. Gareth thanked Deputy Director of Communications, Anna Shaw and the Communications Team for the wide level of engagement that took place and outlined the positive suggestions and changes that have been reflected in the updated strategy. Of particular note was the clinical ambition that has been revised following detailed discussions at the Trust's Medical Advisory Committee (TMAC). The strategy has also been simplified and tailored around the 'people first' values

	and objectives. Julia Tabreham was interested to know what systems are in place to monitor the impact that the strategy might have on people with protected characteristics and if anything arose from the consultation with colleagues that the Board would need to be mindful of. Gareth described how detailed feedback on the strategy had been sought from the LGBT+ network that was concerned about how the Trust's estate would focus on the implementation of single gender wards. Claire Wright added that the Board was mindful that some people do not live in a binary world and would consider their needs in a wider sense. Carolyn Green observed that that delivering great person centred care is an important focus of the strategy. She added that if this quality improvement focus is applied to actions resulting from patient stories to the Board like the one from Max today this will evidence how the Trust is delivering improvement work. The Board was pleased to note that the revised strategy captures the 'People First' value which confirms the Trust's focus on its staff and approved the updated draft. The plan on a page will be developed to show the components of the strategy and will clearly evidence the commitment of the Board and the Board Committees to equality and diversity. Further engagement with the strategy will take place with the Council of Governors at their meeting later on 2 July. It was agreed that Caroline Maley would if necessary progress any response received from the Council of Governors through a Chair's action. **RESOLVED: The Board of Directors noted:** **1) Noted the progress and changes that had been made following engagement on the Trust Strategy** **2) Approved the updated Trust Strategy, with a Chair's action to accommodate any further feedback received from the Council of Governors.**
DHCFT 2019/104	**<u>INTERIM PEOPLE PLAN</u>** Amanda Rawlings' report provided the Board with an insight into the NHS Interim People Plan; the five key themes supported by eight national work streams and the implications that the plan will have on the Trust. Amanda outlined the five key themes with each theme having a number of core actions. She emphasised that, as part of the theme of making the NHS the best place to work, the government is bringing forward a consultation on new pension flexibility for senior clinicians. This proposal would give senior clinicians the option to halve the rate at which their NHS pension grows, in exchange for halving their contributions to the scheme. Amanda would like to see that the proposed flexibility is made available to support the retention of all members of the workforce. The Board concentrated on what the Trust needs to focus on to deliver 21st century care and noted that the Chief Operating Officer, Director of Nursing and Medical Director are working with Amanda to review and change the workforce model to enhance the skills mix, enhance workforce supply and work life balance. Richard Wright noted the Trust's retention rate amongst doctors and asked how this could improve. Amanda explained that the main reason for doctors leaving the organisation is through retirement and that work will be taking place to ensure their working model is based on a more family friendly approach that offers flexibility for

	a multi-generation workforce that will help improve retention rates. Margaret Gildea made the challenge that it is clear that people within the Trust are already working hard and fast. The People and Culture Committee is monitoring increasing the pace of recruitment and improving retention. This programme of work has a significant momentum behind it and can be enriched through improved collaboration through the NHS staff bank. The Board recognised that the interim people plan is aligned to the Trust's people plan and that our work plan skill mix needs to progress with more pace. The Trust will be following the national way of working as this develops and will continue its focus on increasing mandatory training compliance, progress planned skill mixing with more pace along with the development of our urgent care work. **RESOLVED: The Board of Directors:** **1) Noted the national plan and the work we are doing as a Trust against the themes** **2) Recognised the increased pace and focus that is required for the Trust to be a 'Great Place to Work' enabled by inclusive and compassionate leadership.**
DHCFT 2019/105	**<u>TREAT ME WELL CAMPAIGN UPDATE</u>** This report presented by Carolyn Green updated the Board on the national campaign led by MENCAP called Treat Me Well that was shared with the Trust Board on 3 July 2018 when the Board made a specific commitment to improve the Trust's performance in this area. Having reviewed the positive progress and improvements made with the Treat Me Well campaign since it was introduced twelve months ago, the Board noted that the Trust's Learning Disabilities (LD) services standards directly respond to the Treat Me Well campaign. The next phase of work will continue to be implemented with learning from the improvements that have been made so far from continually listening to the voice of the EQUAL Forum and the community. The Board recognised that the number of individuals with Profound Multiple Learning Disabilities (PMLD) with complex needs is increasing in the community and the needs of this section of the local community are significant. The population growth remains a risk for the Trust's wider community and commitments are in place by the Board and commissioners to review these patient groups in particular to meet the health population needs. Executive Directors have raised this with local authority colleagues and are giving feedback on the long term plan. Geoff Lewins asked if all issues that need to be taken into consideration have been identified and whether there are aspects that commissioners should provide. Executive Directors have raised the needs of these patient groups with commissioners and will continue to apply strategic lobbying. Areas of the Greenlight toolkit to enable Learning Disability and Autism Standards will continue to be implemented compiling a multi-layering approach that will influence services in the long term. The Board reflected on the importance of understanding people and taking a people centred approach and not making assumptions about people's background or relationships as so many times when the Board has heard stories told by patients they are concerned about personal interaction.

	The Board was pleased to see the connection with the Treat Me Well Campaign and today's patient story and agreed that the Quality Committee will continue to have oversight of the progress being made with the Treat Me Well Campaign. **RESOLVED: The Board of Directors:** **1) Noted the progress made so far on the Treat Me Well campaign and improvements made after twelve months** **2) Noted the medium term to long term commitment to Profound Multiple Learning Disabilities (PMLD) and that the population growth remains a risk for the Trust's wider community, commitments are in place by the Board and commissioners to review these patient groups in particular. Executive Directors have raised this group with local authority colleagues and are giving feedback on the long term plan.** **4) Agreed that the Quality Committee will continue to have oversight of the progress being made with the Treat Me Well Campaign.**
DHCFT 2019/106	**<u>BOARD COMMITTEE ASSURANCE SUMMARIES AND ESCALATIONS</u>** Assurance summaries were received from the Board Committees and highlights were provided by the respective Non-Executive Chair. **Mental Health Act Committee 7 June:** Chair, Anne Wright was pleased to report that this had been an effective meeting. This was due to the Committee's operational group performing well. She was pleased to report that the Committee was satisfied that gaps in control associated with 2018/19 BAF Risk 1a *There is a risk that the Trust will fail to provide full compliance with the Mental Health Act (1983) and Mental Capacity Act (2005)* had now been mitigated to a level that they no longer pose a significant threat to the achievement of the Trust's Strategic objectives. The Committee also discussed changes that are to be made to the Mental Health Act and how this will impact the role of Associate Hospital Managers. **Quality Committee 11 June:** Chair, Margaret Gildea, advised the Board that the Committee had reported that the risk rating of 2019/20 BAF Risk 1a *"There is a risk that the Trust will fail to provide standards for safety and effectiveness required by the Board"* will be affected by additional risks arising from the recent CQC report. It was recommended that this risk be raised from high to extreme and this will be reflected in the next version of the BAF to be received by the Audit & Risk Committee on 11 July. **People and Culture Committee 25 June:** Chair, Margaret Gildea reported that the Committee had discussed using data more effectively to determine workforce trends in order to increase the pace of staff recruitment and improve staff retention. The Strategic Workforce Report updated the Committee on what is happening at a national and local level and included the NHS interim people plan, improving people practices, junior doctor contract changes and the impact of the exit payment consultation. **RESOLVED: The Board of Directors received and noted the Board Committee Assurance Summaries.**
DHCFT 2019/107	**<u>IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK</u>**

	No additional issues were raised in the meeting for updating or including in the Board Assurance Framework.
DHCFT 2019/108	**2019/20 BOARD FORWARD PLAN** The 2019/20 forward plan was noted by the Board and is to be updated to reflect the cycle of STP work stream reporting.
DHCFT 2019/109	**MEETING EFFECTIVENESS** Attendees and visitors were thanked for their attendance at today's meeting. It was accepted that as the Trust Strategy had been discussed in various arenas this might have restricted debate. The interim people plan will a big impact on the clinical workforce and will benefit from the work that the Trust carries out locally.
There will be no meeting in August. The next meeting of the Board to be held in public session will take place at 9.30am on Tuesday 3 September 2019 in Conference Rooms A and B, Centre for Research and Development, Kingsway Hospital, Derby DE22 3LZ	

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - SEPTEMBER 2019			
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
2.7.2019	DHCFT 2019/094	Patient Story	Carolyn Green	Letter from an EQUAL member Max to be shared with commissioners	3.9.2019	Shared with commissioners through Public Board papers	Green
2.7.2019	DHCFT 2019/101	Annual Report On Revalidation Of Doctors	Caroline Maley	Trust Chair to sign the statement of compliance required by NHSE for submission by 27 September	3.9.2019	Statement of compliance signed	Green
2.7.2019	DHCFT 2019/101	Annual Report On Revalidation Of Doctors	Ifti Majid	Letter of thanks to be sent to Dr Edward Komocki on behalf of the Board	3.9.2019	Letters sent from Chair and CEO	Green

Resolved	**GREEN**	**3**
Action Ongoing/Update Required	**AMBER**	**0**
Action Overdue	**RED**	**0**
Agenda item for future meeting	**YELLOW**	**0**
		3

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 3 September 2019

Trust Chair's report to the Board of Directors

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on my activity with and for the Trust since the previous Board meeting on 2 July 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 27 June I attended the Schwartz Round held at the Radbourne Unit. Schwartz Rounds provide an opportunity for any member of staff, including students, to pause and reflect upon their work related experiences in a safe and supportive environment. They are designed to support employees with the emotional impact of work. The topic was "Standing in the Gap" and the session was led by our chaplaincy team. It was a very moving sharing of the experiences of the team, and then others in the room, of the emotional impact on them of the work that they do. This could be in terms of their clinical and support work, but also the interactions between members of staff.

   I have been reflecting on the experiences of a number of staff who shared feeling undermined and undervalued; not being respected for their own skills and experiences they bring to the table, if not "qualified" as a member of a clinical team; living with the emotional impact of being bullied by patients or their families and the emotional impact of losing a patient and then not receiving support from their team or the Trust. I do believe that these experiences underline the need for us to change the culture throughout the Trust, living the Trust values of people first, respect for others, honesty and doing your best. We need to press on with the work that we are doing through the leadership work and making the Trust a Great Place to Work, to ensure that we are truly changing the culture that exists throughout the Trust.

3. On 3 July I visited St Oswalds to meet with the older adult and adult services teams based there. It was unfortunate that the teams were unaware of my visit, and so there was only a handful of staff in that day. However, it was great to see that our older adults team were delighted to be thanked by the family of a service user publicly in the notices in the local paper for the support they had given to a service user and his family. The teams do feel remote in this location, and it reinforced for me the extra mile that we need to go to ensure that all our staff feel a part of the Trust and their work is valued.

4. On 10 July I spent the day with the Crisis Team North, where I went out with a member of the team to carry out an assessment following a GP referral. The referral was not appropriate, and there were a number of facts that were incorrect leading the GP to ask for a rapid response. However, it was very useful for me to see as this is of course what our teams face regularly. The situation was handled with care and compassion by the team, and also appropriate guidance given, including identifying that the service user already had a referral to IAPT with the telephone call the following week. It was apparent that a lot of paperwork still needed to be completed for this referral, and I wonder if we could streamline this whilst still recording all that was needed. I also attended the team multi-disciplinary meeting, and have raised concerns about the inefficiency of the meeting with the Director of Nursing.

5. On 23 July I attended the drug multi-disciplinary team meeting, and then the team meeting of the Drug and Alcohol Recovery Service based at St Andrews House. The meeting is attended by staff from our Trust, Aquarius and Phoenix Futures. It was good to see the partnership working seamlessly across the service in the best interests of the service users, and the knowledge that all staff have of their clients. I was also pleased to be able to stay for the team meeting, and to be able to invite staff to shadow me today.

6. Also on 23 July I visited the Research and Development team in the Ashbourne Centre and was able to gain an insight into the research projects and way that these teams work. Once again I have been impressed about the commitment of the staff to working across boundaries with other organisations, both locally and nationally.

7. On 30 July, I took part in the quality visit at London Road, Ward 1. We heard from a patient and her family of the care that she had received, not just from the ward, but also from the community team and the in reach team prior to admission, and following discharge. There were no improvements that they could suggest for the services, and were full of praise for the great care they had received. It is clear that the team at Ward 1 work very well across disciplines and together in the best interests of the patients.

8. On 7 August, I joined some of the Non-Executive Directors in visiting the in-patient adult acute wards at the Hartington Unit. It was good to see that improvements continue to be made to improve the quality of care in our acute services and the focus by the Acute Services Transformation Team on working as a cohesive unit to deliver the transformation plan.

9. It has been good to hear unprompted from a number of staff at the services listed above that they see the change that it is taking place in the Trust culture. I am sure that this is as a result of the hard work that has been put in to our strategy, culture and values work over the past year or so.

Council of Governors

10. We have seen a number of resignations from public governors in the last few months, and will be holding elections to fill these, as well as elections where

governors' terms will be ending shortly and over the next six months. I would like to recognise Denise Baxendale for all the work that she does in supporting our governors to do their role, and for the recruitment of members of the public to stand for election when we start the election process.

11. On 2 July I chaired the Council of Governors meeting, which was well attended. Based on the recommendations of the Nominations and Remuneration Committee, the Council confirmed the reappointment of three of our existing NEDs, and approved revised terms of reference for the committee. We also heard from the mental health liaison team at the Royal Derby on their work there to inform governors of the role that they play in supporting those with mental health issues in the emergency department.

12. On 9 July I had my first meeting with Lynda Langley, who will be taking over from John Morrisey as Lead Governor on her return from holiday in early September. Regular meetings between the Lead Governor and Chair are an important way of building a relationship and understanding of the working of both governing bodies. I look forward to working with Lynda in the future. Outstanding business remains the appointment of a Deputy Lead Governor.

13. On 23 July I met with Kelly Sims, chair of the Governance Committee to review the agenda for that meeting and look toward the agenda for the Council meeting on 3 September.

14. On 6 August I chaired a short extraordinary meeting of the Council of Governors to approve the recruitment of an additional Non Executive, and to confirm Richard Wright as Deputy Chair.

15. On 6 August I attended the Governance Committee of the Council of Governors. This Committee was chaired by Kelly Sims and included a discussion about membership and engagement, and the groups that we should target in terms of increasing the diversity of our membership.

16. On 8 August, the Nominations and Remuneration Committee led the process for the recruitment of a new Clinical NED for the Trust. This appointment should be ratified by the Council of Governors on 3 September, at which point I will be able to announce who our new NED will be.

17. The next meeting of the Council of Governors will be on 3 September after the public Board meeting. The next Governance Committee takes place on 10 October. The Nominations and Remuneration Committee will be meeting as required over the course of September and October to appoint a new NED.

Board of Directors

18. Julia Tabreham has stood down as Deputy Chair of the trust, a post she has held since September 2016. I would like to thank Julia for her support as my deputy and look forward to continue working with her as a non executive director on the Trust Board. Richard Wright has been appointed as Deputy Chair with effect from 1 August 2019. Margaret Gildea continues as the Senior Independent

Director for the Trust. I would like to thank all of the NEDs for their dedication and commitment to the Trust.

19. Board Development on 26 June covered three main strategic themes: our clinical strategy development work; how we could use data differently in our work; and a review of the corporate governance framework. The Board also completed its mandatory training on health and safety.

20. The Board also had a development day on 17 July, with a session on developing a compassionate approach to patient care. The Board also used virtual reality to experience what it is like to have dementia. The afternoon was spent discussing our estates strategy.

21. Over the course of this period I have been supporting the recruitment of a clinical NED. My thanks to the Nominations and Remuneration team and all those involved in the focus groups for making this a robust and good process. We specifically tried to extend our reach into the BME communities to encourage BME candidates who meet the criteria of a clinical background / qualification and experience at Board level. This is to ensure we are doing all that we can to be inclusive in our recruitment processes and perhaps address the diversity of the Board to be more representative of the communities we serve. Our shortlisting was a 50:50 split, and I believe that we need to build on this process for future recruitment exercises.

22. In July I met with Richard Wright for his regular NED quarterly development meeting. 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.

23. I am delighted that Perminder Heer will be joining us for 12 month placement as a NExT Director. Perminder's background is in HR, organisational development and talent management. Perminder started her indication programme at the end of July and joined our Board for its meetings in the month of August.

System Collaboration and Working

24. Joined Up Care Derbyshire (JUCD) has appointed an Independent Chair, John MacDonald, who is also Chair of Sherwood Forest Hospitals NHS Foundation Trust, a role he will continue to hold. Our Trust holds the contract for John's appointment, as we do for all other appointments for the JUCD team.

25. I attended the Joined Up Care Derbyshire Board on 18 July. As I have been on annual leave, Margaret Gildea attended the meeting on 15 August as my deputy. Attached as Appendix 1 are the key messages noted from both these meetings.

26. JUCD has asked that its Prevention Strategy be circulated and this is attached at Appendix 2.

27. On 25 July I attended a System Development session, hosted by Mike Farrar for the system on leadership. Our Trust was well represented, with attendance by 6 of the Board.

28. On 31 July, I took part in a webinar on ICS /STP issues for lay members and NEDs. It is apparent that there is no clear direction of how NEDs in particular will be involved in ICS / STP development. There is guidance being developed and resource packs and tools but these are not as yet ready for sharing. I will share these as and when they become available and will seek to clarify within the Derbyshire system how we use our resources for the best effect for the people of Derbyshire.

Regulators; NHS Providers and NHS Confederation and others

29. On 4 July, Ifti Majid and I attended a regular Chiefs and Chairs meeting hosted by NHS Providers. Speakers at the meeting included, Peter Wyman, Chair of CQC, reflecting on the performance of our sector as shared in the last CQC Board meeting; Jon Ashworth MP, Shadow Secretary of State for Health and Social Care, reflecting on the priorities that Labour would give to health and social care if in government; and a strategy and policy update from Chris Hopson, CEO of NHS Providers. Ifti was also filmed for the NHS Providers conference.

Beyond our Boundaries

30. I am available to take 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 **great care** by delivering compassionate, person-centred innovative and safe care	X
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	X
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	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

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

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 we are supporting the development of those who may find it more difficult to be appointed as a NED in the NHS. Perminder Heer has started her placement thereby continuing to support the system development of future potential NEDs from diverse backgrounds.

New recruitment for NEDs and board members will proactively seek to appoint people from protected characteristics, thereby trying to ensure that we have a Board that is representative of the communities we serve.

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

JUCD Board – 18 July 2018 – Key Messages

Our Workforce

We continue to develop the STP workforce strategy in light of the STP refresh process and agree the actions required to respond to the NHS Interim People Plan (IPP). Published in May 2019, the IPP identifies some immediate actions to support systems and organisations in achieving the Long Term Plan ambitions:

- Making the NHS the best place to work
- Improving our leadership culture
- Addressing urgent workforce shortfalls in nursing
- Delivering 21st century care
- A new operating model for workforce

Solving the workforce challenges we face is crucial, including addressing shortages in key staff groups, ensuring our staff are supported in delivery and making the NHS a better place to work continues to be a shared priority. We aim to offer attractive packages in Derbyshire for a career with integrated organisations offering CPD; mentoring; safe and supportive places to work. The aim is to improve the staff experience and strive towards making Derbyshire the best place to work, focussing on some key areas.

- How do we attract people to work in Derbyshire?
- How do we understand the impact on workforce as a result of transformation?
- How do we work to identify and recruit and retain the required workforce for the system, rather than doing this on an individual organisational basis?
- How do we equip our staff in Derbyshire with the required skills in the developing world of the NHS?

Place Alliance Update

Place Alliances involve commissioners, community services providers, local authorities, primary care, the voluntary and community sector and the public working together to meet the needs of local people. Place Alliances are about empowering people to live a health life for as long as possible through joining up health, care and community support for citizens and individual communities.

There are eight places, and each has developed a work programme to tackle issues specific to their area. Information on Place Alliances is being collated and will be available at www.joinedupcarederbyshire.org.uk later in July.

There has been an initial focus on supporting the frail elderly population, and Tracking of activity and spend on this group of patients shows that last year shows 787 less people being admitted to hospital compared to a ‘do nothing’ plan. This is a 6.8% reduction and represents a saving of £1.48m (4.2%).

Finances

The Derbyshire system has saved £16m in the first three months of 2019/20. This is a significant achievement and despite being short of the £21m target at this stage of the year, it represents strong progress towards achieving the £140m system savings requirement for the year.

Partner organisations are increasingly working together on the financial challenge to treat it as a 'system' challenge rather than a challenge for each individual organisation, and jointly owning the risk that comes from not achieving our financial targets.**Board**

Update on Joined Up Care Derbyshire – August 2019

PURPOSE

This report provides an update on key developments related to Joined Up Care Derbyshire Chair, the local Sustainability and Transformation Partnership. The aim is to ensure partnership boards, cabinets and governing body are kept abreast of progress.

MATTERS FOR CONSIDERATION

JUCD Chair

Following the formal interviews on 1 July 2019, John MacDonald was been appointed as the Independent Joined Up Care Derbyshire (JUCD) Chair. The appointment follows formal approval from Simon Stevens, NHS England and Improvement CEO. John commenced in post on 1 August and chaired his first meeting on 15 August. John retains his role as Chair of Sherwood Forest Acute Hospital.

STP Refresh

We are now required to develop 5 year plans in response to the ambitions set out in the NHS Long Term Plan published in January 2019. The Derbyshire system has agreed that our plans will be a refresh of the original STP rather than a completely re-write with a shift in focus to:

- People not patients
- Outcomes to ensure so that the people of Derbyshire 'have the best start in life, stay healthy, age well and die well'
- The wider determinants of health such as housing, education and air pollution management
- Stronger focus on addressing inequalities and population health management
- Our transition to becoming an Integrated Care System by April 2021
- The refresh will be informed and developed through strong engagement with people, patients, staff and wider stakeholders – this will drive our approach. In doing so, ALL partners will be involved in developing and subsequently delivering our 5 year plan.

In response to the confirmed timescales for submission, we have revised our local timescales to enable these to be met as follows:

Action	Deadline
Work stream review and update of original Outline Business Cases to inform STP plan and submit to STP core team to incorporate into the refresh	26 July
STP Team review of plans and feedback to work streams	9 August
Stakeholder engagement sessions/ Lay Representative confirm and challenge sessions to further inform and update 5 year plans (having developed the initial view of plans and priorities work streams should engage with the public if they haven't done so already to further inform the plans). * see note below	16 August
Work streams ensure all feedback built into final submissions to the STP Team	19 August
Final OBCs to be submitted to STP Team	19 August
Review/ refinement and read across of plans	30 August
STP Team final consolidation and write up of STP refresh (ongoing work with final inputs received above)	30 August to 13 September
Submission to JUCD Board	13 September
JUCD Board sign off (draft plan)	20 September
Submission to NHSE/I	27 September
Trust Boards, Governing Body, Health & Wellbeing Boards approval	End October
Final submission to NHSE/I	15 November

The NHS Long Term Plan Implementation Framework technical guidance has now been issued and clarifies the submission requirements with four component parts:

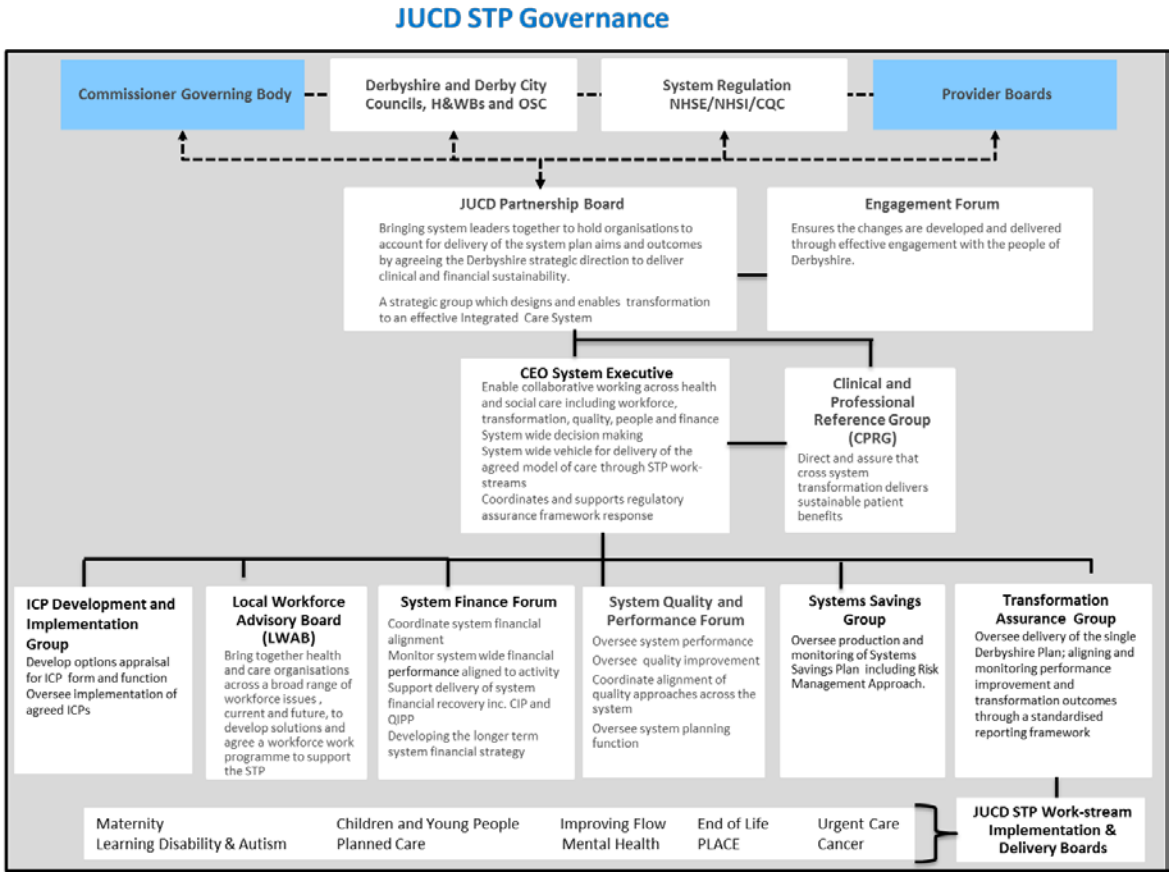
- **System Narrative Plan**: to describe how systems will deliver the required transformation activities to enable the necessary improvements for patients and communities as set out in the Long Term Plan.
- **System Delivery Plan** (Strategic Planning Tool): to set the plan for delivery of finance, workforce and activity, providing an aggregate system delivery expectation and setting the basis for the 2020/21 operational plans for providers and CCGs. The system delivery plan will also cover the LTP 'Foundational Commitments'.
- **Metrics tool**: a small number of metrics have been confirmed in the technical guidance. We are anticipating circa 35 metrics in total which are still in development, to be confirmed in August 2019
- **Detailed workforce submission** in addition to the strategic planning tool a further workforce tool requiring more granular Trust level detail will be required. This tool will be released via HEE, date yet to be confirmed.

Through the refresh discussions, the focus of the next phase of Joined Up Care Derbyshire is being considered. A letter has been circulated to partner Chief Executives and Chairs aimed at prompting the discussion around the way in which JUCD can identify critical system priorities that enable the delivery of shared ambition and enable transformation to take place at pace at a Derbyshire level that adds value to the ongoing business of the partner organisations. This discussion will continue at the Joined Up Care Derbyshire Board in the coming weeks.

STP Governance

Following recent discussions, the governance structure for Joined Up Care Derbyshire has been amended to reflect steps taken to further strengthen system working on Finance and other areas. The revised structure is included below for information of Board and Governing Bodies. It is also proposed that a finance sub-

committee is added to the JUCD governance process and this will be included in the diagram in due course.



Finance Update

At month 3 All Organisations are reporting to deliver to plan at year end; the CCG has reported £10.6m outside of forecast outturn to NHS England on eight savings schemes, which are all in the system risk share agreement. There remains risk to the delivery of the financial plan which may mean that the second half of the financial year continues to challenging. The System Savings Group continues to review these risks and in particular is ensuring that the impacts of any financial risks within each partner organisation are understood to mitigate against unintended consequences.

Integrated Care System (ICS) Development Programme Outputs

JUCD STP has completed a 16 week ICS Development Programme initiated by NHS England and Improvement. The programme has supported the system to reaffirm its vision and priorities, as well as providing an opportunity to develop our system roadmap to become an ICS by April 2021.

Urgent & Emergency Care Strategy

In February 2019, the Derbyshire Urgent Care Strategy Working Group was formed as a sub group to the Urgent Care System Transformation Board to translate existing work into a coherent emerging long term strategy for urgent and emergency care in Derbyshire. This included creating a shared vision for our system, which is specific enough to create alignment for the programme and overcome competing priorities.

The group have been meeting weekly to lead this work engaging with colleagues from the Place, Primary Care, Mental Health and Children's programmes and also holding two dedicated workshop days where the vision, strategic priorities and strategic dependencies were agreed.

JUCD Board received an update on progress to date, with a draft urgent and emergency care model emerging which aims for only people with more serious or life threatening physical health needing to present at A&E, with the majority of people accessing suitable alternatives within the community and that no people will need to attend A&E as a result of being unable to access same day primary care provision.

Next steps are to broaden the group of clinicians currently involved in the strategy development, to model the potential activity profiling which might occur as a result of the strategy, and also to socialise the strategy with patients and the public to seek their views about the offer being made as an alternative the existing position where patients often default to A&E provision through a lack of understanding or faith in the existing model of provision.

East Midlands Ambulance Service Clinical Model

EMAS has undertaken considerable strategy development works during the last 12 months, including the creation of the new Clinical Operating Model. This includes the introduction of specialist and advanced practice roles within the operational function of EMAS to drive improvements in the care delivered to patients. Associated benefits of this future approach include greater local collaboration and increased safer discharge at scene.

The JUCD Board considered the wider implications of the EMAS Clinical Operating Model in the context of the emerging Primary Care Networks and Place Based Care.

NHS England and Improvement Aims and Ambitions

Following the Leadership event held in June 2019, Dale Bywater, Midlands Regional Director for NHS England and Improvement, has written to STP/ICS systems to outline a high-level framework for delivering a number of jointly agreed change management programmes. The priority areas are as follows:

- Reducing health inequalities
- Reducing unwarranted variation in quality of care
- Clinical and financial sustainability

A number of priority and enabler task and finish groups have been established under these headers, led by regional directors to progress this collective work. The agreed

2019/20 aims, priorities and enablers for the Midlands region are designed to be compatible with the NHS Long Term Plan Implementation Framework.

System Capacity to Enable Delivery

Further to the System Executive: CEO/FDs Groups' agreement to support the release of organisational resource to enable delivery of the STP system priorities, relevant staff are now working with managers to deliver this. In many cases, the named staff are already involved in delivering the work programmes but have previously been doing the work without a formal organisational mandate or time in their working day.

In addition, there were a number requests for input from specific roles (rather than named people) such as Business Intelligence capacity. The next step will be to agree a process to identify and release this capacity.

Improving Digital Patient Communications

Following discussion at the Provider Alliance Group (PAG), a small task and finish group has been established to explore opportunities to improve GP practice level digital communications with patients.

Good communication is considered critical in ensuring patients are kept well informed of:

(1) practice development
(2) Derbyshire-wide development
(3) public health and
(4) national NHS communications.

A pilot will commence at Avenue House practice in Chesterfield to provide plasma screens in patient waiting areas as this is considered a great opportunity to share the above key messages. This project is initially being run as a pilot. The practice is working with commissioners to explore how this can rolled out longer term within the practice and across other practices within Derbyshire.

Joined Up Care Derbyshire:

Prevention Strategy

2018 Onwards

Final Draft

Contents

Our Vision

Our vision is of a Derbyshire that champions prevention across all organisations and works together to create healthy, resilient communities and populations

Our Aim


Everyone in Derbyshire enjoys good health and wellbeing
And:
Gets The Best Start in Life;
Stays Healthy;
Ages well.
By:
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
Through:
1. Healthy Environments and Resilient Communities
2. Workforce Development
3. Healthy Lifestyles
4. Quality Communication

Purpose of this strategy

"The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health….. If the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness".(Five year forward view)

Prevention undoubtedly works best with a joined-up approach. The purpose of this strategy is to set out the ambition for prevention within Joined Up Care Derbyshire and identify the actions through which it can be achieved. The vision and actions within this strategy aim to complement those of health and wellbeing board strategies, which have a broader focus on the wider determinants of health, and the strategies of other work streams such as Mental Health, Sexual and Reproductive Health and Child Health. Thus, these strategies are interdependent and taken together, provide a whole system approach to prevention across Derbyshire.

JUCD recognises the huge importance of the community and voluntary sectors in achieving its goals. Many local voluntary organisations have representation on the prevention board, and important contributions also come from other, wider parts of the system such as the Local Medical Committee and the Local Pharmaceutical committee. This joined-up, partnership approach to prevention is vital to the success of our vision of a healthier, happier Derbyshire.

Priority 1: Enable people in Derbyshire to live healthy lives

Key Indicators

- Life expectancy, Healthy life expectancy
- Mortality under 75 years from CVD (Preventable), Number of NHS Health Checks delivered
- 100% smoke-free hospitals, Smoking at time of delivery, Smoking Prevalence – Adults & 15 yr. olds
- Overweight & Obesity Prevalence in adults and children, Physical Inactivity adults and children
- Alcohol related mortality
- Emergency admissions due to falls
- Chlamydia detection rate, Abortions under 10 weeks, Under 18s conception rate, HIV late diagnosis rate
- Population vaccination coverage flu in at risk groups, gram negative blood stream infections, incidence of outbreaks within care setting, persons in drug misuse services who inject drugs who have received hepatitis C testing, hepatitis C detection rate, hospital admission for hepatitis C

Why is this a priority?

Smoking, poor diet, physical inactivity and excess alcohol consumption are some of the most important causes of ill health in Derbyshire, and in the UK. Known risk factors are

estimated to contribute to 40% of ill health in the UK, with smoking and poor diet being the two largest individual contributors to overall disease burden[1]. It is therefore important that any strategy for preventative measures should dedicate some significant attention to helping address these factors. Eating unhealthily or being physically inactive can have a number of negative effects on health and wellbeing, both in children and in adults. According to Derbyshire Observatory data; rates of diabetes, stroke, hypertension and coronary heart disease at all ages are significantly higher in the county compared with England data, and in Derby city, the age-standardised mortality rates from cardiovascular disease which is considered preventable are significantly higher than in England overall.[2] The Public Health Outcomes Framework alcohol profiles for Derbyshire show that in the county, 26.6% of adults are drinking more than the recommended 14 units per week (compared with the England average of 25%).[3]

As part of the NHS five year forward view, Public Health England has committed to work together with STPs and NHSE to focus on implementing identified cardiovascular prevention measures at scale; 50-80% of CVD cases are preventable and CVD is strongly associated with health inequalities.

Good sexual health is an important part of physical and mental wellbeing. It implies that people have the right to a safe and satisfying sex life and the freedom to decide if and when to reproduce and how often.[4]

Every year in England, around 1 in 3 people aged over 65 years will experience at least one fall, with around a tenth of these leading to serious injury. In addition to this, having a fall can result in significantly reduced quality of life for the affected person, who might fear further falls and consequently restrict their activities. Helping older people remain active and avoid social isolation has a multitude of benefits to health, including decreasing risk of falls and improving general wellbeing.

Health Protection can play an important role in reducing morbidity and mortality and associated burden on health and social care. Protecting the health of people most susceptible to infection, particularly the very young, frail older people and those with chronic conditions, is an important health protection priority. Consistent application of standard infection prevention and control measures in all settings where susceptible people are cared for, including hospitals, nursing and care homes and in people's own homes can help reduce infections. This not only reduces the burden of disease on individuals, but also reduces costs to the health and social care system. Preventative measures such as vaccination can also play an important cost effective mechanism to reducing communicable disease and associated morbidity and mortality. Hepatitis C is a significant public health issue, affecting 160,000 people in England. NHS England are committed to reducing the burden of hepatitis C and prioritising treatment. Working with partners to increase testing and access to treatment locally could support reductions in preventable liver disease across the County.

[1] https://publichealthmatters.blog.gov.uk/2015/09/15/the-burden-of-disease-and-what-it-means-in-england/

[2] Public Health Outcomes Framework Data https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/

[3] https://fingertips.phe.org.uk/profile/local-alcohol-profiles/

[4] United Nations Populations Fund via https://www.unfpa.org/sexual-reproductive-health

Everyone has a role in enabling and supporting the local population to make healthier choices; JUCD organisations are critical in providing system leadership to ensure prevention is everyone's business.

JUCD strategic actions

Initiative	Description	Deliverable
Healthier Choices: Access to wellness services	Community Wellness hub The overall purpose is to improve health and wellbeing, reduce inequalities, and reduce the need and demand for health and social care provision. The focus for hubs is 'Wellness' in local communities, rather than treatment services for disease or illness. This is based on the evidence that the factors that make the greatest impact and contribution to improved health outcomes are social, economic and environmental factors, which account for 50% and people's individual health behaviours that account for 30% of health outcomes. Community Wellness Hubs will provide an opportunity to support individuals to address these socio-economic and lifestyle factors in a holistic, integrated way.	• Creation of a network of community venues where local residents can receive information and advice to 'wellness services'
Healthier Choices: Obesity	JUCD system organisations will be a leader in enabling staff, patients and visitors to be active and eat healthy through: 1. Ensuring organisational policies and infrastructure create an environment that enables healthy eating and active travel 2. Ensuring weight management services, support and advice for all age groups are promoted and signposting/referring into services is systematic 3. Utilising nationally developed resources such as 'fitter, better sooner'/'Stop before the Op'	• All JUCD organisations to have healthy eating & active travel policies • All JUCD partners to promote/signpost/refer patients & staff to lifestyle services
Healthier Choices: Smoking	JUCD system organisations will be a leader in enabling staff, patients and visitors to become smoke-free through: 1. Implementing smoke free sites polices, normalising smoke-free 2. Provision of pharmacotherapy for inpatients 3. Systematic promotion, signposting and referral to stop smoking services especially at key opportunities like antenatal care	• 100% of hospital settings to be smoke-free • Inpatients provided with pharmacotherapy • All JUCD partners to promote/signpost/refer patients & staff to lifestyle services
Healthier Choices: **Alcohol**	JUCD system organisations will provide leadership in: 1. Ensuring organisational policies and infrastructure create an environment that enables people to understand the harms associated with alcohol and to drink alcohol within the recommended limits	• Increased numbers of adults in Derbyshire drinking within the recommended limits • Decreased rates of alcohol related admissions

	2. Ensuring lifestyle and support services for alcohol and advice for all age groups are promoted to patients and families, and signposting into services is systematic 3. Utilising and promoting relevant national campaigns and initiatives	• Increased rates of dependent drinkers accessing services
Healthier Choices: **Falls**	1. Systematic promotion of and signposting to physical activity opportunities across JUCD partners to increase the number of people being active as they approach older age 2. Referral & signposting to falls prevention services 3. Implementation of the Derbyshire falls pathway	• Falls pathway is implemented at place
Healthier Choices: Sexual Health	The sexual health system in Derbyshire is an integrated service commissioned across partners; the CCGs, Derby City Council, Derbyshire County Council and NHS England, thus providing opportunity for the kind of joined-up working at the heart of the JUCD. Clear, consistent communication of health promotion messages and a responsive service should help us: • Work together to improve uptake of STI screening across the region • Improve uptake of contraceptive services with a special focus on long-acting reversible contraception (LARC) • Improve early access to abortion services (under 10 weeks) • Help the population of Derbyshire to feel empowered and able to take control of their sexual health and wellbeing by providing an easily accessible service and freedom from fear of stigma or discrimination	• Improving access to long-acting reversible contraceptives • Improving STI detection rates • Reducing HIV late diagnosis rate • Reduced under 18s conception rate
Cardiovascular Disease (CVD) Prevention	• Determine current prevalence and associated mortality of a range of CVD conditions, and evidence for effective and efficient services • Healthcare providers such as primary care, A+E or pharmacies to maximise CVD prevention opportunities across the CVD prevention pathway e.g. AF detection	• CVD needs assessment to determine current prevalence, mortality of a range of CVD conditions and evidence for effective and efficient services is undertaken • Increased detection & treatment of CVD risk factors e.g. AF, high blood pressure, diabetes, cholesterol • Increased number of NHS Health Checks delivered
Health	• Determine current capacity and need with regards to Infection prevention control (IPC) provision	• Equity within IPC services across

Protection	• Ensure robust IPC services which are reactive, but also proactive in seeking to improve quality and IPC standards, so reducing associated morbidity and mortality. • Ensure clear governance processes to seek oversight of IPC across the system including strategic support to reduce gram negative blood stream infections. • Ensure processes to support uptake of flu vaccination specifically amongst high risk groups including at risk groups. • Ensuring access to Hep C testing and treatment	system. • Reductions in number of outbreaks and bed closures as a result of communicable disease such as norovirus and influenza within community. • Reduction in E Coli gram negative blood stream infections. • Improvement in uptake of flu vaccination. • Reduction in preventable liver disease as a result of Hepatitis C

Priority 2: Build mental health, wellbeing and resilience across the life course

Key Indicators

- Self-reported wellbeing: happiness & anxiety
- WEMWBS scores
- Suicide rate
- School Absence rates

Why is this a priority for Derbyshire?

It is estimated that 1 in 4 people with have a mental health problem in any given year, and up to 1 in 10 children have a clinically diagnosable mental health problem[5]. Across Derbyshire, this equates to many thousands of adults and children that are struggling with the human and social cost of mental ill health and in 2017, 59 people died from suicide or undetermined injury[6]. Mental health is everyone's business and as with all prevention measures in this strategy, a joined-up, partnership approach is essential for success. The figures below show how Derbyshire is doing in comparison to the England values for some important health indicators.

PHE Fingertips figures for Mental Health problems in Adults

Indicator	Period	Derbyshire		Derby		Region	England
		Count	Value	Count	Value	Value	Value

[5] Derbyshire Mental Health Prevention Framework 2017-2021 'Driving Better Mental Health For Derbyshire'
[6] Figures based on registered deaths

Indicator	Period	Derbyshire		Derby		Region	England
		Count	Value	Count	Value	Value	Value
Depression recorded prevalence (QOF): % of practice register aged 18+	2017/18	74,961	11.5%	22,097	9.8%	10.8%	9.9%
New cases of psychosis: estimated incidence rate per 100,000 population aged 16-64	2011	81	16.6*	41	25.7	21.2*	24.2*
Severe mental illness recorded prevalence (QOF): % of practice register all ages	2017/18	6,999	0.87%	2,719	0.94%	0.84%	0.94%

PHE Fingertips Profiles Data for Mental Health Problems in Children and Young People

Indicator	Period	Derby City		Derbyshire		Region	England
Estimated prevalence of mental health disorders in children and young people: % population aged 5-16	2015	3,740	9.8%*	9,499	9.3%	9.4%*	9.2%*
Prevalence of potential eating disorders among young people: estimated number aged 16 - 24	2013	4,321	4,321*	10,284		-	*
Hospital admissions as a result of self-harm: DSR per 100,000 population aged 10-24	2016/17	218	429.6	643	508.4	*	407.1

The benefits of good mental wellbeing include:

Evidence strongly supports a life-course approach to supporting population mental health and wellbeing. This approach enables prevention efforts to be targeted at key life stages that can represent 'pressure' points of increased risk to a person's mental wellbeing, and for people who are most vulnerable. Some examples include:

- the perinatal period is important as it is known to increase the risk to mental health
- half of all mental health problems manifest by 14 years of age and childhood is key in influencing health outcomes later on in life
- for common mental health problems and psychosis, prevalence of mental illness peaks among those aged 35 to 54 years
- older people can be vulnerable to mental health problems as a result of issues such as social isolation, loneliness and their increased risk of physical ill health

Individual resilience is a person's ability to deal with challenges and changes from internal and external factors throughout their life course. The interaction of individual

resilience with physical, social and economic environments through organisations such as community groups or local government is what gives a community resilience. Resilient communities are able to provide the resource and support for individuals to live happy, healthy lives. The Derby and Derbyshire Health and Wellbeing strategies highlight the need to address many of the wider determinants of health which constitute these social, physical and economic environments such as good quality housing and employment opportunities.

JUCD strategic actions

Initiative	Description	Deliverable
Suicide Prevention & Mental health awareness	• Embed self-harm and suicide awareness as an organisational priority by recognising key campaigns, sharing information and messages, training all staff and supporting people in more vulnerable groups e.g. people diagnosed with a long-term condition, those with substance misuse issues • Help to build the mental health literacy of the wider workforce and the public challenging stigma and discrimination and promoting positive mental wellbeing	• Increased number of staff within JUCD organisations trained in mental health & suicide prevention across all age groups • JUCD organisations engaging with & taking part in campaigns e.g. time to change
Resilience across the life-course	• Identify which particular points in the life-course and around life events when specific partner organisations may be well placed to proactively promote mental wellbeing, to identify need and to provide early intervention if people are struggling e.g. life-course - perinatal, early years, adolescence, transition years, elderly and life events - bereavement, trauma, unemployment, diagnosis of illness	• Local organisations are equipped with the skills & knowledge in mental health and suicide prevention to assess and intervene appropriately
Healthy Settings: Healthy Workplaces	• Healthy workplaces includes improved mental wellbeing too. Live Life Better Derbyshire Healthy Workplaces team and the Livewell Derby Workwell Team can offer support to employers looking to develop a positive proactive and responsive approach to mental health and wellbeing	• JUCD organisations actively engaged with healthy workplaces scheme

Priority 3: To empower the Derbyshire Population to make healthy lifestyle choices

Why is this a priority?

Having Quality Conversations:

Every day brings a multitude of daily interactions between individuals and organisations across the health service which can promote and encourage healthy behaviour and have a positive effect on the wellbeing of individuals and communities. In order to get the most out of these interactions, staff can be trained in coaching approaches. This allows service users

and service providers to work together to work out what matters most to them. Working with where the individual is at, and where they want to be, is an effective way to help improve their overall health. These conversations take place in a wider context of health messaging, conversation tools and promotion of NHS digital resources.

Digital Communication

With over 86% of the population now using the internet, digital communication provides an important channel of health messaging. Social media, used by 99% of 16-24 year olds, provides an opportunity to engage the public in spontaneous and structured conversations across many different platforms.[7]. Harnessing the power of consistent messaging across social media platforms will help to engage a wider audience in the prevention conversation.

The Role of Community Pharmacies

With around 42,990 registered pharmacists working in England from around 11,647 pharmacies; community pharmacy teams have considerable potential to promote public health according to the RSPH. Over 80% of the 217 community pharmacies in Derbyshire are accredited Level 1 Healthy Living Pharmacies (HLP) by the RSPH. The impact of HLPs is:

- To improve the public's health and drive improvements in service quality and innovation
- People walking into a HLP are twice as likely to set a quit date for smoking and then quit than if they walked into a non-HLP
- HLPs consistently deliver high-quality public health services such as NHS health checks, weight management and sexual health
- HLPs reach out to local communities with health improvement advice and services

Health Literacy & Patient activation

Health literacy is about people having the knowledge, skills, understanding and confidence they need to be able to use health and care information and services. Having good levels of health literacy can support the self-management of conditions.
Patient activation describes the knowledge, skills and confidence that people have in managing their own health conditions and care. People with low levels of activation are less likely to play an active role in staying healthy and are less good at seeking help when they need it.
Both health literacy and patient activation play an important role in allowing people the confidence to look after their health and wellbeing.

[7] http://www.nhsemployers.org/-/media/Employers/Publications/Social-media/Social-Media-Toolkit.pdf

JUCD strategic actions

Initiative	Description	Deliverable
Quality Conversations	Develop, implement and evaluate a quality conversations model to enable staff to have the skills and confidence to deliver key health and wellbeing messages	• Pilot & evaluation of quality conversation model undertaken and learning shared across the JUCD system
Joined up Communications & Digital resource	Have a coordinated approach to communications across the JUCD system and partners, maximising national communication campaigns, ensuring key health and wellbeing messages are consistent	• All JUCD organisations engaged in prevention communications e.g. supporting national communications
Health Literacy	People play a key role in protecting their own health, engaging in healthy lifestyles and managing long term conditions. Good levels of health literacy can support people to be more actively involved in the self-management of their long term condition.	• All JUCD organisations are engaged in supporting people to manage their own health conditions

Priority 4: To build strong and resilient communities where people are supported to maintain and improve their own wellbeing

Why is this a priority?

A community is a group or collective of individuals who identify with each other and have something in common, this may be the place where they live or it may be a personal characteristic or condition that they share. Individuals can belong to more than one community.

Resilience is the ability to deal with challenges and adversity. Community resilience therefore is the ability for a collective of individuals with something in common to deal with challenges and conditions or situations as they arise.

Everyone has a level of resilience, collectively communities have greater resilience and are better able to support themselves and each other. Resilient communities have strong networks, are able to make the most of their assets, and are involved in design and delivering community solutions. Community assets are anything that helps to improve the

quality of community life; they can be people, physical structures or buildings, organisations and events and the community themselves.[8]

The role of communities in improving health is receiving increasing attention in health policy & practice. There is a need to better recognise and develop this work in particular to support prevention objectives.

Prevention is everyone's business, and communities play an important role in delivering prevention objectives. Individuals and communities are the best people to maintain and improve their own wellbeing and that of their community (or communities).

In Derbyshire, communities play an important role in delivering Joined Up Care Derbyshire objectives, however, in order to maximise the benefit to be gained from their input, it is important that this is understood across all partners.

Key Principles for Embedding Community Resilience

- People (individuals and groups) are empowered to mobilise community assets in order to respond to need.
- All stakeholders to recognise the potential benefits of co-production with the partnership of communities when working together to deliver prevention objectives.
- People are supported to manage and improve their wellbeing and those of their community (self-care, group activities)
- Communities are supported to develop social networks and be connected with social activities to address health and wellbeing needs (social prescribing)
- Communities play an important role in delivering whole population health
- VCS infrastructure support services are reviewed to provide a more consistent and equitable solution for health and social care, that includes a focus on prevention
- Appropriate performance indicators are defined to assess impact

Taking a broader view

A true population-level approach to prevention requires a wider consideration of the social, cultural and economic environments in which we live and work. The Derby and Derbyshire Health and Wellbeing Boards aim to reduce health inequalities and improve health by working across communities, and their Health and Wellbeing Strategies focus on their priorities for wider determinants of health in the region. It remains a key component of the vision for the current Derby City Health and Wellbeing Strategy:

Our vision is to improve the health and wellbeing of the people of the city, and to reduce inequalities (2014-2019)

The Prevention work stream of Joined Up Care Derbyshire will also work in tandem with the others to address a wide range of factors to support healthier communities and populations.

[8] Community Tool Box, online: https://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/identify-community-assets/main

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 September 2019

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. The NHS mental health implementation plan 2019/20 – 2023/24 sets out how a £2.3bn local investment fund will be used to build upon the work of the Five-year forward view for mental health. The overview section describes how the implementation plan fits with the system planning approach and other sections of the NHS long term plan3. The second part considers each ambition in more detail; it sets out the targets for the next five years; the funding that will be available to support each one; and the workforce necessary to achieve it. NHS Improvement (NHSI), NHS England (NHSE) and Health Education England (HEE) have published the interim NHS People Plan with the final plan being published soon after the 2019 spending review is published in the autumn.

   Ring fenced investment of at least £2.3bn each year will be made available for mental health services by 2023/24. This funding will be used to support work across the core ambitions of the NHS long term plan:

   - specialist community perinatal mental health
   - children and young people's mental health
   - adult common mental illnesses (IAPT)
   - adult severe mental illnesses (SMI) community care
   - mental health crisis care and liaison
   - therapeutic acute mental health inpatient care
   - suicide reduction and bereavement support
   - problem gambling mental health support
   - rough sleeping mental health support

   These areas will be supported by investment in:

   - provider collaboratives and secure care
   - digitally enabled mental health care
   - improving the quality of mental health data

   Delivery of the commitments in these areas will be a mix of 'fixed', 'flexible' and

'targeted' approaches.

- Fixed deliverables will have a national trajectory to ensure that the whole country moves at the same pace to deliver the change. The trajectories will combine the commitments from the Five-year forward view for mental health and the implementation plan. A tool will be made available to regions during summer 2019, to apportion the national target to local systems.
- Flexible deliverables allow the pace of change to be determined locally, with the target to achieve the same end point by 2023/24.
- Targeted deliverables will only apply to certain sites who will receive specific funding for these elements.

The implementation plan expects systems to work in partnership with mental health providers to develop their five-year plans. It is also expected that local health systems will work jointly to develop and confirm clinical commissioning group mental health investment plans, including a lead mental health provider in the process.

Workforce numbers stated in the implementation plan are in addition to the existing requirements specified in Stepping Forward to 2020/21: the Mental Health Workforce Plan for England. The implementation plan sets out indicative numbers to inform local workforce planning. Overall, by 2023/24 it is anticipated that there will be an additional 27,460 whole time equivalent staff working in the sector, with over 10,000 of these in community care for adults with severe mental illness.

The NHS long-term plan made the commitment that investment in mental health services will grow faster than the overall NHS budget. In order to demonstrate that this will be achieved, systems are required to set out how they will meet the mental health investment standard (MHIS); use the investment in CCG (Clinical Commissioning Group) baselines set out in the implementation plan; and how the transformation funding identified will be used.

The CCG baseline allocations are based upon a national notional assumption of growth funding in mental health programmes. National payment approaches will be developed which will review the current work into a national currency model.

The implementation plan states that the involvement of the voluntary, community and social enterprise (VCSE) sector in the design and delivery of services can ensure that they are genuinely co-produced, recognising the local context. Systems, commissioners and mental health providers are asked to consider how the VCSE sector could support local ambitions and whether the current commissioning approach encourages, or blocks, their involvement.

2. NHS England and NHS Improvement's joint paper "The NHS patient safety strategy: Safer culture, safer systems, safer patients (July 2019)" is the culmination of a two-year paradigm shift in the way the NHS treats patient safety. The transformation of the NHS Litigation Authority into NHS Resolution, creation of the Health Service Investigations Branch and upcoming reforms to clinical negligence claim handling, are all indicative of a move away from a culture of blame, to one of learning. The Secretary of State for Health and Social Care has positioned patient safety as 'a golden thread' running through everything the health service does, with the improvement of safety to be tied to advancements in

technology, and improvements to staff and patient engagement.

Fundamentally, this strategy sets out a new framework to enable a culture transition from blame to learning. It envisions an approach where patient safety initiatives and responses are primarily based on what can be learned rather than who should be held accountable, notwithstanding wilful and malicious negligence. Underscored by the principles of insight, involvement and improvement, the strategy recognises that there is no endpoint when it comes to safety. The strategy defines these principles as follows:

- Insight – Improving understanding of safety by drawing intelligence from multiple sources of patient safety information.
- Involvement – Equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system.
- Improvement – Designing and supporting programmes that deliver effective and sustainable change in the most important areas.

To this end, it outlines a process of continuous improvement where NHS patient safety systems are well positioned to respond to patient needs and system priorities in a dynamic way – constantly searching areas of improvement in partnership with national bodies, patients, staff and NHS organisations.

In addition to broader changes in the way the NHS thinks about patient safety, the document outlines a number of more specific initiatives tasked with improving individual aspects of the patient safety framework:

- **Patient safety incident response framework** –This system will make reporting easier and more rewarding, providing a platform for insights from all parts of the NHS. It will be deployed in an attempt to enhance what goes well rather than just focussing on what goes wrong and will draw upon artificial intelligence and machine learning to better enable national bodies to sift through incident reports and identify trends. Crucially, it will focus on what goes right rather than what goes wrong.

- **Medical examiner system** – The creation of a medical examiner system (MES) aims to improve safeguarding, quality of certification, and quality of care in the NHS by creating a network of medical examiners, operating independently from trusts to scrutinise and sign off all deaths across a local area. This system will sit within NHS Improvement's patient safety team and the examiners themselves will be expected to take up membership of the Royal College of Pathologists.

- **National Patient Safety Alerts Committee (NaPSAC)** – The creation of NaPSAC is intended to lead the redesign and standardisation of patient safety alerts. They will also take on responsibility for supporting local systems to respond to and implement findings from the Healthcare Safety Investigations Branch (HSIB)* as well as working with them and directly with providers to improve the quality of local investigations.

- **Patient safety partners (PSPs)** – These roles will be created across all trusts in England, drawing on patients, their families and carers, to help improve safety in the NHS. PSPs will not be employees of the trust as such but will be remunerated for their work. They will work at a number of levels, at the most basic level this means taking responsibility for their own

safety and, at higher levels, advising boards and sitting on regional safety groups.

- **Patient safety specialists (PSS)** – A network of senior PSSs in providers and local systems will become 'the backbone' of patient safety in the NHS. These roles will sit in providers, systems, regional arm's length bodies, regulators and commissioners. These roles will not be filled by recruiting new staff, but should instead identify existing staff who can be supported to become specialists.

As a Trust, Dr John Sykes remains our lead for Patient Safety with assurance through the Quality Committee to Board. It is exciting that the changes in the national approach, to focus on learning rather than blame, dovetail with our move towards a Team Derbyshire Healthcare Just Culture where we strive to enable personal development, growth and learning when things don't go well, for example in response to incidents, conduct or complaints.

3. The Mental Health Policy Group - a coalition of six organisations working together for better mental health – has published "Towards Equality for Mental Health, Developing a Cross-Government Approach". This new report considers in detail the steps that must be taken if the ambition of 'parity of esteem' for mental health is to be achieved in England by 2030/31. Its starting point is the belief that improving the nation's mental health cannot be achieved through a focus on health services alone, vital though these are. A much more ambitious, cross-government approach to mental health is also required.

   Towards Equality for Mental Health makes a number of practical recommendations to develop this cross-governmental approach, based around five key areas:

   - Promoting good mental health and prevention
   - Tackling inequalities in mental health
   - The NHS and support at the point of need
   - Helping people with mental health problems to live well in the community
   - The mental health workforce

   Towards Equality for Mental Health was shaped through the views of a broad range of organisations and professionals from the wider health and voluntary sectors, including those representing physical health conditions, money and debt, homelessness and addiction. The Mental Health Policy Group hopes that these recommendations for future action will gain support from everyone who shares their ambition for achieving equality for mental health.

Local Context

4. The Joined up Care Derbyshire (JUCD) Board met on 18 July and 15 August 2019. The key highlights that I think are relevant to our Organisation are as follows:

   - The August JUCD meeting was the first meeting chaired by John MacDonald our new independent Chair. I have included some reflections from him under section 6 of my report.

- JUCD reviewed the latest financial position of the system at both month 3 and early indications at month 4. It was noted that all Organisations were now reporting on plan with risks relating to efficiency delivery of circa £10m in the CCG and CIP/in year pressures in providers.

- The Board reviewed the Long Term Plan Implementation Framework noting the requirements that link to our Derbyshire refreshed plan submission.

- We received assurance around the workforce and OD work underway across the system in particular:

    - The work to develop a unified workforce system dashboard now completed
    - The place organisational development programme
    - Joined up Careers – an initiative to promote Derbyshire as a place to work
    - Engaging with schools and providing enhanced work experience
    - Workforce modelling programme.

- We reviewed the outputs from the ICS Development Programme, supported by PWC, and importantly how through our emerging governance system, those conversations and outputs would be embedded.

- We received the final Joined up Care Urgent Care Strategy and it was really good to see the influence of colleagues from our Trust services in the final document.

- East Midlands Ambulance Service presented their clinical model for the next 5 years, very relevant to our services, particularly the link with our urgent care services, conveyance to ED for mental health patients and liaison with our triage hub.

5. On 16 August I was part of the JUCD Team that attended the System Performance Review Meeting with NHSI/E. This system meeting replaces the previous PRMs with each individual Organisation. My reflections of this meeting are that whilst it was a great start to system accountability, there is still some way to go to avoid it feeling like five performance review meetings bound together, rather than a system meeting.

   A key area of discussion was around system finance and concern from the regulators about a system assessment of financial risk. Interestingly their concerns were not dissimilar to those raised by our Board and others in the System about assurance flows and confidence in mitigations. This was particularly relating to the back year loading of many of the savings schemes. Performance conversations were centred around ED and waiting times, as well as a very helpful conversation about mental health 12 hour breaches, and the work we had done to share understanding between ourselves and UHDB (University Hospital of Derby and Burton).

6. It is useful for the Board to be sighted on John MacDonald's reflections on JUCD, following his discussions with a number of Board members, attending the JUCD Board and the NHSE/I Review (mentioned in 5 above) in the first ten days of his

tenure as our Independent Chair.

John felt he identified four themes:

- *Pace and scale* – Derbyshire, in common with other health and care systems, is facing significant sustainability, workforce, operational and financial challenges in responding to the needs of an increasingly elderly and less healthy population. We need to be clear about what our priorities are and where our resources and effort need to be focussed. Meeting the challenges will require ambition. John sighted some examples that came up in discussions:

    - What is the 'offer to the public' which will be attractive enough for them to go to other settings than A and E for emergency care and how do we develop this offer.
    - Closing the financial gap requires some big ticket initiatives such as managing use of our estate collaboratively.
    - Currently there are ten workstreams and five enabling workstreams. There is a need to simplify and focus, be clear what the 'big ticket items' from across the work-streams are, and to focus greater resources and efforts on these areas. This does not mean we forget about the other areas and these need to be embedded in our JUCD STP 'business as usual'.
    - The leadership, managerial and analytical capacity to deliver integrated care will require investment and, more importantly, rationalisation and consolidation of current resources across providers and commissioners. Secondly 80% of the transformational change will be at Place (ICP, PCN) level and how we need to deploy the capacity needs to reflect this.

- *Adding value* - The development of the architecture to deliver integrated care, the move to strategic commissioning, and the merger of NHS I/E mean that the purpose and roles of all the NHS bodies is changing and will continue to change.

    - Clarity on roles (job cards) of the ICS, ICPs, PCNs and Commissioners. At the same time the way in which the NHS and local authorities work together in social care, housing and education, as well as the relationship with the Health and Wellbeing Boards, need defining more clearly.
    - Governance arrangements need to be strengthened in light of the above and the wider refresh. Specifically:

        - By September a Finance Sub-Committee of the JUCD Board will be established. The Committee will comprise the Chairs of the Finance Committees (or equivalent) from the statutory organisations, together with Directors of Finance. Proposed terms of reference will go to the September JUCDB.
        - A decision-making framework, to enable decisions to be made at a system level without undermining the statutory responsibilities of individual organisations, needs to developed and enacted.
        - Avoid duplication by, for instance, using existing system wide Committees (Quality and Performance Forum, A&E Delivery

Board, Cancer Board etc.) to underpin delivery and/or transformation where this is appropriate. This should, over time, enable a reduction in the duplication of such meetings at organisational level.
    - A performance framework which (i) underpins both Delivering Today and Transforming for Tomorrow and (ii) gives greater visibility of the high priority workstreams and enablers.
    - Review the JUCD STP system risk management framework that provides assurance to the JUCD Board, to ensure that it is also seen by the statutory board as the single source of assurance at a system level.

- Meaningful Engaging - The way in which the public, patients, clients and carers are involved in shaping integrated care, including care pathways and decision making will need to be strengthened further. The way in which local authorities and some services, such as mental health, engage with clients, as well as best practice elsewhere, may help us to inform how we do this.

  We need to be sure that in managing risk we are managing the risks to patients and people and not just those of organisations and professionals. Keeping the elderly too long in hospital so they lose their independence is one example where, it can be argued, we do not always get this balance right.

  Language is critical to patients and frontline staff. RTT (Referral to Treatment), four hour wait etc. are all useful, as we understand they cover more than just those points in the clinical process, but they don't excite front line staff or the public. They also can make us jump to conclusions rather than focus on what problem we are trying to solve. We need a language which covers both local authorities and the NHS. Like most STPs (Sustainability and Transformation partnership) / ICSs (Integrated Care System) we are still too NHS focused.

- Working differently - Developing a system approach demands a different way of working to the last 20 years of competition! Work on the architecture of an integrated system is well underway. Are the system level clinical, quality, planning, and financial and other processes fit for purpose as the architecture is developed?

  The work being led by Prem Singh (Chair Derbyshire Community Health Services NHS Trust (DCHS)) on OD, agreed after the session with Mike Farrar, is critical. We need to find ways of understanding each other's perspective and 'walking in others' shoes:' to make our relationships productive as well as positive.

  Critical to how we work at a system level is the further development of clinical leadership. We have asked Dr Avi Bhatia, as Chair of the Clinical Professional Group, to discuss with clinical leaders how we might do this at a system level.

In hearing these early reflections from John I note how it chimes with some of the discussion that has occurred in our Board, particularly linking to pace of

change, financial and risk overview, and system capacity to enable working differently. I would like to propose to the Board that we invite John to attend a public Board meeting, to enter into a discussion with our Board about some of these issues, and importantly how we change the current pace of change.

7. As part of developing a new way of working to support the implementation of New Care Models for Mental Health (the management of services previously commissioned by NHSE specialist commissioning hub), the CEOs of the five East Midlands NHS Mental Health Trusts and St Andrew's Healthcare, have agreed to work together to establish a mental health provider alliance in the East Midlands. This will be consistent with the national mental health leadership view that in the future, each provider Trust will be part of a local system provider alliance, and then a wider regional provider alliance.

   Each CEO and their nominated lead director fed in their views on how an East Midlands Alliance should work, and what it should cover, to a review that then produced a set of recommendations. The key feedback themes included:

   - Strong desire to work together on a more formal strategic footing.
   - Desire to establish a platform to deliver the Long-Term Plan across the East Midlands.
   - The need to look across New Care Models (NCM) in a more strategic co-ordinated way, sharing common consistent material and approaches and avoiding duplication and silos.
   - The need to collectively agree a hosting arrangement for staff moved out of NHS England via TUPE, as part of NCM work, making them available to all NCMs.
   - Keenness to keep a formal Alliance as tight as possible, with a membership of those providers formally involved in financial risk and gain share, across multiple NCMs.
   - Exploring opportunities for each NHS provider to take a lead role with a New Care Model.
   - Each New Care Model to establish their own Board of clinical and managerial experts with issues escalated to this Alliance Board as necessary.
   - Enthusiasm to use a single collective voice to more strongly represent mental health in the East Midlands.

   At our meeting on 31 July we agreed the next steps in taking this exciting development forward would include:

   - Establishing quarterly meeting dates with the next meeting on 5 September.
   - Establish a lead Director meeting to lead the work agreed by the CEO meetings (our lead Director is Gareth Harry).
   - An updated paper to be reviewed by the CEOs on 5 September, prior to presentation to the constituent organisation Boards.
   - CEOs to receive an outline proposal on structure and potential legal form for an Alliance on 5 September.
   - CEOs to receive a proposal on part-time senior leadership and administrative support to take forward this Alliance on 5 September.
   - After more formal Board engagement, a communication plan will be developed to explain this Alliance to the CCGs, STPs, the national team

and wider sector media, focussing on why this is positive for patients.
- CEOs to receive a proposal on the regional hosting of NHS England TUPE staff.

This briefing is to provide the Board with initial sight of conversations taking place to shape a new way of working. Any formal partnership agreement, through whichever chosen mechanism, will require formal sign off by our Board and the Boards of the other provider Organisations.

Within our Trust

8. On 3 July I attended the Health Visitors away day for the Team based at Coleman Street in Derby. Some real passion about traditional public health based preventative nursing with children and families and sadness at how the pressures associated with current demands, particularly around safeguarding, are pulling them away from what was considered core business. Some very helpful feedback associated with Great Place to Work and how it is the simple things such as ease of booking A/L, access to printers, relevance of training, that have a real impact on feeling valued.

9. I met with Dr Penny Blackwell, a GP from Wirksworth and the new Chair of the JUCD Place Board. Penny was concerned about mental health input into the Board and opportunities for joint working with the mental health workstream around primary care mental health and mental health prevention. Since the meeting we have confirmed senior representation from the Trust into each Place Alliance Board, and shared some opportunities around the development of mental health wellbeing hubs, planned to be piloted in the High Peak and Derby City.

10. I was privileged to have been invited to speak at our CAMHS (Child and Adolescent Mental Health Service) service wide meeting in July, with a focus on national policy, our new Trust strategy and the move towards a Just Culture (Team Derbyshire Healthcare equivalent). There was such desire to drive forward innovation and I was struck by the services' desire as a whole to learn, and through learning and reviewing, to improve. Some real challenges, availability of staff (particularly CAMHS Consultants), growing demand and shrinking associated services elsewhere in the community, that impact on our capacity.

11. During August I met with Margita Cechova, who is a community influencer within the Roma Community in Derby. It was helpful to understand more about the local 6000 strong Roma Community, their historical ambivalence towards health services, and their unwillingness to engage with mental health services and children's services, such as Health Visiting. It was good to hear the difference the Charity Roma Community Care is making to some of these more traditional values, and how they are keen to work with us to offer drop in sessions within the community around mental health and substance misuse issues. Understanding local community traditional access patterns, is vital to understanding how to support increased ease of access to our services, as is developing an understanding of local tensions with communities. I have committed our Trust to work in partnership with Roma Community Care to support an enhanced understanding for local families of how and where to get support from when needed.

12. On 14 August myself, Claire Wright, Amanda Rawlings, Harinder Dhaliwal, Surrinder Kakh, Bal Singh and Tray Davidson met for the first time as the steering group for our Trust Reverse Mentoring for Diversity and Inclusion Programme. It was fantastic to support our first cohort of Mentors as they take the lead in developing cohort 2 to support the learning and development of leaders and managers that are responsible for running groups of services, such as our ASM's and GM's. We hope to be in a position to announce more details at our BME Annual Conference on the 25 September. All Board members are welcome to attend the conference and places can be booked through emailing clare.meredith3@nhs.net.

13. The Trust continued to generate positive and proactive media coverage in July and August. On a national level, our CEO involvement in promoting BAME (black, Asian and minority ethnic) awareness and inclusion within the NHS led to me being quoted in an article in The Voice and writing a blog post for the NHS Confederation website.

    On a local level, we continued to ensure positive coverage for Trust colleagues with features appearing in the Derby Telegraph (both in print and online) about the winning teams at our Quality Awards and the success of community mental health nurse, Kelly-Hellen Hitchcock, who has been shortlisted in the 'Rising Star' category at the 2019 Nursing Times Awards. There was also a very positive reference to the "amazing staff" at the Radbourne Unit in a Derby Telegraph article about an individual struggling with suicidal thoughts. Meanwhile both Dr Subodh Dave and CPN Jane Foulkes were quoted in print and online following the success of the #Runwalktalk event that they helped to organise at Darley Park.

    We also promoted our wider community responsibilities through the local media. Both the Derby Telegraph and Derbyshire Times ran stories about our Delivering Excellence Awards, encouraging local people to submit award nominations, while news of our upcoming governor election in Erewash appeared on Erewash Sound and was shared by the Ilkeston Advertiser on social media.

    We continued to work closely with the local media around the importance of reporting suicide responsibly. During July and August our Communications team twice engaged with reporters to ensure that articles about suicide complied with the Samaritans media guidelines in order to prevent imitative behaviour.

    On social media there was a significant response to our support for Belper Pride, attended by members of the LGBT+ Staff Network and other Trust colleagues and allies. In terms of wider engagement work, our HART Group – made up of representatives from CAMHS, Early Intervention, Children's Services and Breakout+ – attended Merrill Academy in Alvaston to offer support and advice to young people and their parents, and also received feedback from the City of Derby Academy that their work during the year had been "of great benefit to the students and the parents." The school is now recruiting emotional wellbeing ambassadors from amongst its Year 10 students and will be training them in the near future.

14. During July and August I have enjoyed getting out and meeting staff through continued engagement visits. I have held *Ifti on the Road* engagement events at Temple House, Derby, where I was able to meet some of our CAMHS

Colleagues, and at The Mews, Ripley, where I was able to meet colleagues from both the Substance Misuse Team and the Erewash Neighbourhood based at the Library in Ripley. I also have spent time with the Ward 36 Team and the Triage Hub Team at Ripley Police Station, as well as carrying out Quality Visits to Morton Ward and CAMHS Assist Service at Temple House. (I am not reporting here on the outcomes from the quality visits).

On the Road feedback

- Real concerns about the sustainability of on call rotas in CAMHS (Dr John Sykes has met with the consultants).
- The impact that some colleagues are feeling around career progression being limited in specialist services, due to our policy on core professional qualification (Carolyn is leading our response).
- Some great feedback about our Review of Retire and Return to give local managers more control.
- Positive feedback about our enhancement of systemic family therapy services.
- Some great examples of the benefits of in-person communication rather than rapid fire emails!
- Building pressures for the neighbourhood team in Ripley that are part of our strategy review.
- Fluctuation in older adult referrals and the impact of the memory assessment and functional older adult rapid response team.

These issues are logged and cross referenced through conversations with our Freedom to Speak up Guardian.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	X
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	X
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	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

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

This document is a mixture of a strategic scan of key policy changes nationally and changes in the Derbyshire Health and Social Care environment that could have an impact on our Trust. The report also covers updates to the Board on my engagement with colleagues in the Trust and the reporting of internal actions and feedback I have received relating to the strategy delivery.

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

This paper demonstrates some strong features of good practice relating to inclusion and diversity in its broadest sense. The engagement with local communities is key in understanding how we support their access to services and relates not just to the BME protected characteristic, but also my meeting with the Roma community enhanced my understanding of the traditional roles females in Roma society adopt, as well as their approach to long term illness. I was also made aware of tensions between young males in the Roma Community and young males in the Pakistani Community, partly about religion and partly linked to cultural differences and similarities. It is important to constantly consider intersectionality in our work around inclusion as people rarely do fit neatly into a single characteristic.

Wave 2 of the Trust's Reverse Mentoring programme is focussed on enhancing understanding around what it feels like to be BME and work in our Organisation, with a hope that as other networks develop, we will enhance the programme.

I noted in my visit to Coleman Street to see our Health Visitors the real link between depravation and safeguarding with some clear causation around poverty. As a Trust we are in discussions with public health about how we support the number of vulnerable families around safeguarding and the core role of Health Visiting with these communities.

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.
3) Invite the new Independent Chair, John MacDonald, to a future Board meeting.

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

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

Mental Health Implementation Plan – Expected funding streams 2019/20

Area	Requirements	Transformation or Central Funding	CCG Baseline
Perinatal Services	Supporting the expansion of specialist community perinatal mental health teams	Yes	
	Sustaining and expanding specialist community perinatal mental health teams		Yes
Children and Young People	Piloting UEC, CYP Eating Disorder (specifically Avoidant Restrictive Food Disorder) and young adults pathway adjustments in select areas	Yes	
	Continuing to pilot the impact of 4 week waiting times in selected areas	Yes	
	Establishing and expanding Mental Health Support Teams in selected areas	Yes	
	Service expansions for 0-18 community and crisis CYPMHS		Yes
	Sustaining and expanding CYP Community Eating Disorder Teams		Yes
IAPT	Salary support for IAPT Trainees (distributed via HEE to providers)	Yes	
	Sustaining and commissioning IAPT services (including IAPT-LTC Services)		Yes
	A 2019/20 CQUIN for achieving 65% of referrals finishing a course of treatment, which had paired scores recorded in the specific anxiety specific measures (ADMS), has been introduced for all IAPT providers		Yes
Adult Severe Mental Illness Community Care	Testing, evaluating and refining new models of integrated primary and community care for people with SMI in select areas	Yes	

Area	Requirements	Transformation or Central Funding	CCG Baseline
	Central / transformation funding will also be used to fund NHS England and Improvement-led and -coordinated developments to increase the capacity of the workforce to support community-based care, including: • Commissioning training places for improving access to psychological therapies for people with psychosis, bipolar disorder and complex mental health difficulties associated with a diagnosis of a 'personality disorder'; • Working to improve the competence and confidence of the workforce to understand and respond to the needs of people with complex mental health difficulties associated with a diagnosis of 'personality disorder', based on the Knowledge and Understanding Framework; • Work to improve the availability of staff with the skills required to support and deliver evidence-based treatment for adults with eating disorders in community-based services, in line with recommendations from the Parliamentary and Health Services Ombudsman report "Ignoring the Alarms: How NHS eating disorder services are failing patients"; • Work to improve skills and knowledge around improving physical health care for people with SMI; and • Work to accelerate the development of the peer support workforce.	Yes	
	Stabilising and bolstering current core community services		Yes
Mental Health Crisis Care and Liaison	Crisis alternative provision and expansion, through STP fair-share allocations.	Yes	
	Expanding Crisis Resolution and Home Treatment Team (CRHTT)	Yes	
	Sustaining and expanding existing crisis services and those established via central / transformation funding.		Yes

Area	Requirements	Transformation or Central Funding	CCG Baseline
	Investment in new mental health ambulance vehicles will be subject to the Government Spending Review, expected in Autumn 2019.	Yes	
Therapeutic Acute Mental Health In-Patient Care	A 2019/20 CQUIN has been introduced focussing on follow up with patients after discharge. Providers will be paid for achieving 80% of adult mental health inpatients receiving a follow-up within 72 hours of discharge.		Yes
Specialist Gambling Clinics	Central transformation funding will be made available to systems (via targeted allocation) to establish a total of 15 new NHS specialist problem gambling clinics by 2023/24.	Yes	
Rough Sleeping	Central / transformation funding will be made available to systems (via targeted allocation) for establishing mental health provision for rough sleepers in at least 20 areas by 2023/24.	Yes	
NHS Specialist provider led Collaboratives	Trialling specialist community forensic teams will be made available to selected sites within NHSE-led Provider Collaborative commissioning - adult medium and low secure mental health services.	Yes	

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 September 2019

Integrated Performance Report

Purpose of Report

The purpose of this report is to provide the Board of Directors with an overview of Trust performance at the end of July 2019.

This report is provided in a new format, using run charts to review performance over longer periods of time, with a particular focus on whether the Trust consistently achieves agreed targets and / or whether there is variation which needs attention.

Executive Summary

This new report has been developed following several discussions with Board colleagues over recent months. As with the previous integrated performance report it provides the Board of Directors with information that shows how the Trust is performing against a set of key targets and measures. There are some areas where national targets have not been set, which will require further internal discussion about whether proxy targets should be set.

Performance is summarised in an assurance summary dashboard with each target being measured using the criteria below. Where a specific target hasn't been agreed or specifically commissioned, colleagues will be able to track performance over time and discuss/challenge any specific variation that may be of concern or unusual. Further detailed run charts for the measures are included in appendix 1.

Where a specific standard or target has been agreed performance is assessed using the following criteria, which is included in the dashboard.

Key:

	The system is expected to consistently pass the target
	The system may achieve or fail the target subject to random variation
	The system is expected to consistently fail the target

Presenting the data in this way shows that the Trust continues to perform favourably against many of its key measures. Some examples of assurance narrative have also been added for a number of measures. Further detail can be provided in future reports and/or separate 'measure specific' reports can be provided to enable a more detailed discussion and to provide more robust assurance on actions being taken.

In addition, the Board of Directors agreed that this report would also provide an overview of performance across the Acute Care Division (Acute north, south and assessment services). This has been provided as a sub-section of overall Trust performance.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	X
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	X
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	X

Assurances

This report 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.

The use of run charts will provide the Board with a more detailed view of performance over time as it enables the differentiation between normal and special cause variation.

Consultation

Versions of this new style report have been considered in various other forums, such as Board development and Executive Leadership team

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

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

- This report reflects performance related to all of the Trust's service portfolio and therefore any decisions that are taken as a result of the information

provided in this report is likely to affect members of those populations with protected characteristics in the REGARDS groups.

- Any specific action will need to be relevant to each service and considered accordingly, so for example, as parts of the report relate specifically to access to Trust services; we will need to ensure that any changes or agreed improvements take account of the evidence that shows variable access to services from different population groups.

Recommendations

The Board of Directors is requested to:

1) 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 Henson, Head of Performance, Delivery & Clustering
	Kathryn Lane, Deputy Director of Operational Services
	Rachel Leyland, Deputy Director of Finance
	Catherine Pynegar, Business Intelligence Manager
	Celestine Stafford, Assistant Director of People & Culture Transformation

1. Trust Assurance Summary

Indicator	Rating[1]	Assurance Summary
Financial		
Cumulative surplus / (deficit)	n/a	At the end of July the surplus of £1.1m is ahead of plan by £0.2m. The forecast is to achieve the planned surplus of £1.8m although there are significant cost pressures and risks to be mitigated.
Agency expenditure against ceiling		Agency spend is below the ceiling YTD and forecast to remain below the ceiling of £3.03m.
Agency costs as a proportion of total pay expenditure		YTD agency expenditure equates to 2.7% of total pay expenditure.
Liquidity		Liquidity is better than the plan.
Cumulative cost improvement programme	n/a	CIP is behind plan YTD but forecast to deliver in full.
Cumulative capital expenditure	n/a	Capital is behind plan YTD but forecast to spend to plan.
Out of area and step down expenditure		Expenditure is slightly over budget YTD but is forecast to breakeven at the end of the financial year.
Operational		
CPA 7 day follow-up		7 day follow-up: in response to the evidence from the National Confidential Inquiry into Suicide and Safety in Mental Health that people are more vulnerable to suicide in the first 2-3 days following discharge took part in a pilot project in partnership with NHS England to provide 48 hour follow-up to patients discharged from mental health inpatient units. The pilot was carried out within a quality improvement framework, and was introduced on Morton ward and the associated community mental health teams in March 2019, extended to the rest of the Hartington Unit from July 2019 and across the whole Trust in August 2019. Evaluation of the pilot on Morton demonstrated that a mean of 93% of people were followed-up within 48 hours, and learning from the pilot was valuable in informing how this was subsequently rolled out more widely. OOA and PICU: A sub-group of the Mental Health STP delivery board has been established in order to ensure that there is jointly agreed system wide plan to deliver the national commitment of zero Out of Area placements by March 2021. The outcomes of this group will be overseen by the Mental Health STP delivery board and will be reported periodically through Finance and Performance Committee.
Data Quality Maturity Index (DQMI) - MHSDS data score		
Early Intervention (EIP) RTT within 14 days - complete		
EIP RTT within 14 Days - incomplete		
IAPT referral to treatment (RTT) within 18 weeks		
IAPT referral to treatment within 6 weeks		
Patients placed out of area - PICU	See chart	
Patients placed out of area - adult acute	See chart	
Waiting list for care coordination – number waiting	See chart	
Waiting list for care coordination – average wait (weeks)	See chart	
Waiting list for ASD assessment – number waiting	See chart	
Waiting list for ASD assessment – average wait (weeks)	See chart	
Waiting list for psychology – number waiting	See chart	
Waiting list for psychology – average wait (weeks)	See chart	
Waiting list for CAMHS – number waiting	See chart	
Waiting list for CAMHS – average wait (weeks)	See chart	
Waiting list for community paediatrics – number waiting	See chart	
Waiting list for community paediatrics – average wait (weeks)	See chart	

Indicator	Rating[1]	Assurance Summary
IAPT people completing treatment who move to recovery		Talking Mental Health Derbyshire continues to achieve in excess of its performance targets for both recovery rates (target >50%) and reliable improvement (target >65%) in every month of 2019/20. We monitor both the Trust performance and that of our sub-contractors with regular contract and operational meetings internal to the service and with our partners. Our dashboards update daily so that we can monitor up to date data and react to fluctuations in performance both monthly and in month achieving the national targets. We openly share our performance across the service with clinicians and they can access their own performance data through line managers for regular supervision and case management.
Quality		
Staff friends and family test - recommended care		Although staff FFT results have been consistently below the national average, a recent run of 8 months above the mean suggests improvement in staff views of care provided.
Friends and family test – positive responses		
Workforce – Trust level		
Annual appraisals		Monitored at performance reviews and monthly operational meetings. All managers required to attend Appraisal training as mandated in the Leadership masterclasses.
Annual turnover		Turnover remains below the regional and national average for Mental Health Trusts and continues to follow this track
Compulsory training		Extra training courses have been put in place to manage capacity and improve compliance, all areas are monitored at performance reviews and operational meetings and individuals and managers are now being emailed when they have DNA'd to rebook
Sickness absence		Work is ongoing across all Divisions in the Trust to tackle increasing levels of sickness absence. Focus is on long term sickness cases and what support is in place to either support the employee back to work in a more timely way or to look at alternative solutions. Attendance training is now mandatory for line managers.
Supervision - clinical		Monitored at performance reviews and monthly operational meetings.
Supervision - managerial		

Indicator	Rating[1]	Assurance Summary
Vacancies		Focus on inpatient areas to recruit and initiatives to recruit and retain have recently been approved. Rolling adverts have been refreshed and application/ interview processes have been enhanced.

[1]The rating symbols were designed by NHS Improvement

Key:

	The system is expected to consistently pass the target
	The system may achieve or fail the target subject to random variation
	The system is expected to consistently fail the target

Focus on Acute Services	Rating[1]	Assurance Summary
Assessment Services		
Annual appraisals		Appraisals currently at 84%. Assurance to ASM that all appraisals are complete for those in work, bar 1 in crisis south that is booked in.
Annual turnover		Annual turnover has increased recently, however there have been several additional posts created and retire and returns which has impacted.
Compulsory training		Training is currently at 88% on target-with action plans for those areas needing completion.
Sickness absence		Sickness is currently 7%. Support is being received from HR re long term and short term issues. Stages of sickness reviewed by ASM.
Supervision - clinical		Supervision: clinical overall 83% and management overall 79%.
Supervision – managerial		All staff have nominated supervisors.
Vacancies		Vacancies are significantly reduced, approximately 3 wte across the service line.
Urgent Care North		
Annual appraisals		The Acute Inpatient Transformation plan oversees appraisal, supervision and training. It aims to be meeting KPI's of 85% for the end of September but may not achieve Safeguarding Adults L3 due to lack of any available courses by the LA. Internal training is planned but any slippage on ratification of the training will impact on compliance. A rolling advert for HCAs and B5 nurses has been placed. Recruitment initiatives have now been approved by JNCC so it is hoped this will encourage staff to apply to the acute inpatient areas.
Annual turnover		
Compulsory training		
Sickness absence		
Supervision - clinical		
Supervision - managerial		
Vacancies		
Urgent Care South		
Annual appraisals		The Acute Inpatient Transformation plan oversees appraisal, supervision and training. It aims to be meeting KPIs of 85% for the end of September but may not achieve Safeguarding Adults L3 due to lack of any available courses by the LA. Internal training is planned but any slippage on ratification of the training will impact on compliance. We have placed a rolling advert for HCAs and B5 nurses. We have 10 newly qualified nurses commencing in September. We will be closely monitoring their experiences to ensure any issues are dealt with in a timely manner to increase retention
Annual turnover		
Compulsory training		
Sickness absence		
Supervision - clinical		
Supervision - managerial		

Focus on Acute Services	Rating[1]	Assurance Summary
Vacancies		Recruitment initiatives have now been approved by JNCC so it is hoped this will encourage staff to apply to the acute inpatient areas.

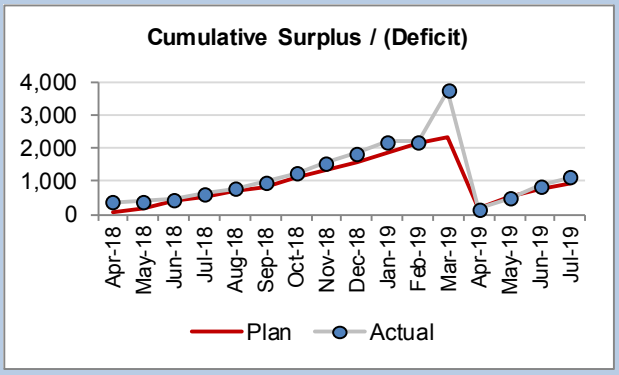
([1]The rating symbols were designed by NHS Improvement)

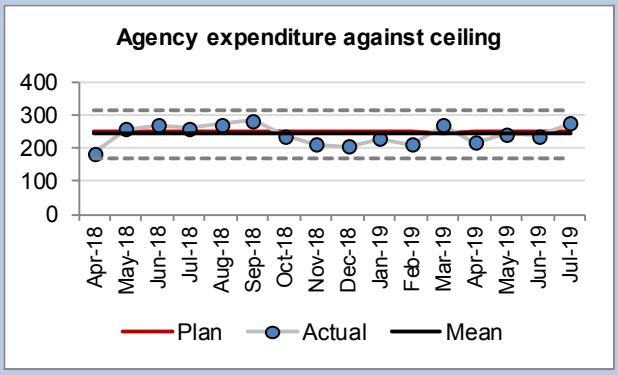
Key:

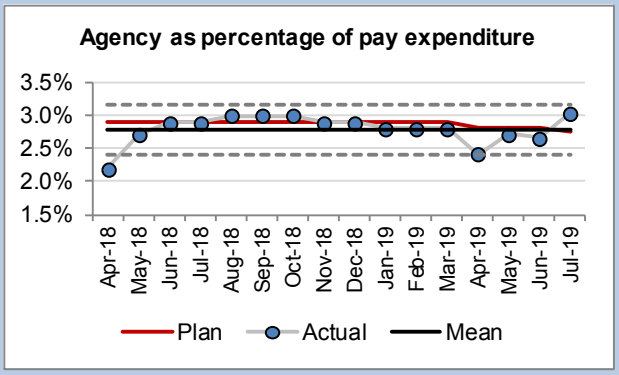
	The system is expected to consistently pass the target
	The system may achieve or fail the target subject to random variation
	The system is expected to consistently fail the target

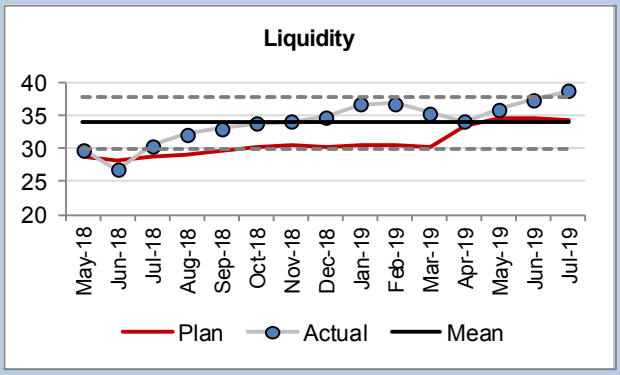
Appendix 1 – Charts

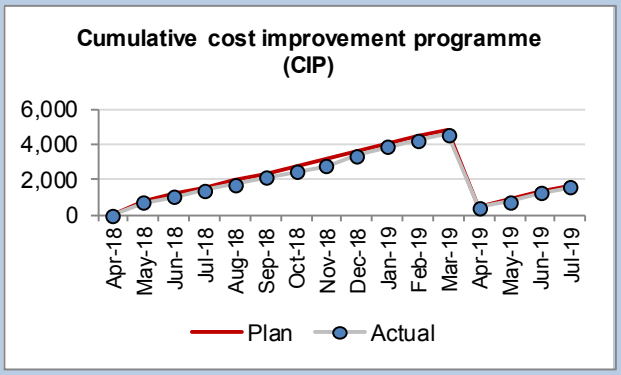
Financial Indicators

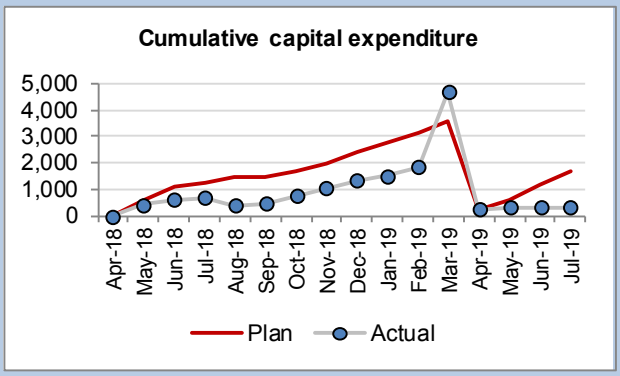


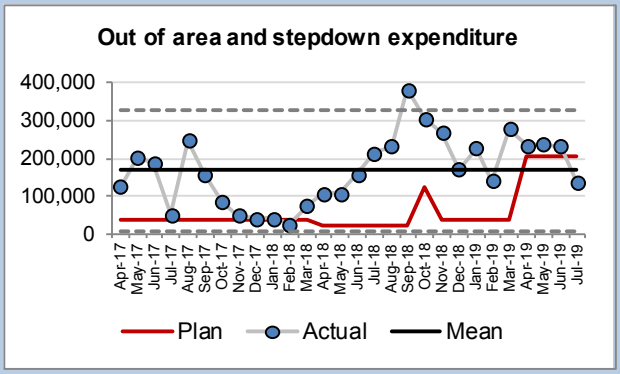






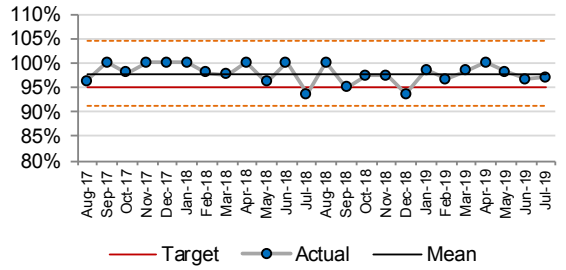




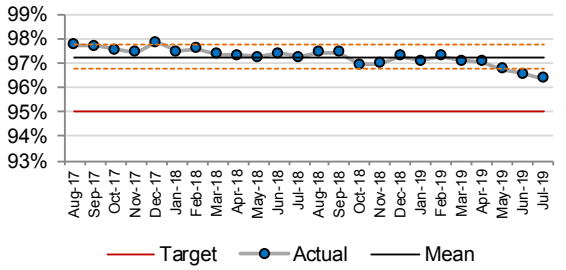


Operational indicators

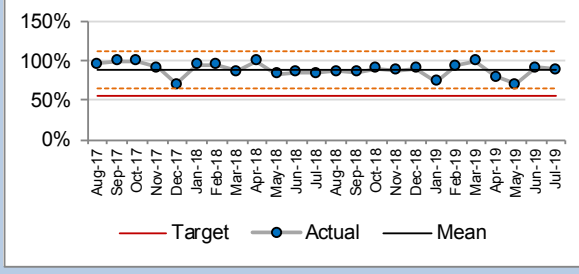
CPA 7 day follow-up



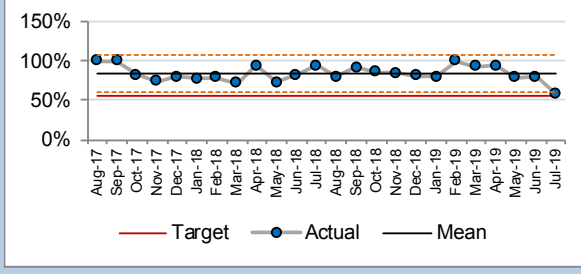
Data quality maturity index



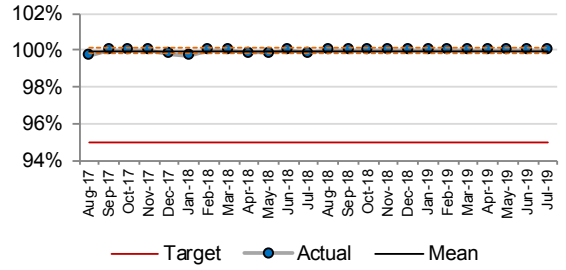
Early intervention 14 day referral to treatment - complete



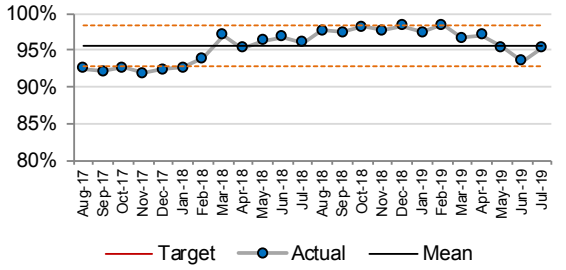
Early intervention 14 day referral to treatment - incomplete



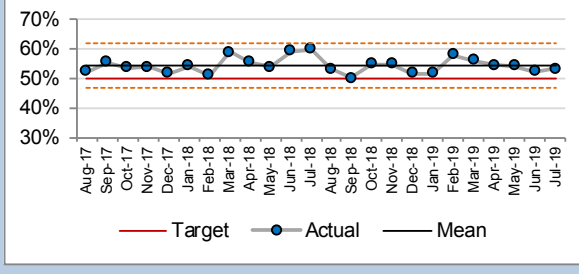
IAPT 18 week referral to treatment



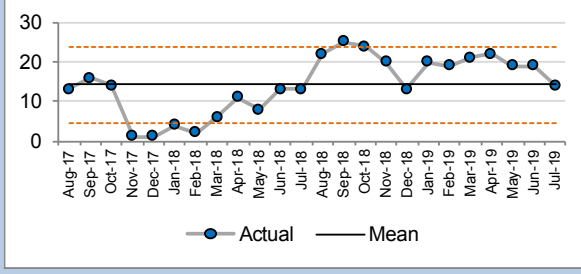
IAPT 6 week referral to treatment



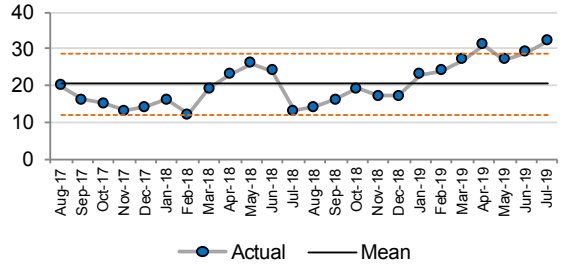
IAPT patients completing treatment who move to recovery



Patients placed out of area - adult acute

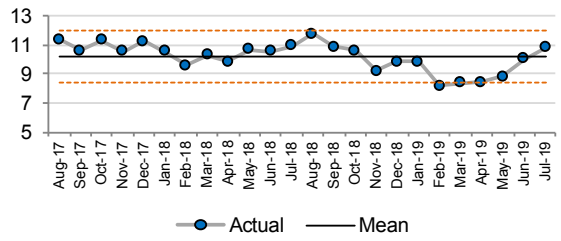


Patients placed out of area - PICU

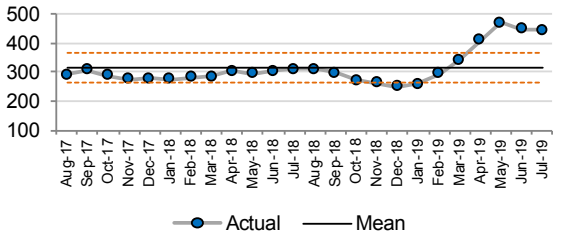


Operational indicators

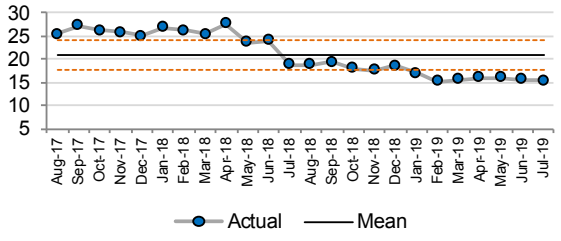
Waiting list - CAMHS - average wait to be seen



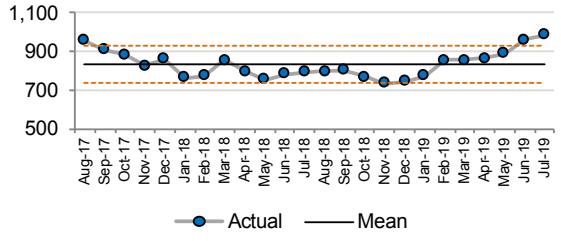
Waiting list - CAMHS - number waiting at month end



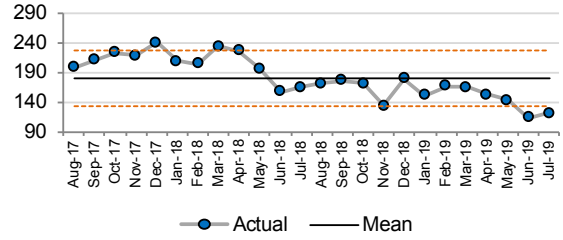
Waiting list - community paediatrics - average wait to be seen



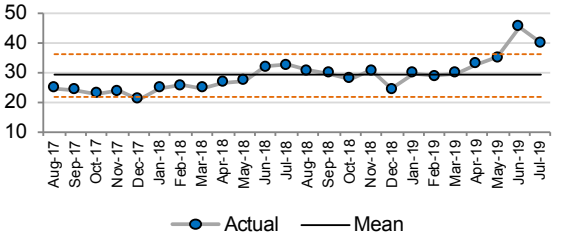
Waiting list - community paediatrics - number waiting at month end



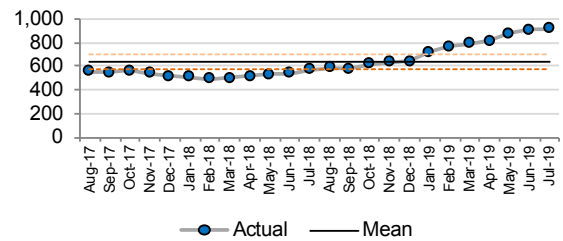
Waiting list - care coordination - number waiting at month end



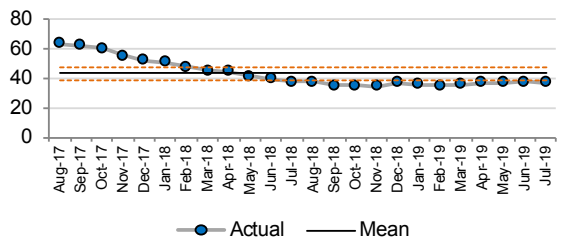
Waiting list - care coordination - average wait to be seen



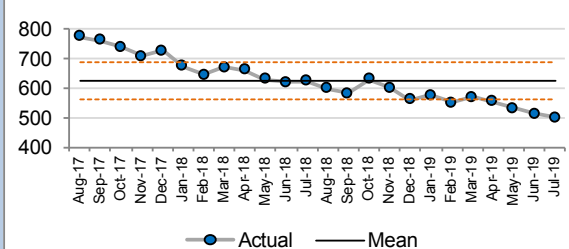
Waiting list - ASD assessment - number waiting at month end



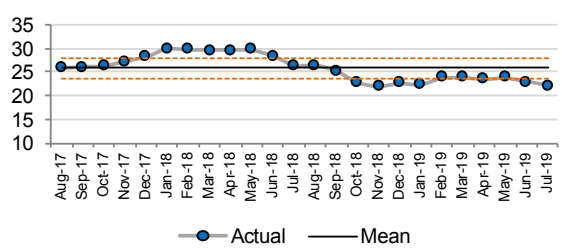
Waiting list - ASD assessment - average wait to be seen



Waiting list - psychology - number waiting at month end

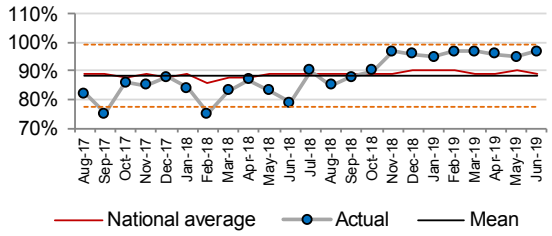


Waiting list - psychology - average wait to be seen

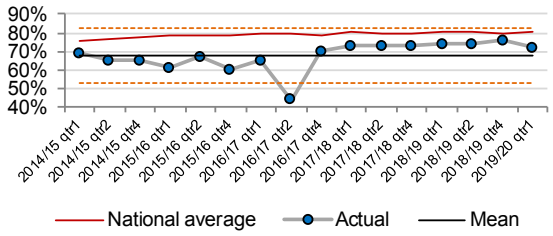


Quality Indicators

Friends and family test - positive responses

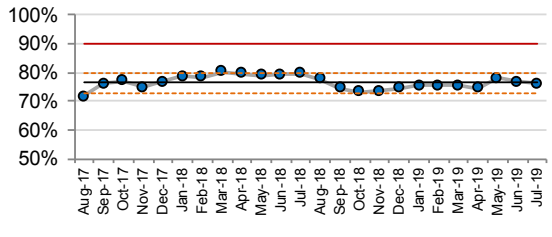


Staff friends and family test - recommending care

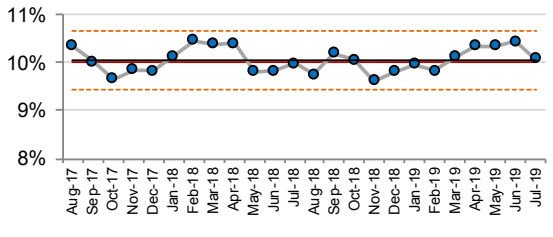


Workforce indicators

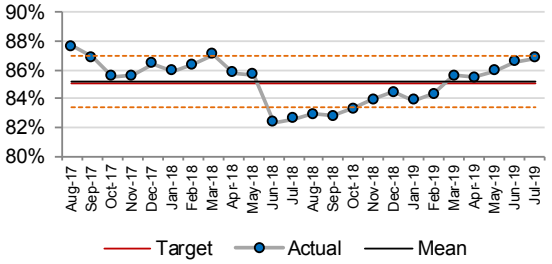
Annual appraisals



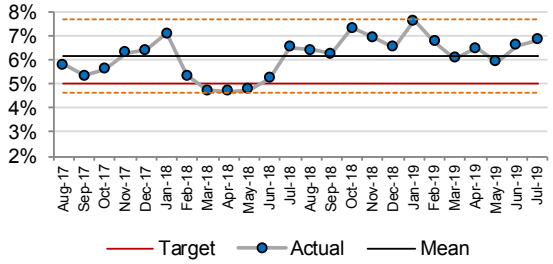
Annual turnover



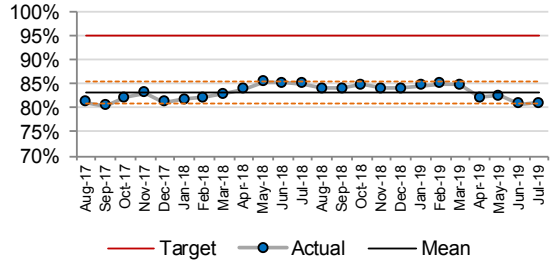
Compulsory training



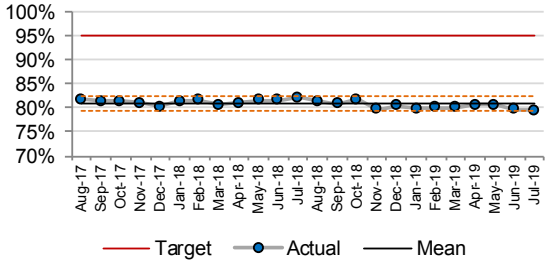
Staff sickness



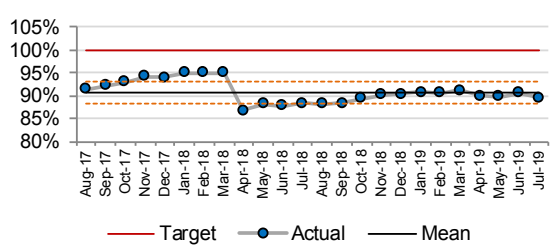
Supervision - clinical



Supervision - managerial

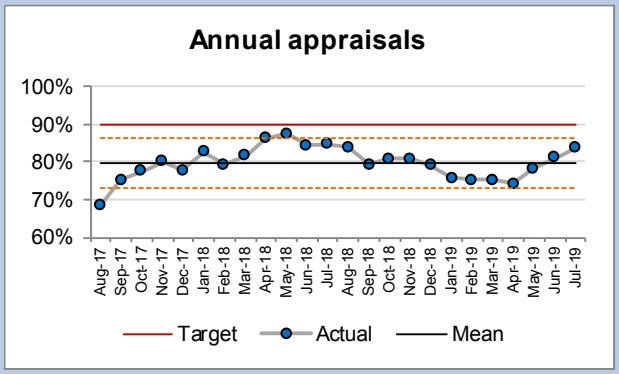


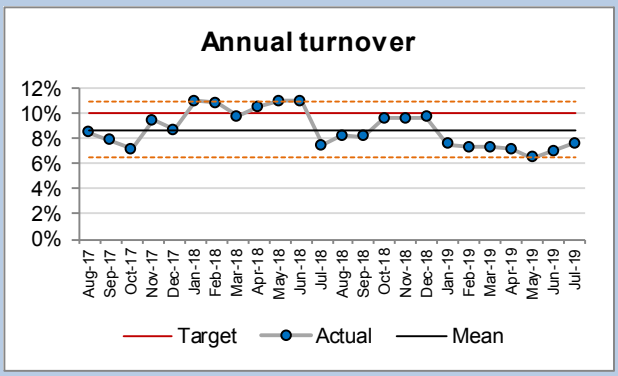
Vacancies - proportion of posts filled (staffing level KPI)

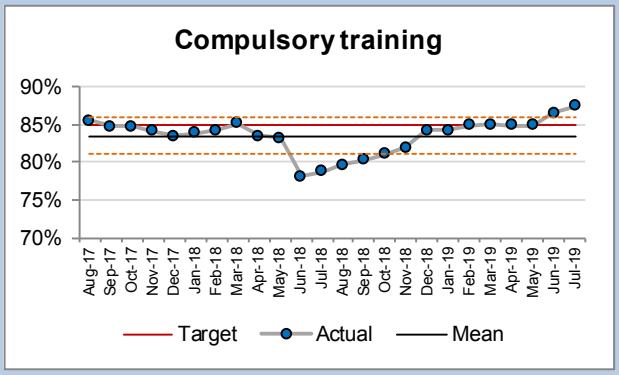


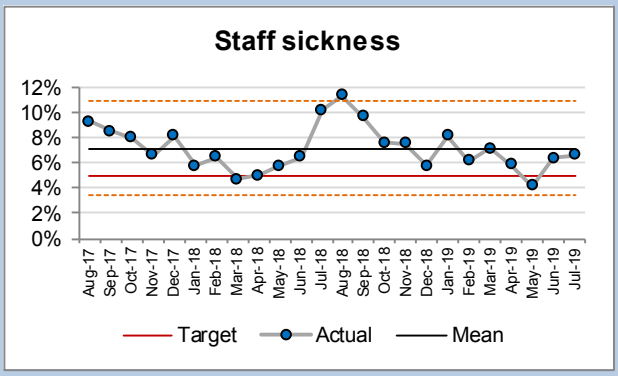
Focus on… Acute Care

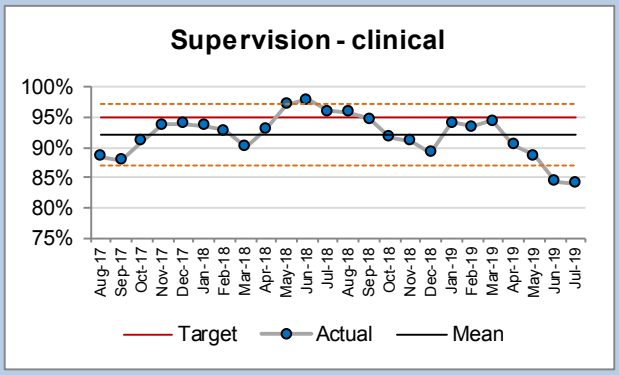
Assessment Services

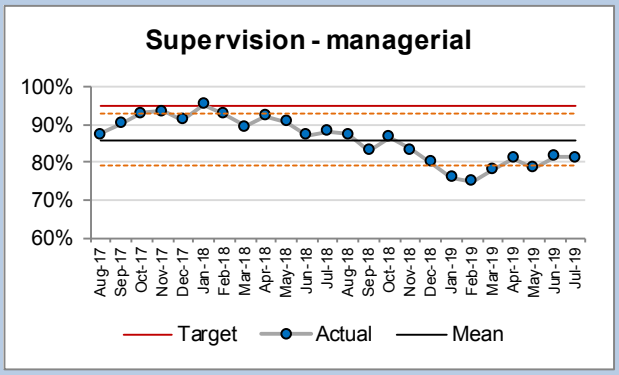


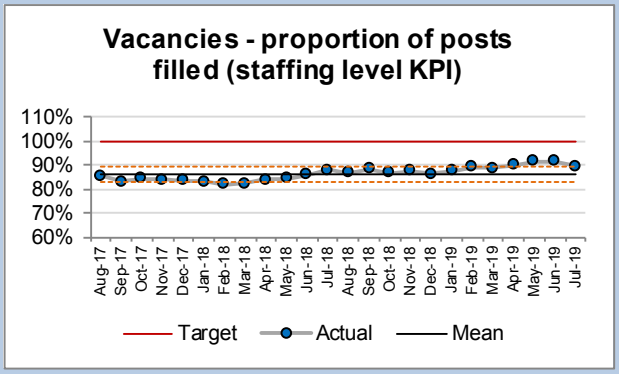






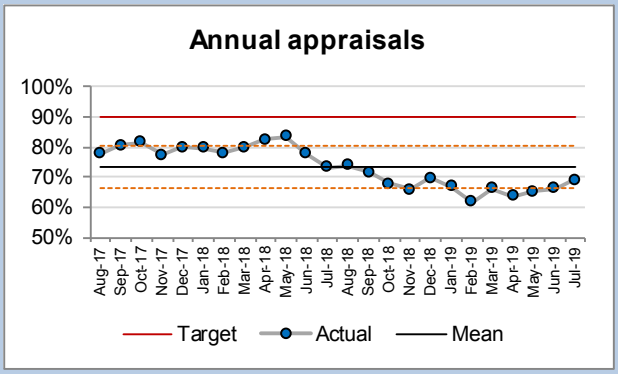


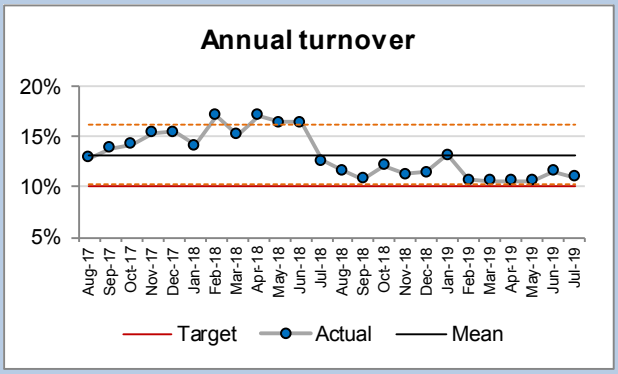


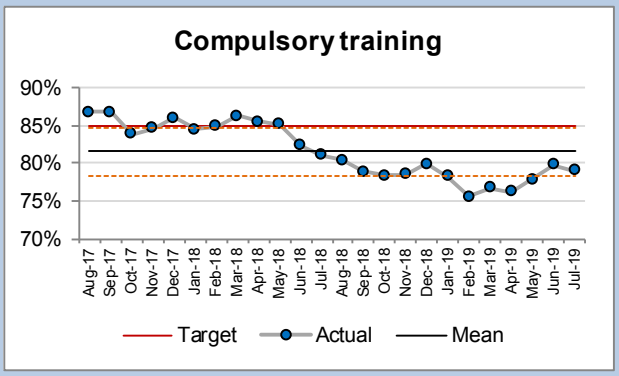


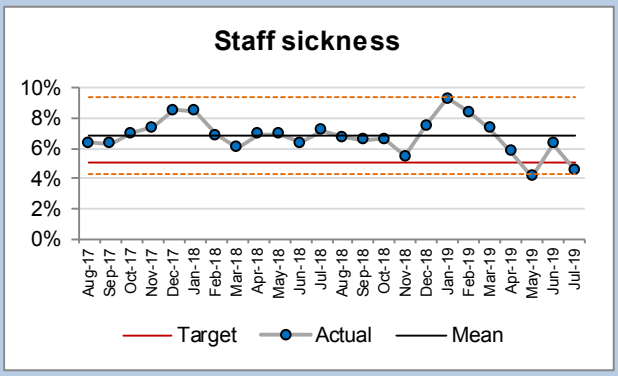
Focus on… Acute Care

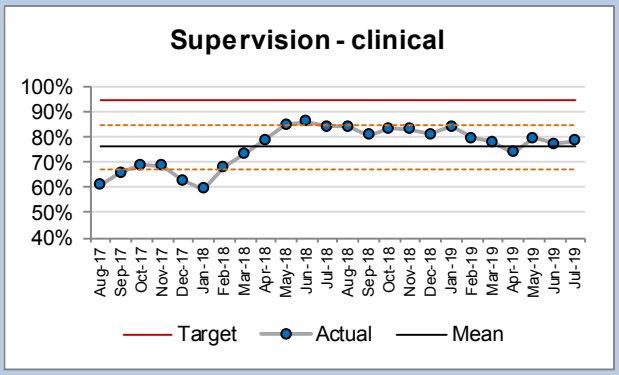
Acute Inpatient North

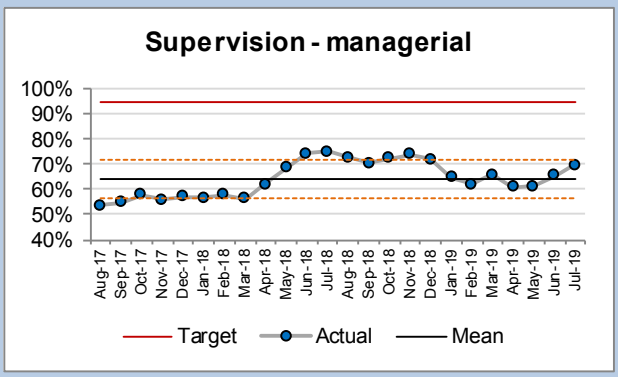


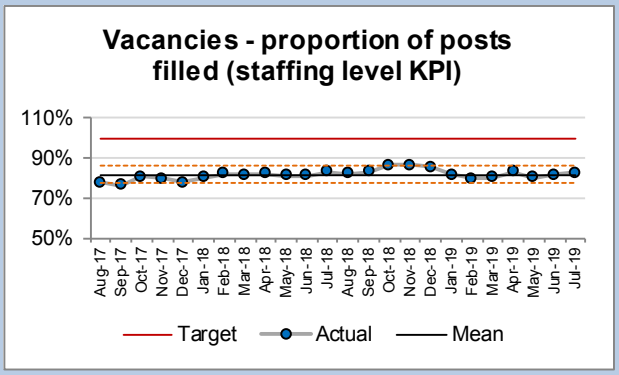






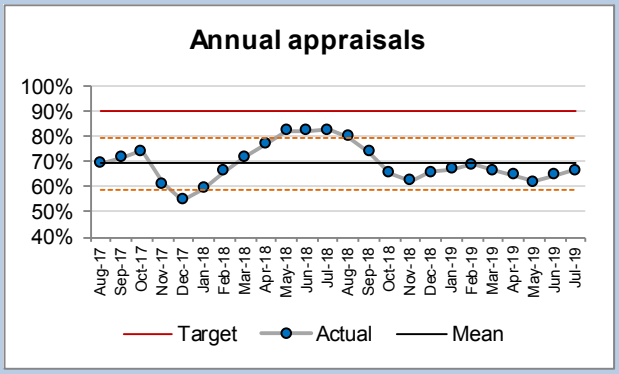


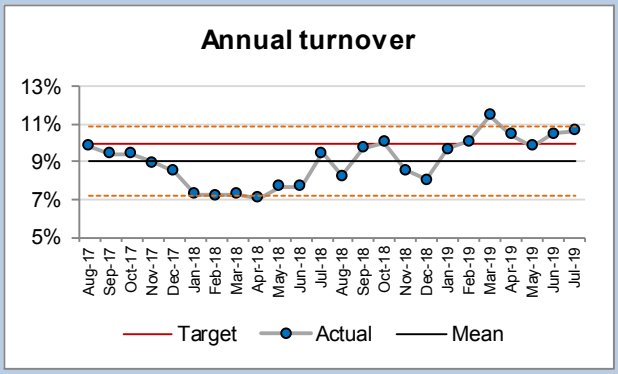


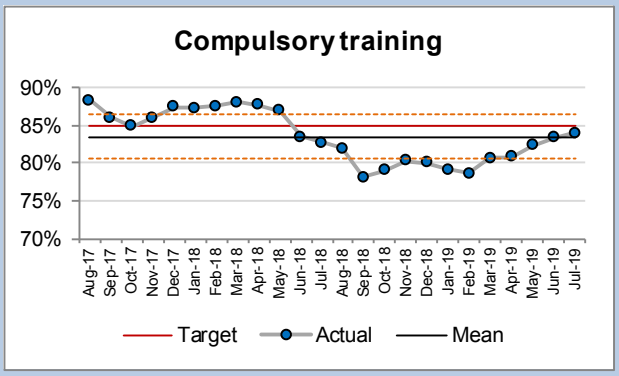


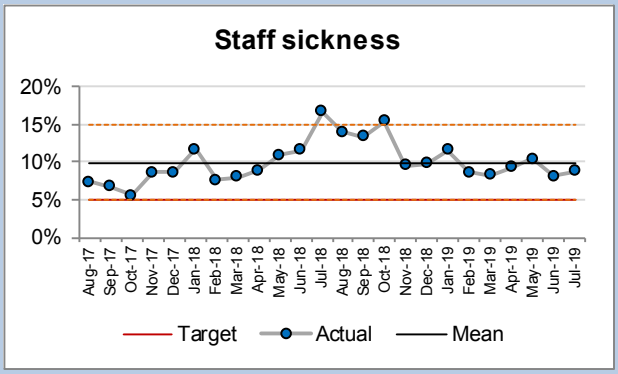
Focus on… Acute Care

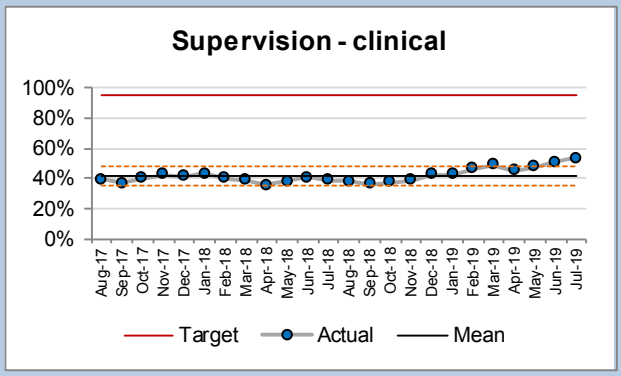
Acute Inpatient South

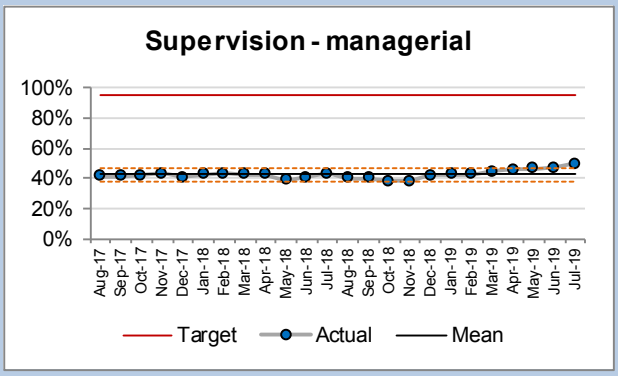


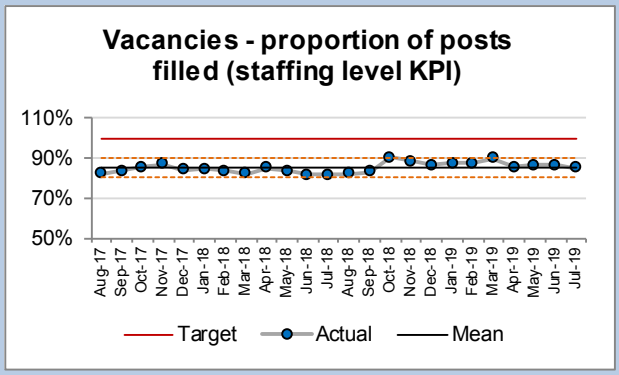






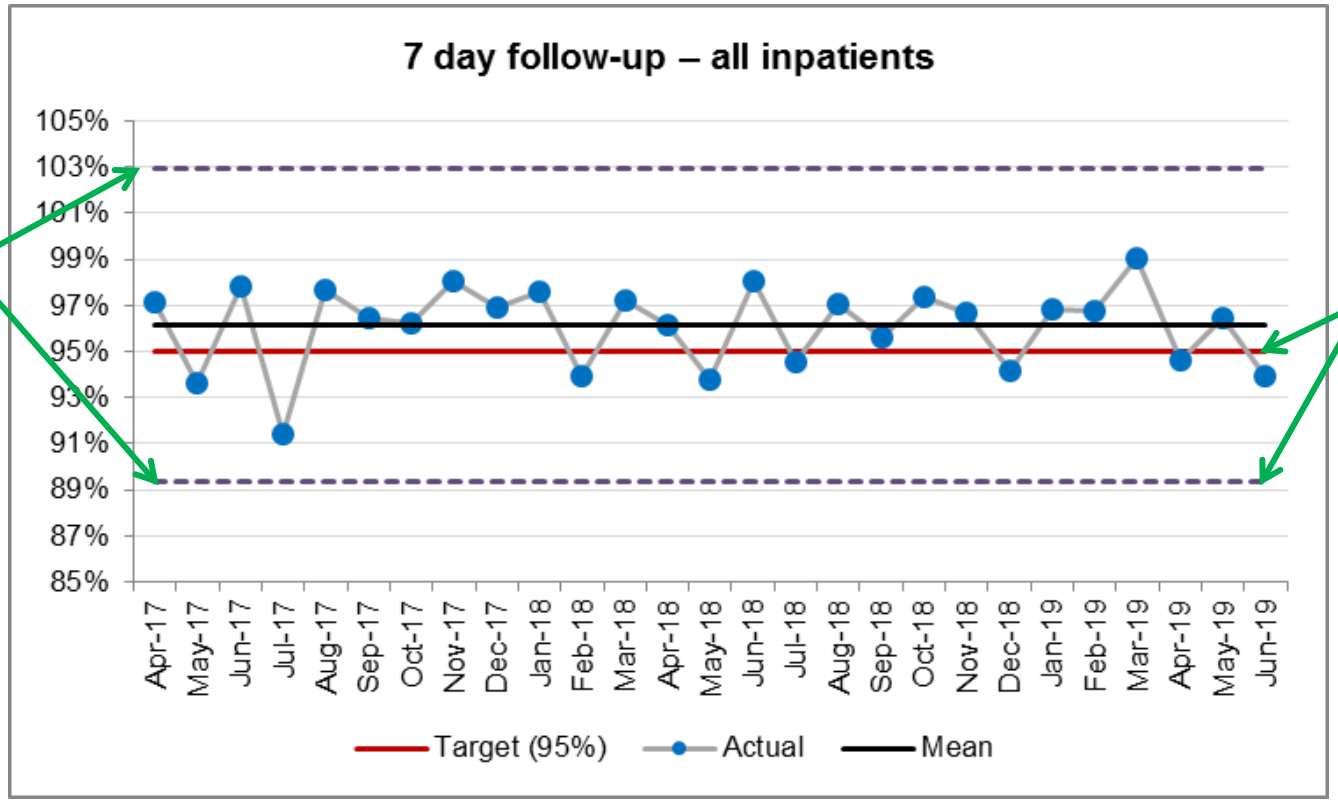






How to Interpret a Run Chart (also known as an SPC chart)

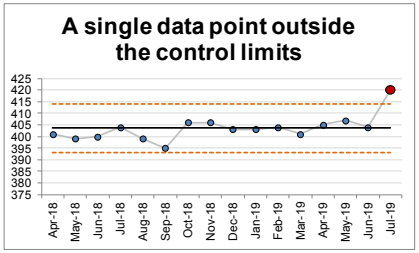
The dotted lines are the “control limits”. Any performance between these 2 lines is normal for the current system. This is known as “normal variation”

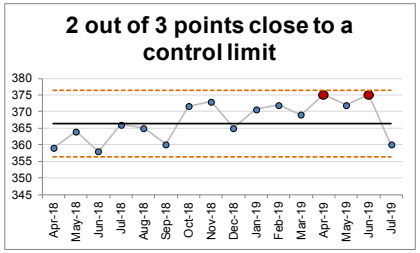


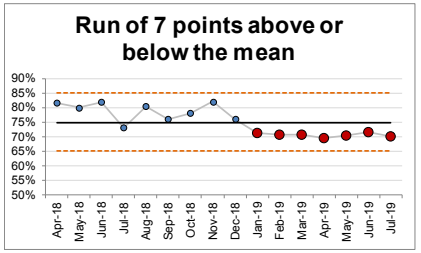
If the system is effective, the **lower** control limit will be above the target line (for targets where higher is better) or the **upper** control limit will be below the target line (for targets where lower is better). In that scenario we have nothing to worry about and can be assured our system is performing well.

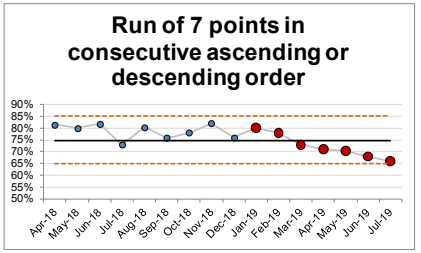
In this case the target line is above the lower control limit which indicates that the system is ineffective.

A run chart also enables us to see when something unusual has happened in the system. This is known as “special cause variation”. This can be seen in 4 ways:









Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors - 3 September 2019

Use of Resources

Purpose of Report

This paper provides Trust Board with an update report regarding the Use of Resources in support of our strategic objective: 'Best Use of our Money' as well as in support of Regulator assessment of Use of Resources.

Executive Summary

The previous Use of Resources report concluded that our highest ten priorities were:

1. Increasing our focus on improving staff wellbeing and satisfaction in particular to reduce rates of sickness absence and the associated costs (in people and financial terms)
2. Delivery of the new Leadership and Management strategy supporting recruitment, retention and workforce development
3. Implementation and oversight of more robust e-rostering and job planning
4. Elimination of Adult Out of Area placements
5. Better use of digital technology
6. Medicines optimisation and e prescribing
7. Streamlining access to services and improving missed appointments
8. Optimising utilisation of estates (particularly addressing empty wards)
9. Considering the appropriate size and function of corporate services
10. Improved administration and communication

The Board will be aware of the significant amount of work that is taking place to address many of these priorities.

For many of the areas, in particular sickness absence and staff wellbeing, our data does not yet show an improvement, but there are also green shoots emerging in some areas.

Current programmes of work are rooted in measurement and improvement methodology and clearly obtain and maintain a line of sight between the aims and outcomes from development through to delivery.

There are some earlier programmes of work linked to benefit realisation that progressed outside of the current approach, these are being revisited for evaluation for reporting on in quarter 3.

Aligned to the highest priority areas identified in the top ten priorities the current programme of work includes initiatives focusing on:

- Programme on eliminating OOA with five work streams progressing a personality disorder pathway, effective 24/7 crisis response, optimal length of stay / patient flow, step-down and step-up support, Clozaril initiation clinic and enhanced pharmacy in the community.
- A wellbeing programme of work is underway. Work streams are focusing on staff turnover and recruitment and retention; improved support and management related to returning to work and sickness management training and support; and bank control system and optimisation of e-rostering to deliver a fit for purpose and compliant with wellbeing best practice.
- There is an enhanced suite of leadership and management training support on offer including mandatory leadership masterclasses led by the CEO which includes sharp focus on the expected culture, behaviour and values in order to shine a bright light on the 'how' and 'why' and to challenge leaders in order to bring change in their individual and collective behaviours
- Digital technology is being piloted in the exploration of DNA (did not attend) reduction.
- Nurse-led clinics are being piloted to explore alternative or complementary component to the community / outpatient offer.
- Medicines optimisation and e-prescribing is progressing and benefits of a trust-wide solution is being scoped.
- Data is being collated to inform work on unwarranted variation community services and will align with external benchmarking through the mental health model hospital.
- Utilisation of estate is being progressed from September, including use of wards and Kingsway corporate areas and will inform / be informed by a corresponding piece of work on the Sustainable Development Management Plan.

The size and function of corporate services is being evaluated, informed by a programme of activity commencing in quarter 3 from the mental health model hospital.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	X
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	X
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	X

Assurances

The consideration of the use of resources touches on many of the risks on the Board Assurance Framework, not just the delivery of financial plans. The financial performance is a direct result of the use of resources in its broadest sense.

The proposed level of assurance for this paper is **limited** due to limited evidence of achievement to date against highest priorities.

Consultation

This paper has not been formally considered by any other groups or Committees but has been jointly produced by the Finance team and the Programme Office.

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

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

This paper explores the use of resources at whole Trust level rather than by patient or staff groups who may have protected characteristics.

The Board will be aware that there are known equality, diversity and inclusion issues that will without doubt adversely affect some of the measures of use of resources.

These include for example:

- The differential experience of BME colleagues as reported in workforce race equality standards (WRES).
- Gender pay gap.
- Staff Network feedback about adverse experiences e.g. bullying and harassment and inflexibility or inconsistency in management behaviour.
- Intelligence contained in the Staff Survey, Pulse check and Friends and Family Tests.

Whilst there are many examples of positive experiences there are also still too many negative experiences.

Negative workforce experience of course adversely affects reported staff experience but also rates of innovation, satisfaction, sickness or wellbeing, attendance levels, fill rates, flexible working and recruitment and retention to name but a few. All of which

impact on patient experience and outcomes.

The Executive are revising the Equality, Diversity and Inclusion framework to draw together the many strands of EDI work that is taking place in the Trust. This will inform and support the Trust ambitions and strategy to be a great place to work, to receive great care and to make best use of money.

Recommendations

The Board of Directors is requested to consider the extent to which we have so far addressed our top ten Use of Resources priorities and any associated strategic impact.

Report presented by:	**Claire Wright** **Deputy CEO and Finance Director**
Report prepared by:	**Claire Wright** **Deputy CEO and Finance Director**
	Rachel Leyland **Deputy Finance Director**
	Joe Wileman **Head of Programme Delivery**

Quality Report – Use of Resources

1.0 Policy and Regulatory context

1.1 The NHSI Single Oversight Framework - NHSI Finance Score

The monthly finance score is calculated by scoring providers on a scale of 1 (best) to 4 against the following five metrics and averaging these scores to derive an overall figure:

- Capital service capacity
- Liquidity
- Income and expenditure margin
- Distance from financial plan
- Agency spend

Performance against these measures are covered in the final section of the report

1.2 NHSI/CQC Use of Resources Assessments

From 5 March 2018, for non-specialist acute trusts the CQC consider a sixth key question alongside their CQC's existing quality ratings for safe, caring, effective, responsive and well-led. Like CQC's five quality questions, Use of Resources is given a rating of outstanding, good, requires improvement or inadequate.

This paper considers equivalent or nearly equivalent measures to enable the Board to have a strategic discussion of the use of our resources.

1.3 Carter: NHS operational productivity: unwarranted variations in mental health and community health services

This review led by Lord Carter covered the operational productivity of English NHS community and mental health services. The final report made 16 recommendations and indicated productivity benefits worth £1bn can be achieved of which 80% of this will be through clinical and workforce productivity.

2.0 Performance

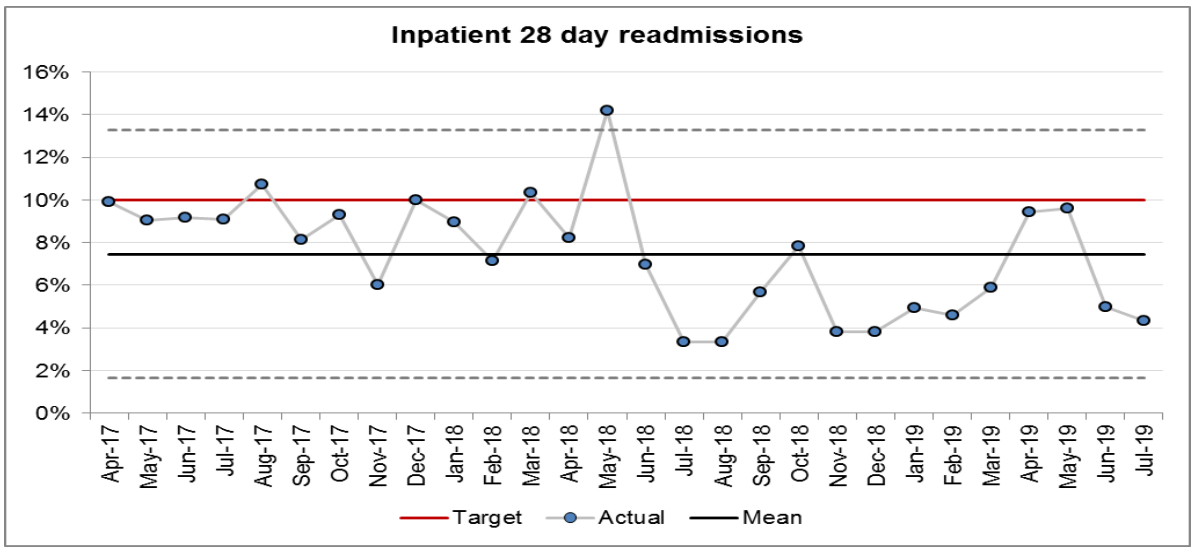
This section looks at the actual metrics which have been identified and reports the monthly position for 2019/20 including where applicable historic information including SPC and any benchmarking information reported on Model Hospital.

2.1 Clinical Services: How well is the Trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit

Emergency readmissions (28 days)

Readmissions have been below the target of 10% since June 2018, and for the last 2 months have been below the mean of the last 16 months.

There is no benchmarking data available on the Model hospital for this metric.

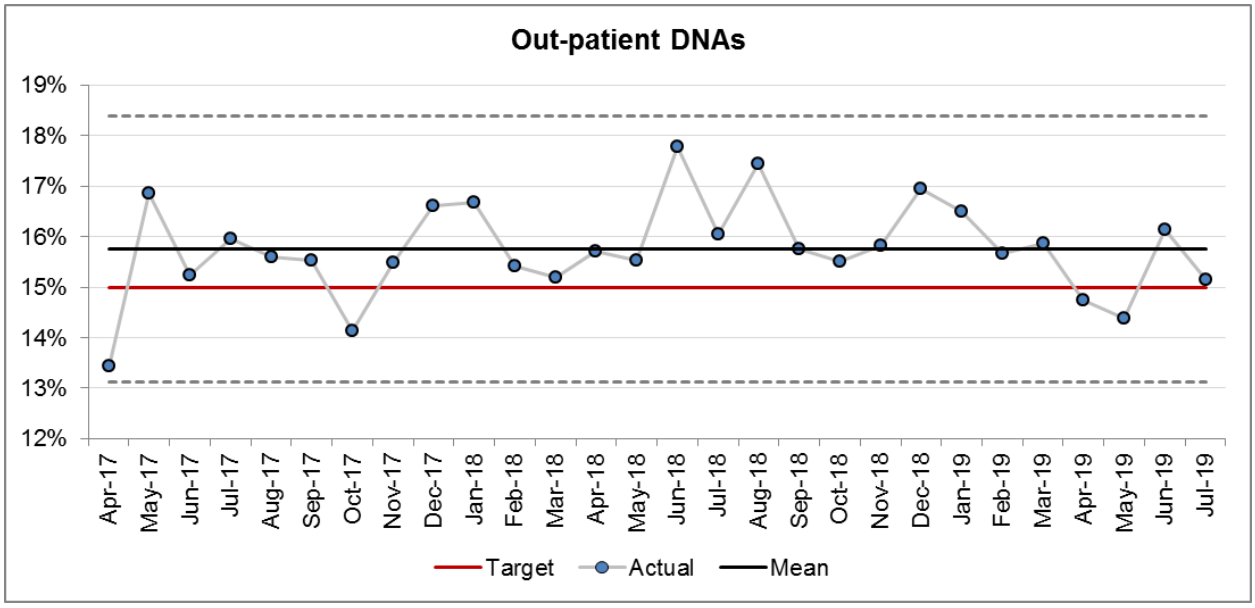


Development to the CRHT teams will assist with staying under target. The table below shows referrals to CRHT within 28 of discharge which is an indicator of their role in admission avoidance.

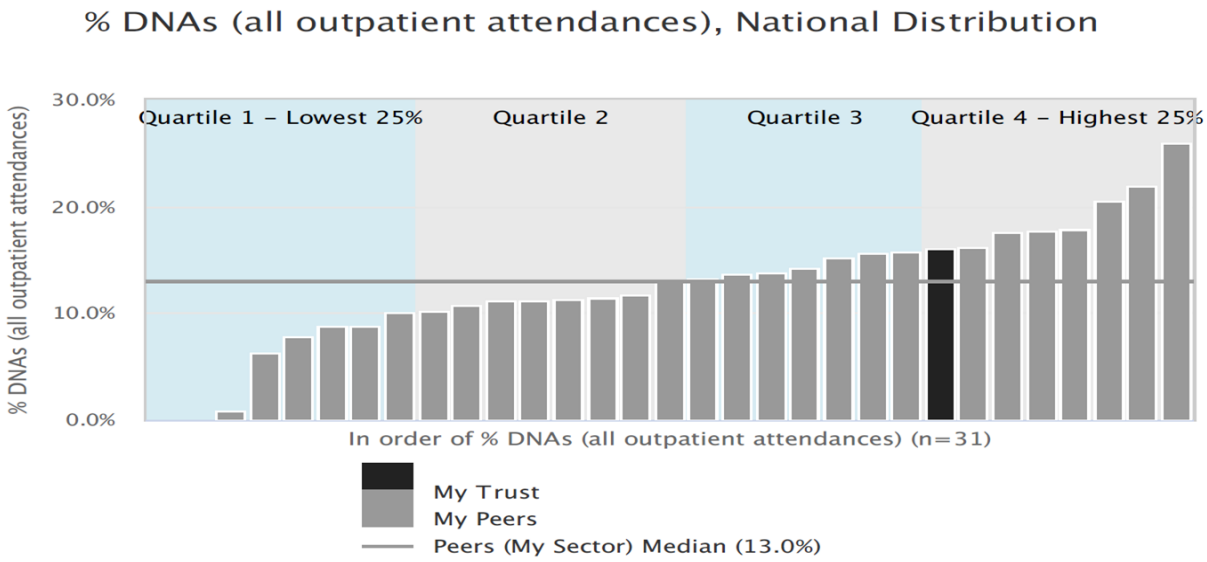
Has 28 Day Inpatient Readmission After Discharge						
Row Labels	Apr	May	Jun	Jul	2019 Total	Grand Total
CRHT CHESTERFIELD	4	4	9	0	19	19
CRHT HP&N DALES	0	0	1	1	2	2
CRHT STH & CITY	8	11	5	0	26	26
Grand Total	**12**	**15**	**15**	**1**	**47**	**47**

Did not attend (DNA) rate

The mean is 16% which is above the target of 15%. April and May of 2019/20 have been below target.



The most up to date information contained on the Model Hospital relates to quarter 3 of 2018/19, which shows our average at 16% against the National median of 13% and Peer median of 14.8% (see below).



Improvements in the level of DNAs and emergency readmissions are opportunities to make better use of resources. Carter cites that 16% of mental health appointments are missed, leading to significant waste of clinical capacity and to compromise in patient outcomes.

Digital contacts

A pilot study is in development in Chesterfield looking to the use of digital (video) contacts to complement the trust typical face to face offering in community and outpatient settings. This initiative is being driven by the team with support from the Transformation team and comes from the clinically-led strategic development workshops which took place over the spring and summer.

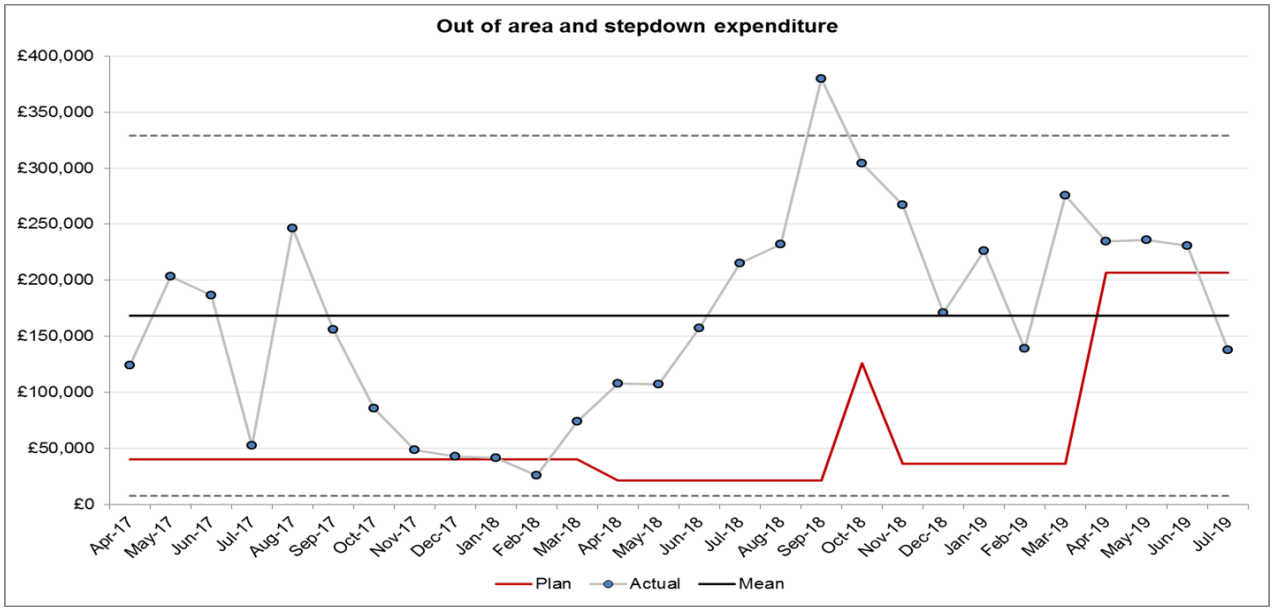
Data supporting the pilot shows that around 15,000 contacts take place each year and undertaking 10% of these digitally in the longer-term would deliver 1500 contacts with no associated travel time and costs. It would also have a positive impact on the number of DNA and cancellations recognising this may be a preferable alternative for patients who may struggle to attend appointments. Data for one doctor in the scoping shows 22 patients who have DNA on 10 or more occasions and that this is not untypical.

Currently the technology is being tested and licenses acquired for the associated software and identified clinicians are identifying suitable patients for the pilot study. The pilot is scheduled to commence on 9th September with first evaluation expected mid-October.

Adult Acute Out of Area placements

Carter references the concept of GIRFT (Getting it Right First Time) and in his report points to out of area placements as a key area for improvement. We are well sighted on this because it is already highlighted as one of our most important areas to improve from a quality perspective as well as financial. We have significant work still to do to improve this. (There is also the regulatory requirement to eliminate inappropriate out of area placements by 2021).

The Out of Area (OOA) and Step-down (SD) budget was overspent by £2m at the end of 2018/19 financial year. Commissioners non-recurrently funded this overspend going into 2019/20 hence the step increase in the plan line in the graph below. At the end of July the budget is overspent by £11k YTD, which has improved in July due to lower placement numbers. The forecast assumes that this budget breaks even by the end of the financial year.



This means progress on driving number of out of areas down hasn't been as expected and required and is an area that needs to be addressed both in numbers of placements and the variability in cost of placements which is proving to be a stubborn challenge.

In April a programme of work was established focusing on the drivers for reducing OOA. It seeks to improve through:

- Reducing the flow of people into crisis and acute pathways of care.
- Ensuring that an inpatient admission is only made when clinically necessary.
- Ensuring that inpatient length of stay is based on patient need and in accordance with NICE guidance.
- Developing provision to support people leaving mental health inpatient beds, so they are able to continue on their recovery journey in the community and reduce the risk of readmission.

Metrics and dashboards have been developed to support the programme looking at the key outcome measures of OOA bed days and cost, lengths of stay and occupancy by cluster. What they indicate at this time for example is that there is:

- Continued overspend on acute and PICU OOA placements at a steady rate although July shows a month on month reduction.
- There is variation in lengths of stay between wards and between units e.g. Hartington Unit having almost half the length of stay as wards on Radbourne Unit.
- There are significant numbers of patients who were admitted more than 50 and 100 days ago, indicating deviation from national average and provides a focus for system improvement.

There are five work streams to the programme progressing development of a personality disorder pathway, effective 24/7 crisis response, optimal length of stay / patient flow, step-down and step-up support, Clozaril initiation clinic and enhanced pharmacy in the community.

Progress in these areas results in fewer admissions and reduced length of time spent as an inpatient which serves to release capacity which can be used to treat patients who would otherwise have gone out of area. Metrics have been established for each and constructed into a dashboard for programme management.

Personality disorder pathway

This seeks to improve interventions available to people with a personality disorder, improve outcomes for patients with a personality disorder, develop staff skills and knowledge and improve staff morale and staff retention. It will decrease treatment costs in terms of prescribing costs and costs associated with crisis presentation, overdose, inpatient admission and delayed discharge and reduce lengths of stay for inpatients. As at August, recruitment has started and it is expected the team should be impacting on admission reduction by December.

Effective 24/7 crisis response

Assessment of the CRHT teams has shown that they are not reaching all the core fidelity requirements. This work stream aims to ensure crisis teams are effective and meet core fidelity standards through:

- 24/7 hours of operation for crisis and home treatment functions by March 2020
- Staffing in line with high fidelity services by 2021: expectation of around one qualified staff per 9-12k population across crisis assessment and home treatment functions, dependent on local MH need and with multi-disciplinary skill mix.
- Provision for older adults CRHT functions across Derbyshire by March 2021.

Key metrics for this work stream monitor inpatient admissions and 28 day readmissions as well as CRHT core fidelity scores, 4 hour referral to assessment performance, reduced demand for 4 hour emergency assessments, patient and carer feedback on CRHT and wider crisis support provision.

Admissions to acute beds are averaging around 95 per month currently and are showing little movement across the full cohort. It is expected as these teams further establish over the next quarter there will be positive impact on admission reduction.

Patient flow / optimal length of stay

Currently bed occupancy consistently exceeds the 85% maximum and length of stay exceeds the top quartile benchmark which reflects both operational issues and the capacity of wider services (such as Social Care) to support discharges.

The current dashboard shows no significant movement in the length of stay trend to date but does indicate length of stay on the Hartington Unit is roughly sixty percent that of the Radbourne Unit and more likely half excluding the older people cohort on Pleasley. This provides internal benchmarking opportunity which is factored into the work.

Key activities within the work stream to bring LOS down are focusing on:

- Adherence to RCP inpatient standards
- Achievement of full staffing complement in place and the provision of a range of interventions and treatments to meet patient's needs, including access to support from outside agencies (separate vacancy and recruitment metric)
- Joint working between acute wards and CRHT and community teams so that an inpatient stay is managed as part of patient's entire care-pathway.
- A care pathway is used and understood by all professionals and easily explained to service users and carers.
- Daily patient reviews and decision making in place.
- Early discharge planning with everyone admitted to a mental health ward having an Estimated Discharge Date (EDD) within 72 hours of admission.
- Barriers to discharge identified daily, with ownership of actions and clear escalation processes.
- Agreed discharge protocols in place.

Step-down and step-up support

Through the development of bed manager posts and step-down and crisis beds in the south, there is an aim to impact positively in reduced admissions and reduced length of stay by June 2020. Particular focus is on:

- Community rehabilitation teams supporting service users when they leave hospital or move to supportive accommodation providers.
- Provision needs matched to clinical needs.
- Supportive accommodation provision, (either step up or step down), providing day-to-today support for service users to live in the community.
- Provision provided by multidisciplinary and agency staffing.
- Advocacy and peer support provision, supporting social inclusion, occupation and entry to employment.

Pharmacy in the community

A model of pharmacy intervention is in place to support those patients in clusters 12 and 13 (being those for people with ongoing and recurrent psychosis with high disability and/or symptoms) who have a reasonable history of inpatient bed use in the previous 2 years in order to reduce the need for further admission.
Current data from our dashboard shows between two thirds and three quarters of cluster 12 and 13 patients are admitted under section and typically they are

inpatients for longer with average lengths of stay in excess of 50 days (54 days and 87 days respectively). There are signs of a positive trend with admissions for this cohort dropping from 18 in April to 11 by June and 12 by July.

Pharmacy teams are using a variety of interventions within a flexible “package”. The nature of the package will evolve through a Quality Improvement process but will broadly address the following:

- Patients’ understanding of their medication and the consequences of not taking it
- Exploration of any side effects that are troubling the patient
- Planning of any remedial steps to alleviate side effects
- Signposting to further information or support services
- Patient experience of the intervention
- Carer involvement
- Planning of any follow-up required

The work stream is currently establishing its PDSA cycle and will review in December and June at 6 and 12 months.

Unwarranted variation in community provision

In terms of delivering clinical services the majority of activity takes place in community settings and Carter suggests that there is significant variation in structure, composition and skill mix of community teams and that there is scope to exploit improvement through better use of digital technology, streamlining access to services, better communication and administration in order to reduce missed appointments.

There are metrics on the Model Hospital which give comparative values for cost per clinical WTE, cost per patient, numbers of contacts and percentage of clinical time. The data considers a number of comparators suggesting a mix of favourable and adverse performance. As the latest data available at this time however is from quarter 3 in 2018/19 it does not reflect changes to demand and capacity as well as operational process in the last year.

Community Mental Health

Productivity	Trust Value	Peer median	National median
Average cost per substantive clinical FTE	£10,500	£10,672	£10,959
Average clinical staff cost per patient	£589	£209	£302
Contacts per clinical FTE per day	1.5	2	1.7
% of clinical contact time	16.30%	25.90%	22.80%

Crisis Home Treatment

Productivity	Trust Value	Peer median	National median
Average cost per substantive clinical FTE	£10,843	£10,392	£10,410
Average clinical staff cost per patient	£2,485	£1,978	£2,904
Contacts per clinical FTE per day	2.0	1.8	1.7
% of clinical contact time	22.8%	14.8%	15.1%

Particularly noticeable is average clinical staff cost per patient. This gives an indication of the total average clinical staff cost component of the cost of delivering patient care in the service, including bank and agency staff. A higher number as in this case indicates that the clinical staff cost component per patient is higher in this service than in similar services delivered by other organisations, including our peers. This can be used to compare the staff cost of the service against the size of the caseload, and to identify potential areas of improvement. For example, higher staff costs could indicate that staff are more highly trained or experienced, or that there are more hours being worked.

We need to establish in these early stages of using model hospital benchmarking data how much of the variation is due to calculation (what is included in the numerator and denominator) and how much is actual performance. When we consider against our peers, there is significant range between Northamptonshire at £75 average clinical staff cost per patient and Worcestershire at £589. That stated however we are in the highest 25% for this metric and the trust is participating in a model mental health hospital programme, assembled in July this year which brings organisations together to focus on reducing variation in team configurations, patient types / clusters and caseload numbers compared to cost and outcomes.

Aligned with this are a number of trust schemes looking at effective use of resources as part of a continuous quality improvement programme and pipeline, including particularly a scheme to look at unwarranted variation in community teams.

<u>Community based schemes underway or in development</u>

There are two nurse-led clinic pilots underway in Derby City and Killamarsh. These clinics each work with 12 patients over a 12 week period to deliver 144 contacts and suggest potential for a high proportion of patients diverted from CPN caseload and / or earlier and supported discharge. Early indications of data from a small sample size suggest this could be around 80%. The first PDSA evaluation is scheduled for September 2019.

Voice recognition software is being piloted in paediatric physiotherapy and occupational therapy to alleviate administrative demand and capacity pressures. It commenced August 2019 with its first evaluation scheduled for mid-September.

2.2 People: How effective is the trust using its workforce to maximise patient benefit and provide high quality care?

Carter clearly highlights that workforce is a key driver for efficiency improvements and emphasises the link between productivity and culture, leadership and engagement. He suggests that mental health staff report poorer levels of overall satisfaction compared to the acute sector and he suggest Trusts should have leadership strategies that address these issues and that there be more training for staff moving into management. These factors have been taken into account in developing our new Leadership and Management strategy and in our Leadership masterclasses.

As the Board will recall, Carter also points to the levels of bullying, harassment, sickness absence and vacancy rates in mental health and community services and cites that our sector loses on average an extra two days per staff member per year to sickness compared to acute sector. Intensity of work, varied geography, work-life balance and levels of patient acuity are all differentiating factors compared to acute. Furthermore, he says that staff working in mental health trusts in particular are more likely to experience physical abuse, bullying or harassment.

With regard to staff turnover again the MH sector performs worse than the acute sector, with turnover rates ranging from 9% to 45% at the time of the Carter report (May 2018). Factors highlighted include ageing workforce, national pay policy, access to Continuing Professional Development and suggests Trusts should have a specific retention policy.

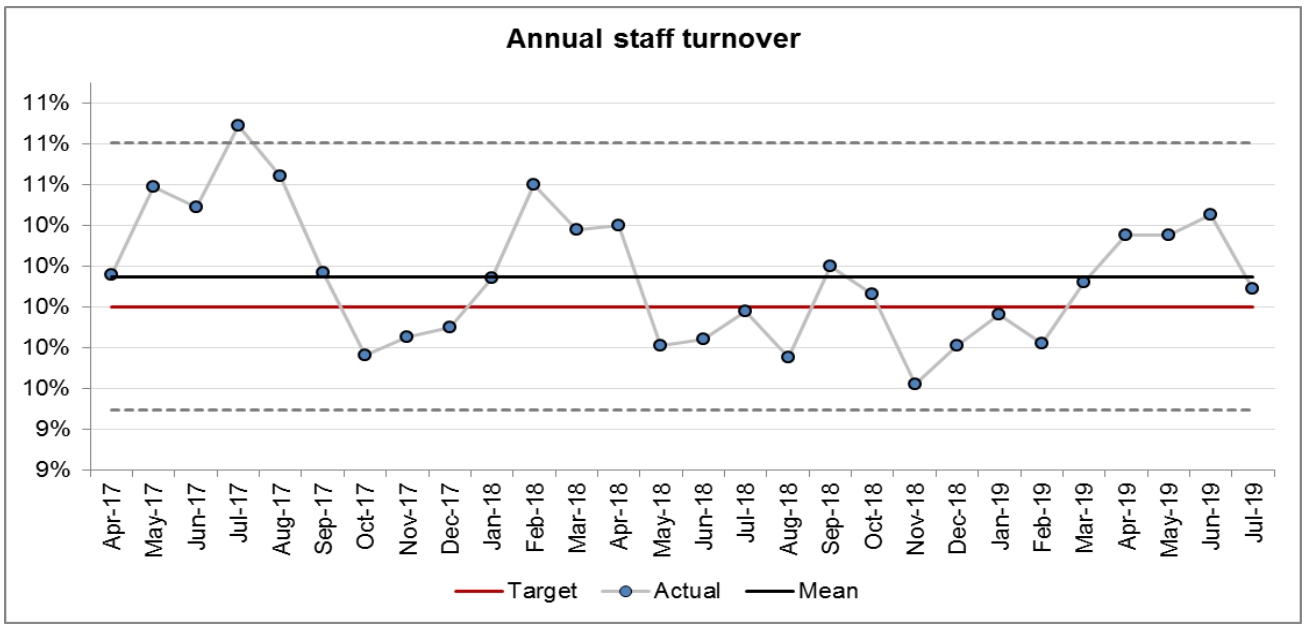
Clearly optimising workforce wellbeing and engagement is a top priority for us and we continue to seek ways to improve colleagues' experiences, retention and wellbeing. Our workforce data including specifics such as WRES and staff survey inform us that we are not yet where we want to be.

Investment has been made in a best-in-class level wellbeing offer and a wider programme of work is underway. There are a number of strands focusing on the following:

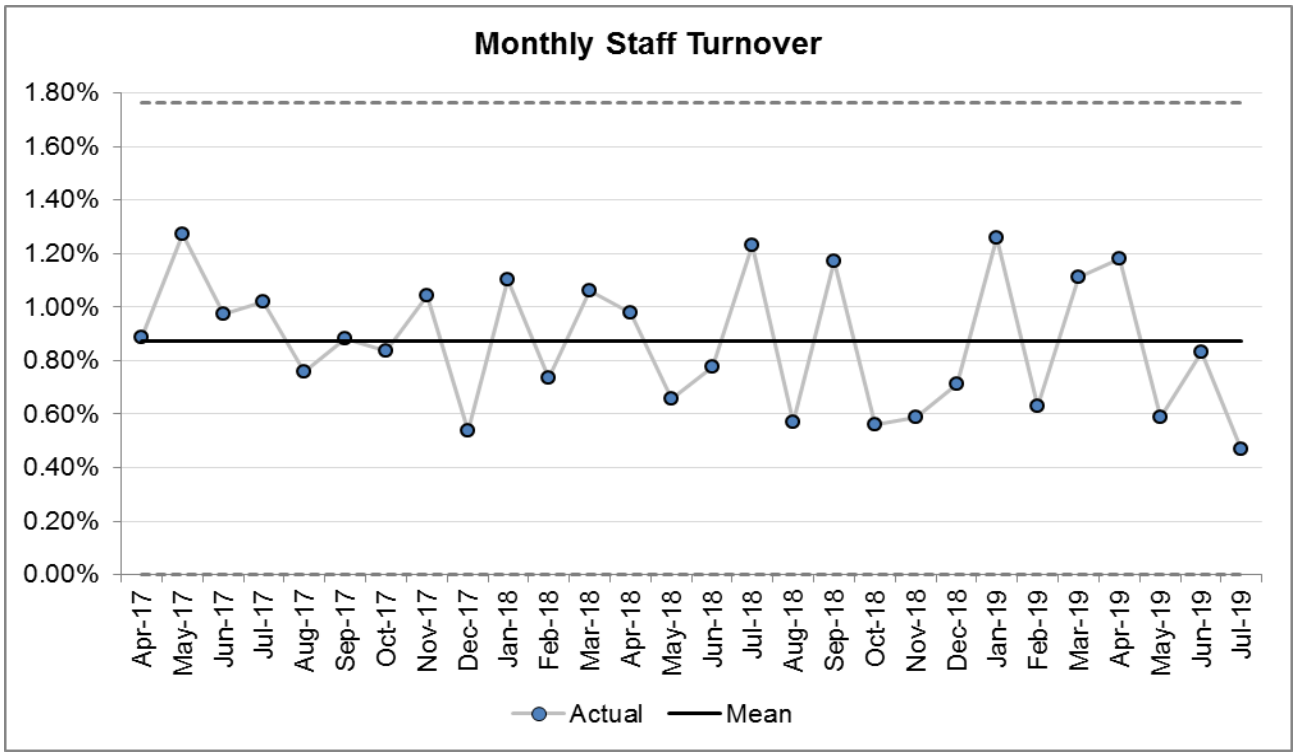
- Reducing staff turnover and improving recruitment and retention
- Improved support and management related to returning to work and sickness management training,
- Bank control system and usage and preparation for the implementation of e-rostering – fit for purpose and compliant with wellbeing best practice.

Staff Turnover rates (annual and monthly)

The information shown in the graph below is taken from the Trust dashboard (as of 08/08/19). This information is based on the 'annual turnover' which counts the number of leavers over the last 12 months and divides by the average headcount for the last 12 months.

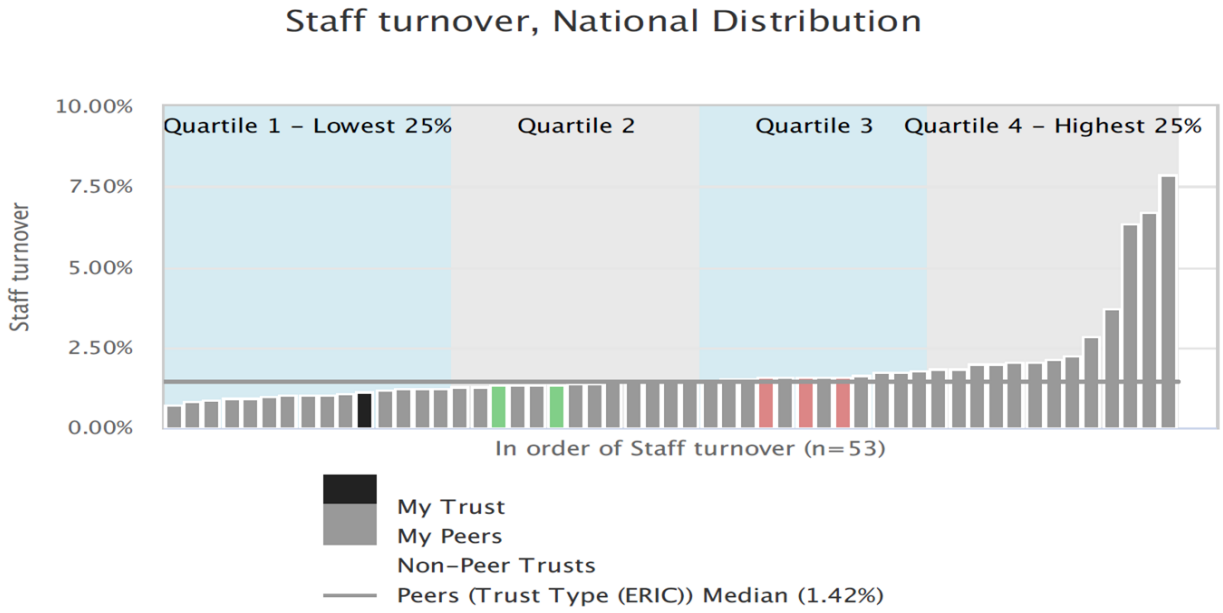


Instead of annual turnover the Model Hospital uses 'monthly turnover' rate. The monthly turnover rate shows the number of leavers for the month divided by average headcount for previous 12 months. This information has been calculated by People Services and is presented in the graph below. The percentages fluctuate between 0.47% and 1.26%.



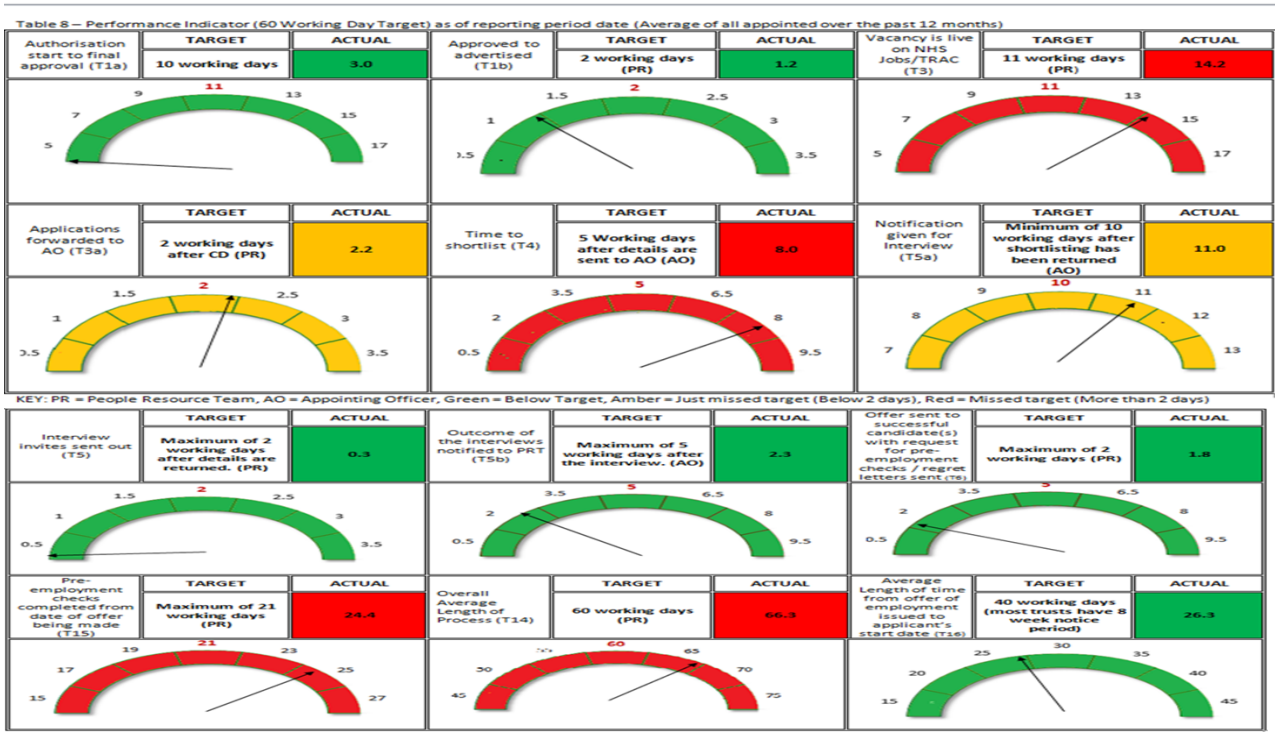
The graph below shows the benchmark information from the Model Hospital for monthly turnover. For March 2019 it is reporting the Trust at 1.14% against a peer median of 1.42% and national median of 1.44%.

Benchmarking for monthly staff turnover



The data indicates a steady turnover rate that is comparatively lower than other trusts.

Recruitment to vacancies is an associated aspect is being progressed by the programme and a dashboard is established to monitor performance in this area.



It suggests recruitment across the entire process is currently taking an average of 66 days on a target of 60 days. Within the data it is identified where the areas of focus

are and these are time taken to shortlist and pre-employment checks which are areas of focus in the programme activity.

Improved support and sickness management training

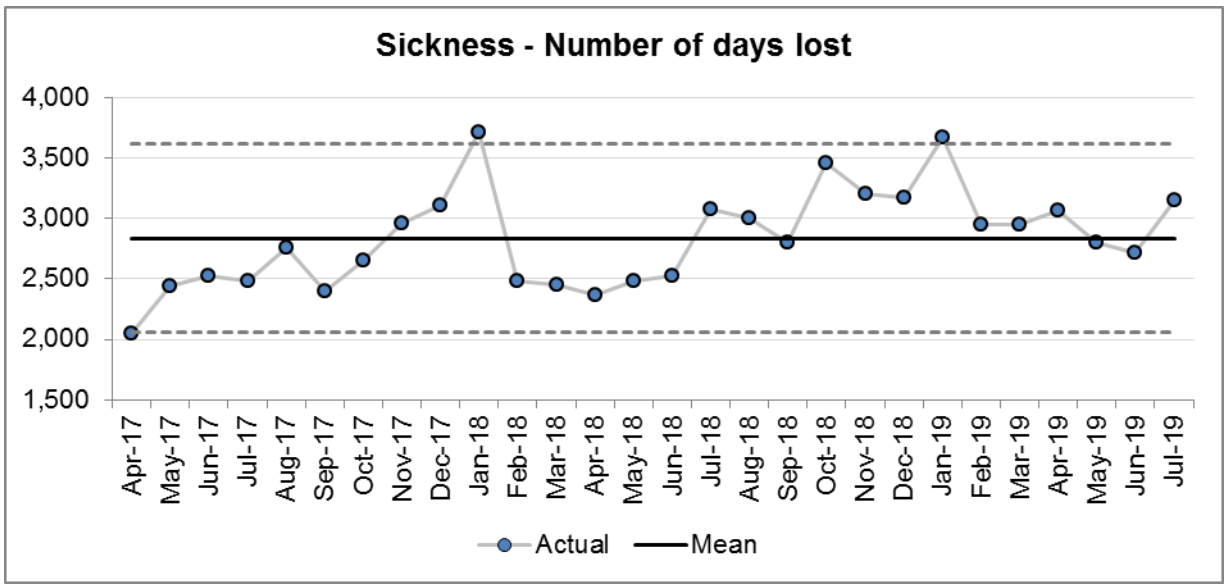
There are a range of training and development to support core managers in being effective leaders and manager in the management of staff, including sickness management and these are incorporated into the programme of work looking at wellbeing.

In our leadership and management masterclasses we have conversations about how to apply policy compassionately and 'giving permission' to core leaders to change the way things have historically been approached.

Significantly, the Trust has invested £100k in an improved 'wellbeing offer' including rapid access to on site counselling to support colleagues to remain at work or have more support resulting in a shorter absence.. The staff wellbeing and support offer for example has been revised in 2019 and current levels of take up indicate 64 staff have used it between April and June this year compared 14 staff for the whole of last year. This is in line with a target trajectory of 10% of the organisation. Metrics being monitored in the programme are establishing the link between this uptake and reduced average duration of sickness absence.

Sickness absence

The chart below shows the number of days lost to sickness each month during the last 16 months (as reported through Firstcare).



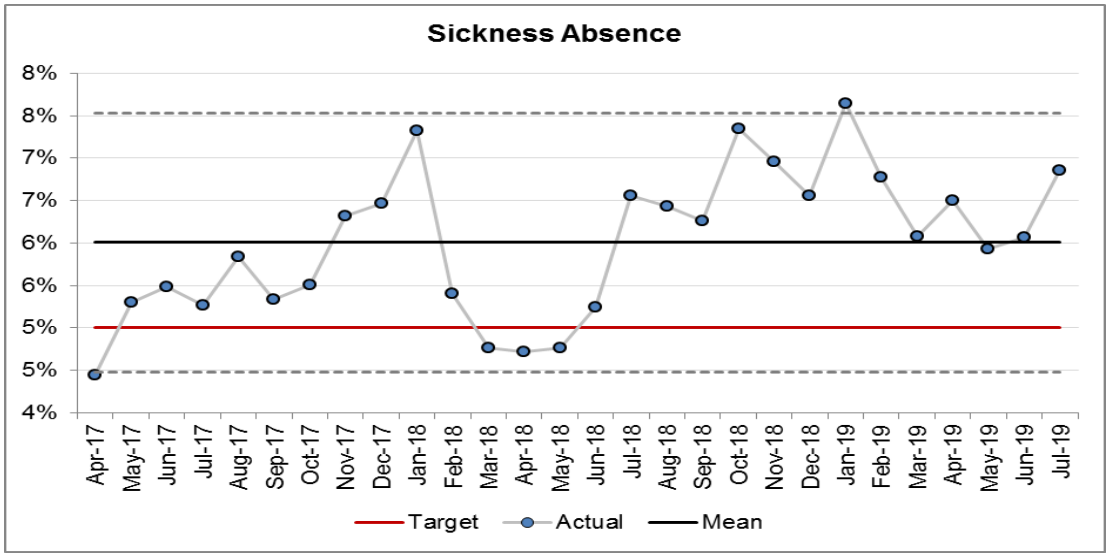
The least is 2,368 in April 2018 and the highest is 3,667 in January 2019. This is the same profile as the previous year with the least of 2,049 days lost in April 2017 and the highest of 3,715 days in January 2018.The average daily cost of our workforce is c£115 per person per day. Losing 2,368 days would equate to £272k in that month and losing 3,667 days would equate to £422k in that month. Between April 18 and March 19 we lost 35,671 days (32,049 in 2017/18) to sickness costing something like £4.1m. This is calculated using the average cost of one person and not including the additional cost of backfill. **There has been an 11% increase in the number of days**

lost between 2017/18 and 2018/19. Between April 19 and July 19 we have lost 11,735 days year to date (£1.4m), an average of 2,934 days per month.

WTE have increased between 2017/18 and 2018/19 from 2181.56WTE to 2266.48 (3.9%).

Carter says mental health providers lose on average an extra two days per staff member per year to sickness. With an approximate number of staff of 2,500 with an average cost per day of £113; if we could improve by an average of two days per worker not lost to sickness this would save £600k a year.

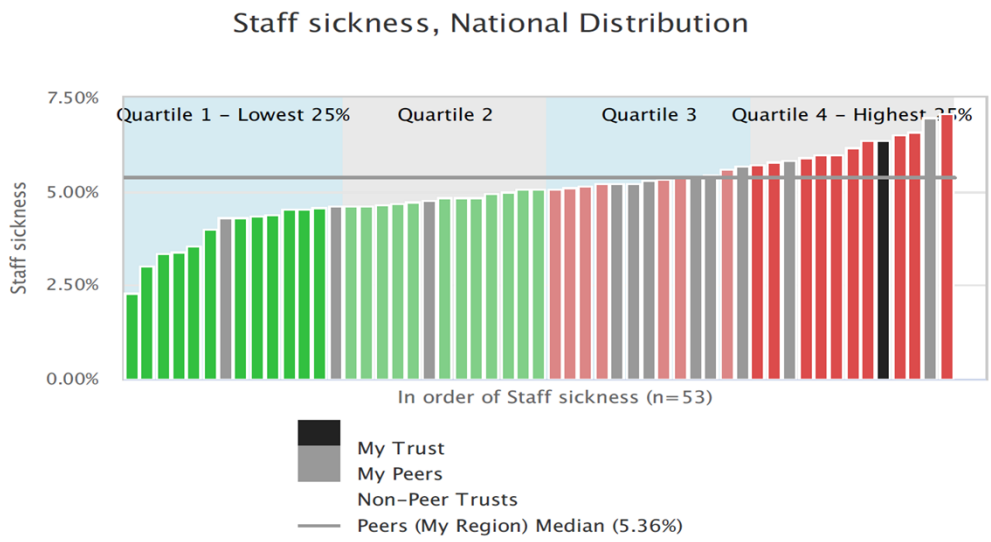
In terms of % rates and trends, the following information is taken from the Trust dashboard (as of 08/08/19).



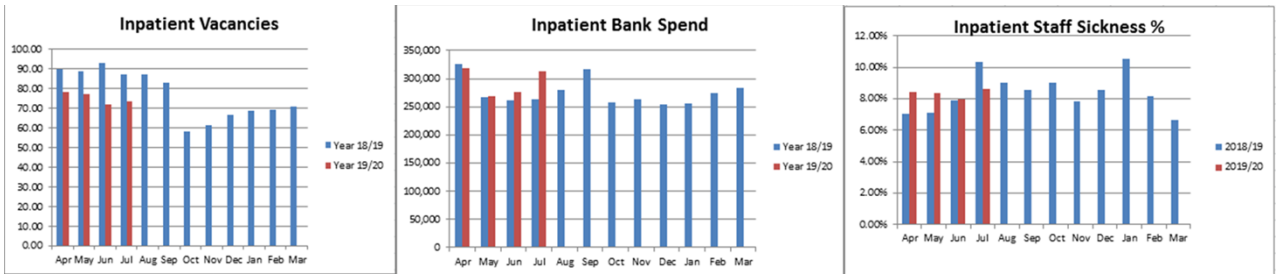
The chart above shows that our current sickness levels are higher than the same time period the previous year.

The chart below from the Model Hospital is based on data as at *February 2019* and shows that the Trust at 6.34% compared to the national median of 5.06% and peer median of 5.36%.

Benchmarking for staff sickness



Alongside recruitment and retention and training and support for managers, the wider wellbeing programme monitors sickness and absence and use of flexible staffing solutions as an indicator of improved performance in those areas and as a direct impact on organisational cost. The cost improvement aims of the work seek a year on year reduction in expenditure on flexible staffing resources of £279k and a dashboard and a PDSA cycle of improvement is established to monitor and manage.



The dashboard shows that despite a reduction in vacancies, bank expenditure and sickness absence has increased year on year. The actions within sickness management as highlighted are expected to impact from quarter 3 and are phased as such in the plan. Month 4 shows the first year on year reduction in inpatient sickness and the programme will monitor as the actions take effect. In the next phase of the work it is recognised that £279k reduction over 6 months equates to a circa £0.5m full year effect and this will be explored in the aims for 2020/21.

E-Rostering

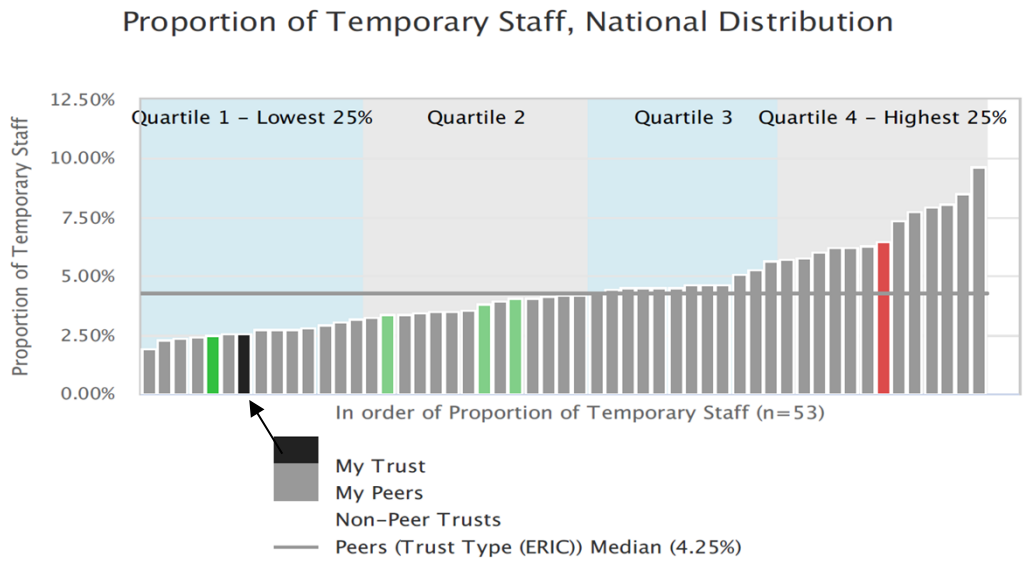
As part of the recommendations from the 'NHS operational productivity: unwarranted variations in mental health and community health services' review there was a recommendation that 'all community and mental health trusts should use an effective e-rostering system and set up formal processes to tackle areas of rostering practices that require improvement'. Carter found that there is scope for significant

improvements to better manage unused hours, approve rosters six weeks in advance and reduce spend on bank and agency staff for example.

Generally, the use of all kinds of temporary staffing, whether bank, agency or overtime, features highly in our efficiency programme and is one of the main objectives of the e-rostering project.

With regard to agency in particular the Trust has made excellent progress in reducing agency expenditure from c£5m in 16/17 to under £3m in 18/19 and forecast to remain under the ceiling of £3m in 2019/20. In terms of the measure of agency spend as % of total pay costs the Trust now benchmarks well (see following chart)

Benchmark: May 2019 - **Agency** temporary staff costs (as defined in measuring performance against the provider's cap) as a proportion of total staff costs



The Trust does have an E-rostering system already across all in-patient units but it is not as yet working to optimise use of resources.

A detailed and lengthy project to optimise e-rostering in inpatient areas is now in consultation phase with staff, with an expectation of rollout in quarter 4 for full year effect from April. It is expected that a fully functioning, managed electronic roster will optimise effective deployment of inpatient staff, ensuring adherence to costed establishment and resulting in better working environment, fewer absences and less reliance on flexible staffing solutions. This will be monitored through use and expenditure of bank staff (as above) and monthly budget management.

In 2019/20 the impact of the e-rostering scheme was deferred as non-recurrent cost improvement with the recurrent impact being accounted for in 2020/21.

Ahead of full rollout, the adult acute inpatient areas are adopting the principles of good electronic rostering including rostering to a 12 week window to improve longer-term workforce planning, allowing expected leave and absence to be better planned for.

The workforce approach also includes developing a medical job planning / e rostering IT system. This is in scoping and expected to progress to planning phase in September.

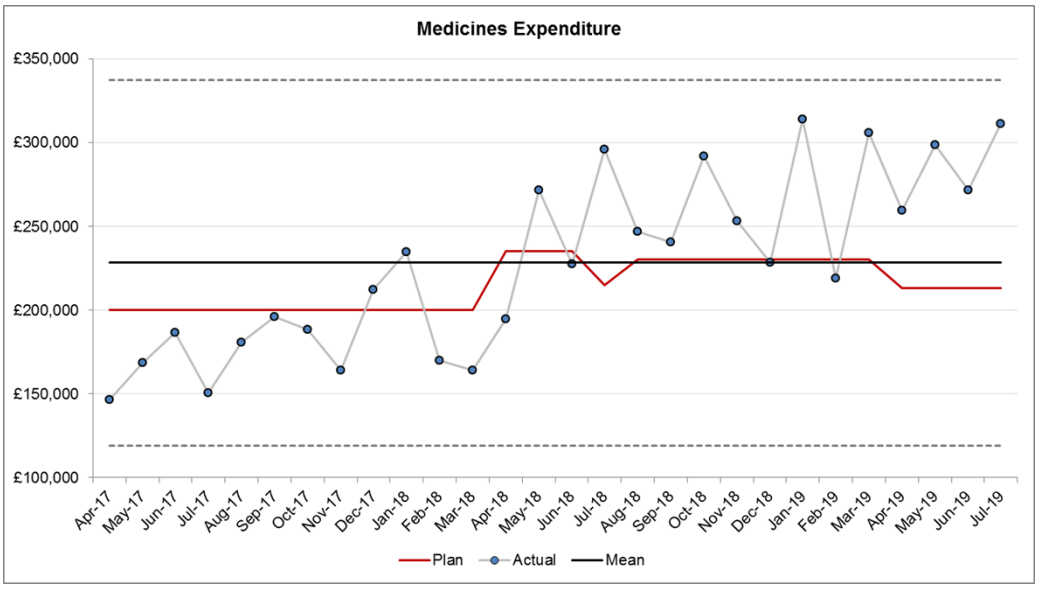
In summary, in terms of optimising clinical resources Carter recommends developing measures for analysing workforce deployment, using effective rostering, reviewing job planning to ensure the right doctor is available at all times using effective and comprehensive job planning and rostering as well as identifying any improvements in clinical efficiency and productivity. In addition he highlighted medicines and pharmacy optimisation as key to enable pharmacy staff to spend more time with patients and on medicines optimisation which is covered later in this report.

2.3 Clinical Support services: How effectively is the trust using its clinical support services to deliver high quality sustainable services for patients?

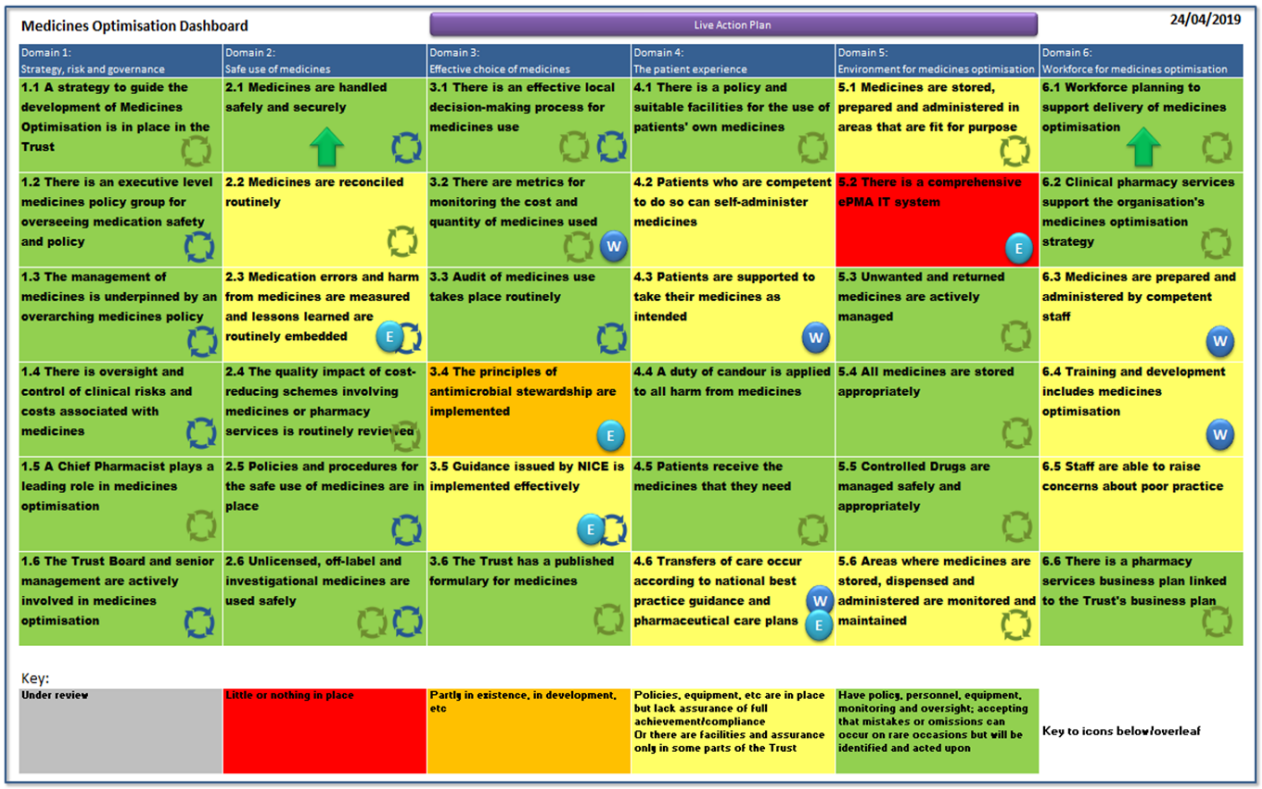
Medicine Costs

This information is not yet reported on the Model Hospital website, although this is an area of development and the compartments are set up but they contain no data.

Therefore the cost for this measure is taken from the financial ledger. The costs reported in the table below are after any recharges that are made which are income backed. The quarterly figures for 2018/19 are based on the average for that period.



These values are clearly a function of cost, volume and prescribing choices. In order to support deeper understanding of this area the Chief Pharmacist has developed interactive dashboards reported at Trust Management Team, examples are shown below.

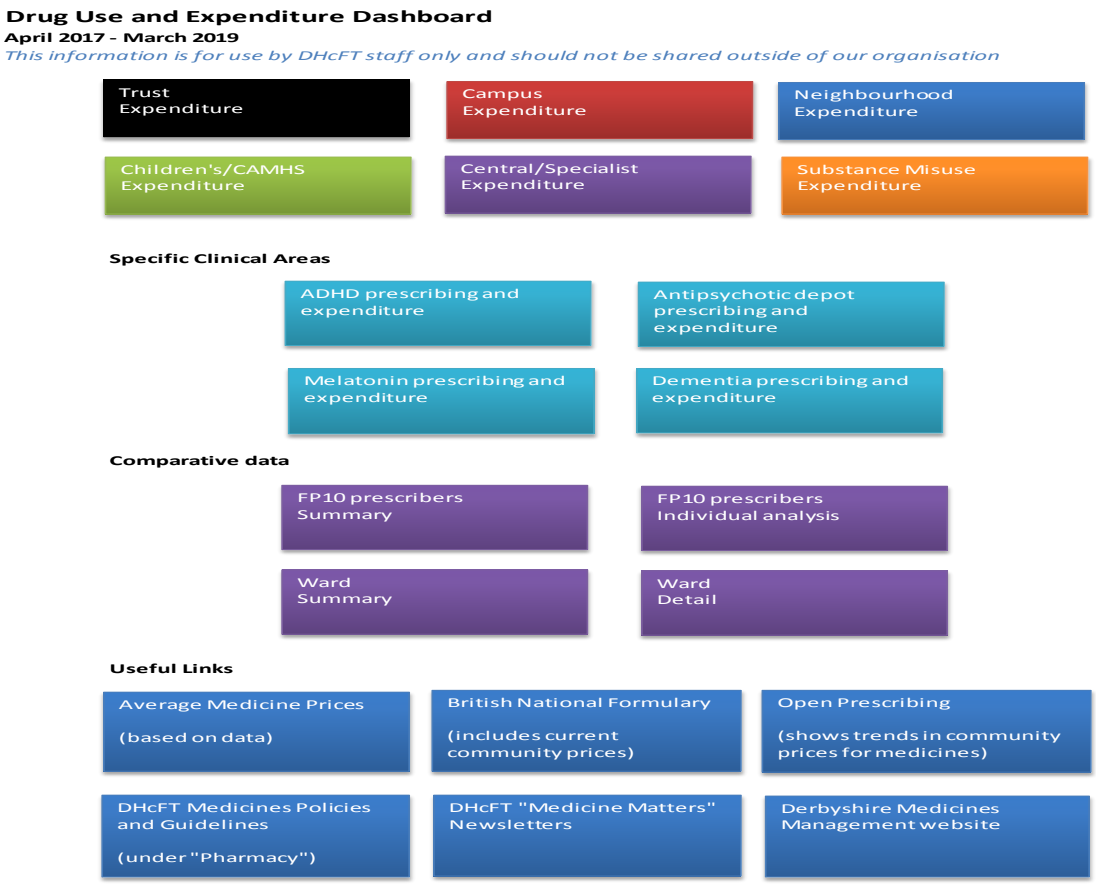


Medicines Optimisation Dashboard — Live Action Plan — 24/04/2019

Domain 1: Strategy, risk and governance	Domain 2: Safe use of medicines	Domain 3: Effective choice of medicines	Domain 4: The patient experience	Domain 5: Environment for medicines optimisation	Domain 6: Workforce for medicines optimisation
1.1 A strategy to guide the development of Medicines Optimisation is in place in the Trust	2.1 Medicines are handled safely and securely	3.1 There is an effective local decision-making process for medicines use	4.1 There is a policy and suitable facilities for the use of patients' own medicines	5.1 Medicines are stored, prepared and administered in areas that are fit for purpose	6.1 Workforce planning to support delivery of medicines optimisation
1.2 There is an executive level medicines policy group for overseeing medication safety and policy	2.2 Medicines are reconciled routinely	3.2 There are metrics for monitoring the cost and quantity of medicines used (W)	4.2 Patients who are competent to do so can self-administer medicines	5.2 There is a comprehensive ePMA IT system (E)	6.2 Clinical pharmacy services support the organisation's medicines optimisation strategy
1.3 The management of medicines is underpinned by an overarching medicines policy	2.3 Medication errors and harm from medicines are measured and lessons learned are routinely embedded (E)	3.3 Audit of medicines use takes place routinely	4.3 Patients are supported to take their medicines as intended (W)	5.3 Unwanted and returned medicines are actively managed	6.3 Medicines are prepared and administered by competent staff (W)
1.4 There is oversight and control of clinical risks and costs associated with medicines	2.4 The quality impact of cost-reducing schemes involving medicines or pharmacy services is routinely reviewed	3.4 The principles of antimicrobial stewardship are implemented (E)	4.4 A duty of candour is applied to all harm from medicines	5.4 All medicines are stored appropriately	6.4 Training and development includes medicines optimisation (W)
1.5 A Chief Pharmacist plays a leading role in medicines optimisation	2.5 Policies and procedures for the safe use of medicines are in place	3.5 Guidance issued by NICE is implemented effectively (E)	4.5 Patients receive the medicines that they need	5.5 Controlled Drugs are managed safely and appropriately	6.5 Staff are able to raise concerns about poor practice
1.6 The Trust Board and senior management are actively involved in medicines optimisation	2.6 Unlicensed, off-label and investigational medicines are used safely	3.6 The Trust has a published formulary for medicines	4.6 Transfers of care occur according to national best practice guidance and pharmaceutical care plans (W) (E)	5.6 Areas where medicines are stored, dispensed and administered are monitored and maintained	6.6 There is a pharmacy services business plan linked to the Trust's business plan

Key:

Under review	Little or nothing in place	Partly in existence, in development, etc	Policies, equipment, etc are in place but lack assurance of full achievement/compliance Or there are facilities and assurance only in some parts of the Trust	Have policy, personnel, equipment, monitoring and oversight; accepting that mistakes or omissions can occur on rare occasions but will be identified and acted upon	Key to icons below/overleaf



Drug Use and Expenditure Dashboard

April 2017 - March 2019

This information is for use by DHcFT staff only and should not be shared outside of our organisation

Trust Expenditure

Campus Expenditure

Neighbourhood Expenditure

Children's/CAMHS Expenditure

Central/Specialist Expenditure

Substance Misuse Expenditure

Specific Clinical Areas

ADHD prescribing and expenditure

Antipsychotic depot prescribing and expenditure

Melatonin prescribing and expenditure

Dementia prescribing and expenditure

Comparative data

FP10 prescribers Summary

FP10 prescribers Individual analysis

Ward Summary

Ward Detail

Useful Links

Average Medicine Prices (based on data)

British National Formulary (includes current community prices)

Open Prescribing (shows trends in community prices for medicines)

DHcFT Medicines Policies and Guidelines (under "Pharmacy")

DHcFT "Medicine Matters" Newsletters

Derbyshire Medicines Management website

The 'Medicines Optimisation Dashboard' is action-focused across the 6 key domains of medicines optimisation: strategy; safety; choice; experience; environment; workforce. Its aim is to address the difficulty in presenting meaningful and digestible information about medicines management and medicines optimisation. These are

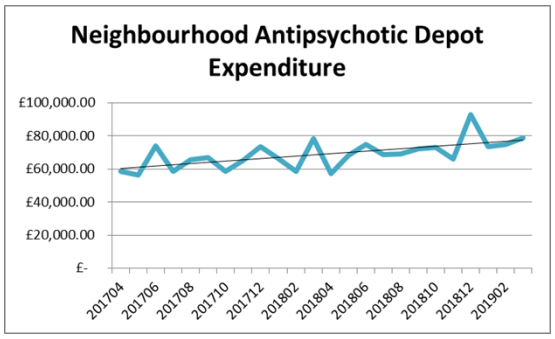
subjects that have historically been challenging to make relevant to non-pharmacists and to share widely. The fundamental need to be addressed was to unambiguously explain medicines optimisation as being the business of the whole organisation and not something that pharmacy could manage alone or in isolation.

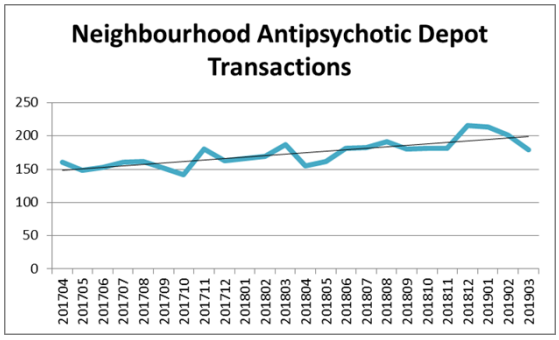
The dashboard is a whole workbook approach to managing information and actions, divided into 36 criteria within 6 domains as defined in a 2014 paper by the then NHS Trust Development Authority. Detailed information sits “behind” the dashboard’s front page and can be easily navigated or used to efficiently and consistently create reports and updates for key Trust managers and committees.

To date, the MOD has helped to identify key themes that affect progress in multiple criteria. Among these are the difficulty in effectively creating and implementing policies and the lack of an implemented ePMA IT system across the main clinical services of the organisation. The last set of information was reported to TMT in June 2019.

The Drug Use and Expenditure Dashboard indicates an increasing expenditure trend linked to increased demand in Children’s and Neighbourhood services. And in campus areas for example, there is new and increasing demand for use of inhalers and nicotine replacement as well as an alternative anti-coagulant.

Psychosis medication is by far the largest contributor to medicine expenditure and dashboard metrics show correlation between increased expenditure and increased demand.





E Prescribing

As part of the recommendations from the Carter review it was found that Pharmacy services are ‘underused in both community and mental health services’. It highlights opportunities including the implementation of electronic prescribing and medicines administration.

The Trust is keen to develop electronic prescribing and medicines administration (ePMA) IT system as soon as it is able in the near future. This will present a strong opportunity to understand how best to improve use of these resources (there is partial use of e-prescribing in substance misuse services and children’s services).

2.4 Corporate Services, procurement, estates and facilities: How effectively is the trust managing its corporate services procurement, estates and facilities to maximise productivity to the benefit of patients?

For corporate services as a whole, Carter highlights that mental health trusts operate smaller corporate entities and the spend in this area does tend to benchmark higher than other organisations therefore report advises that trusts consider the most appropriate scale of their business functions.

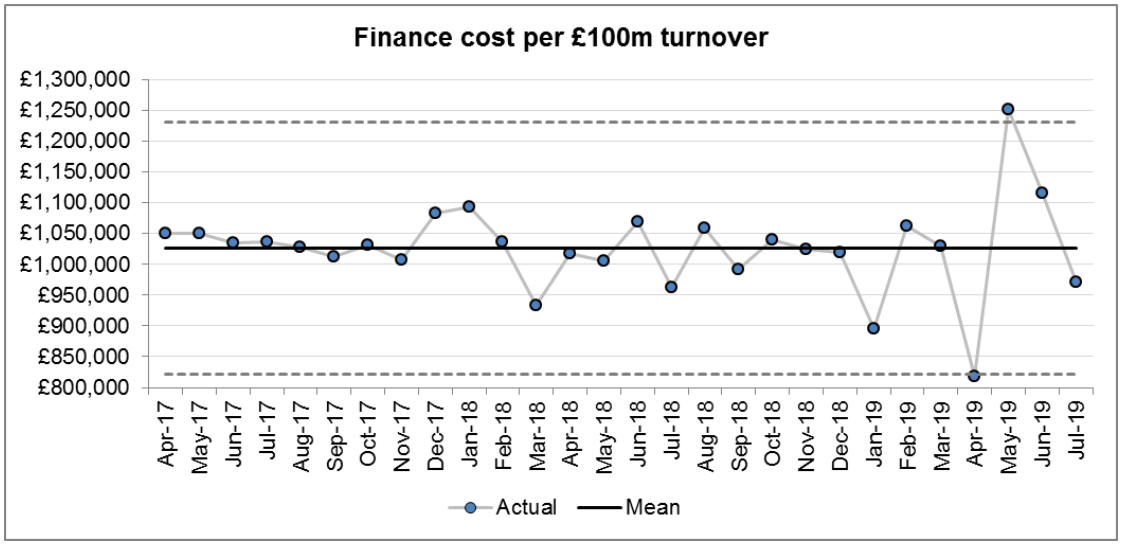
Carter advises that there is clear efficiency of scale with larger organisations spending less on corporate services as a proportion of turnover and suggests collaboration to standardise and share corporate services especially for smaller trusts.

Finance and HR cost per £100m turnover

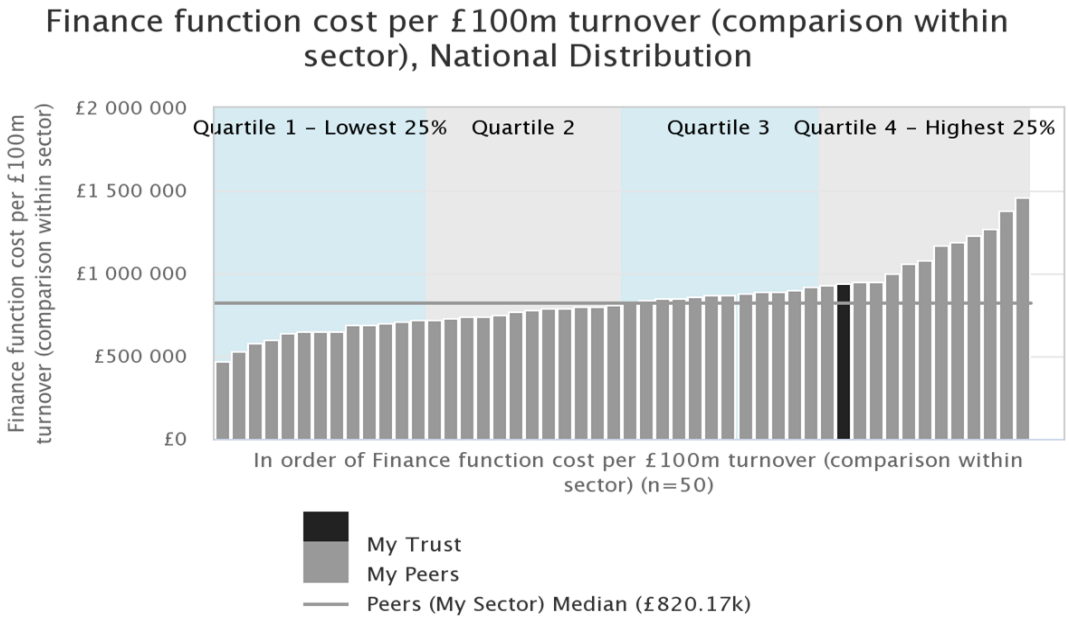
The above two measures are taken from the NHSI Corporate benchmarking exercise and are also included on the Model Hospital website. The most recent set of data relates to 2017/18 as we have only just submitted the corporate benchmarking information in July for 2018/19. However as this exercise is only done once a year for the benchmarking return a more simple calculation for 2018/19 and 2019/20 is included in this report as well.

The costs for the two measures covering 2018/19 and 2019/20 are taken from the financial ledger for the Finance Department and the People Services Team. The benchmarking return includes other teams within the 'Finance' label benchmark such as the Contracting and Transformation Teams. It also includes costs for audit and SBS which may differ from other trust's submissions and lead to non-like for like comparison. This will be explored in the model mental health hospital benchmarking programme as discussed earlier in the report.

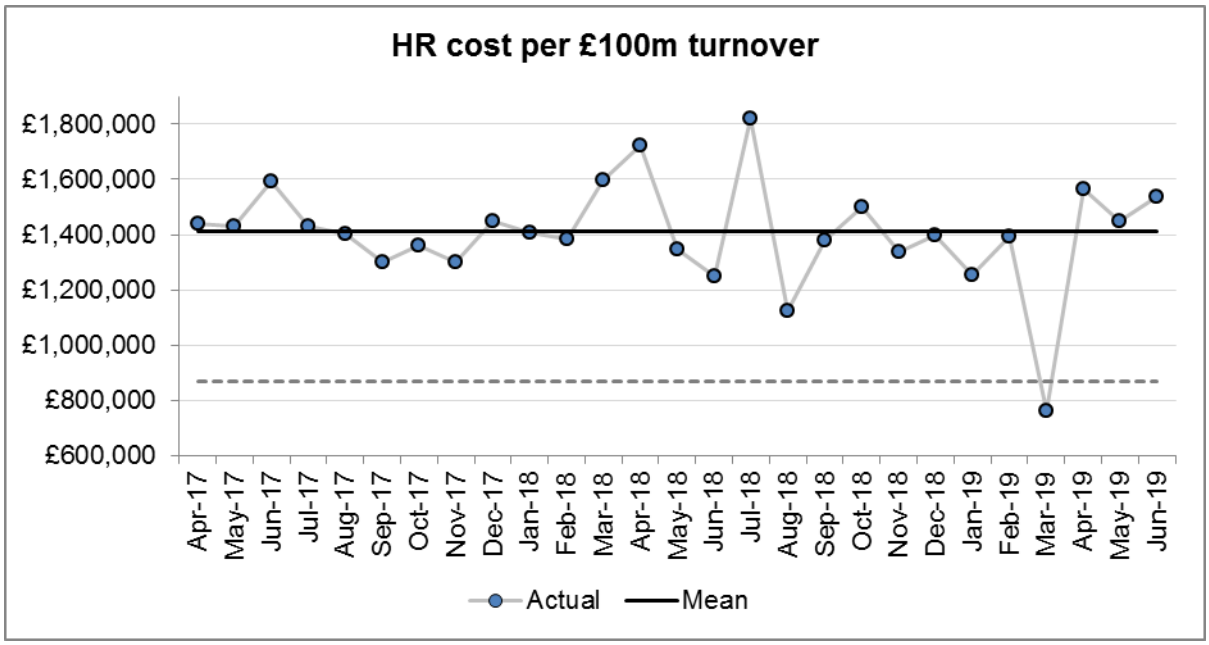
Finance Costs



The corporate benchmarking from 2017/18 reports the Finance cost per £100m turnover at £942k (£951k 2016/17) against a median of £820k (peers in sector) and a national median of £715k.

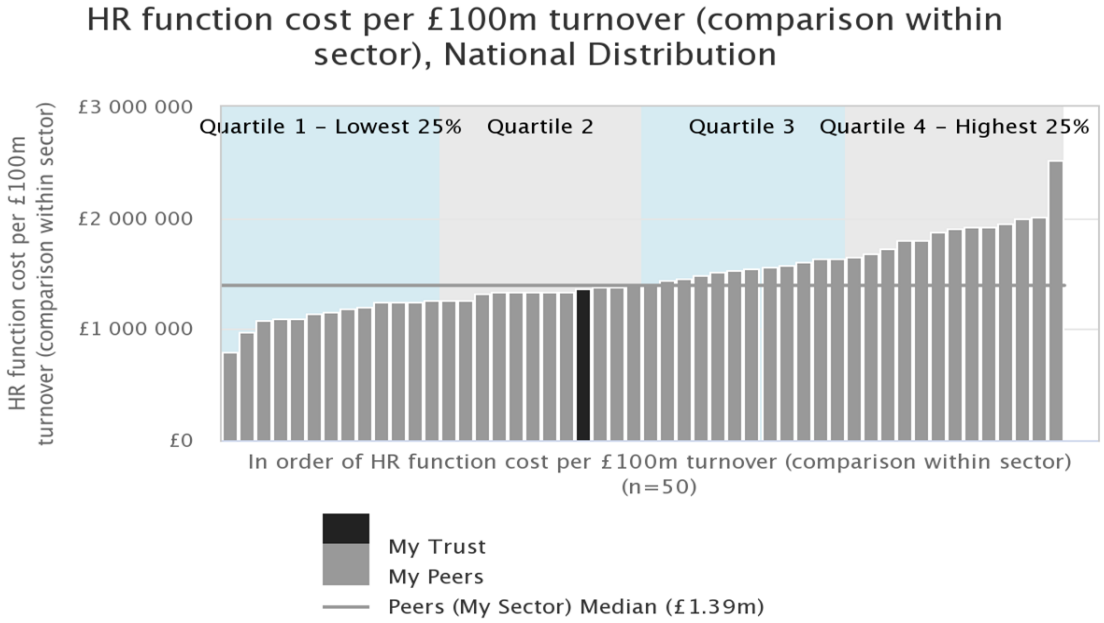


Human Resources costs



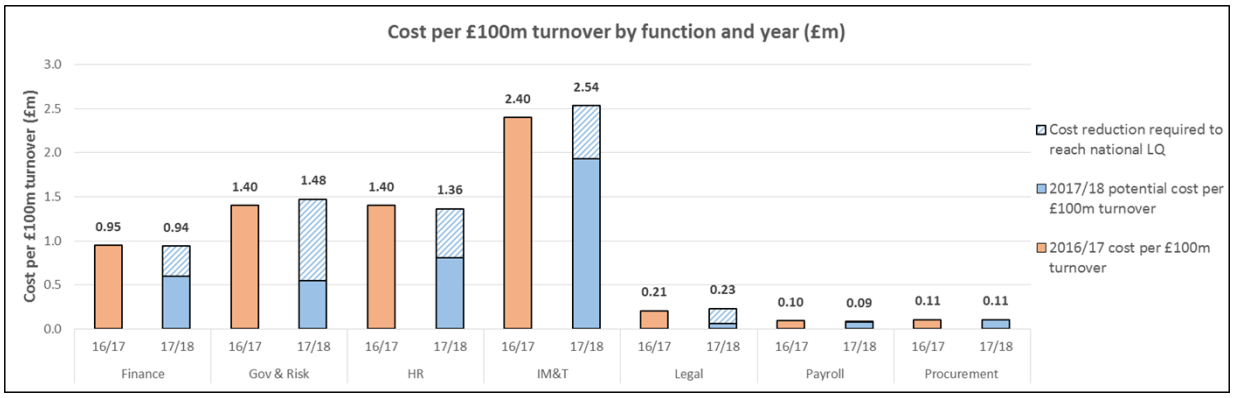
There was a dip in costs in March which is mainly due to benefit share from the Joint Venture.

The graph below is taken from the Model Hospital which is based on the submitted corporate benchmarking information from 2017/18. The Median is at £1.39m (peer sector) with our Trust below that at £1.36m per £100m turnover (2016/17 £1,404k). The national median is £1.09m.



Overall Corporate benchmarking opportunities

The 2017/18 corporate benchmarking exercise is available on the Model Hospital. The summary results are shown in the graph below for the different corporate functions with the comparison to the previous year's results.



The graph illustrates the differences in cost per £100m turnover that could be achieved if we reached the lowest quartile for each of the functions

The top four biggest opportunities identified by the Model Hospital on 17/18 info are:

- Governance and Risk with costs of £1.48m per £100m turnover – opportunity to national median is £942k or to the national best quartile is £1.29m
- IM&T with costs per £100m turnover of £2.54m – opportunity to national median is £693k or £1.18m to the national best quartile
- HR with costs per £100m turnover of £1.36m – opportunity to national median of £376k or £773k to national best quartile

- Finance with costs per £100m turnover of £942k – opportunity to national median is £316k and £479k to national best quartile.

Back office discussions continue within the STP which could lead to further opportunities when current contracts are due to expire.

Procurement Process Efficiency

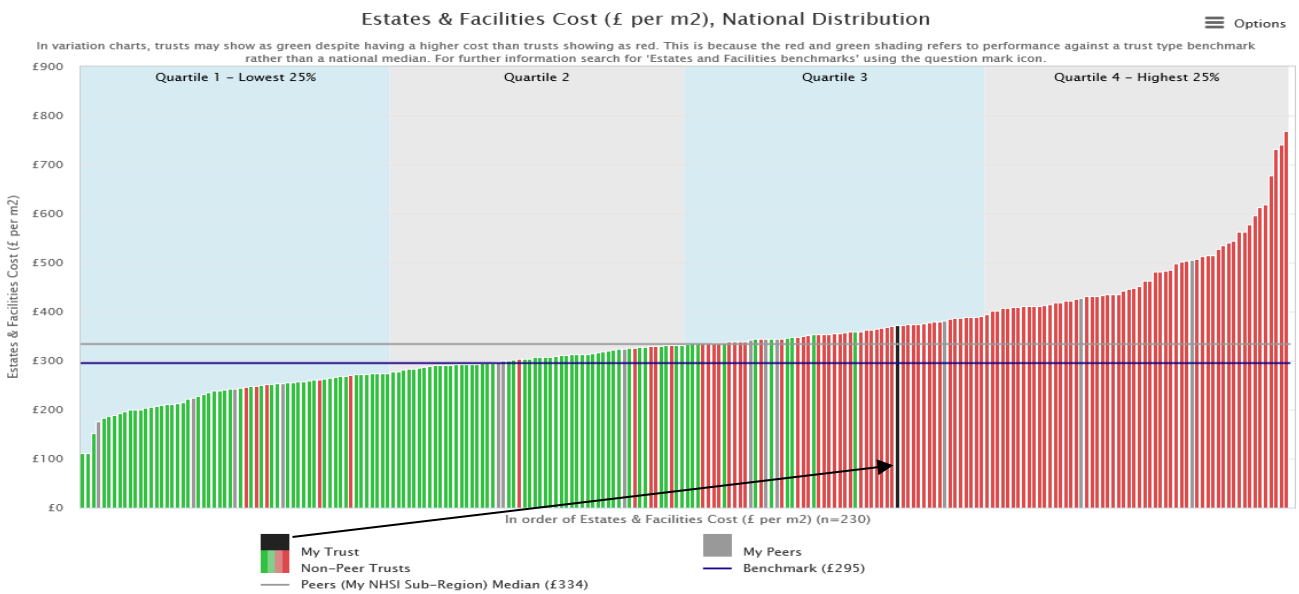
At the time of the last report there were several procurement metrics that were published on the Model Hospital website under Purchase Price Index and Benchmarking (PPIB). This information is no longer included on the Model Hospital site. NHSI have replaced the Purchase Price Index Benchmarking tool with another system which is due to go live on 1 August 2019.

Estates costs

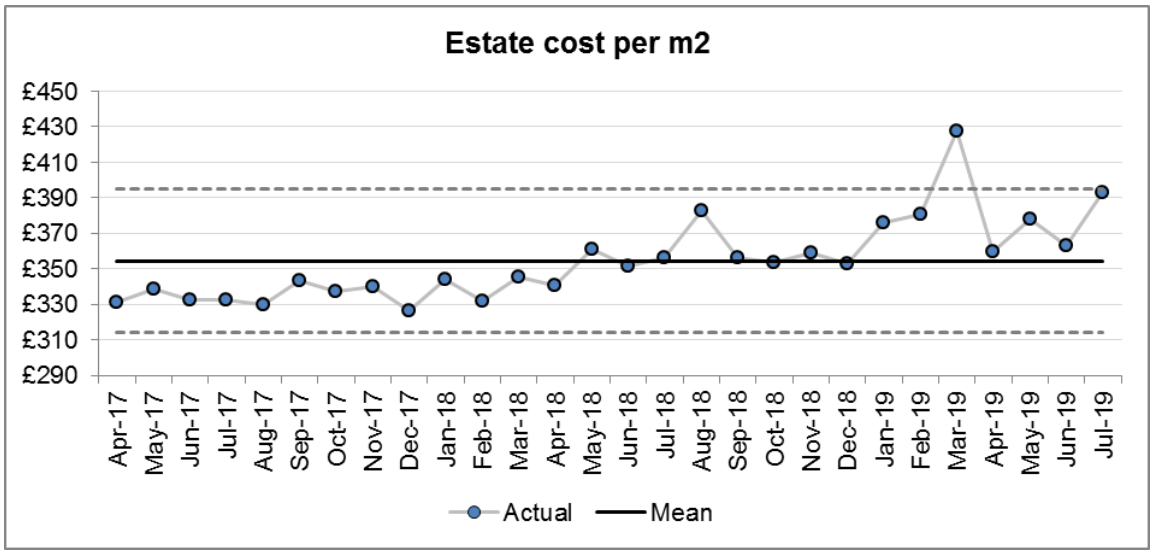
The information reported on the Model Hospital site (latest relates to 2017/18) is based on the information submitted through the Estates Return Information Collection (ERIC) return. This has recently been completed and submitted for 2018/19.

In 2017/18 our estate costs were £372 per m2 (£386 in 2016/17) against a benchmark of £304 per m2.

<u>Benchmarking EFM costs per m2 for 2017/18</u>



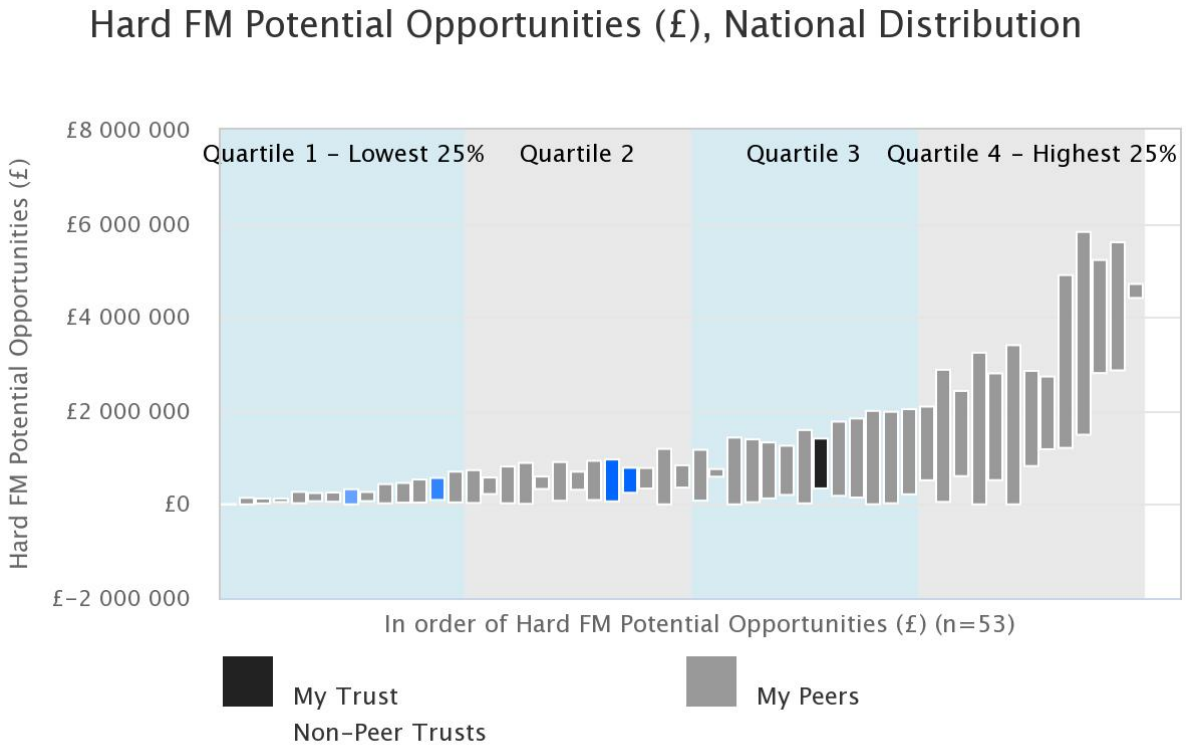
The chart below tries to replicates similar information.



The Model Hospital highlights Estates and Facilities as an opportunity for us, with an estimated productivity gain of between '£0.3m and £1.7m'.

The 3 metrics they identify that provide us with opportunities are:

- Hard FM potential opportunities – see graph below
- Amount of under-utilised space
- Soft FM potential opportunities – *however when you drill down through the Model Hospital information it shows our average cost of £81 per m2 compared to the benchmark of £86 per m2 and peer median of £115 per m2.*



The mental health model hospital benchmarking data will inform the trust work on the sustainable development management plan (SDMP) and associated self-assessment against the standard within each of the 10 focus areas.

A delivery group for the SDMP is commencing in September and in this phase will particularly consider use of estate on the Kingsway site as well as systems for booking clinical space. A decision was made not to start in August as room use monitoring equipment may return false low returns due to higher than usual annual leave.

Carter highlighted better succession planning, improved sustainability and energy consumption along with addressing empty and underutilised estate. It suggests rationalising estate within the STP footprints. We have PFI buildings, two empty older adult wards as well as heavily over-occupied adult acute wards with dormitory stock.

The Trust's new estate strategy is in development and will look to address several key priorities not least the removal of dormitories which will be a very large undertaking and require new build to address fully. The strategy will also consider the wider implications on the development of single rooms on acute inpatient capacity as well as interdependencies and interface with the acute OOA work within the sustainable inpatient plan. ; the longer-term developments for PICU, rehabilitation provision; wards 1 and 2 and wider Derbyshire-wide STP estate plans.

The Board should note that the significant capital investment as well as revenue costs related to these changes will of course impact on the ERIC and benchmarking figures in the future

In addition, separate schemes are at various stages of progress which come under the SDMP scope such as reducing journeys and mileage and alternatives to car use which positively impact mileage expenses, parking costs and availability and staff wellbeing.

2.5 Finance: How effectively is the trust managing its financial resources to deliver high quality sustainable services for patients?

Finance Score

The high level Finance Score information is generated each month from the monthly returns sent to NHSI. This score is reported in the Regulatory dashboard to the public board meeting. This information is also published on the Model Hospital website.

	2017/18	2018/19	Apr-19	May-19	Jun-19	Jul-19
Capital service cover rating	1	2	2	2	2	2
Liquidity rating	1	1	1	1	1	1
I&E margin rating	1	1	1	1	1	1
I&E margin: distance from financial plan	1	1	2	2	1	1
Agency rating	2	1	1	1	1	1

The Trust has historically achieved satisfactory outcomes in terms of overall financial year end outturn. But within that overall performance there has been considerable variance in actual income and cost compared to initial planning expectations. We have also experienced increasing difficulty meeting recurrent cost improvement requirements. These factors cannot be appreciated from the high level summary metrics in the table above.

The capital service capacity measure is our worst score and is affected by having PFI as a liability and so would require a much larger surplus to pass the threshold for a score of 1.

We had anticipated a very different approach to financial performance with the revised financial framework including a move towards breakeven, not surplus, being the target/norm. As yet though NHSI performance metrics are unchanged

In essence, our overall financial sustainability will be driven by issues such as:

- The successful delivery of productivity and quality improvement;
- Risk management
- Long term recurrent CIP/efficiency delivery
- Successful contracting and capital bid outcomes (and addressing all the capital and revenue consequences of the estate strategy)
- STP system collaborative working
- Robust income streams (in a payment system that fairly that reimburses for demand and activity.

Benefits realisation

The Trust strategy points to the need for us to be able to assess how well we achieve best value and assess benefits from current and future investment.

With regard to schemes and improvement ideas developed over the last two years it is sometimes difficult to conclude how well some of these schemes have realised the benefits they set out to do. There is a piece of work taking place in September and October to establish the findings and report back on realised benefits within this group of schemes.

Going forward new ideas and schemes will fall into an established quality improvement methodology rooted in measurement and PDSA (Plan, Do, Study, Act), a recommended approach of NHSI. The transformation team will support this process providing guidance in this and other tools as appropriate and maintain oversight for interdependency, learning and reporting purposes.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 September 2019

Freedom to Speak Up Guardian (FTSUG) – half yearly report

Purpose of Report

This paper is a half yearly report to the Foundation Trust Board of Directors to ensure the Board is aware of Freedom to Speak Up (FTSU) cases within the Trust, an analysis of trends within the organisation and actions being taken.

Executive Summary

This report sets out a summary of the concerns raised in the last six months with the FTSU Guardian.

The two emerging themes are:

- The need for a compassionate and supportive response where staff have been assaulted by patients. The Trust is developing a serious incident staff resource and this will allow the FTSUG to support staff affected and also ensure that there is learning around responses to serious incidents.

- Ongoing concerns around bullying and harassment. Awareness training on Bullying and Harassment will be delivered by the FTSUG to FTSU Champions to support staff to act when there are concerns of this nature. A bullying and harassment booklet produced by Trust staff is being used as a resource by the FTSUG and this has been well received.

The report also contains a comprehensive list of actions taken to improve visibility and promote FTSU to ensure that the FTSU Culture is continuously improved.

The National Guardian's Office (NGO) has recently written to all Chairs and Chief Executives with guidance around the development of a FTSU training programme that should be on a par with other mandatory training, for all workers.

The FTSUG is currently working with the Trust's Organisational Development Team to develop a tiered training programme. Training for FTSU Champions is scheduled for 10 October 2019. The development of the FTSU champions network will support workers to raise their concerns as the earliest opportunity as well signposting workers to the FTSUG for advice and guidance.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	X
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	X
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	

Risks and Assurances

Reporting on concerns raised is presented to the Trust Board six monthly and to the Audit and Risk Committee six monthly going forwards to provide assurance on progress made. The People and Culture Committee also receive the issues as part of the wider staff feedback.

The Board undertook a self-review of FTSU using the NHSI toolkit in 2018. The areas for development have been regularly monitored by the Audit and Risk Committee. The toolkit provides a benchmark and assurance that our work to promote and respond to raising concerns and speaking up at work is progressing. The toolkit was revised in July 2019 and the Board will carry out a self-review again in March 2020.

There are a number of risks to having a culture where staffs do not feel able to safely voice their concerns. There are potential impacts on patient safety, clinical effectiveness and patient and staff experience, as well as possible reputational risks and regulatory impact.

Consultation

None.

Governance or Legal Issues

Trusts are required to have a FTSUG as part of NHS standard contract terms and conditions.

Public Sector Equality Duty & Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

The report discusses Bullying and Harassment including discrimination faced by staff with protected characteristics who have approached the FTSUG. These cases are not yet substantiated but are now being looked after by Employee Relations. Direct work with the Trust's Equality, Diversity and Inclusion Staff Network Groups to promote the FTSU role will help support all workers who are facing Bullying and Harassment concerns.

Recommendations

The Board of Directors is requested to:

1. Discuss and note the content of the paper.
2. Support the roll out of Speaking Up / Raising Concerns training, including an in-house e-learning module for all workers.
3. Support the development of a Speaking Up Strategy which will be shared with key stakeholders, discussed and agreed by the Board, and is linked to or embedded within other relevant strategies
4. Support the current mechanisms and activities in place for raising awareness of the FTSU agenda.

Report presented by: **Tamera Howard**
Freedom to Speak Up Guardian

Report prepared by: **Tamera Howard**
FTSUG with support from

Justine Fitzjohn
Trust Secretary

Freedom to Speak Up Guardian Report

1. Introduction

1.1 The Freedom to Speak Up Guardian (FTSUG) is part of a culture of speaking up but also develops cultures where safety concerns are identified and addressed at an early stage. Freedom to Speak Up has three components: improving and protecting patient safety, improving and supporting worker experience and visibly promoting learning cultures that embrace continual development.

1.2 The Care Quality Commission assesses a Trust's speaking up culture under the Well-Led domain of its inspections.

1.3 The report covers January to June 2019; Quarter 4 2018/19 and Quarter 1 2019/20. Reporting is on a six-monthly basis.

1.4 The Trust had a changeover of FTSUG at the end of April 2019.

2. Aim

2.1 This report aims to provide the Board with:

- an understanding of concerns and trends identified from January to June 2019
- any emerging themes and areas for learning and improvement
- action taken to improve the FTSU culture in the Trust, including progress in the promotion of the FTSUG role and addressing barriers to speaking up
- updates from the National Guardians Office (NGO)
- key recommendations

3. Summary of concerns raised

3.1 Concerns are categorised in accordance with the NGOs guidance and recorded by service area. The NGO requires concerns relating to Patient Safety and Bullying and Harassment to be reported to them along with numbers of anonymous concerns.

3.2 This report covers reporting of the previous FTSUG for Q4 2018-19 and Q1 from 1 April – 28 April 2019. Reporting from the new FTSUG covers Q1 period 29 April – 30 June 2019.

3.3 The FTSUG has seen an increase in number of cases (individuals) approaching in June 2019 which may be due to extensive promotion of new FTSUG, as well as workers feeling more able or comfortable given concerns raised around the previous FTSUG also worked for People Services. This has continued into Quarter 2 with 28 individuals approaching the FTSUG by 23 August 2020.

Table 1: FTSU Data Q4 2018/19 and Q1 2019/20

FTSU Data Q4 2018/19 and Q1 2019/20		
Types of Concerns	**Q4 Jan - Mar 2019**	**Q1 Apr – Jun 2019**
Attitude and Behaviours	7	13
Culture	0	4
Policies, Procedures including Management of Change	24	19
Health and Safety	4	2
Staff Safety	0	3
Bullying & Harassment (NGO / PIDA)	**3**	**6**
Patient Safety (NGO / PIDA)	**4**	**6**
Lack of availability of Managers	0	1
Performance	0	2
Fraud - potential	0	2
Total No of concerns	**42**	**61**
Corporate	12	3
Campus	8	13
Central	6	3
Children's	3	5
Neighbourhoods	13	5
Other - Medical	0	1
Cases reported to FTSUG	**28**	**22**
Public Interest Disclosure Act Concerns	**12**	**15**
Reportable to NGO: Bullying & Harassment / Patient Safety	**7**	**12**
Staff raising more than 1 concern	**8**	**15**
Open cases	**0**	**3**
Anonymous	**3**	**2**

3.4 Currently more workers from Campus Services are approaching the FTSUG with greater numbers of concerns. More promotion was also carried out within the Campus Services. Further promotion work is needed across Neighbourhoods and some areas of Central Services.

3.5 **Ethnicity:** the ethnicity of workers approaching the FTSUG in Q1 was 20% Black and Minority Ethnic (BME), 75% White British with 5% unknown - anonymous case.

3.6 **Professional backgrounds:** the majority of concerns in Q1 came from Nurses (47%), AHP (17%), Nursing Assistants (10.5%), Admin (10.5%), Domestic (5%), Students (5%) and Anonymous (5%).

3.7 **Patient safety or worker experience issues:** Patient safety concerns in Q1 were limited to 6 concerns. The new FTSUG logged 3 of these concerns. Two of these were linked to concerns around the new model for the Learning Disabilities Service. The FTSUG has been assured that this new model has been quality assured. The concerns were not progressed further by the Learning Disabilities Service despite extensive contact by the FTSUG and were not able to be further investigated. The last safety concern related to patient safety alongside a concern around bullying and harassment. This case is currently under investigation by Employee Relations.

3.8 **Bullying and Harassment:** June 2019 saw an increase in the recording of Bullying and Harassment. NGO Guidance states Bullying and Harassment must be logged if the individual approaching the FTSUG feels that this is their experience, or if following discussion with the FTSUG, the concern is recognised as bullying and harassment. These allegations are not yet substantiated through an investigatory process.

Fig 1: Comparison of Concerns Raised by Area Q4 2018/19 and Q1 2019/20

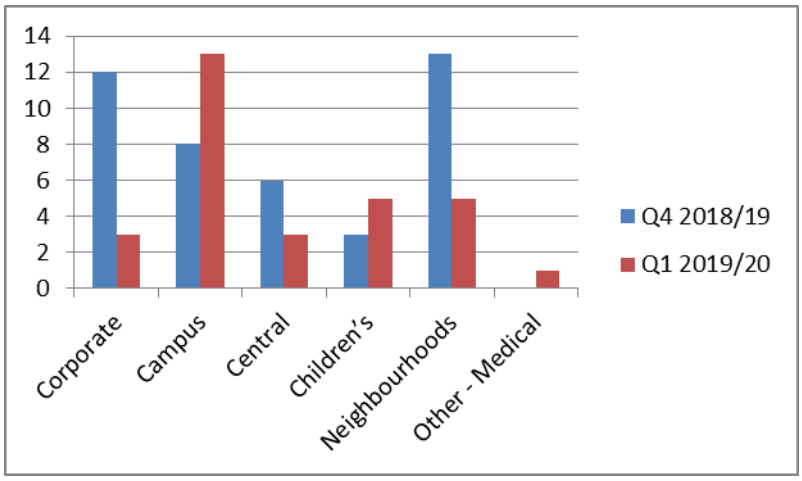
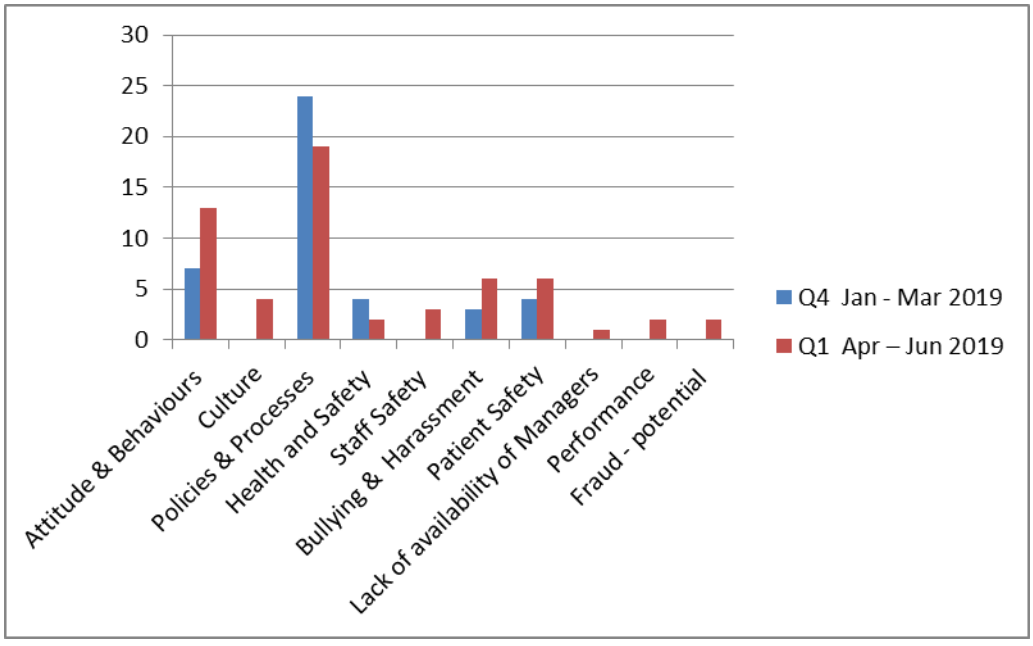


Fig 2: Comparison of concerns raised by type Q4 2018/19 and Q1 2019/20



4. Emerging or ongoing themes

The current FTSUG has been in post since 29/04/2019 and during this time, concerns raised in Quarter 1 of 2019/20 have highlighted some of the following areas for consideration as well as learning and development:

4.1 **Staff Safety - Response to Serious Incidents:** A number of staff have reported on their experience of the lack of support post a serious incident where the staff member was attacked by a patient. Staff explained that they did not feel the support from management and colleagues post each incident was adequate. One staff member had not received a direct call from their manager following a patient attack although some other staff were supportive. Another member of staff felt that the response from management to a physical attack was not supportive without real concern or follow-up shown.

4.2 **Learning and Development:** The FTSUG is attending the development of the Serious Incident (SI) resource focus groups. The FTSUG has also encouraged the staffs who reported these concerns to attend these staff forums and to seek support from Resolve (Staff Support Service) if they have not already done so.

4.3 The FTSUG attended a meeting looking at learning from serious incidents arranged by the Risk and Assurance lead where they also flagged up these concerns. These concerns have also been discussed with the Chief Executive in a one-to-one setting.

4.4 Supportive responses to staff and ongoing support are needed and it is hoped that these will develop and improve as we learn and move forward with new resources and policies geared towards a just and compassionate culture.

4.5 **Bullying and Harassment:** Staff have spoken up about situations where they feel that the Trust values of dignity and respect are not always being upheld during interactions. These instances were reported to have taken place during formal and informal team meetings, in ward based settings and during individual interaction. Some of the concerns involved managers not responding effectively to resolve Bullying and Harassment issues.

4.6 **Discriminatory behaviours:** A number of BME staff member reported concerns and these are now being investigated by Employee Relations. One concern has been successfully resolved through mediation.

4.7 **Learning and Improvement:** The FTSUG has attended a BME staff network group to explain her role to members. There is the potential to offer Equality, Diversity and Inclusion training for FTSU Champions to support workers.

4.8 The Trust has already recognised the work required to address Bullying and Harassment and is delivering workshops to managers and leaders which cover this topic. The Trust has also produced a Bullying and Harassment booklet to support workers with their concerns. All FTSU Champions will attend Bullying and Harassment training as part of their development to support staff. All staff who suspect Bullying and Harassment are provided with a copy of the Dignity and Respect at Work policy and the Bullying and Harassment booklet. This new booklet, designed by staff, has been very well received.

5. Action taken to improve FTSU culture

5.1 The FTSU Guardian has taken a number of actions to improve visibility and promote speaking up channel though the communications team, networking, meetings and visits. These actions are detailed in **Appendix 1**.

5.2 **Networking:** The FTSU has had positive experiences in meeting General Managers (GM) and Area Service Managers (ASM).

5.3 **People Services:** The FTSUG has met with People Services leads and Organisation Development and holds regular meetings. These meetings consider culture, feedback on concerns directed towards Employee Relations, concerns around policy and processes, future improvements and developments. The relationships with People Services leads are positive and supportive.

5.4 **Speaking Up Policy:** the FTSUG is working on developing the current policy in line with NGO and NHS Improvement guidance. The renewed policy will be clearer in content and follow speaking up policy guidelines.

5.5 **Addressing barriers to speaking up:** Further work is needed to identify and support workers who might struggle to access FTSU promotion or drop-ins such as those on night shifts and workers from service areas such as Estates and Facilities who may not access their emails. Future promotion includes sending out information with pay slips as well as through the Estates and Facilities newsletter, and attending night shift handovers. The FTSUG hopes to recruit a champion from Estates and Facilities.

5.6 Attending Staff Network Groups to promote FTSUG role and offer support also plays an important part in addressing barriers to speaking up. At a BME staff network group meeting attended by the FTSUG, a staff member raised a concern with the FTSUG.

5.7 **Developing a network of FTSU Champions:** One of the speaking up priorities for the next 12 months is to increase the reach of the FTSUG is the recruitment of Speak up Champions. This is both a national expectation and also a local need.

5.8 An Expression of Interest was circulated for workers to register interest in the champion role. There has been a good response with 9 potential interested champions from a range of clinical and non-clinical backgrounds along with 4 FTSU Champions already in place. There has also been interest from 18 staff who have attended inductions and these staff have also been contacted about the role.

5.9 Local regional FTSU Champions training co-delivered with the FTSUG (certified FTSU trainer) from University Hospitals and Derby Burton (UHDB) will take place on 10 October 2019. The training event will be will be promoted during October Speaking Up Month and featured by Communications. After the local training, Champions details and remit will be publicised across the Trust.

5.10 The Champions will be following a signposting/support model and not the mini-Guardian model. This will ensure information and intelligence is not lost yet allows for a greater reach of the FTSU agenda. Regular support and supervision will be provided to all Champions from the Guardian and the positions will be reviewed after 3 months, 6 months and then 12 months. The FTSUG has met with 4 of the 5 previously recruited Champions. New champions have been recruited from face-to-face meetings, through market stall induction, team meetings and also online.

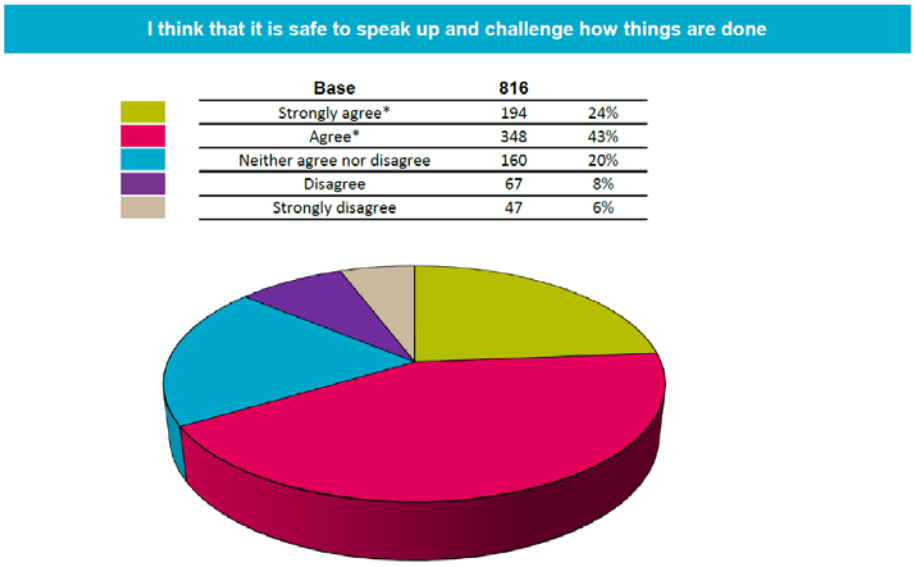
5.11 **Non-Executive Directors (NEDs):** The FTSUG would like to thank, Margaret Gildea, NED lead for Speaking Up, for all of her support in relation to developing and supporting the speaking up culture in the Trust and is looking forward to working with the new NED for Speaking Up, Julia Tabreham, who takes over this role in September 2019.

6. Learning and improvement

6.1 **CQC feedback on FTSUG:** In the CQC report into acute services dated 4 June 2019, most staff knew how to use the raising concerns process, who the Freedom to Speak Up Guardian was and what their role was. However, not all student nurses had been aware of this role. Staffs were clear they could speak up without concerns of retribution. The FTSUG has met with Suki Khatkar, student placement facilitator and will attend future student forums to promote the FTSUG role.

6.2 **Evaluation feedback on Speaking Up:** A short evaluation form for individuals who have spoken up is sent out and the responses received have been positive and is attached as Appendix 2.

6.3 **Pulse Check Q1 2019/2020:** Data shows that 77% of staff strongly agree / agree that it is safe to speak up and challenge how things are done. 14% disagree or strongly disagree with that this is the case.



6.4 Staff in Campus, Central, Estates and Facilities, Neighbourhood, Nursing and Quality are less likely to think that it is safe to speak up and challenge how things are done. FTSUG promotion and visits will be focused on some of these areas. The FTSUG is linking with Organisational Development for Derbyshire Healthcare Estates Strategy Engagement Event Week in September 2019 to provide Speaking Up promotion. (Appendix 3 gives the Q1 Pulse Check response by area).

6.5 **Triangulation of data:** The FTSUG has met with the Patient Experience Lead, People Services Leads, Datix and Risk Leads, but would like to develop a greater overview of trust wide concerns from all sources.

6.6 **Speaking Up Training:** Following guidance from the National Guardian's Office (NGO), the FTSUG would like to see a comprehensive training programme across the Trust which will improve the skills, knowledge and capability of workers to speak up; to support others to do so.

6.7 The FTSUG is involved in the co-production of a decision making methodology to be used across the Trust in situations when things have gone wrong. NHS England and NHS Improvement have launched 'A fair experience for all' which requires Trusts to develop a decision making methodology for local investigations and disciplinary procedures. An understanding of a fair culture for all will support the FTSU process. The FTSUG will also be involved in the Board Development session on Just Culture in September 2019.

7. National Guardian's Office Updates

7.2 In July 2019, The National Guardian's Office (NGO) published Guidance for Boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts. This guidance details how the Executive Lead for FTSU is expected to help the Board reflect on its current position and the improvement needed to meet NGO expectations.

7.3 Developing an improvement action plan will help Trusts to reflect on their current Speaking Up culture as part of their overall strategy and create a coherent narrative for their patients, workforce and oversight bodies.

7.4 The guidance also suggests that inviting workers who have spoken up to come and talk to the Board about their experience is valuable and the FTSUG hopes to build on this in the future.

7.5 Dr Henrietta Hughes wrote to all NHS Chairs and Chief Executives (12 August 2019) explaining that the NGO that training on Freedom to Speak Up had not kept pace with developments in the field and did not fully reflect the NHS's approach to speaking up. The NGO has developed national guidelines that are designed to improve the quality, clarity and consistency of training on speaking up across the health sector.

7.6 The guidelines are for any individual or organisation commissioning or delivering Freedom to Speak Up training for their workers. They are set out in three parts covering: Core training for all workers, Line and middle management training and Senior Leaders training. The guidelines explain that FTSU training should be treated with parity to other 'mandatory' training that organisations may have.

7.7 In June 2019 the National Guardian's Office published the speaking up review for Brighton and Sussex University Hospital NHS Trust. The report consists of two main parts: speaking up and equality and diversity in the Trust and overall speaking up culture in the Trust.

7.8 As a result of this review, the National Guardian has made a number of recommendations and encouraged all other organisations to reflect on these and apply the learning to their own cultures and processes. It is hoped that this case reviews will be taken to the Equality Diversion and Inclusion staff network groups in the future to review the content and recommendations with reference to current speaking up messages and mechanisms in the Trust.

7.9 The FTSUG will use the published recommendations to inform case progression, highlight and challenge current processes, identify best practice and support future action planning.

8. Recommendations

The Board of Directors is asked to:

- Support the roll out of Speaking Up / Raising Concerns training, including an in-house e-learning module for all workers.
- Support the development of a Speaking Up Strategy which will be shared with key stakeholders, discussed and agreed by the Board, and is linked to or embedded within other relevant strategies.
- Support the current mechanisms and activities in place for raising awareness of the FTSU agenda.

Tamera Howard

Freedom to Speak up Guardian

Appendix 1

Promotion of FTSU role through communications, networking, meetings and visits

- Promotion of FTSU on Connect, Screen Savers and through paper posters and leaflets as well as communications information
- Securing a presentation slot at Trust inductions
- Walked areas of DHFT including Campus and Central Services with Pulse Check staff
- Met with General Managers (GMs) and Area Service Managers (ASMs) across the Trust
- Presenting to workers at a Children's Services Professionals Meeting – over 100 staff
- Attended a range of team meetings to present on FTSU culture and role
- Regular meetings held with People Services Lead, Head of Employee Relationships and Head of Culture and Transformation
- Met with all Executive Directors
- Met with General Managers and ASMs – ongoing meetings
- Met with Patient Experience Lead to work to consider sharing of data for triangulation
- Met Risk and Assurance Lead
- Attended first listening and learning around reporting from incidents meeting
- Met with staff side representatives
- Met with Organisational Development at DCHS to discuss opportunities for joint working
- Engaged with preceptorship and student leads and will be attending forums to promote FTSU role
- Met with Chaplain to discuss FTSU role and promote
- Attending Staff Forum
- Attending LGBT, BME and Disability and Wellbeing networks on a regular basis.

Support Network

- Held regular supportive and informative meetings and telephone conversations with FTSUG buddies at UDBH and Leicester Partnership Trust (LPT).
- Attended monthly supervision and ongoing coaching for support and development within role.
- Regular meetings with Executive Lead for Speaking Up
- Met with NED for Speaking Up.

Training and Development

- FTSUG attended Guardian training at NGO / CQC offices and training with Nottinghamshire Healthcare NHS Foundation Trust.

National Guardian's Office and FTSU Midlands network

- Engaging with NGO on regular basis through calls/emails/webinars.
- Completed 2018/19 data return.
- Part of Midlands FTSUG network and attending first meeting on 3/10/19.
    - Keeping up-to-date with NGO developments, guidelines and case reviews.

Evaluation feedback on Speaking Up

Response 1:
Given your experience, would you speak up again?
Yes, I would definitely speak up again.

Please explain your response?
My experience with meeting yourself Tam, was very positive, supportive, understanding, and I felt very listened to, and I felt my 'concerns' were taken very seriously by yourself. I appreciated that you kept in regular contact with myself, to let me know what was happening, and you did exactly what you said you would try and do on my behalf, and as we know to a satisfactory, (fingers still crossed), outcome.

Additional comments or suggestions
Within my supervision of a Band 3 (Team Administrator) I recommended yourself, and I said what a positive experience I had with yourself. The member of staff has advised me she has been to see you following my recommendation, and thanked me for my recommendation, as she too had a positive experience with yourself. Keep up the Good work Tam.

Response 2
Given my experience I maybe would speak up again.

It made no difference regarding the issue I raised. My manager wasn't willing to engage in the options suggested e.g. mediation and in the end I gave up. In the long term am not sure this was the right thing to do and I should have pursued via more formal channels. But generally I don't feel the trust really engages with concerns – not yourself I think you did. But unless the responses are different I feel most of the time the likelihood is that things don't change.

Having said that I would raise concerns to have the satisfaction of knowing that I had done what I thought was right professionally.

Q1 Pulse Check response by area

	Responses	Response Rate	I think that it is safe to speak up and challenge how things are done
Derbyshire Healthcare NHS Foundation Trust	840	34%	66%
Business Improvement and Transformation	8	57%	100%
Campus	143	22%	63%
Central Services	127	32%	53%
Children's Services	125	34%	73%
Clinical Services Management	20	63%	75%
Complex Care	3	75%	***
Corporate Central	20	80%	89%
Estates and Facilities	92	49%	66%
Finance Services	18	86%	83%
Med Education and CRD	16	36%	75%
Neighbourhood	186	31%	66%
Nursing and Quality	26	52%	65%

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 September 2019

Board Assurance Framework (BAF)
Third Issue for 2019/20

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the third issue of the BAF for 2019/20.

Executive Summary

- It was proposed by the Quality Committee in June 2019 that risk 1a: *There is a risk that the Trust will fail to provide standards for safety and effectiveness required by our Board* be escalated from high to extreme, due to failings in governance identified in the adult urgent service pathway, resulting in the CQC retaining their overall rating for the services as inadequate. An extraordinary Board meeting was undertaken on 7 August 2019 to focus on the plans and assurances required to mitigate this risk.
- A gap in assurance in relation to compliance with the current smoking policy has been added to risk 1a.
- A gap in assurance in relation to adherence to national guidance and policy requiring the elimination of mixed sex wards and dormitory style inpatient facilities has been added to risk 1b.
- Gaps in relation to compliance in specific areas of mandatory training across adult acute care services i.e. safeguarding, ILS and physical interventions, have been included in risk 2a.
- A gap in assurance in relation to the system wide risk share agreement has been included in risk 3a.
- Changes to national requirements to access standards have been included as a root cause to risk 1a. If required, a more detailed gap in control will be included once the national requirements have been issued to the NHS.
- A root cause has been added to risk 1a in relation to financial investment in health visiting and school nursing being below recommended national level. An associated action has been added to risk 2a in relation to discuss standards for safeguarding practice with commissioners and implementation of an improvement plan.
- The recommendation (3) of the Deloitte phase 3 Well Led governance review to expand the BAF to include information on mitigating actions for all high and extreme rated operational risks continues to be included in the first and third issues of the BAF during 2019/20. At the point of the latest extract from Datix (20/08/19) there are 17 operational risks currently rated as high, none are rated as extreme. This has reduced from 23 high risks when this report was considered by the Audit and Risk Committee in July 2019.This is due to a number of staffing related risks being reduced or closed. New risks relating to high office temperatures have been raised.

As with previous versions of the BAF, changes made between each issue are highlighted in blue text. An expected completion date for each action is shown alongside the action review date, shown in brackets, to enable Board Committees to focus the reports and reviews required to mitigate the risks identified.

One risk continues to remain removed from formal reporting through the BAF due to commercial sensitivities.

The BAF deep dive programme is attached. Due to the proposed increase in the risk rating for risk 1a, the deep dive for this risk will now be presented to the Audit and Risk Committee in Oct 2019

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	x
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	x
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	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: 01 July 2019
- Audit and Risk Committee: 11 July 2019
- CEO (minor refresh): 21 August 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

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

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) Approve this third 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) Approve Risk 1a to be increased from high to extreme risk
3) Agree to continue receive a quarterly update of the 2019/20 BAF risks as outlined in the forward plan.

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

Rachel Kempster
Risk and Assurance Manager

Report prepared by: **Justine Fitzjohn**
Trust Secretary

Rachel Kempster
Risk and Assurance Manager

Board Assurance Framework

Movement of risks and deep dive programme for Third 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 third 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)	HIGH (4x4)	EXT (5x4)			
19_20 1b	There is a risk that the Trust estate does not comply with regulatory and legislative requirements	Chief Operating Officer	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)			
19_20 2a	There is a risk that the Trust will not be able to retain, develop and attract enough staff and protect their wellbeing to deliver high quality care	Director of People and Organisational Effectiveness	EXT (4x5)	EXT (4x5)	EXT (4x5)			
19_20 3a	There is a risk that the Trust fails to deliver its financial plans	Executive Director of Finance	EXT (4x5)	EXT (4x5)	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)	HIGH (4x4)	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. The deep dive for risks with a residual risk rating of extreme will be undertaken by the Audit and Risk Committee, the responsible committee for these risks is also shown (in brackets).

The plan for BAF Deep Dives for 2019/20 is shown below.

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	Audit and Risk Committee (Quality Committee) October 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 November 2019
19_20 2a	There is a risk that the Trust will not be able to retain, develop and attract enough staff and protect their wellbeing to deliver high quality care	Amanda Rawlings	Audit and Risk Committee (People and Culture Committee) July 2019. Completed
19_20 3a	There is a risk that the Trust fails to deliver its financial plans	Claire Wright	Audit and Risk Committee (Finance and Performance Committee) January 2020
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 December 2019

Summary Board Assurance Framework Risks 2019/20. Issue 3.2

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	EXTREME 5x4	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 and 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.

Operational risk data extracted from Datix 27 06 19. Refreshed 20 08 19

Summary Board Assurance Framework Risks 2019/20. Issue 3.2

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
k) Changes in national requirements to access standards
l) Financial investment in health visiting and school nursing below recommended national level

BAF ref: 1a	**Director Lead**: Executive Director of Nursing/Medical Director	**Responsible Committee**: Quality Committee

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	EXTREME	5	4	↑	MODERATE	3	4			

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. 2018/19 internal audits: Risk Management; Data Quality: RTT (internal audit; Data Security and Protection; IT General Controls; Divisional Governance 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 acute 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 acute 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 Not achieved 31/12/2019 (Revised date)	CQC report published 5/6/19. Trust remains inadequate across acute adult services. Responsive domain rated as good. Recovery plan being implemented and monitored by Board. Concern remains in reaching training targets. Extraordinary meeting with board undertaken Aug 2019. Next inspection due Dec 2019	
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 (30/09/2019) 30/09/2019	Gap analysis updated for ELT June 2019. 6 month review of progress against the Physical Health Care Strategy planned for Sept 2019. Benchmarking standards against other Trusts (June 2019) identify low compliance Implementation plan developed and overseen by PHCC. Plan to include principles of shared care with primary care	

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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 (30/09/2019)	Suicide prevention CQUIN continues to be on track, The design of pathway specific safety planning tools is underway Plan drafted for ELT Jul 2019 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 March 2020) [ACTION OWNER DON]	85% of care and /or relapse prevention plans are assessed as patient centred and are made available to the patient	31/03/2020 (30/09/2019)	New model for care planning including relapse planning is in design. Work will be embedded through the acute care improvement plan	
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~~ 30/09/2019	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. Workshops for all clinically led strategies completed, with exception of learning disability which will be undertaken in Sept 2019	

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] Implementation of EQUAL forum (by March 2020) [ACTION OWNER DON]	Agreed Patient Experience Strategy to Board (by July 2019) (specific measurables with respect to impact to be identified and added)	31/03/2020 (30/09/2019) 31/03/2020	Draft Patient Experience Strategy, agreed with Patient Experience Committee Aug 2019. To be presented to Quality Committee Sept 2019 for approval EQUAL forum 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	~~31/05/2019~~ ~~31/07/2019~~ 30/09/2019 ~~(31/07/2019)~~ 30/09/2019	13 actions remain to be completed from previous inspection. 18 actions from the acute care review have been added 77 actions from Jan 2019. As of July 2019 36 remain overdue. Escalation underway Monitored by MHA Ops group.	
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	
Staff feedback and patient surveys identify that the current policy around smoking on Trust premises is not fit for purpose	Using staff feedback and patient survey results to develop a new smoking policy focusing on harm reduction. [ACTION OWNER DBI&T]	Increased compliance with the Trust smoking policy as measured by: improved feedback from staff and patients and a reduction in levels of smoking in undesignated areas	31/03/2020	Policy agreed by Quality Committee July 2019. To launch revised approach through summer 2019	
Related operational high/extreme risks:					

Summary Board Assurance Framework Risks 2019/20. Issue 3.2

ID	Division	Title	Description	Mitigating actions	Date of next review
21189	Community Mental Health Services (Adults)	Admission criteria to Eating Disorders Service	Service currently has BMI admission to service criteria. Concerns there are significant people with eating disorders who cannot access specialist therapeutic services. Possible risk of impact on increasing prevalence and chronicity of eating disorders across Derbyshire without early and timely clinical intervention.	Provisional acceptance of shared care medical monitoring and gastro clinic model to support care. If progressed this will support care for complex patients, but will not alter the admission criteria. No further progress with CCG on wider AED expansion for community service. Likely to move forward with NHSE AED New Care Models across East Midlands proposals for 20/21.	30/09/2019
21473	Corporate Services	Data Accuracy	There is evidence to support that electronic clinical data is inaccurate in terms of discharge and that there are gaps in the electronic record in relation to REGARDS This is a clinical risk in terms of the accuracy of the patient care record but also serves to skew performance reporting and requires constant cleansing resolutions	The pre-registration forms have been introduced into Neighbourhood teams but to date have not impacted upon improving REGARDS data. There are other developments that are also likely to have positive effect upon other data accuracy e.g. PLICs developments, Channel. This is ongoing work but no change in risk currently	31/10/2019
3009	Specialist Care Services: Learning Disability	Demand for ASD assessment Service far outstrips contracted activity	Demand continues to outpace assessment supply on a monthly basis leading to an increasingly extended waiting list. This in turn means that NICE recommended waiting times are not adhered to and that organisationally complaints are received about long waiting times and the lack of any follow-up treatment service.	Internal review has highlighted the efficiency of the referral system in terms of diagnosis, DNAs and drop-out rates. In addition the workforce has stabilised in the past 6 months but remains vulnerable due to low numbers and high level of experience required for recruitment/retention. Referral rates remain high and exceed the number of assessments available. New ASD Working Group (CCG, LA and DHcFT) to look at pathway gaps and propose changes via the STP and CCG Risk created early 2016 and remains high	30/09/2019
21615	Campus Services	Provision of Speech and Language Therapy Services and implementation of International Dysphagia Descriptors	Patients affected by range of issues including: No urgent SLT provision.; Lack of specialist SaLT (SLA currently provides 2 days SLT to 3 Campus areas across DHCFT); SaLT not commissioned for initial screening.	Key individuals met Feb 2019, and produced an action plan. Further meetings have continued to progress.	31/07/2019

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21628	Acute Mental Health Services (Adults)	Ward 33 Beds - points of ligature under bed frames.	Ward 33 have several beds that are currently posing a ligature due to wires under the metal frames. Risk of patients upending the bed and using these wires as ligatures/points of ligature. Risk of strangulation/death.	Rob Morgan (H&S) to undertake work with ward to amalgamate all POL risk assessments into one overall risk.	30/09/2019

Summary Board Assurance Framework Risks 2019/20. Issue 3.2

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
d. National capital funding restrictions expected for 2019/20

BAF ref: 19_20 1b	**Director Lead**: Chief Operating Officer	**Responsible Committee**: Finance and Performance Committee

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	⟺	MODERATE	3	4			

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 and ongoing continuous improvement reported to TMT and ELT	
	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)	(31/12/2019)	Report to TMT July 2019 which outlined progress against three highest risks: legionella; asbestos; electrical safety	
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 commenced June 2019, to enable focus on key issues	
Lack of adherence to emerging national guidance and policy requiring the elimination of mixed sex wards and dormitory style inpatient facilities.	Deliver a single room development plan (by Aug 2019) [ACTION OWNER COO]	Achievement of single room development.	31/08/2019 (plan)	Concept mapping undertaken allowing estimation of initial bed number reductions	
	Develop a long term Estates Strategy (by Nov 2019) [ACTION OWNER COO]	Board approved long term Estates Strategy	30/11/2019		

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Related operational high/extreme risks:					
ID	Division	Title	Description	Mitigating actions	Date of next review
21717	Acute Mental Health Services (Adults)	Excessive temperature in Ward Office	Concerns raised with ASM regarding the temperature in the Nursing Office on Ward 36. The temperature has been monitored to record and evidence the working environment temperature since the middle of May. The temperature is having a direct impact on the health and wellbeing of staff particularly the admin staff who has medication patches that are ineffective. At the time of writing - 08.47 temperature of ward office is 29.1	Consideration by Carrina Gaunt and Scott Dickinson as part of wider review of temperatures on RU (see attached email)	30/09/2019
21736	Corporate Services	Room temperatures in all training rooms	The temperatures in the training rooms have become unbearable due to lack of air conditioning. In the past training has been cancelled in the hot months or shortened. We are in a position now where we cannot cancel any training due to the critical position which the organisation is in. Both trainers and attendees have repeatedly reported that it is now getting more and more difficult to be in the rooms. The following are affected, All internal staff attending training in the Centre for Research and Development. All staff who have offices in the Centre for Research and Development. All people who attend meetings in the Centre for Research and Development.	Consideration by Carrina Gaunt and Scott Dickinson as part of wider review of temperatures on RU (see attached email)	19/08/2019

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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 and 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
g. Traditional workforce structure

BAF ref: 19_20 2a	**Director Lead**: Amanda Rawlings, Director of People and Organisational Effectiveness	**Responsible Committee**: People and Culture Committee

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 including targeted campaigns, refresh 'Work For Us' intranet page, leadership development, new role and skill mix changes, leadership development programme, increased well-being support.
Detective – Performance report identifying specific hotspots and interventions to increase recruitment and retention.
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 HEE returns against funding EG for TNA's Safe staffing reports and CHPPD reporting (planned v's actual staff) WRES, WRED and Gender pay gap reporting 2018/19 internal audits: Recruitment; Acting up

Key gaps in control:	Key actions to close gaps in control:	Impact on risk to be measured by:	Expected completion	Progress against action:	Action on

Summary Board Assurance Framework Risks 2019/20. Issue 3.2

			date./(Action review date):		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 [ACTION OWNER DP&OE, COO] Discussion with commissioners re health visiting and school nursing practice standards for safeguarding. Implementation of improvement plan by division. [ACTION OWNER DON]	Reduction in vacancies in identified hotspot areas to below 10% Reduction in vacancy rates and turnover.	31/03/2020 (30/09/2019) (31/12/2019)	Acute inpatient ward focused work on recruitment and retention including revised offer to staff. Improvement plan in design for submission to TMT and assurance to the Safeguarding/ Quality Committee	
Fully delivered leadership and management development programme	Roll out of the Leadership Launch and masterclasses (~~by June~~ during 2019) and monitor up take [ACTION OWNER DP&OE] Move from Pilot to scale for 360 feedback leadership tool [ACTION OWNER DP&OE] Develop middle leaders programme with East Midlands Academy [ACTION OWNER DP&OE]	90% of Leaders attend the Leadership Launch 50% uptake of Management Masterclasses Attendance at the programme, take up of a coach and 360 appraisal to improve individual performance	31/03/2020 (30/09/2019) 31/03/2020] (31/01/2020) 30/09/2019	77% of leaders have now attended the leadership sessions. Continuing through 2019. Increasing no of masterclasses being offered 360 feedback tool now in place, pilot completed. Tool is being offered to leaders to use To be launched by Sept 2019	
Focus on 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	Reduction in sickness absence rates to 5% or below (target date tbc as linked to CIP agreement) Reduction in sickness absence rates as a result of MSK issues	31/03/2020 (30/09/2019) 01/03/2020 (30/09/2019)	Well-being offer launched, positive uptake. Sickness absence rate Aug 2019 is 6.34% Rapid response to MSK services now being rolled out.	

	counselling service [ACTION OWNER DP&OE] Roll out of DHCFT specific flu vaccination plan [ACTION OWNER DP&OE]	Increased uptake of staff flu vaccination to ~~75~~% 80% (increase in national target)		Flu campaign to relaunch Oct 2019	
Development of a funded Workforce Plan	Develop and implement 2019/20 of the Workforce Delivery 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 Development Plan agreed by PCC and Board. Includes CPD investment, apprenticeship levy spending and progress with implementation of new roles 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 (31/10/2019)	Action 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]	90% of staff achieve their mandatory training requirements (by March 2020)	31/03/2020 (tracked monthly)	Acute inpatient 'hotspot' areas monitored weekly. Remains below trajectory.	

	Review E-Learning offer and system improvement requirements in terms of ease of use [ACTION OWNER DP&OE] Focused action plan in acute care services in relation to: safeguarding; ILS and physical intervention training	Achievement of training targets for acute care services: safeguarding (70% by 30/09/2019) ILS (80% by 30/09/2019) physical intervention training (70% by 30/09/2019)		Issues identified with respect to E learning. Solutions being developed	
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.	
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	

Related operational high/extreme risks:

ID	Division	Title	Description	Mitigating actions	Date of next review
21222	Corporate Services	Compliance - Resus Training(ILS & BLS)	Training compliance continues to be monitored across the trust. Resuscitation training which includes BLS, ILS and APBLS continue to be a challenge due to a long term sickness / absence and insufficient resources in the training team. This means services / divisions continue to see a drop in their compliance as we attempt to catch up with a Training backlog.	Risk increased by TMT 7/5/19 from moderate to high.	31/08/2019

2772	Children's Care Services: CAMHS	Insufficient resources CAMHS workforce	Insufficient CAMHS workforce resources to ensure safe reliably consistent, high quality care. Vacancies, sick leave and maternity leave leading to a lack of care coordination within new pathway model leading to increased reliance on medical team. 1	Medical director working up the joint rota proposal, now being supported by CAMHS consultants. Positive meeting with CRH, again willing to scope a joint rota. Agency cover for OOH and gaps remains in place.	31/07/2019
21510	Campus Services	Poor levels of compliance with positive and proactive training in acute ward areas	Risks have been identified in relation to training compliance for positive and proactive training (previously called C&R training) with respect to the following: - Overall compliance with positive and proactive training (as of Oct 2018) sits at around 50%. This poses a significant risk to staff not being equipped to intervene in potentially dangerous situations where there is escalating violence on the ward - Bank staff are not accessing this positive and proactive training, despite an agreement in 2014 by the director of nursing that such training would be funded once a member of bank staff had completed 26 shifts. The funding route for accessing the training is not clear, with no designated budget identified.	From Jan 2019, proposed courses for new starters did not all go ahead, due to shortage of staff. Positive and safe trainer lead now in post. Report presented to ELT June 2019 requesting positive and safe team to support training. This has been agreed and an implementation plan is underway. Further 3 five day courses have been arranged and staff are being individually booked on to maximise course attendance. Issues of booking bank staff on courses raised with Temporary Staffing Manager.	31/10/2019
20993	Children's Care Services: Universal 0-19	Staff shortage Children and Therapies	We are currently without one full time band 5 therapist and a half time band 6 OT this situation has lasted longer than anticipated due to difficulties recruiting to the band 6 post. Patients affected adversely by forthcoming breaches in waiting times (over 18 weeks).	Band 6 OT vacancy still not filled. Discussion around possibility of current staff working more paid hours to help support staffing, but this won't be fully affective until Oct 2019. Band 3 Admin worker has started in post 22.7.19; still waiting for both band 2 workers to commence. 2 temporary admin staff will remain in post during the transitional period. Physiotherapy are currently fully staffed; no vacancy's at present	30/09/2019
21207	Acute Mental Health Services (Adults)	Staffing issues	Note: MHTH is based at Police Head Quarters in Ripley Due to a current lack of staff the service is struggling to provide the commissioned service to police, EMAS, Out of hours GP's, and Social care. Furthermore on some days no service can be provided. Minimum staffing levels should be 2 clinicians per shift. At present there is often only one	Staffing levels remain low. 1 Staff remains on long term sick. 1 Staff vacancy filled, awaiting recruitment process and start date. We now funding for a further 2 nursing band 6 posts. One of these posts will be offered to the second person that was also appointable at the last interview week commencing the 5th August and the other post will	04/11/2019

			staff member by themselves. social care have not yet recruited social care post for the service.	be put back out to advert this coming week. In the interim contingency plans are in place as per previous progress. Staff will also be offered bank shifts. ASM aware. level.	
21477	Acute Mental Health Services (Adults)	Staffing levels as a team,	High sickness and vacancy rate on Ward	Current staffing levels remain below safer staff. 1 band 6 LTS, 0.8 Band 5 on LTS	30/09/2019
3385	Neighbourhood Services	Waiting Times for Psychological Assessment and Intervention	There are continued long waits across areas of the neighbourhood, although these are variable depending upon referral practice by team members and psychiatry. Additional resources have been agreed to support the cover of maternity leave in Amber valley and Derby City. There are three vacancies from staff leaving, these are out to advert.	There are continued long waits in some neighbourhood adult services. This has been exacerbated by 3 maternity leaves and some vacancies. In order to try to reduce waits different staffing models are being explored and there is currently an active recruitment drive. Risk created early 2016, remains high	30/09/2019
3386	Acute Mental Health Services (Adults)	Radbourne Unit - Staffing risk assessment	Main Issues (Vacancy Breakdown provide further down): • Increasing B5 RMN vacancy factor • Poor retention • Decreasing level of clinical experience • New and acting in nursing leadership posts • Increasing bed demand • Increasing acuity/ self-harm/ dual diagnosis/ placement breakdown/ ASD - and increasing observations activity impacting on need for further staff to manage activity. - which staff feel ill equipped for • Medical leadership – across x4 acute inpatient wards, leading to unclear or absent discharge plans, ward staff feeling unsupported in complex risk and increased pressure to make big decisions without support. • Inability to fully resource bleep shifts • Pressures being expressed from other services lines who	Description and controls updated. Risk increased to high.	31/10/2019

			are being called upon to shift		

Summary Board Assurance Framework Risks 2019/20. Issue 3.2

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
f) Enacting system risk sharing agreement

BAF ref: 19_20 3a	**Director Lead**: Claire Wright, Executive Director of Finance	**Responsible Committee**: Finance and Performance Committee

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
EXTREME	4	5	EXTREME	4	5	⟷	MODERATE	2	5			

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. Basis of agreement of risk share.

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. Risk mitigation activity and oversight at STP level.

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	- Internal Audits– significant assurance rating for 2018/19 audit: Integrity of the general ledger and key financial systems; Internal audit review - Sickness Absence review (Counterfraud) - 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

strategic approach to effective use of resources		- Deloitte Well Led review – positive affirmation of the effectiveness of the Finance and Performance Committee			
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-recurrent 2019/20 CIP with recurrent CIP ahead of 1st April 2020 Size of pipeline for continuous improvement plans for future years	31/03/2020	CIP was discussed at an extraordinary F&P in July and schemes were identified to close the gap	
				Non recurrent CIP still needs replacing with recurrent CIP. Progress relating to plan to be reported to Finance and Performance Committee July 2019, with further plan to be developed by 30/09/2019	
				Finance and Performance Committee May 2019 scrutinised progress with 2019/20 and future pipeline	
Delivery of specific benefits realisation as described in investment cases, including the Mental Health Investment Standard (MHIS)	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 (MHSDB)	31/03/2020 (30/09/2019)	Contract signed	
				E-Roster, shift pattern and E job planning not yet in place, consultation underway. MHIS monitored at MHSDB	
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)	

Lack of sight of detailed and approved schemes to close system gap (risk share)	System sharing group oversight (reporting to CEO/Finance Director group) and JUCD Board [ACTION OWNER DOF]	Size of risk share pot and DHCFT portion	31/03/2020 (30/09/2019)	Joint system oversight process through Systems Savings Group. Developing a Finance Assurance Group to include at all F&P Committee Chairs.	

Summary Board Assurance Framework Risks 2019/20. Issue 3.2

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

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 MOD	Likelihood 3	Impact 4	Accepted	Tolerated	Not accepted

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	NHSE/I agreement of plans Mental Health Delivery Board and checkpoint meetings with central STP team Bimonthly performance meetings with NHSI

- Engagement with staff though managers, staff side, focus groups etc - 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 acute 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 acute 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. Enhanced focus agreed with learning disability workstream – June 2919 JUCD Board.	
				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] Link in with Joined Up Care Derbyshire	The lack of major or critical incidents affecting the Trust resulting from risks associated with leaving the EU	31/10/2019	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. Risk associated included in leadership development programme	

	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. Currently suspended	
				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 agreed by ELT April 2019 Chair and CEO continue to attend events to ensure early notification on planned changes to policy. Three national influential leaders visited Trust during May/June 2019 giving opportunity to discuss national policy	

Related operational high/extreme risks:

ID	Division	Title	Description	Mitigating actions	Date of next review

Summary Board Assurance Framework Risks 2019/20. Issue 3.2

21503	Acute Mental Health Services (Adults)	Non-commissioned Older adults Crisis service	The Crisis Resolution and Home Treatment (CRHT) Team in North Derbyshire was established and became operational 24 hours/ day in 2005. There is currently no equivalent service for adults aged 65 and over. The Older Adult (OA) Consultant Psychiatrists and CMHTs deal with urgent referrals in this age group without the support of a CRHT. This has an impact on their ability to perform their day-to-day duties and often means staff having to work extra hours in the evenings and at weekends.	No further progress at present although the crisis team do continue to support older adult services and review referrals on a case by case basis if the patient is close to working age or if the presentation is primarily functional.	17/12/2019

Summary Board Assurance Framework Risks 2019/20. Issue 3.2

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 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	COO	Chief Operating Officer
DOF	Executive Director of Finance	DON	Executive Director of Nursing and Patient Experience
MD	Medical Director	DP&OE	Director of People and Organisational Effectiveness
DBI&T	Director of Business Improvement and Transformation		

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 September 2019

Pulse Check Results and Staff Survey Plan

Purpose of Report

The purpose of this paper is to update the Trust Board on the recent Pulse Check results, which show our current position based on the Q1 all staff survey; and share the plan for the 2019 NHS Staff Survey.

Executive Summary

This report contains the recent Pulse Check results, which show the current position based on the Q1 all staff survey.

- We maintained our response rate of 34% in Q4
- We saw a great increase in our Friends and Family Test (FFT) score – recommend as a place to work (from 65% - 68%)
- There was a decline in our FFT score – recommend as a place to receive/care and treatment, the paper gives an indication as to why we believe this may be
- Six of our other eight Pulse Check questions have improved over the past two years, one area has stayed the same and we saw a 1% decrease in the number of staff who said time passes quickly when they are working
- The Divisional People Leads (DPLs), supported by the wider Organisational Effectiveness Team, are working with managers to understand their results, identify any key issues and work with colleagues to improve them
- The Q2 Pulse Check opens on 27 August and runs for three weeks, closing on 15 September 2019 and we are 'sampling' all acute inpatient ward areas.

The report then goes to on to share the plan for the 2019 NHS Staff Survey – including updates on what we have done over the past year.

- We are running a full census again this year, with all staff opting for electronic surveys, other than both Estates and Facilities staff who are opting for paper copies of the survey
- Provisional dates are to launch on 16 September and close on 29 November 2019
- There has been significant progress since the 2018 NHS Staff Survey including: the work we have done around tackling bullying and harassment, investment in our leadership development, ensuring colleagues are able to have a meaningful appraisal and the refresh of our Trust Strategy etc.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	X
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	X
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	X

Assurances

Risks associated with the report are linked to the BAF as follows:

Strategic Objective 2. Engagement: 18_19 2a - There is a risk that if the Trust doesn't engage our workforce and create an environment where they experience the aims and values of the Trust, there will be a negative impact on the morale and health and wellbeing of staff which may affect the safety and quality of patient care.

Over the past two years:

- The Pulse Check response rate has gone from 18% – 34%
- Our Staff FFT question – recommend as a place to work has increased by 10%
- Six out of eight of our other Pulse Check questions have improved
- We have a number of actions completed as a result of what colleagues told us in the 2018 NHS Staff Survey to use ahead of the 2019 survey.

Consultation

All information on our previous NHS Staff Survey results was shared with appropriate stakeholders and governors once the embargo was lifted on 26 February 2019.

The Q1 Pulse Check results were shared with Directors and their Deputies on 12 August 2019, and local team level reports have already been cascaded to Heads of Service, General Managers etc.

Governance or Legal Issues

- Staff FFT questions are reported and benchmarked nationally
- CQC analyse the NHS Staff Survey results.

Public Sector Equality Duty & Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

- All staff are given the opportunity to complete at least 1 Pulse Check and 1 NHS Staff Survey every year
- Our NHS Staff Survey results are be broken down by protected characteristics and further analysis is done by the Head of Equality, Diversity and Inclusion in conjunction with all Staff Network Groups.

Recommendations

The Board of Directors is requested to:

1) Receive and review the Q1 Pulse Check results
2) Note and take assurance regarding the plan for the 2019 NHS Staff Survey.

Report presented by:	**Amanda Rawlings,** **Director of People and Organisational Effectiveness**
Report prepared by:	**Clair Sanders** **Engagement and OD Lead**

Pulse Check Results and Staff Survey Plan

Introduction

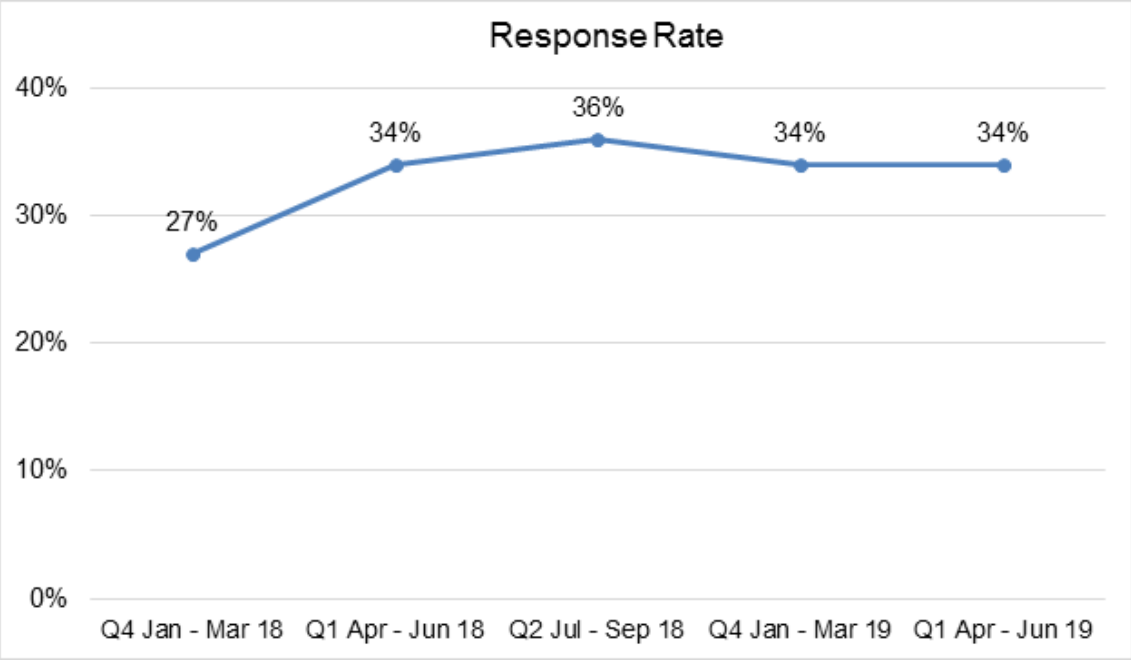
This report for Derbyshire Healthcare NHS Foundation Trust contains the recent Pulse Check results, which show our current position based on the Q1 all staff survey. It then goes to on to share the plan for the 2019 NHS Staff Survey – including updates on what we have done over the past year.

Section 1: Q1 Pulse Check Results

The Derbyshire Healthcare Pulse Check, which includes the National Staff Friends and Family Test (FFT), was launched in April 2016 and offers an indicator throughout the year as to how staff are feeling. The Pulse Check provides information to allow focus and relevant action to be taken each quarter rather than once a year.

The Q1 survey ran from Monday 3 – Sunday 23 June 2019. Whilst we have seen a steady incline in many of our areas, there is always work to be done to continue to improve quarter by quarter. The latest results are summarised below:

Response rate

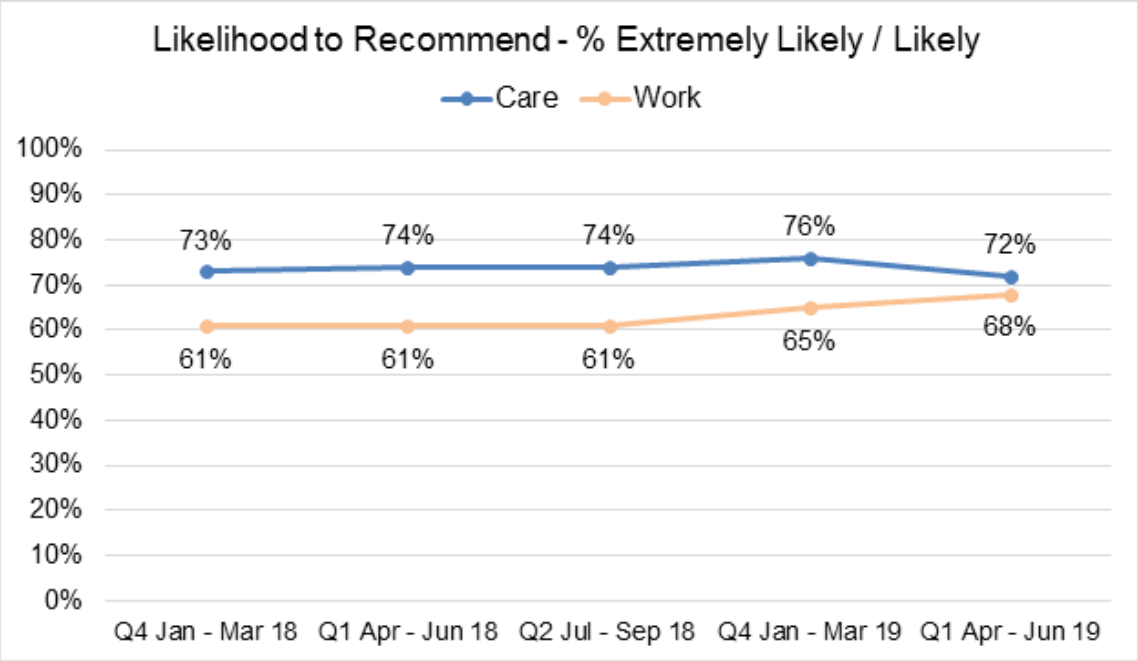


Whilst we have maintained our response rate of 34% again this quarter, it was thought pertinent to highlight how far we have come in the past 2 years – compared to an 18% response rate in Q1 2017.

Staff Friends and Family Test (FFT) results

The Staff FFT results focus on two key questions (exact wording below) and the percentage results are created from the number of staff who answer either 'likely' or 'extremely likely':

1. How likely are you to recommend this organisation to friends and family if they needed care or treatment?
2. How likely are you to recommend this organisation to friends or family as a place to work?



It is great to see yet another increase in our 'recommend as a place to work' score – which has gone up a staggering 10% since Q1 2017 (58%).

The 'recommend the Trust as a place to receive care and treatment' appears to have dropped 4% and on further analysis and triangulation against the comments we believe that it appears that a number of colleagues have been voting 'no' or 'would not recommend' due to their family and friends living outside of Derbyshire.

As these are our 2 mandatory questions we are unable to change the exact question wording to help reduce this in future surveys, however be assured that we will be working with our Communications and Involvement Team to encourage colleagues to answer this question as '***If your friends and family lived in Derbyshire…*** would you recommend the Trust as a place to receive care and treatment?'.

Comparison to where we were on other areas this time last year

Question	April - July 2018	April – July 2019	Change since last year
Care of patients/service users is the trust's top priority	77%	79%	↑**2%**
I am able to make suggestions to improve the work of my team/department	79%	79%	↔
There are frequent opportunities for me to show initiative in my role	73%	74%	↑**1%**
I am able to make improvements happen in my area of work	67%	69%	↑**2%**
I think that it is safe to speak up and challenge how things are done	61%	66%	↑**5%**
I look forward to going to work	61%	63%	↑**2%**
I am enthusiastic about my job	75%	76%	↑**1%**
Time passes quickly when I am working	80%	79%	↓**1%**

Please see appendix 1 for the: *Q1 Pulse Check organisational results summary*

What next?

The detailed results and all free text comments were shared with Directors and their Deputies on 12 August 2019, and local team level reports have now been cascaded to Heads of Service, General Managers etc. The full results can also be found on Connect here: ***http://connect/Corporate/WorkforceOrganisationalDevelopment/HumanResources/SitePages/NHS%20Staff%20Survey%20and%20Pulse%20Check*** so all staff can access everything freely (other than the comments) in line with our open and transparent culture.

The Divisional People Leads (DPLs), supported by the wider Organisational Effectiveness Team, are working with managers to understand their results, identify any key issues and work with colleagues to improve them.

Quarter 2 – sample

As agreed, due to the increase of time between the survey closing and receiving the results from Picker Europe (now 8 weeks), coupled with feedback from colleagues regarding being 'over surveyed' and managers requesting more time to follow up, act on and make changes from their individual results the Q2 and Q4 Pulse Checks will only survey a sample of staff across the Trust.

Essentially, this will mean all staff get two full surveys a year, a Pulse Check in Q1 and the NHS Staff Survey in Q3. The remaining quarters Q2 and Q4 will include the national requirements of the two Staff FFT questions being asked to a random sample of staff.

The Q2 Pulse Check opens on Tuesday 27 August and runs for three weeks, closing on Sunday 15 September 2019 and we are 'sampling' all acute inpatient ward areas.

Target teams

People Services have recently undertaken a comprehensive triangulation exercise using key people metrics (our sickness absence, retention and engagement data) to identify ten target teams/additional hot spot areas for focussed intervention. Our Staff Wellbeing Team are leading on this piece of work and will be working with the Divisional People Leads and Area Service Managers to identify and support with any bespoke OD interventions deemed necessary.

Section 2: 2019 NHS Staff Survey Plan

The provisional launch date for our 2019 NHS Staff Survey is on Monday 16 September and will run until midnight on Friday 29 November by our independent contractor Picker Europe.

Derbyshire Healthcare will run a full census this year – we will be asking all staff to share their views and complete the survey.

We have asked all Directors and/or General Managers (GMs) from each locality on their preferred mode for the 2019 survey – details which have been confirmed can be found below. This approach is hoped to improve response rate again this year.

LOCALITY 1	Lead	Mode*
Business Improvement & Transformation	Gareth Harry	Electronic
Campus	Michelle Hague	Electronic
Central Services	David Hurn	Electronic
Children's Services	Hayley Darn	Electronic
Clinical Serv Management	Mark Powell	Electronic
Corporate Central	Justine Fitzjohn	Electronic
Estates & Facilities	Scott Dickinson	Paper
Finance Services	Claire Wright	Electronic
Med Education & CRD	John Sykes	Electronic
Neighbourhood	David Tucker	Electronic
Nursing & Quality	Carolyn Green	Electronic
Ops Support	Peter Charlton	Electronic
People Services	Amanda Rawlings	Electronic

We are yet to hear about any question changes for the 2019 NHS Staff Survey, but expect it to be similar or the same as the 2018 NHS Staff Survey as there were lots of changes introduced last year, particularly around the NHS England theme reporting.

Main points to note are as follows:

- Picker will only accept localities that have a minimum of 11 staff in them, which is why you may see some differences in the groupings above
- Bank/flexible workforce staff are not included in the survey as per the NHSE guidance
- Staff on maternity or adoption leave and staff who are currently suspended are included in the survey and will receive paper copies to their home addresses
- *There are also approximately an additional hundred staff who will be receiving paper surveys as they currently have no email address registered in ESR or with NHS Mail.

We are unable to change survey mode mid-way through the survey; however, there are alternative ways which can be arranged for staff to access the survey. The Organisational Effectiveness Team and Divisional People Leads will be out within services encouraging completion via the use of iPads etc.

Sharing updates on what we have done over the past year

Communication of updates as we progress, relating to the key focus areas have been labelled under the following:

- We said, we are doing…
- We said, we did/have…
- We said, we can't do because… (to feedback and show we have still taken on board and listened and explained why we cannot change if applicable)

We have summarised all of these into the poster found in appendix 2 which will accompany Ifti's CEO letter to launch the 2019 NHS Staff Survey.

A summary of the key highlights include: the work we have done around tackling bullying and harassment, investment in our leadership development, ensuring colleagues are able to have a meaningful appraisal, the refresh of our Trust Strategy and much more…

Please see appendix 2 for the poster: What have we done since the 2018 NHS Staff Survey?

Appendix 1: Q1 Pulse Check organisational results summary

Staff Friends and Family Test

Q1 2019/20

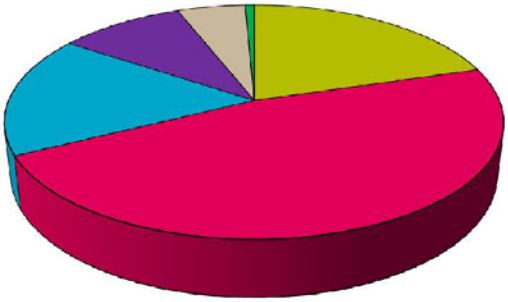
Derbyshire Healthcare NHS Foundation Trust

How likely are you to recommend your organisation to friends and family if they needed care or treatment?

Base	837	
Extremely Likely*	187	22%
Likely*	418	50%
Neither likely nor unlikely	166	20%
Unlikely	38	5%
Extremely Unlikely	18	2%
Don't Know	10	1%

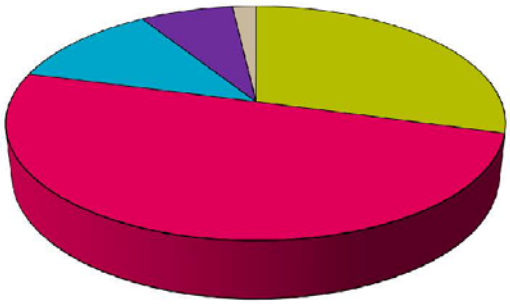
How likely are you to recommend your organisation to friends and family as a place to work?

Base	839	
Extremely Likely*	171	20%
Likely*	396	47%
Neither likely nor unlikely	141	17%
Unlikely	81	10%
Extremely Unlikely	44	5%
Don't Know	6	1%



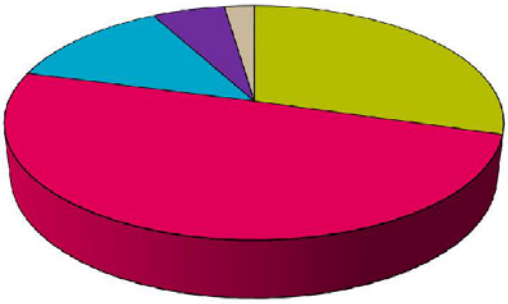
Care of patients/service users is the trust's top priority.

Base	823	
Strongly agree*	241	29%
Agree*	410	50%
Neither agree nor disagree	98	12%
Disagree	59	7%
Strongly disagree	15	2%



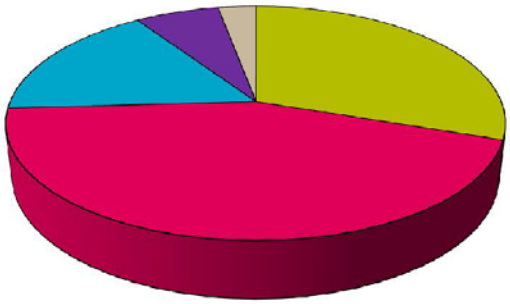
I am able to make suggestions to improve the work of my team/department.

Base	820	
Strongly agree*	242	30%
Agree*	407	50%
Neither agree nor disagree	106	13%
Disagree	46	6%
Strongly disagree	19	2%



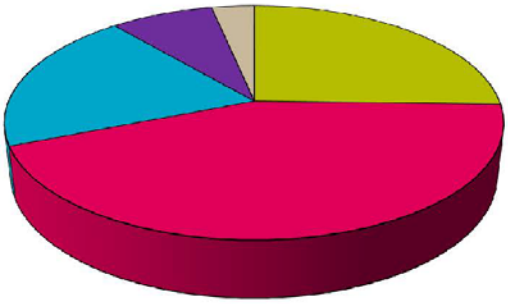
There are frequent opportunities for me to show initiative in my role.

Base	819	
Strongly agree*	247	30%
Agree*	360	44%
Neither agree nor disagree	135	16%
Disagree	53	6%
Strongly disagree	24	3%



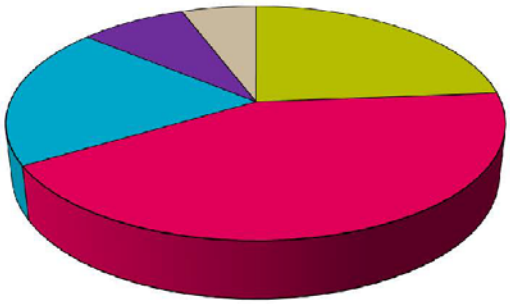
I am able to make improvements happen in my area of work.

Base	818	
Strongly agree*	208	25%
Agree*	356	44%
Neither agree nor disagree	162	20%
Disagree	65	8%
Strongly disagree	27	3%



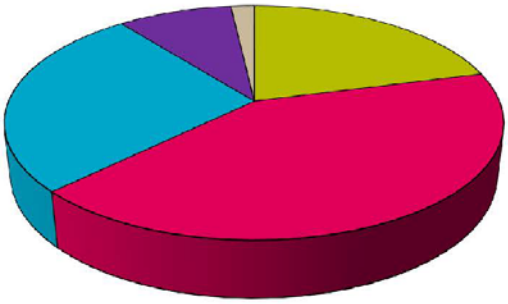
I think that it is safe to speak up and challenge how things are done

Base	816	
Strongly agree*	194	24%
Agree*	348	43%
Neither agree nor disagree	160	20%
Disagree	67	8%
Strongly disagree	47	6%



I look forward to going to work.

Base	826	
Always*	173	21%
Often*	345	42%
Sometimes	220	27%
Rarely	73	9%
Never	15	2%

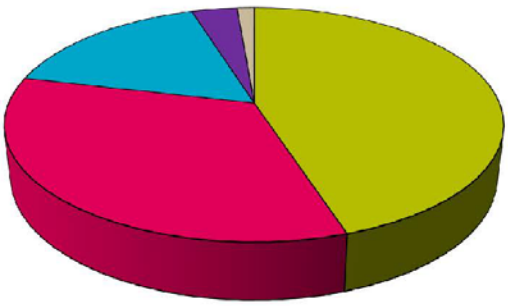


I am enthusiastic about my job.

Base	819	
Always*	305	37%
Often*	320	39%
Sometimes	148	18%
Rarely	41	5%
Never	5	1%

Time passes quickly when I am working.

Base	825	
Always*	371	45%
Often*	278	34%
Sometimes	136	16%
Rarely	29	4%
Never	11	1%



YOU SAID WE HAVE

What have we done since the 2018 NHS Staff Survey?

"We get asked to complete lots of surveys, it takes too long and we don't always get the feedback before the next survey!"

"Reduced the number of Pulse Checks we are running this year, to allow more time for action on the results."

"We don't think the appraisal paperwork is quite right and doesn't provide the opportunity to discuss our wellbeing."

"Reviewed and updated the paperwork based on your feedback, in line with our values and this is now on Connect for all to use, with supportive training available."

"Can we improve our access to talking therapies for staff?"

"Invested significantly in a new onsite counselling service. The Resolve staff support service is now available for all staff, via self-referral, and you can be seen at a site convenient for you, in work time, and with little to no wait."

"We want clearer expectations of staff, but also what the Trust commits to in return."

"Developed the Team Derbyshire Healthcare Promise in partnership with colleagues, to outline a shared set of expectations."

"What alternatives (in addition to training) can we access to enhance our development?"

"Worked with our partners to bring together a group of 'Derbyshire Coaches' which will be open across both Derbyshire Healthcare and DCHS, that colleagues can access for support with their development."

"Is there anything more we can do to reward colleagues with additional staff benefits to make the Trust a better place to work?"

"Just launched our brand new exciting staff benefits platform – Vivup! Sign up now for access to exclusive discounts – such as 10% off Amazon, amazing gym discounts and new salary sacrifice schemes…"

"We need more ways to show value and appreciation of all staff…"

"Introduced new thank you cards, to provide opportunities for spontaneous feedback.

"Colleagues are reporting bullying and harassment in pockets across the Trust…"

"Worked with colleagues to develop a booklet which defines bullying and harassment, giving examples and scenarios, as well as detailing suggestions for guidance and support."

"What can you do to enhance our leadership development offer at all levels?"

"Created a number of initiatives including: launching a variety of one-off People Management Masterclasses, developed an Aspiring to Be Programme for aspiring leaders which opens for applications in September and are introducing both a Senior Leaders Programme and a Supporting Transformation Programme for middle managers. There is also now a 360 feedback tool available to help colleagues plan their personal development and our Leadership Forums have been revamped and will run twice a year, inviting guest speakers to share their experience/best practice."

"Can more be done to recognise staff who have completed long service in the NHS?"

"Recently amended the policy to introduce long service award badges for 10, 20, 30, 40 and 50 years' service and are introducing celebration afternoon tea events to begin in January 2020."

"The Trust Strategy needs to be simpler and easier to relate to roles across the Trust."

"Refreshed the Trust Strategy following engagement with staff and introduced visual summaries of key documents."

"We need a new intranet and a website that is easier to navigate and works on mobile phones and other devices."

"Launched a new, mobile-ready website and started to develop our new staff intranet – Focus."

"If something doesn't feel right, we want to raise concerns confidently and without fear, knowing that we will be listened to…"

"Appointed a permanent Freedom to Speak Up Guardian, Tam Howard and are recruiting and training Freedom to Speak Up Champions across the Trust to create and support a positive culture of speaking up for all."

"It would be great to encourage more colleagues to be part of the Staff Forum…"

"At least one Staff Forum member from every area in the Trust now to ensure as many views as possible from all roles and teams are represented at the forum."

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 September 2019

Workforce Race Equality Standard (WRES) 2018-19

Purpose of Report

This report presents the annual Trust level Workforce Race Equality Standards (WRES) 2018/19 Draft blue template and WRES tracker 2015-19 to the leadership for consideration and approval. It highlights our position, actions to date and the areas we need to focus on based on what the data is telling us and the steps we need to take to drive improvement. This will then be published on our external website by 27 September, 2019 and shared with lead commissioners as part of the quality schedule.

Executive Summary

This report provides an opportunity for the leadership to understand the data, reflect on our journey in progressing race equality since 2015 and the actions to date. The areas we need to focus on across the Trust and leadership to address the known disparities at pace.

Our current position and the steps we are taking to improve our performance are summarised in the attached documents. Please refer to WRES Blue Template which includes actions to date (Appendix 1) WRES tracker 2015-19 (Appendix 2) and WRES Improvement Plan 2018/19 (Appendix 3) which identifies the streams of work to close the gaps across the indicators – this will be further refined with leaders to ensure ownership at the BME Network annual conference on 25 September, 2019 and project managed.
The WRES has nine metrics, four specifically focussing on workforce data, four from the NHS Staff Survey, and one requiring organisations to ensure that their Boards are broadly representative of the overall workforce. It requires NHS organisations to close the gap between the BME and white staff experience for those indicators.
The aim of the WRES is to improve workplace experiences, treatment and employment opportunities for Black and Minority Ethnicity (BME) colleagues. It also applies to BME people who want to work in the NHS and therefore helps to 'future proof' our Trust in terms of attracting and securing the necessary workforce to deliver high quality patient care and services to an increasingly diverse population.

Current position

In summary, our WRES 2018/19 positon and tracker 2015-2019 shows there is considerable work to be done to address the variations in experience, disciplinary, workforce representation, progression and development for Black and Minority Ethnic (BME) people. In the benchmarked data we have of 8 out of the 9 standards we are worse than the national average in 6 of those 8 standards (Appendix 2).

Driving change through organisational culture and performance indicators – there is commitment from the top drive change but creating an organisation that is culturally aware and inclusive requires all of our leaders being held to account for creating culturally inclusive workplaces and services. If we are to make a difference then high performing teams should be able to demonstrate/link their performance to inclusive approaches, improved staff experience and workforce diversity.

This includes the introduction of new BME Inclusion Targets to achieve a diverse workforce spearheaded by the Chief Executive and BME Executive Sponsor. This will be incorporated into the Workforce Dashboard to track our overall performance against the 15% corporate BME target from September 2019

1: BME Inclusion Targets – as at 27 July 2019

Derby and Derby City Combined average BME population*	9.1%	Derby City BME Population*	24.7%
		Derbyshire County BME Population*	4.2%
DHcFT target set as Median due to wide difference between City and County**	15%		
DHcFT Cohorts	Cohort BME Target	Cohort BME Actual	RAG Rating
All Staff	15%	**14%**	Red
AFC band 2 &3	15%	**18%**	Green
AFC Band 4&5	15%	**11%**	Red
AFC Band 6&7	15%	**9%**	Red
AFC Band 8a above	15%	**5%**	Red
None AFC Medics	15%	**50%**	Green
Trust Board	15%	7%	Red

Information provided by Systems & Information 29/7/2019.*Data from 2011 census **median 14.5% rounded up to 15%

2: WRES current positon and key headlines

- White colleagues are 2.86 times more likely to be appointed from shortlisting compared to BME colleagues. This figure has increased significantly from 2017-18
- The relative likelihood of BME colleagues entering the formal disciplinary process compared to white colleagues has improved slightly this year from 3.03 times more likely to 2.45 times more likely.
- Bullying and harassment in the organisation is still high, with 1 in 3 BME colleagues (32.6%) experiencing harassment, bullying or abuse from staff in the last 12 months, compared to 19.3% of white colleagues. The gap between white and BME colleagues for this indicator has been widening since 2016
- 16.4% of BME colleagues have personally experienced discrimination at work from their manager/team leader/other colleagues, compared to 5.3% of white colleagues. This represents a worsening trend.
- In the benchmarked data we have of 8 out of the 9 standards we are worse than the national average in 6 of those 8 standards.

Indicator	Positon 2018/19
WRES Indicator 1 - compare the data for white and BME staff: Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	There is a significant under-representation of BME talent in higher AfC bands, particularly at senior leadership pipeline levels. In the Non-Clinical workforce, 87.5% of BME employees are employed within Bands 1-4.

WRES Indicator 2 - compare the data for white and BME staff: Relative likelihood of staff being appointed from shortlisting across all posts	White colleagues are 2.86 times more likely to be appointed from shortlisting compared to BME colleagues. This figure has increased significantly from 2017-18 and could be due to the major increase in applications to the Trust from applicants from both white and BME backgrounds. The number of white applicants rose by 91% (from 1639 in 2018 to 3126 applicants in 2019) and the number of applicants from a BME background rose by 248% (from 396 in 2018 to 1377 in 2019).
WRES Indicator 3 - compare the data for white and BME staff: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation (This indicator will be based on data from the most recent two-year rolling average)	The relative likelihood of BME colleagues entering the formal disciplinary process compared to white colleagues has improved slightly this year from 3.03 times more likely to 2.45 times more likely
WRES Indicator 4 - compare the data for white and BME staff**:** Relative likelihood of staff accessing non-mandatory training and CPD	The relative likelihood of white staff accessing non-mandatory training compared to BME staff has improved from last year, from 1.53 times more likely to 0.97 times more likely. A figure below "1" would indicate that white staff members are less likely to access non-mandatory training and CPD than BME staff.
WRES Indicator 5 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months WRES Indicator 6 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	Bullying and harassment in the organisation is still high, with 1 in 3 BME colleagues (32.6%) experiencing harassment, bullying or abuse from staff in the last 12 months, compared to 19.3% of white colleagues. The gap between white and BME colleagues for this indicator has been widening since 2016.
WRES Indicator 7 Percentage believing that trust provides equal opportunities for career progression or promotion	There has been an improvement for both white and BME colleagues in the belief that the Trust provides equal opportunities for career progression or promotion.
WRES Indicator 8 In the last 12 months has you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	16.4% of BME colleagues have personally experienced discrimination at work from their manager/team leader/other colleagues, compared to 5.3% of white colleagues. This represents a worsening trend.
WRES Indicator 9 - compare the difference for white and BME staff: Percentage difference between (i) the organisations' Board voting membership and its overall workforce and (ii) the organisations' Board executive membership and its overall workforce	BME colleagues make up 13.0% of the Trust's workforce, represented by only 7.1% of the Trust's Board membership.

The Trust is a signatory of the Race at Work Charter and has signed up to the five principle calls to action for leaders and organisations across all sectors. Signing up means taking practical steps to ensure their workplaces are tackling barriers that

ethnic minority people face in recruitment and progression and that their organisations are representative of British society today. Leaders are expected to do what the best ones already do, to scrutinise and understand the data and act on it, and then work towards a level playing field where the treatment of staff is not unfairly affected by their ethnicity or other protected characteristics.

Moreover, the NHS Long Term Plan has set an ambitious national goal: that NHS leadership should be as diverse as the rest of the workforce within ten years. The need to ensure BME representation at senior management matches that across the rest of the NHS workforce is not for political correctness; a diverse workforce at all levels will lead to better patient outcomes and increased organizational efficiency.

The NHS People Plan 2019 states: *'It is not enough for the NHS merely to continue to champion the idea of inclusion and diversity. We must recognise our shortcomings in this area and listen to the experience of those who face exclusion and marginalisation to understand how to advance equality and diversity better. We need to develop leaders who have the knowledge, skills and behaviours to create and sustain cultures of compassion and inclusion. We must also urgently intensify our efforts to ensure our teams and organisations, particularly the senior leadership of the NHS, demonstrably reflect the diversity of the communities that they serve, including making progress against the 10-year leadership equality ambition that reflects the Prime Minister's pledge around race equality'.*

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	x
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	x
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	x

Assurances

The Trust will take an organisational development approach to drive change and inclusive leadership through holding leaders to account and tracking performance. The Trust has signed up to the national WRES expert programme to facilitate best practice and guidance. WRES Improvement Plan 2018/19 will be refined with leaders to address disparities. WRES is performance managed via Equalities Forum which has trust wide membership and is part of the governance structure and sub-group of People & Culture Committee. Please see the Public Sector Equality Duty Section.

Consultation

WRES metrics and Improvement Plan has been shared and developed with the BME Colleague Network & Equality Forum to support us with addressing the inequalities and gaps. WRES work streams include representatives from diverse groups of staff, staff side and governors. Trust Management Team Meeting – 1st August 2019.

Governance or Legal Issues

The WRES is a mandatory part of the NHS Standard Contract and the Trust is required to submit WRES and action plan to commissioners outlining progress on implementing the standard (as part of Schedule 4 Evidence for 2019-20) and then published on our public facing website by the 27th September, 2019
Undertaking the EDS2 demonstrates progress and commitment to understanding of duties towards protected characteristics or REGARDS groups under the Equality Act 2010 & Human Rights Act 1998. The Specific Duties regulations already require all public authorities, listed at the schedules to the regulations, to publish information to demonstrate their compliance under the Public Sector Equality Duty (PSED).

Public Sector Equality Duty & Equality Impact Risk Analysis

Differential impact is evidenced via the WRES indicators which capture ethnicity data and identifies the disparities between BME and White colleagues. Moreover the WRES Tracker 2015-2019 establishes a baseline and benchmarking to measure our progress.

The paper encourages leaders to visibly demonstrate living the Trust values in building a 'positively inclusive culture' and using the WRES evidence as an enabler to improve our workforce diversity and person centred and fair/just environment for everyone. It sets out how we will demonstrate visible leadership and driving key actions such as setting targets for ethnic minority representation, recruitment, progression and supporting mentoring and sponsorship.

The Board has signed up to the Race at Work Charter and our WRES action plan has been developed to demonstrate that there is visible commitment from the top to drive change. Making it clear that supporting equality in the workplace is the responsibility of all leaders and managers. The Chief Executive and BME Executive Sponsor has encouraged and invited leaders to attend the BME Network Annual Conference on 25 September 2019 – this will be a call to action and cover their responsibilities to support fairness for all staff and creating inclusive environment. Most importantly the crucial role leaders play in driving up improvement in relation to acting and understanding the causes and playing their part in implementing the WRES action plan and creating workforce t reflects the diversity and talent of the population we serve.

Recommendations

The Board of Directors is requested to:

1) Consider and discuss Trust WRES data and journey – organisational performance and improvement actions .
2) Note the introduction of the new BME Inclusion targets as part of the workforce dashboard.
3) Approve the WRES 18/19 template and associated documents prior to publishing on our website on the 27th September, 2019 and sharing with commissioners.

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

Report prepared by: **Harinder Dhaliwal**
Head of Equality, Diversity & Inclusion and
Clare Meredith
Equality, Diversity & Inclusion Advisor.

Appendix 1: WRES 2018/19 Blue Template which includes actions to date
Appendix 2: WRES tracker 2015-19
Appendix 3: WRES Improvement Plan 2018/19

Workforce Race Equality Standard

REPORTING TEMPLATE (Revised 2016)

Template for completion

Name of organisation

Derbyshire Healthcare NHS Foundation Trust

Date of report: month/year

August 2019

Name and title of Board lead for the Workforce Race Equality Standard

Ifti Majid - Chief Executive

Name and contact details of lead manager compiling this report

Harinder Dhaliwal - Head of Equality, Diversity and Inclusion

Names of commissioners this report has been sent to (complete as applicable)

NHS Derby & Derbyshire Clinical Commissioning Group

Name and contact details of co-ordinating commissioner this report has been sent to (complete as applicable)

Phil Sugden, NHS Derby & Derbyshire Clinical Commissioning Group: philip.sugden1@nhs.net

Unique URL link on which this Report and associated Action Plan will be found

https://www.derbyshirehealthcareft.nhs.uk/about-us/equality-and-diversity

This report has been signed off by on behalf of the Board on (insert name and date)

Ifti Majid, Chief Executive, Board Meeting 3rd September 2019

Publications Gateway Reference Number: 05067

Report on the WRES indicators

1. Background narrative

a. Any issues of completeness of data

108 staff members (4.2% of the workforce) have not disclosed their ethnicity.

Board membership: One Board member is not included as they are not on the Trust's payroll.

b. Any matters relating to reliability of comparisons with previous years

Recruitment: Bank staff were included in the statistics provided by the Recruitment team. The Trust has a larger Bank this year than was in place in 2017-18.

2. Total numbers of staff

a. Employed within this organisation at the date of the report

2586

b. Proportion of BME staff employed within this organisation at the date of the report

336 (13.0% identify as BME)

3. Self reporting

a. The proportion of total staff who have self–reported their ethnicity

White: 82.8%
BME: 13.0%

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity

ESR Self-Service and the importance of disclosing ethnicity has been promoted across the Trust.

c. Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity

ESR Self-Service continues to be promoted.
Trust-wide market stalls.
Communications plan being developed to improve declaration rates of protected characteristics and raise awareness of the benefits of disclosing this information e.g. though the use of screensavers.

4. Workforce data

a. What period does the organisation's workforce data refer to?

01 April 2018 - 31 March 2019

5. Workforce Race Equality Indicators

Please note that only high level summary points should be provided in the text boxes below – the detail should be contained in accompanying WRES Action Plans.

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	For each of these four workforce indicators, compare the data for White and BME staff				
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	Non-Clinical Bands 1-9: White: 21.85% BME: 3.05% Unknown: 0.70% Non-Clinical VSM:	Non-Clinical Bands 1-9: White: 23.42% BME: 3.25% Unknown: 4.85% Non-Clinical VSM:	Among the Non-Clinical workforce, the number of BME employees has decreased by 0.16% and the number of white employees has decreased by 1.34%. In the Clinical Staff group, there has been an increase in the number of both white and BME employees, with a 0.4% increase for BME employees and a 2.76% increase for White	Driving change through organisational culture and performance. Introduction of new BME Inclusion Targets to achieve a diverse workforce spearheaded by the Chief Executive and BME Executive Sponsor. This will be incorporated into the Workforce Dashboard to track our overall performance against the 15% corporate BME target from September 2019. Race at Work
2	Relative likelihood of staff being appointed from shortlisting across all posts.	2.86	1.57	In 2018-19, white staff are 2.86 times more likely to be appointed from shortlisting compared to BME staff. However, we note that the number of shortlisted applicants increased significantly for both BME and white applicants. The number of white shortlisted applicants increased by 91% (1639	BME Staff Network is working with Recruitment to have more BME staff trained to be part of the recruitment process. Establishment of Inclusion Guardians on interview panels. WRES Expert Programme to facilitate best practice to drive change. People Resourcing have used the Network to ask for panel members in senior level appointments.
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.	2.45	3.03	In 2018-19, BME staff are 2.45 times more likely to enter the formal disciplinary process compared to white staff, which represents a decrease from 2017-18.	The Director of People Services and Organizational Effectiveness personally oversees every case that involves a staff member who falls under any of the 9 protected characteristics. Extra check point introduced by Chief Executive.The BME Staff Network commissioned the Employee Relations Team to undertake a deep dive into disciplinary processes and grievance reporting.
4	Relative likelihood of staff accessing non-mandatory training and CPD.	0.97	1.53	In 2018-19, white staff are 0.97 times more likely to access non-mandatory training and CPD compared to BME staff, which is an improvement of 0.56 times upon last year.	-Continue to promote and monitor BME access to NHS national programmes, East Midlands Leadership Academy and ILM programmes that aim to build leadership capacity amongst BME staff. The Reverse Mentoring Programme was established in 2018 and ran concurrently with the University of Nottingham. The next cohort is currently being planned by the Reverse

Report on the WRES indicators, continued

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.				
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White 27.8% BME 26.8%	White 24.7% BME 27.4%	The percentage of white staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months has increased by 2.8%, while the percentage for BME staff has decreased by 0.2%. The difference	Tackling Bullying & Harassment Workshop led by Director of People Services and Organisational Effectiveness. Bullying & Harassment booklet based on learning from the event launched in July 2019 for circulation around the Trust.BME Staff
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White 19.3% BME 32.6%	White 22.1% BME 27.5%	There has been an increase of 5.1% in the percentage of BME staff experiencing harassment, bullying abuse from staff in the last 12 months, from 27.5% in 2017 to 32/6% in 2018-19.	-Bullying & Harassment Workshop and booklet as above. Reaffirm at regular intervals the Trust's position statement on zero tolerance issued by the CEO. Use opportunities including NHS Diversity and Human Rights week, Black History
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.	White 86.1% BME 64.4%	White 80.2% BME 55.6%	White and BME staff have seen an increase in their belief that the trust provides equal opportunities for career progression or promotion. The percentage for BME staff has increased by 8.4% in 2019, and the percentage for white staff	BME Staff Network is supported by leadership with an Executive Sponsor in our Chief Executive. Reverse Mentoring for Equality, Diversity & Inclusion is a learning opportunity which enables senior leaders to gain insight from colleagues
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White 5.3% BME 16.4%	White 6.1% BME 14.2%	The percentage of BME staff reporting discrimination at work from their manager/team leader or other colleagues has increased by 2.4%, while the percentage of white staff experiencing discrimination has decreased by	As above in Indicators 5 and 6.
	Board representation indicator For this indicator, compare the difference for White and BME staff.				
9	Percentage difference between the organisations' Board voting membership and its overall workforce.	Difference between Board voting membership and overall workforce:	Difference between Board voting membership and overall workforce:	The Trust's BME Board voting membership is 9.1% compared with 13.0% of the overall workforce being from a BME background. The percentage difference has increased since last year because the percentage of BME colleagues	-Aim to build BME talent pipeline, leadership capacity and capability in the Trust. NED adverts promoted in community. Non-Executive Director from the NeXT Director Scheme soon to begin at the Trust. This scheme helps people from

Note 1. All provider organisations to whom the NHS Standard Contract applies are required to conduct the NHS Staff Survey. Those organisations that do not undertake the NHS Staff Survey are recommended to do so, or to undertake an equivalent.

Note 2. Please see the WRES Technical Guidance for detailed specifications for implementing each indicator.

Report on the WRES indicators, continued

6. Are there any other factors or data which should be taken into consideration in assessing progress?

7. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.

Click to lock all form fields and prevent future editing

Derbyshire Healthcare
NHS Foundation Trust

DHCFT Workforce Race Equality Standard Tracker 2015-2019 & Benchmarking

Contents

Key Findings

- In the benchmarked data we have of 8 out of the 9 standards we are worse than the national average in 6 of those 8 standards

- **Indicator 1:** There is a significant underrepresentation of BME talent in higher AfC bands, particularly at senior leadership levels. In the Non-Clinical workforce, 87.5% of BME employees are employed within Bands 1-4.
- **Indicator 2:** White colleagues are 2.86 times more likely to be appointed from shortlisting compared to BME colleagues. This figure has increased significantly from 2017-18 and could be due to the major increase in applications to the Trust from applicants from both white and BME backgrounds. The number of white applicants rose by 91% (from 1639 in 2018 to 3126 applicants in 2019) and the number of applicants from a BME background rose by 248% (from 396 in 2018 to 1377 in 2019).
- **Indicator 3:** The relative likelihood of BME colleagues entering the formal disciplinary process compared to white colleagues has improved slightly this year from 3.03 times more likely to 2.45 times more likely.
- **Indicator 4:** The relative likelihood of white staff accessing non-mandatory training compared to BME staff has improved from last year, from 1.53 times more likely to 0.97 times more likely.

- **Indicators 5 & 6:** Bullying and harassment in the organisation is still high, with 1 in 3 BME colleagues (32.6%) experiencing harassment, bullying or abuse from staff in the last 12 months, compared to 19.3% of white colleagues. The gap between white and BME colleagues for this indicator has been widening since 2016.
- **Indicator 7:** There has been an improvement for both white and BME colleagues in the belief that the Trust provides equal opportunities for career progression or promotion.
- **Indicator 8:** 16.4% of BME colleagues have personally experienced discrimination at work from their manager/team leader/other colleagues, compared to 5.3% of white colleagues. This represents a worsening trend.
- **Indicator 9:** BME colleagues make up 13.0% of the Trust's workforce, represented by only 7.1% of the Trust's Board membership.

National Benchmarking of indicators 2 to 9

In the tables below, figures have been colour-coded for Derbyshire Healthcare depending on their position against the national/regional average across all NHS Trusts as at March 2018:

Key
Worse than 2018 national/regional average
Same as 2018 national/regional average
Better than 2018 national/regional average

	All NHS Trusts in England			DHCFT	
WRES Indicator	**2016**	**2017**	**2018**	**2018**	**2019**
2. Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants.	1.57	1.60	1.45	1.57	2.86
3. Relative likelihood of BME staff entering the formal disciplinary process compared to white staff.	1.56	1.37	1.24	3.03	2.45
4. Relative likelihood of BME staff accessing non-mandatory training and CPD compared to white staff.	1.11	1.22	1.15	1.53	0.97
5. Percentage of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months.	29%	29%	29%	27.43%	26.80%
6. Percentage of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months.	27%	26%	28%	27.52%	32.60%
7. Percentage of BME staff believing the Trust provides equal opportunities for career progression	74%	76%	72%	55.56%	64.40%

	All NHS Trusts in England			DHCFT	
WRES Indicator	**2016**	**2017**	**2018**	**2018**	**2019**
or promotion.					
8. Percentage of BME staff personally experiencing discrimination at work from a manager/team leader or other colleagues.	14%	14%	15%	14.16%	16.40%
9. BME board membership	7%	7%	7%	-4.3%	-5.9%

- Data source(s): NHS WRES England: 2018 Data Analysis Report for NHS Trusts; DHCFT Staff Survey 2017-18 and 2018-19.

DHCFT data by indicator and regional benchmarking

Below can be found Derbyshire Healthcare's data split by indicator, showing the Trust's trajectory from 2015 to 2019.

Benchmarking data has also been included to display DHCFT's position against other NHS Trusts in the Midlands & East region and nationally.

Key	
Positive trend	
Negative trend	

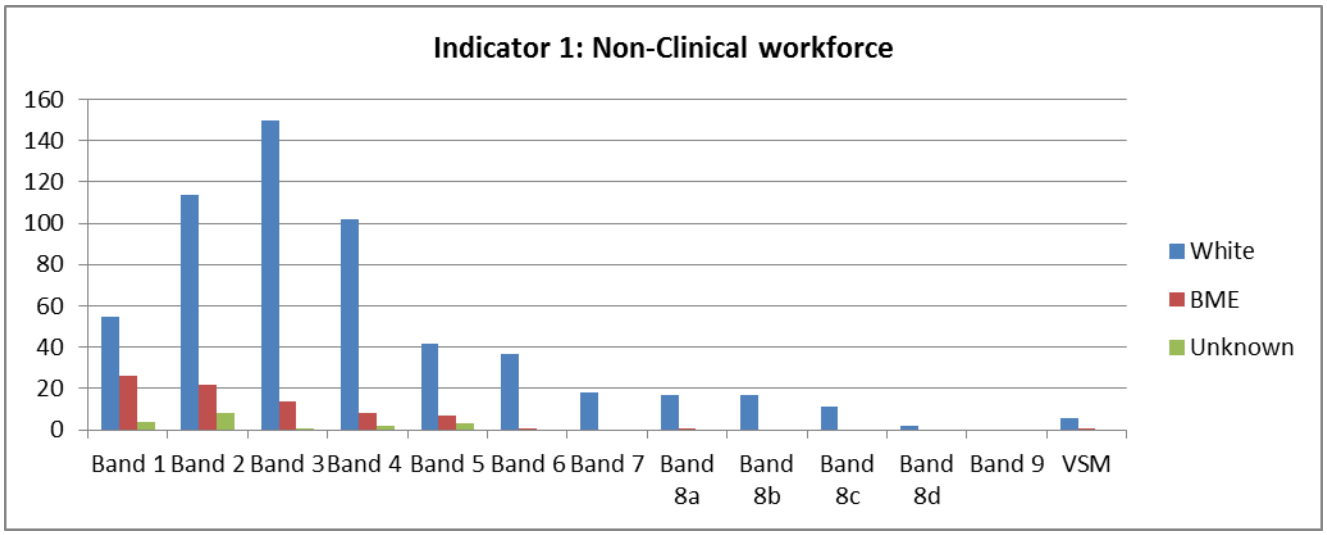
Indicator 1 Percentage of staff in each of the AfC Bands 1-9 and VSM compared with the percentage of staff in the overall workforce.

Ethnicity	2015	2016	2017	2018	2019	Movement 2018-19
Non - Clinical White	22.98%	22.81%	23.52%	23.42%	22.08%	**-1.34%**
Non - Clinical BME	2.55%	2.75%	2.76%	3.25%	3.09%	**-0.16%**
Clinical White	55.03%	55.78%	59.06%	56.06%	58.82%	**+2.76%**
Clinical BME	7.15%	7.15%	6.99%	7.14%	7.54%	**+0.40%**

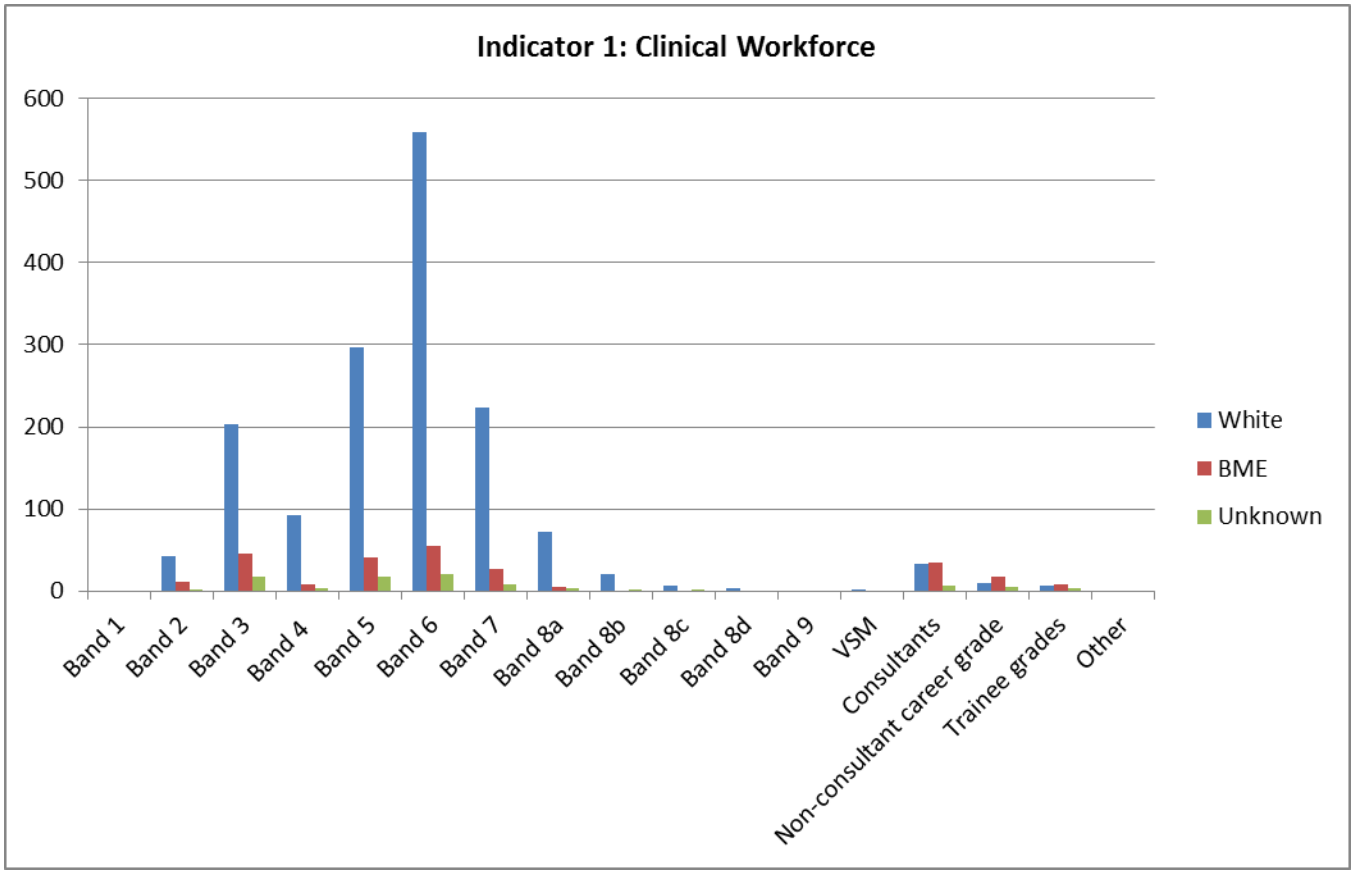
Number of staff in workforce by banding

Number of staff in workforce by banding

Non-Clinical Workforce													
	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9	VSM
White	55	114	150	102	42	37	18	17	17	11	2	0	6
BME	26	22	14	8	7	1	0	1	0	0	0	0	1
Unknown	4	8	1	2	3	0	0	0	0	0	0	0	0



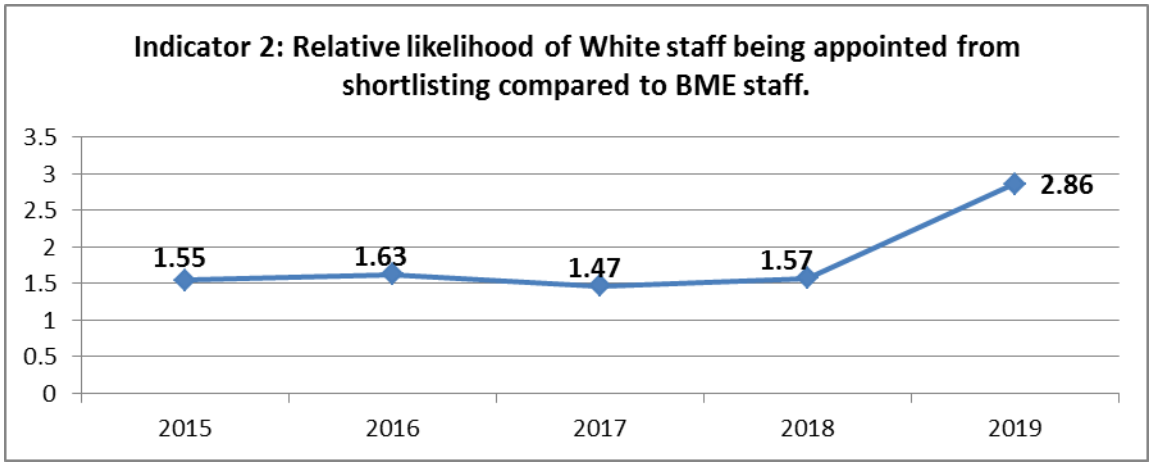
	Clinical Workforce													Medical & Dental			
	B1	B2	B3	B4	B5	B6	B7	B8a	B8b	B8c	B8d	B9	VSM	Consultants	Non-consultant career grade	Trainee grades	Other
White	0	43	203	92	297	559	223	72	20	7	3	0	1	33	10	7	0
BME	0	11	46	9	41	55	27	5	0	0	0	0	0	35	18	8	0
Unknown	0	2	17	4	17	21	8	4	1	1	0	0	0	7	5	3	0



Narrative: The data shows an underrepresentation of BME employees in the higher AfC bands in both the Non-Clinical and Clinical workforce.

Indicator 2 : **Relative likelihood of white staff being appointed from shortlisting compared to BME staff.**

2015	2016	2017	2018	2019	Movement 2018-2019
1.55	1.63	1.47	1.57	2.86	+1.29



Narrative: The relative likelihood of white staff being appointed from shortlisting compared to BME staff has increased significantly this year despite staying fairly regular between 2015 and 2018. The likelihood has increased from 1.57 times more likely in 2018 to 2.86 times more likely in 2019, which demonstrates a negative

change. This could in part be due to the major increase in applications to the Trust from applicants from both white and BME backgrounds. The number of white shortlisted applicants increased from 1639 in 2017-18 to 3126 in 2018-19, while the number of BME shortlisted applicants increased from 396 in 2017-18 to 1377 in 2018-19.

Benchmarking with Peers

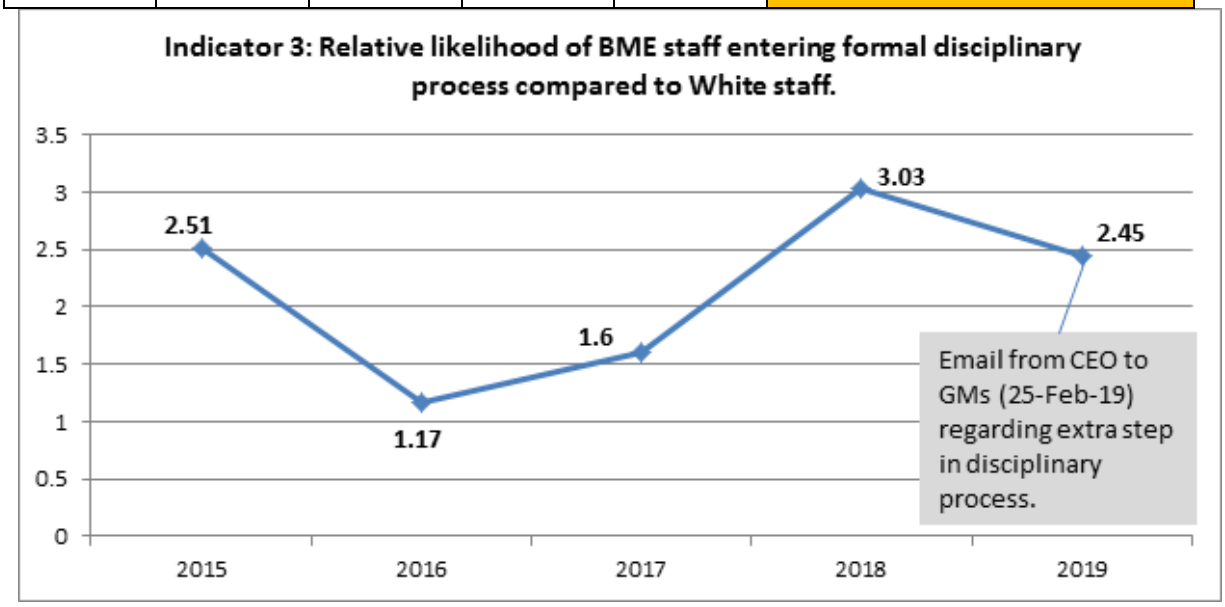
In the benchmarked data we have of 8 out of the 9 standards we are worse than the national average in 6 of those 8 standards

The table below shows Derbyshire Healthcare's position against other Trusts in the Midlands & East Region:

Trust Type	Region	Organisation	2018	2019
Mental Health	Midlands & East	DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	1.57	2.86
Acute	Midlands & East	DERBY TEACHING HOSPITALS (UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST)	1.3	-
Acute	Midlands & East	BURTON HOSPITALS (UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST)	1.49	-
Community	Midlands & East	DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST	3.18	-
Mental Health	Midlands & East	NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	1.8	-
Mental Health	Midlands & East	NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	2.0	-
Mental Health	Midlands & East	NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	2.0	-
Mental Health	Midlands & East	NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	1.7	-
Mental Health	Midlands & East	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	1.5	-
Mental Health	Midlands & East	HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	1.4	-
Mental Health	Midlands & East	DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST	1.4	-
Mental Health	Midlands & East	ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	1.4	-
Mental Health	Midlands & East	LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	1.4	-
Mental Health	Midlands & East	COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	1.4	-
Mental Health	Midlands & East	LEICESTERSHIRE PARTNERSHIP NHS TRUST	1.3	-
Mental Health	Midlands & East	BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	1.1	-
Mental Health	Midlands & East	MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST	1.0	-
Mental Health	Midlands & East	BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST	0.7	-

Indicator 3 : Relative likelihood of BME staff entering formal disciplinary process compared to white staff

2015	2016	2017	2018	2019	Movement 2018-2019
2.51	1.17	1.6	3.03	2.45	-0.58



Narrative: The relative likelihood of BME staff entering the formal disciplinary process compared to white staff has improved this year from 3.03 times more likely to 2.45 times more likely. This figure is now lower than it was in 2015, and work to keep this figure decreasing includes a number of interventions:

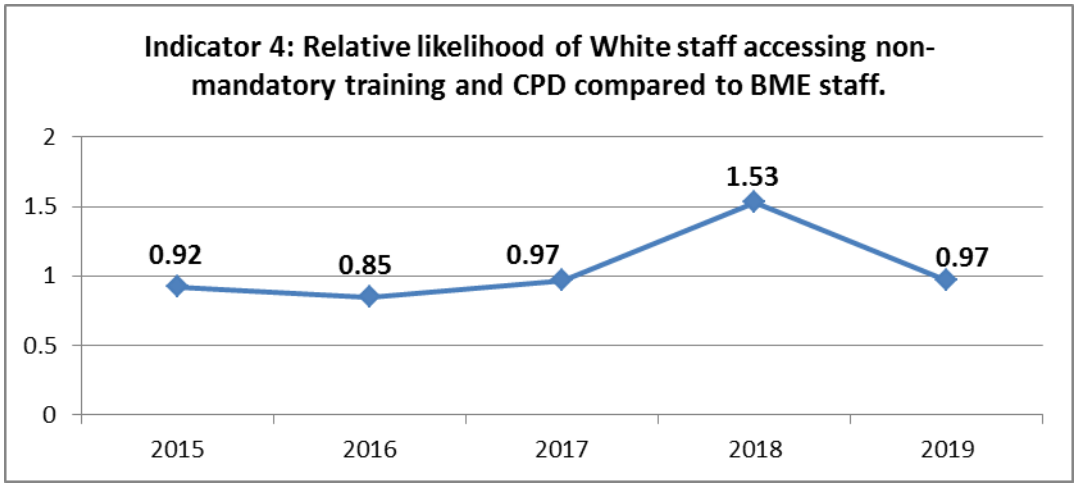
- People Services have developed an Equalities Action Plan to try to get to the bottom of this at the source, such as undertaking a deep dive into employee relations case work by ethnicity from 2014-201. The aim was to understand proportionately and if sanctions were justifiable. The findings were that BME staff were disproportionately subjected to employee relations processes compared to white counterparts. We presented this report to the BME network in in February 2019.
- Extra Checkpoint - the Chief Executive has asked General Managers (email 25/2/2019) asking them to implement an extra step in the Disciplinary/Grievance/Dignity at Work process for any BME staff who find themselves with allegations made against them. Specifically, he has asked that we add a check point into the disciplinary process for those staff who identify as Disabled, LGBT+ or BME whereby before the case is commenced it is reviewed by the GM/Head of Service and Assistant Director People and Culture Transformation and Head of Employee Relations.
- Director of People and Organisational Effectiveness looking at every case that involves a colleague that falls under a protected characteristic and introduction of 'Just culture' campaign (June 2019)

The table below shows Derbyshire Healthcare's position against other Health Trusts in the Midlands & East Region:

Trust Type	Region	Organisation	2018	2019
Mental Health	Midlands & East	NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	10.52	-
Mental Health	Midlands & East	NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	3.57	-
Mental Health	Midlands & East	DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	3.03	2.45
Mental Health	Midlands & East	MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST	2.45	-
Mental Health	Midlands & East	COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	2.34	-
Mental Health	Midlands & East	NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	2.31	-
Mental Health	Midlands & East	HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	2.11	-
Mental Health	Midlands & East	BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	2.06	-
Mental Health	Midlands & East	LEICESTERSHIRE PARTNERSHIP NHS TRUST	1.92	-
Mental Health	Midlands & East	ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	1.60	-
Mental Health	Midlands & East	BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST	1.49	-
Mental Health	Midlands & East	LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	1.24	-
Acute	Midlands & East	DERBY TEACHING HOSPITALS (UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST)	1.10	-
Mental Health	Midlands & East	DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST	1.07	-
Mental Health	Midlands & East	NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	0.84	-
Mental Health	Midlands & East	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	0.75	-
Acute	Midlands & East	BURTON HOSPITALS (UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST)	0.64	
Community	Midlands & East	DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST	0.00	-

Indicator 4: Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff

2015	2016	2017	2018	2019	Movement 2018-2019
0.92	0.85	0.97	1.53	0.97	-0.56



Narrative: The relative likelihood of white staff accessing non-mandatory training compared to BME staff has decreased since 2017 from 1.53 times more likely to 0.97 times more likely. This brings it more in line with the figures from 2015-2017.

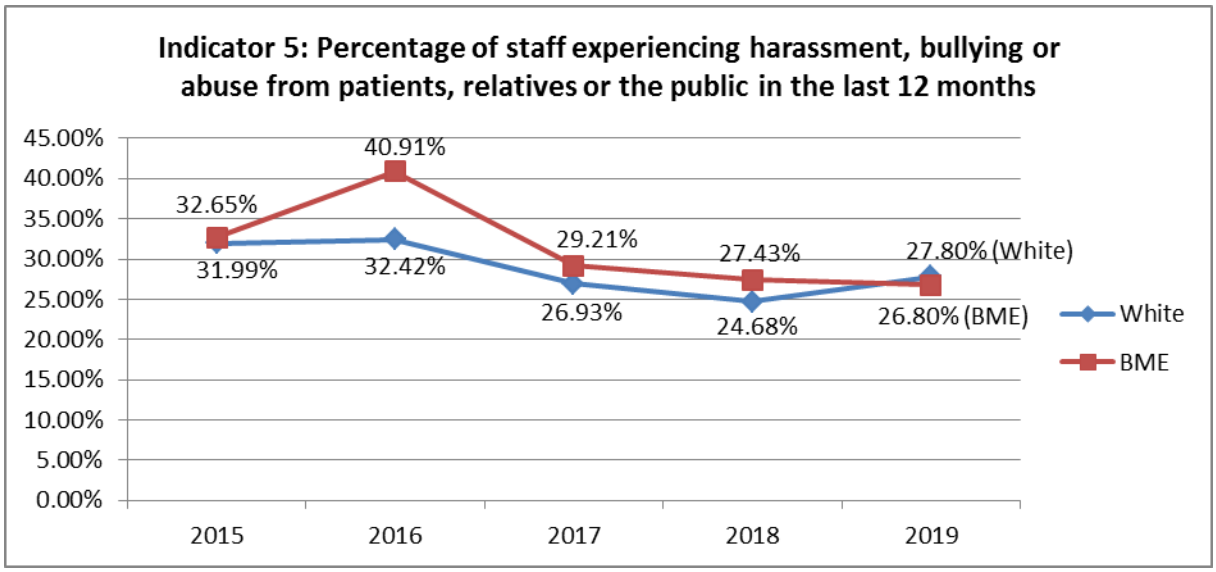
The table below shows Derbyshire Healthcare's position against other Trusts in the Midlands & East Region:

Trust Type	Region	Organisation	2018	2019
Mental Health	Midlands & East	LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	1.96	-
Mental Health	Midlands & East	ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	1.57	-
Mental Health	Midlands & East	DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	1.53	0.97
Mental Health	Midlands & East	COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	1.27	-
Mental Health	Midlands & East	HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	1.19	-
Mental Health	Midlands & East	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	1.06	-
Mental Health	Midlands & East	LEICESTERSHIRE PARTNERSHIP NHS TRUST	1.05	-
Acute	Midlands & East	BURTON HOSPITALS (UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST)	1.04	
Mental Health	Midlands & East	DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST	1.00	-
Acute	Midlands & East	DERBY TEACHING HOSPITALS (UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST)	0.99	-
Mental Health	Midlands & East	NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	0.96	-
Mental Health	Midlands & East	NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	0.95	-
Mental Health	Midlands & East	BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST	0.93	-
Mental Health	Midlands & East	BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	0.88	-

Trust Type	Region	Organisation	2018	2019
Mental Health	Midlands & East	NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	0.87	-
Mental Health	Midlands & East	MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST	0.46	-
Mental Health	Midlands & East	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	0.75	-
Community	Midlands & East	DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST	0.72	

Indicator 5: **Percentage of staff experiencing harassment bullying or abuse from patients, relatives or the public in the last 12 months**

Ethnicity	2015	2016	2017	2018	2019	Movement 2018-2019
White	31.99%	32.42%	26.93%	24.68%	27.80%	+3.12%
BME	32.65%	40.91%	29.21%	27.43%	26.80%	-0.63%



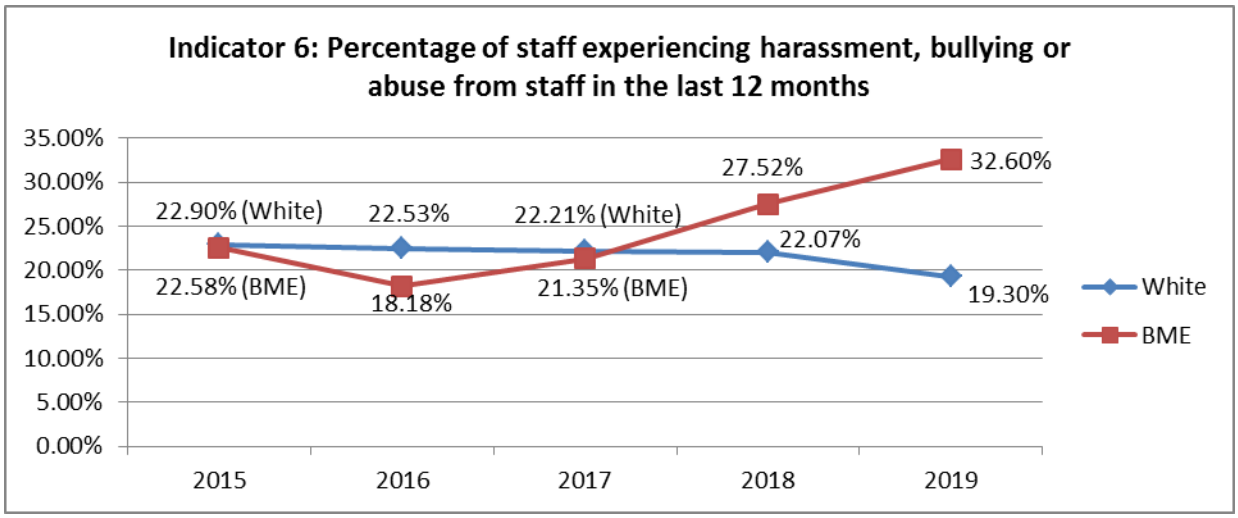
Narrative: Bullying, harassment or abuse from patients, relatives or the public has reduced by 0.63% among BME colleagues to 26.8% and increased by 3.12% among white colleagues to 27.8%. These figures mean that more than 1 in 4 colleagues from a white or BME background have experienced harassment, bullying or abuse in the last 12 months.

The table below shows a comparison between DHCFT and the average for NHS Trusts in the Midlands & East region: 2017-18 and 2018-19.

	2017-18		2018-19	
	BME	White	BME	White
Midlands & East	27.50%	27.40%	Data currently unavailable	Data currently unavailable
DHCFT	27.43%	24.68%	26.80%	27.80%

Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.

Ethnicity	2015	2016	2017	2018	2019	Movement 2018-2019
White	22.90%	22.53%	22.21%	22.07%	19.30%	-2.77%
BME	22.58%	18.18%	21.35%	27.52%	32.60%	+5.08%



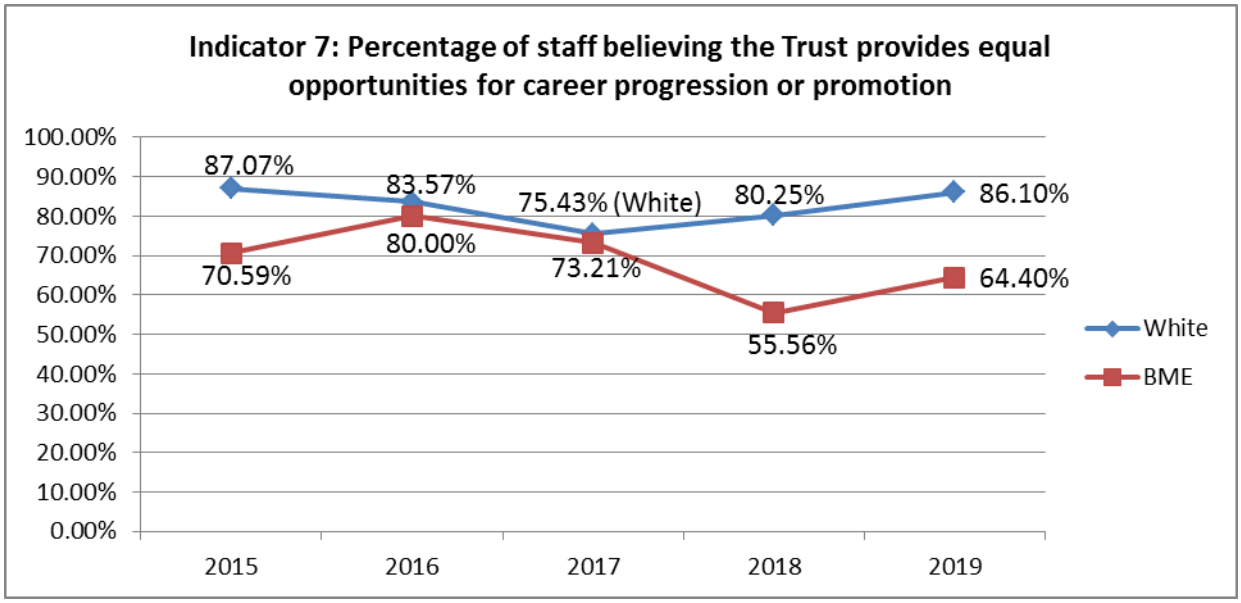
Narrative: 1 in 3 BME colleagues (32.6%) have experienced harassment, bullying or abuse from staff in the last 12 months, compared to 19.3% of white colleagues. The gap between white and BME colleagues for this indicator has been widening since 2016. Harassment & Bullying Booklet and guidance launched July 2019.

The table below shows a comparison between DHCFT and the average for NHS Trusts in the Midlands & East region: 2017-18 and 2018-19

	2017-2018		2018-19	
	BME	White	BME	White
Midlands & East	26.7%	23.7%	Data currently unavailable	Data currently unavailable
DHCFT	27.52%	22.07%	32.60%	19.30%

Indicator 7: Percentage of staff believing the Trust provides equal opportunities for career progression or promotion.

Ethnicity	2015	2016	2017	2018	2019	Movement 2018-2019
White	87.07%	83.57%	75.43%	80.25%	86.10%	+5.85%
BME	70.59%	80.00%	73.21%	55.56%	64.40%	+8.84%

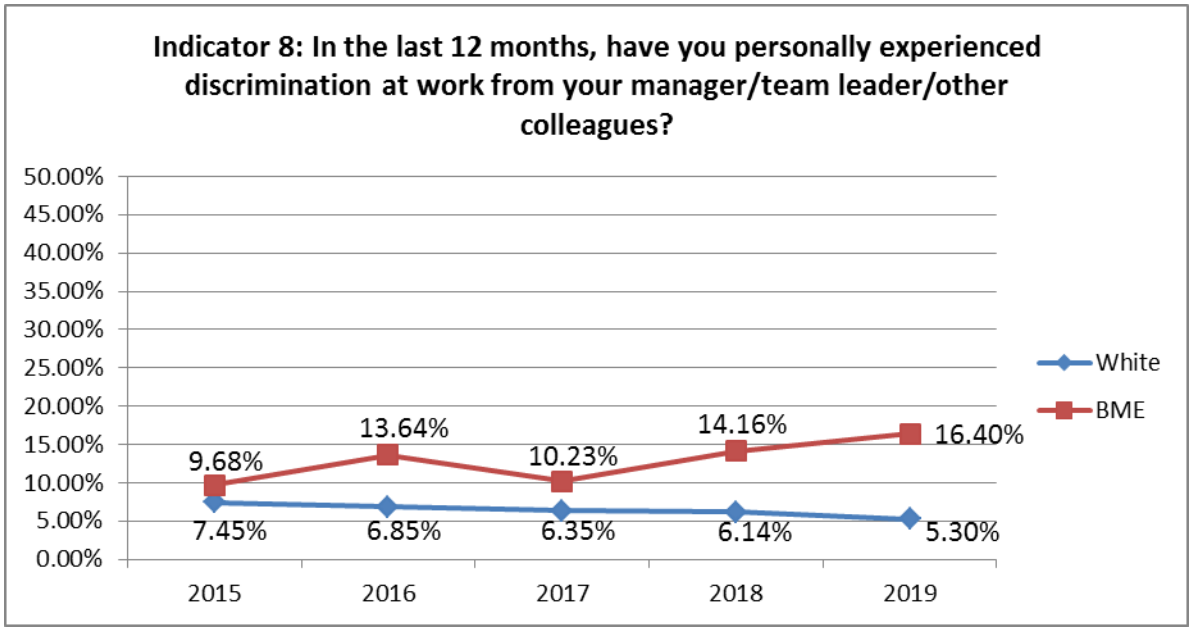


Narrative: There has been a positive increase this year among colleagues believing the Trust provides equal opportunities for career progression or promotion. 2019's data is still lower than it was in 2015 for both BME and white colleagues.

	2017-2018		2018-19	
	BME	White	BME	White
Midlands & East	73.1%	86.3%	Data currently unavailable	Data currently unavailable
DHCFT	55.56%	80.25%	64.40%	86.10%

Indicator 8: Percentage of staff who have personally experienced discrimination at work from their manager/team leader/other colleagues.

Ethnicity	2015	2016	2017	2018	2019	Movement 2018-2019
White	7.45%	6.85%	6.35%	6.14%	5.30%	-0.84%
BME	9.68%	13.64%	10.23%	14.16%	16.40%	+2.24%

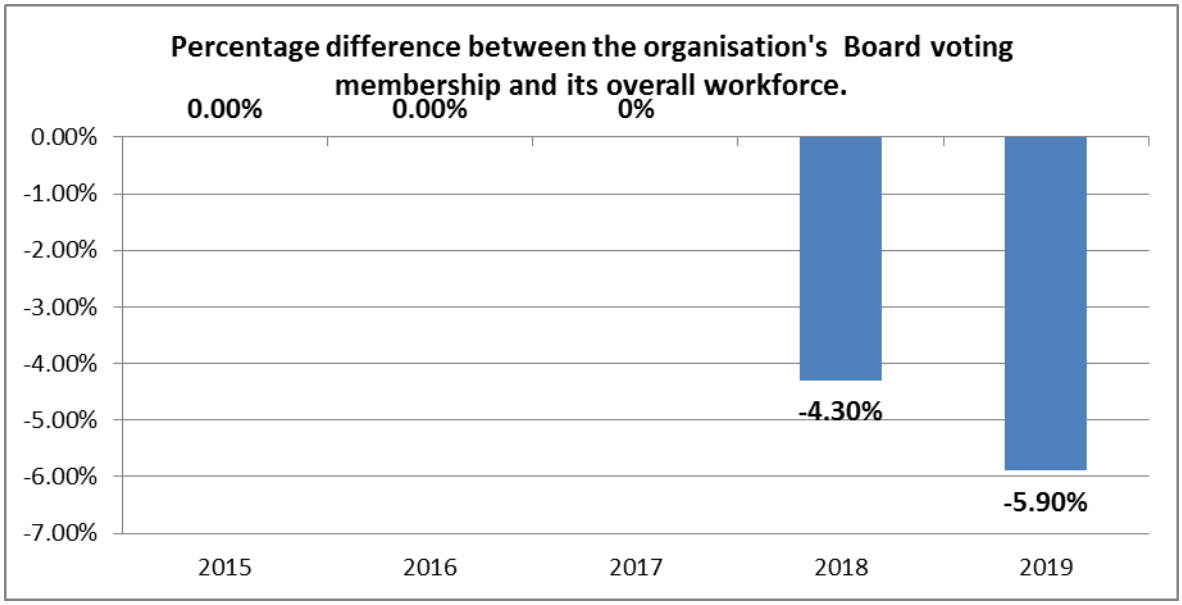


Narrative: BME colleagues experience significantly more discrimination at work from their managers/team leaders/other colleagues than their white colleagues. Fluctuating since 2015, the percentage is currently at its highest at 16.4%, compared to 5.3% of white colleagues. Harassment & Bullying Booklet and guidance launched July 2019.

	2017-2018		2018-19	
	BME	White	BME	White
Midlands & East	14.0%	6.7%	Data currently unavailable	Data currently unavailable
DHCFT	14.16%	6.14%	16.40%	5.30%

Indicator 9: Percentage difference between the organisation's Board voting membership and its overall workforce.

2018	2019	Movement 2018-19
-4.30%	-5.90%	-1.60%



Narrative: The Board voting membership does not represent the overall workforce in terms of ethnicity. In 2018-19, the total percentage of BME Board members is 7.1% and the percentage of BME staff in the overall workforce is 13%. Last year, in 2017-18, the total percentage of BME Board members was 8.3% and the percentage of BME staff in the overall workforce was 12.6%. Schemes to increase representation of BME colleagues in senior leadership positions will improve this figure, with targets and training programmes for BME colleagues across the bands to increase the BME talent pipeline.

Workforce Race Equality Standard (WRES) Improvement Plan 2018-19 (August 2019)

Indicator	Action(s)	Lead	Update August 2019
Organisational Culture Creating an organisation that is culturally aware, positively inclusive and diverse **WRES 1: BME representation in workforce**	**1.1** Implement and measure achievement through the Trust Strategy workforce building block, People Plan, Workforce Plan and Talent Plan. **1.2** BME Inclusion Target (15%) – tracked via Trust Workforce Dashboard from 1st August 2019. **1.3** Review ethnic profile of staff in each AfC pay band structure. **1.4** Promote and monitor BME access to NHS national programmes, Leadership Academy and ILM programmes that aim to build leadership capacity among BME staff. **1.5** The Trust has signed up to the Race at Work Charter and 5 calls to actions	**Amanda Rawlings**, Director of People Resources and Organisational Effectiveness People Services Team **Equality, Diversity & Inclusion Service** Faith Sango, Head of People Development	WRES Tracker and benchmarking 2015-19 completed. BME Inclusion Target set/key performance indicator by CEO/BME Executive Sponsor. Incorporated in Trust Workforce Dashboard – July/August 2019. Head of People Development (FS) to look into how many BME colleagues accessed EMLA courses in last 12 months. Update at BME Conference 25/9/2019 Trust completed Race at Work Charter survey in July 2019. Race at Work event – one year invitation 2/10/2019 at House of Lords. Expressions of interest invited from BME Network to represent the Trust.
WRES 2: To eliminate the gap between White and BME staff who are appointed Following shortlisting.	**2.1** Monitor recruitment processes. **2.2** Unconscious bias and cultural competence training of senior leaders and managers. **2.3** Inclusion Guardians on interview panels. **2.4** Task group to be set up to look at unsuccessful	**Equality, Diversity & Inclusion Service** **Nicola Myronko,** Head of People	Head of People Resources (NM) to present update at BME Conference on 25/9/19. BME Annual Conference Theme: Unconscious Bias in everyday decision-making

	applications vs successful applications. **2.5** BME Network members to complete recruitment training to sit on interview panels.	Resourcing	attended by senior leaders and managers. Link to sign up to recruitment panel training resent to BME membership on 18/7/2019.
WRES 3: **To eliminate the gap between White and BME staff entering the** **formal disciplinary** **process**	**3.1** Task group to be set up to look at disciplinary process involving BME and Disabled colleagues: BME Network is working with Employee Relations to look at the difference between the ethnicity of staff entering the formal disciplinary process and those receiving sanctions, and the differential outcomes of disproportionate disciplinary action against BME staff. The group will also look at setting up 'conscious nudges' during the investigation process to assess the need for escalation. **3.2** Director of People Resources and Organisational Effectiveness to oversee every disciplinary case involving a colleague who falls under any of the 9 protected characteristics. 3.3 Deep dive completed by Employee Relations Team. 3.4 Email message from Chief Executive/BME Executive Sponsor (Feb 2019) 3.5 Just culture campaign launched July 2019. 3.6 Freedom to Speak Up Guardian, to look at developing F2SU Champions, whose role will incorporate an aspect of supporting colleagues dealing with bullying and/or harassment.	**Equality, Diversity & Inclusion Service** **Amanda Wildgust**, Head of Employee Relations **Amanda Rawlings**, Director of People Resources and Organisational Effectiveness Freedom to Speak Guardian	Task group has met and AW to present update at BME Conference on 25/9/19. Director of People Resources and Organisational Effectiveness monitors all employee relations cases. Chief Executive/BME Executive Sponsor (25/2/2019) requests that General Managers involved in employee relations matters to implement extra steps in the process and add an additional check point. Before case is commenced it is reviewed by the GM/Head of Serivce.AD People and Culture Transformation and Head of Employee Relations. Chief Executive issued personal invite to Senior Leaders to attend BME Conference 25/9/2019
WRES 4: Non-mandatory training and CPD	**4.1** Promote and monitor BME access to NHS national programmes, Leadership Academy and ILM programmes.	**Equality, Diversity & Inclusion Service**	FS to present update at BME Conference on 25/9/19.

	4.2 New system notifies People Development team of all applications for funding of non-mandatory training and CPD, including those denied, which will allow the Trust to investigate denied applications. **4.3** Task group to be set up to review randomly selected unsuccessful applications and to develop an appeal process for denied applications.	**Faith Sango,** Head of People Development	
To eliminate the gap between BME and non-BME staff re: experience of bullying and Harassment. (WRES indicators 5-8) **WRES 5: Bullying & Harassment (patients/relatives/public)**	**5.1** Bullying & Harassment booklet is to be launched, which is expected to raise awareness in the Trust. **5.2** Implementation of Just and Learning Culture in the Trust.	**Equality, Diversity & Inclusion Service**	Bullying & Harassment Book launched July 2019.
WRES 6: Bullying & Harassment (staff)	**6.1** Bullying & Harassment booklet is to be launched, which is expected to raise awareness in the Trust. **6.2** Implementation of Just and Learning Culture in the Trust. **6.3** work with the newly appointed Freedom to Speak Up Guardian, to look at developing F2SU Champions, whose role will incorporate an aspect of supporting colleagues dealing with bullying and/or harassment.	**Equality, Diversity & Inclusion Service**	Freedom to Speak Up Guardian connected with BME Network.
WRES 7: Career progression/ **promotion**	**7.1** Reverse Mentoring programme: New cohort mentoring managers at band 6 and above to be launched in 2019. **7.2** Encouraging and promoting BME access to non-mandatory training and CPD through national training	**Equality, Diversity & Inclusion Service** **Reverse Mentoring Steering Group** **Michaela Lebeter,**	Reverse mentoring (Cohort 1 Pilot) completed and celebrated. Cast Study published and shared at number of high profile conferences and published in

	programmes is expected to improve this indicator. **7.3** BME Network to work with Leadership Development Lead to look at ways for BME colleagues to access opportunities to progress their careers.	Leadership Development Lead	FFF. Reverse Mentoring Next Steps meeting to be held on 14/8/19 and 2/9/19.
WRES 8: Discrimination at work (manager/ team leader/other colleagues)	**8.1** Reverse Mentoring programme: New cohort mentoring managers at band 6 and above to be launched in 2019. **8.2** Implementation of a Just and Learning Culture in the Trust to bring about an inclusive culture that prevents discrimination rather than reacts to it with the shared responsibility to create a safe environment for all colleagues.	**Equality, Diversity & Inclusion Service** **Reverse Mentoring Steering Group**	Reverse Mentoring Next Steps meeting to be held on 14/8/19 and 2/9/19.
WRES 9: Percentage difference between Trust Board and workforce	**9.1** Reverse Mentoring programme: New cohort mentoring managers at band 6 and above to be launched in 2019. **9.2** Actions promoting career progression for BME staff will affect this indicator in the long-term as we build our BME talent pipeline. **9.3** NeXT Director scheme (NHS Improvement initiative) increases diversity at board level.	**Equality, Diversity & Inclusion Service** **Reverse Mentoring Steering Group**	Reverse Mentoring Next Steps meeting to be held on 14/8/19 and 2/9/19.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 September 2019

Workforce Disability Equality Standard (WDES) 2018/19

Purpose of Report

The Workforce Disability Equality Standard (WDES) 2018/19 reporting summary and actions are presented for consideration and approval prior to sharing with lead commissioners and publishing on the Trust's public-facing website by 30 September 2019. WRES indicators and on-line reporting form are available as appendices 1 and 2.

Executive Summary

In summary, our initial WDES 2018/19 position shows there is considerable work to be done to address the variations in experience, workforce representation, recruitment progression and development for disabled people.

Declaration rates of staff with disabilities in the Trust are low. Across the NHS, on average 3% of people state that they are disabled on ESR, while 18% declare that they have a disability on the NHS Staff survey, which means a 15% difference in the disability declaration rate. At DHCFT, 4.45% of the workforce has declared a disability on ESR, while 11.06% declared a disability on the NHS Staff Survey. This shows a 6% difference in the disability declaration rate between ESR and the Staff Survey at DHCFT. Furthermore, 31.25% of DHCFT's workforce has not declared their disability status on ESR, and 0.04% would prefer not to say. The data shows that there is an underrepresentation of employees with disabilities in senior leadership levels with no disabled employees at Bands 8c and above, but there is also a corresponding level of unreported disability status in those positions.

As this is the first year of implementation of the WDES, we are learning from the Workforce Race Equality Standard (WRES) as a guideline for implementation. This work will be aligned to the WRES work streams where possible, including recruitment and monitoring grievance and disciplinary by disabilities. The Disability and Wellness Network is sponsored by Director of People & Organisational Effectiveness and engaged at the outset.

Engaging with the Disability and Wellness Network as a platform to develop an effective Action Plan and solutions to target key areas in the WDES in order to make improvements on this year's data. It provides peer support to colleagues with a disability and/or long term condition.

We have a Health and Wellbeing Strategy

Why is the WRES relevant?

It is about positive cultural change for everyone. The Trust seeks to go beyond compliance and be 'positively inclusive' because everyone matters. Ensuring that we treat all of our colleagues equally and fairly is in all of our interests because it makes DHCFT a positive place to work, fosters a person centred culture 'and makes sure that we can get the most out of everyone's experience, talents and input.

The data will prompt and drive NHS organisations to take action and improve the experiences of disabled staff. As a result:

- More transparency, more accurate data reporting and analysis.
- Drive up the declaration rate of disabled staff.
- The collection and reporting of data will enable organisations to better understand the experiences of their disabled staff.
- It will support the development of good practice.
- Improve recruitment processes, and increase the number of Disabled staff recruited.
- It will support positive change for existing employees and enable a more inclusive environment for disabled people working in the NHS.
- Raising awareness of disability will support improvements in patient care.

Why is recruiting those with disabilities important?

- Employee diversity reflects customer base in society
- Disabilities are often acquired during employment
- Specific skills – e.g. autism, dyslexia
- Ageing workforce
- Younger people with more health problems
- Longer life expectancy
- The 'Purple Pound' which is worth £249bn (reflect customers)
- Skills shortages

What is the Workforce Disability Equality Standard (WDES)?

Ten evidence-based metrics which take effect from 1 April 2019 based on 2018/19 financial year data. It is mandated in the NHS Standard Contract and restricted to NHS Trusts and Foundation Trusts in the first two years of implementation. It enables NHS organisations to compare experiences of Disabled/non-disabled staff. NHS organisations to publish results and develop action plans.

The Workforce Disability Equality Standard (WDES) requires all NHS organisations to demonstrate progress against a set of ten indicators in order to assess the experiences of disabled and non-disabled staff. The aim of the WDES is to try and ensure employees who have a disability have equal access to opportunities and receive fair treatment in the workplace.

This is the first year that the standard has been implemented across all NHS Trusts in response to research that shows that disabled staff have poorer experiences in areas such as bullying and harassment, feeling pressure to come to work when feeling ill and in access to opportunities for career progression when compared to their non-disabled colleagues.

The WDES data will be submitted electronically using a reporting template provided by NHS England. It is populated using data extracted from ESR for Indicators 1-3 and 10 respectively, and data from the Staff Survey is used to populate Indicators 4-9. The data informs the development of the action plan to drive improvement across the Trust and will be measured annually to review the progress made against each indicator.

Our current position is summarised below:

Our key priorities and steps planned to improve our performance are outlined below:

Key priorities	Data	Action planned
Indicator 1: Percentage of staff in AfC pay bands or medical and dental subgroups and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce.	Declaration rates of staff with disabilities in the Trust are low. Overall, 4.45% of the workforce has declared a disability on ESR, while 11.06% has declared a disability on the NHS Staff Survey. 31.25% of the workforce has not declared their disability status and 0.04% would prefer not to say. *The data shows that there is an underrepresentation of employees with disabilities in senior leadership levels with no disabled employees at Bands 8c and above, but there is also a corresponding level of unreported disability status in those positions.	Executive champion and sponsor of Disability & Wellness Network - Director of People & Organisational Effectiveness. Improve declaration rates by promoting the importance of colleagues declaring their disability status. Colleagues should feel safe to declare disabilities and long term conditions in order for the Trust to be a more responsive employer catering to the needs of all of our employees (reasonable adjustments). Work with the Disability & Wellness Network, Information Systems and Communications Team to spread this message across DHCFT e.g. data cleansing, screensavers and case studies. *Senior leadership visibly championing disabilities and long term conditions. The Trust is part of the Disability Confident Scheme and has achieved Disability Confident Employer level 2 status. Key themes are : • Getting the right people for your business • Keeping and developing your people. • Offering at least one activity that will make a difference Part of the Midlandsability network – share good practice and resources to progress disability equality. This network was founded in 2017, is a cross organisational forum in the Midlands which brings government, companies and other organisations together to talk about the important issues surrounding disability and long-term health conditions in the workplace. Working with government representatives to support national initiatives, our mission is to connect businesses and colleagues to share experiences, best practice and ideas and capitalise on this knowledge to support others on their journey to become more disability confident and inclusive. British Sign Language Charter signatories.
Indicator 2: Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.	Non-disabled staff is 2.88 times more likely to be appointed from shortlisting than non-disabled staff.	As above. This will be aligned to current WRES work programme to improve recruitment. Working in partnership with the Disability & Wellness Network to review recruitment processes and understand what the data tells us.

Indicator 4: Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying and abuse from: **i) Patients/service users, their relatives or members of the public** **ii) Managers** **iii) Other colleagues**	i) From patients/service users, their relatives or members of the public 33.8% of disabled staff 26.0% of non-disabled staff ii) Managers 14.0% of disabled staff 8.8% of non-disabled staff iii) Other colleagues 17% of disabled staff 14.5% of non-disabled staff	Work with the Disability & Wellness Network to target the high rates of harassment, bullying and abuse of disabled colleagues. Harassment and Bullying Booklet launched in July 2019 for circulation across the Trust based on the learning achieved by a series of workshops conducted in 2019. The implementation of a 'Just Culture' at DHCFT will encourage managers to treat staff involved in a patient safety incident in a consistent and fair way. It supports a culture of openness, fairness and learning in the NHS by making staff feel confident to speak up when things go wrong rather than fearing blame. Work with the newly appointed Freedom to Speak Up Guardian, to look at developing F2SU Champions, whose role will incorporate an aspect of supporting colleagues dealing with bullying and/or harassment. Disability network invited to attend the BME AGM on 25 September, 2019.
		Engage with the Disability & Wellness Network to develop an effective Action Plan and solutions to target key areas in the WDES in order to make improvements on this year's data. The next Disability & Wellness Network meeting on 11th September 2019 will focus on the Action Plan as the main agenda item, and the data will be shared with the membership electronically in August 2019 to enable those unable to attend the main meetings to contribute to the discussion with suggestions and recommendations.

Other targeted actions :

The Trust has a Chronic Health Condition(s)/Disability Policy and Procedure, to which the Reasonable Adjustments Passport is appended. In addition, our Trust offers a menu of options such as:

- Referral to our Occupational Health & Wellbeing Services.
- workplace risk assessments
- stress risk assessments
- flexible working patterns
- peer support through the Disability & Wellness Staff Network
- Health-related redeployment, phased return to work for employees, returning to work from long-term sickness absence.
- Signposting employees to the Access to Work scheme run by the Department for Work and Pensions.

The NHS WDES Technical Guidance (2019) is being used to apply good practice in the implementation of the standard and action plan: https://www.england.nhs.uk/wp-content/uploads/2019/06/wdes-technical-guidance-v2.pdf.

This is the first year of the WRES and the Equality, Diversity and Inclusion service will start to track and benchmark year on year improvement following production of national WDES report.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	x
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	x
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	x

Assurances

- The Equality, Diversity and Inclusion Team are working in partnership with the Trust's Disability & Wellness Network, for which the Director of People and Organisational Effectiveness is the Executive Sponsor. WDES will be performance managed via Equalities Forum.
- Disability Confident Employer Status.

Consultation

- WDES data was presented to the Disability & Wellness Network on 10 July 2019 for their views and for information, and the EDI Service held an interactive session on 15 August 2019 to explore the data and consult with the Network on the Action Plan.
- The Action Plan will be created in partnership with the Network and shared with the Equality Forum with a view to supporting the Trust to address disability inequalities.
- Trust Management Team – 1 August, 2019

Governance or Legal Issues

- The WDES has been commissioned by the Equality & Diversity Council (EDC) and is mandated through the NHS Standard Contract to ensure effective collection, analysis and use of workforce data.
- The WDES is linked to the EDS2 which is also mandatory for all NHS Trusts.
- Supports meeting the Equality Act 2010 and duty to make reasonable adjustments.

Public Sector Equality Duty & Equality Impact Risk Analysis

Below is a summary of the equality-related impacts of the report:

The WDES is a set of measures that identifies inequalities in the experience of disabled staff in the workplace in comparison with their non-disabled counterparts. It is a barometer of our culture and lived experience of disabled colleagues. Our current position highlights a need to increase the declaration rates of disabled staff in our Trust, in order to allow us to better identify inequalities and close the gaps. The data clearly identifies a difference in workplace experience, treatment and progression of disabled colleagues. The aforementioned Action Plan being developed in partnership with the Disability & Wellness Network outlines the steps that will be taken to close the gaps.

We have the second largest deaf community outside of London.

Workforce diversity as at 31/3/2019 (2586)

- Disability **-** total of 809 employees, 31.28% of the Trust have not declared their disability status. 4.45% of staff within DHCFT have declared some form of disability (115 staff).
- Ageing workforce - 50-54 age group accounts for 17.13% of the Trust head count equating to 443 employees. A total of 1,012 employees, 39.13% of the Trust head count, is aged 50 or over which shows an aging workforce within the Trust. The Trust employs only 1 member of staff who is aged under 20. In total there are just 72 employees (2.78%) within the Trust who are aged under 25.
- Gender - majority of employees are female 2,068 (79.97%) but looking at Senior Managers (band 8c & above) the female/male divide is much closer at 54.17% and 45.83%; closer still at Director level 50% and 50%. Male employees are over represented in senior positions compared to female employees.

Disability in the workplace and Public Health Data:

- 1:6 of working age have a diagnosable mental health condition
- 52% unskilled; 33% professionals have long term conditions
- By 2030 40% workforce have long term condition
- By 2020 1:3 workers will be 50+
- Young people – impact repetitive strain injury, muscular skeletal injuries and isolation
- 50% mental health conditions begin before age 14
- TUC reported disability unemployment rate has increased between 2013 and 2016

Other data:

- There are 6 million people of working age with a disability. Only 48% of them are in work compared with 80% of people in work without a disability.
- 83% of people acquire their disability whilst at work.
- Hearing lost is a major public health issue affecting 10 million people
- 1 in l0 affected by Tinnitus
- 1 in 10 living with dyslexia

73% of employers who said they had made a reasonable adjustment said it was easy to do (ENEI)

Recommendations

The Board of Directors is requested to:

1. Note findings against the 10 performance indicators and the need to improve the disclosure rate so that we can support colleagues with reasonable adjustments.
2. Approve the WDES Report that will be published on the Trust's website by 30 September 2019 and shared with commissioners.

Report presented by:	**Amanda Rawlings** **Director of People & Organisational Effectiveness**
Report prepared by:	**Harinder Dhaliwal** **Head of Equality, Diversity & Inclusion** **Clare Meredith** **Equality, Diversity & Inclusion Advisor**

Appendix 1: WRES 18/19 indicators
Appendix 2: WRES 18/19 On-line reporting form

DHCFT Workforce Disability Equality Standard (WDES) 2018-19: Data

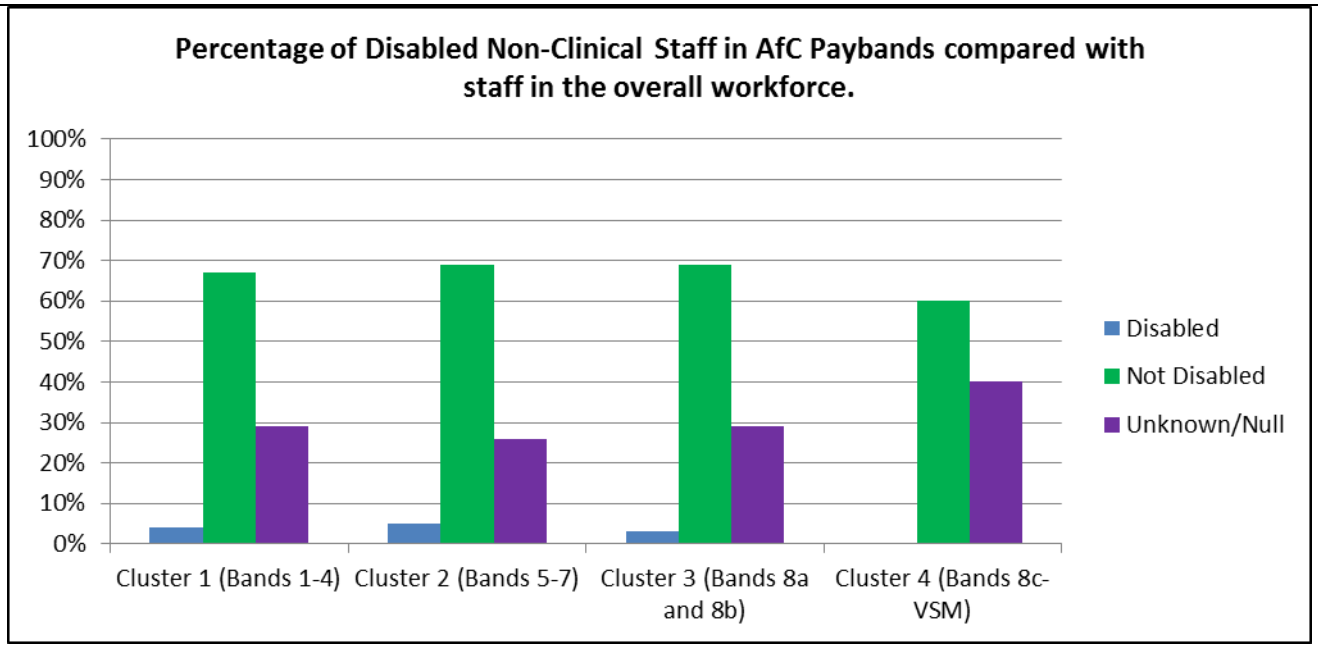
<table>
<tr><th>Indicator</th><th>Data</th></tr>
<tr><td>1</td><td>
Indicator 1: Percentage of staff in AfC paybands or medical and dental subgroups and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce.

Overall Workforce Profile:
Total workforce: 2586
Disabled: 115 (4.45% of workforce)
Non-Disabled: 1662 (64.23% of workforce)
Prefer not to say: 1 (0.04% of workforce)
Unknown/Null: 808 (31.25% of workforce)

The data shows the declaration rates for the Trust are low, with 31.28% of the workforce not declaring their disability status on ESR (this includes ‘Prefer not to say’ and ‘Unknown/Null’ as above).

Non-Clinical Staff

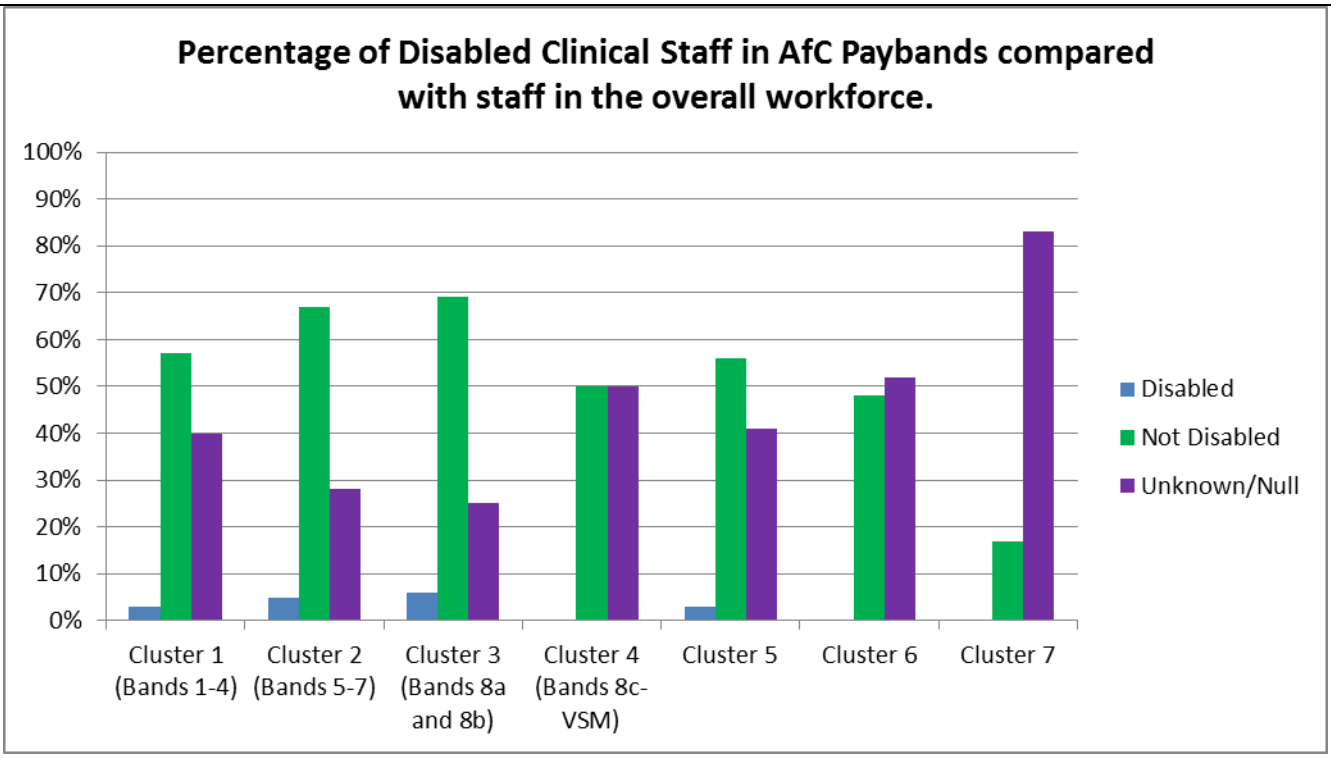
<table>
<tr><th></th><th>Disabled</th><th>Average Disabled across DHCFT workforce</th><th>Percentage difference</th><th></th><th>Not Disabled</th><th>Disability Unknown/ Null</th></tr>
<tr><td>Cluster 1 (Bands 1-4)</td><td>4%</td><td>4.45%</td><td>-0.45%</td><td></td><td>67%</td><td>29%</td></tr>
<tr><td>Cluster 2 (Bands 5-7)</td><td>5%</td><td>4.45%</td><td>+0.55%</td><td></td><td>69%</td><td>26%</td></tr>
<tr><td>Cluster 3 (Bands 8a-8b)</td><td>3%</td><td>4.45%</td><td>-1.45%</td><td></td><td>69%</td><td>29%</td></tr>
<tr><td>Cluster 4 (Bands 8c-9 & VSM)</td><td>0%</td><td>4.45%</td><td>-4.45%</td><td></td><td>60%</td><td>40%</td></tr>
</table>
</td></tr>
</table>



The data shows an underrepresentation of disabled staff in senior leadership positions with no disabled employees at Bands 8c and above, but it also shows a higher proportion of employees with unknown disability status in the higher bands, suggesting more needs to be done to increase declaration rates among all colleagues, and particularly those in senior leadership roles.

Clinical Staff

	Disabled	Average Disabled across DHCFT workforce	Percentage difference		Not Disabled	Disability Unknown/ Null
Cluster 1 (Bands 1-4)	3%	4.45%	-1.45%		57%	40%
Cluster 2 (Bands 5-7)	5%	4.45%	+0.55%		67%	28%
Cluster 3 (Bands 8a-8b)	6%	4.45%	+1.55%		69%	25%
Cluster 4 (Bands 8c-9 & VSM)	0%	4.45%	-4.45%		50%	50%
Cluster 5 (Medical & Dental Staff: Consultants)	3%	4.45%	-1.45%		56%	41%
Cluster 6 (Medical and Dental Staff: Non-consultants career grade)	0%	4.45%	-4.45%		48%	52%
Cluster 7 (Medical & Dental Staff: Trainee grades)	0%	4.45%	-4.45%		17%	83%

	 Similar to the data for Non-Clinical staff, the data above shows a need to focus on improving declaration rates at all levels, and particularly those in senior leadership roles, and in the medical and dental staff groups.
2	Indicator 2: **Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.** Non-disabled colleagues are **2.88 times more likely** to be appointed from shortlisting compared to disabled colleagues.
3	Indicator 3: **Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.** Disabled colleagues are **0 times more likely** to enter the formal capability process compared to non-disabled colleagues. (A small number of people entered the formal capability process during 2018-19, all of whom had not declared their disability status, therefore we have a 0 entry for this indicator).
4	Indicator 4: Staff Survey Q13 **a) Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying and abuse from:** i) Patients/service users, their relatives or other members of the public 33.8% of disabled staff (95 of 281 respondents) 26.0% of non-disabled staff (236 of 909 respondents) ii) Managers 14.0% of disabled staff (39 of 278 respondents) 8.8% of non-disabled staff (78 of 889 respondents)

	iii) Other colleagues 17% of disabled staff (47 of 277 respondents) 14.5% of non-disabled staff (130 of 896 respondents) b) **Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.** 55.0% of disabled staff (66 of 120 respondents) 53.2% of non-disabled staff (151 of 284 respondents)
5	Indicator 5: Staff Survey Q14 **Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.** 78.5% of disabled staff (128 of 163 respondents) 85.2% of non-disabled staff (506 of 594 respondents)
6	Indicator 6: Staff Survey Q11 **Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.** 20.4% of disabled staff (40 of 196 respondents) 14.6% of non-disabled staff (66 of 453 respondents)
7	Indicator 7: Staff Survey Q5 **Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.** 37.2% of disabled staff (105 of 282 respondents) 48.9% of non-disabled staff (442 of 904 respondents)
8	Indicator 8: Staff Survey Q28b **Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.** 83.3% of disabled staff (130 of 156 respondents)
9	Indicator 9: Staff Survey a) **The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.** Disabled staff: 6.5 (285 respondents) Non-disabled staff: 7.0 (911 respondents) Organisation average: 6.9 (1273 respondents) b) **Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)**

	Yes **Note: For your Trust's response to b) If yes,** please provide at least one practical example of current action being taken in the relevant section of your WDES annual report. **If no**, please include what action is planned to address this gap in your WDES annual report. Examples are listed in the WDES technical guidance. DHCFT examples: - Disability & Wellness Network - Disability & Wellness Executive Sponsor - Engagement with the Disability & Wellness Network to work on the WDES Indicators and Action Plan. First meeting on 10th July 2019. - Task group is to be set up as a subgroup of the Disability & Wellness Network to review policies affecting employees with disabilities and long-term conditions.
10	Indicator 10: **Percentage difference between the organisation's Board voting membership and its organisation's overall workforce** -4.00% Percentage of Disabled Voting Board Members: 0% Percentage of Disabled Overall Workforce: 4%

Response ID ANON-VQQ5-M7NH-7

Submitted to **Workforce Disability Equality Standard (WDES) online reporting form**
Submitted on **2019-08-22 10:02:29**

Trust information

1 Name of organisation:

Name of organisation::
Derbyshire Healthcare NHS Foundation Trust

2 Date of report:

Month/year::
August 2019

3 Name and title of the Board lead for the Workforce Disability Equality Standard:

Name and title of Board lead for the Workforce Disability Equality Standard::
Amanda Rawlings, Director of People and Organisational Effectiveness

4 Name and contact details of the lead compiling this report:

Name and contact details of lead compiling this report:
Harinder Dhaliwal - Head of Equality, Diversity and Inclusion
Email: harinder.dhaliwal1@nhs.net

5 Does your organisation participate in any programmes or initiatives that are focused on disability equality and inclusion?

Yes

If yes, please provide details::
- Disability and Wellness Staff Network
- Executive Sponsor of the Network and champion for disability equality and inclusion is Amanda Rawlings, Director of People and Organisational Effectiveness.
- Armed Forces Network (Executive Sponsor: Gareth Harry, Director of Business Improvement and Transformation)
- Equality Forum
- Staff Forum
- People and Cultures Committee (PCC)
- Freedom to Speak Up Guardian
- Reasonable Adjustments Passport
- Equality task and finish groups that focus on reducing employment and workforce inequalities across the protected characteristics including disability regarding recruitment, improving disability declaration rates, training and development and sickness absence management.
- Our Trust is signed up to the British Sign Language (BSL) Charter.
- Our Trust is signed up to the Mindful Employer Charter.
- Our Trust participates in the MidlandsAbility Network which meets quarterly as part of the Employers Network for Equality and Inclusion (ENEI).

Trust information

6 Name and contact details of the commissioner(s) this report will be sent to:

Name and contact details of commissioner(s) this report will be sent to:
Phil Sugden
Philip.sugden1@nhs.net
NHS Derby & Derbyshire Clinical Commissioning Group

7 Unique URL link, or existing web page, on which the WDES Metrics data and associated Action Plan will be published:

Unique URL link, or existing web page, on which the WDES Metrics data and associated Action Plan will be published::
https://www.derbyshirehealthcareft.nhs.uk/about-us/equality-and-diversity

8 Date of Board meeting at which organisation's WDES Metrics data and action plan were, or will be, ratified:

Date of Board meeting at which organisation's WDES Metrics data and action plan were, or will be, ratified::
3 September 2019

9 Total number of staff employed within the organisation on 31 March 2019:

Total number of staff employed within the organisation on 31 March 2019:
2586

% Disabled staff::
4.45%

% Non-disabled staff::
64.27%

% Unknown/Null::
31.25%

% Other::
Not applicable

% Prefer not to say::
0.04%

Data quality

10 Did your organisation undertake the NHS Staff Survey in the past year?

Yes

Full staff survey

11 Give the total number and % of responses to the NHS Staff Survey in your organisation:

Give the total number and % of responses to the NHS Staff Survey in your organisation::
Survey sent to 2378 staff - 1284 (54%) returned.

12 Give the total number and % of Disabled staff responses to the NHS Staff Survey in your organisation:

Give the total number and % of Disabled staff responses to the NHS Staff Survey in your organisation::
286 Disabled staff responded - 23.8% of survey respondents.

13 Do your staff have access to the ESR self-service portal?

Yes

Metric 1 - Workforce representation

14 Please describe any challenges that your organisation has experienced in reporting data for this Metric:

Please describe any challenges that your organisation has experienced in reporting data for this Metric::
The declaration rate for disabled staff is low in our Trust, with only 4.45% of staff declaring a disability.
The Trust encourages new starters to declare at induction and as part of the WDES Action Plan, actions are planned this year to improve the declaration rate.
We shared this with the Disability & Wellness Staff Network so we can work together to improve our workforce disability equality.

15 Have any steps been taken in the last 12 months within your organisation to improve the declaration rate for disability status on ESR?

Yes

16 Please share any examples of interventions that have increased declaration rates at your organisation:

Please share any examples of interventions that have increased declaration rates at your organisation::
There is ongoing work to improve declaration rates across our Trust.
For example,
-A member of Employee Relations visited the Disability & Wellness Network on 10th July 2019, to inform the Network how to declare disability status on ESR.
- As part of Equality and Human Rights Week, the Equality, Diversity and Inclusion Service visited Kingsway Hospital on 17th May 2019 with a display on the importance of colleagues declaring their protected characteristics and the reasons why the organisation needs to know.

Metric 2 - Shortlisting

17 Please describe any challenges that your organisation has experienced in reporting data for this Metric:

Please describe any challenges that your organisation has experienced in reporting data for this Metric::
- Declaration rates require improvement.
- Some staff with long term health conditions do not consider it to be a disability.

18 Has your organisation signed up to the Disability Confident Scheme?

Yes

Level 2 - Employer

19 Does your organisation use a Guaranteed Interview Scheme?

Yes

Metric 3 - Capability

20 Did your organisation submit data for Metric 3 this year?

Yes

If yes, please describe any challenges that your organisation has experienced in reporting data for this Metric::
Yes. A small number of people entered the formal capability process during 2018-19, all of whom had not declared their disability status, therefore we have a 0 entry for Metric 3.

If no, please explain why you did not submit data for this year::
N/A

21 Is capability on the grounds of ill health and capability on the grounds of performance managed by different policies in your organisation?

Yes

If yes, please state the policies::
Capability on the grounds of performance: Employee Performance Improvement Policy and Procedures
Capability on the grounds of ill health: Health and Attendance Policy

22 What are your views about including capability on the grounds of ill health and performance as two parts of a future Metric?

What are your views about including capability on the grounds of ill health and performance as two parts of a future Metric?:
The Trust is supportive of this suggestion.

Metric 4 - Harassment, bullying and abuse

23 Are there any issues with the data for this Metric?

Are there any issues with the data for this Metric?:

24 Has your organisation compared Staff Survey results against other datasets that may be held, e.g. bullying and harassment advisers, Freedom to Speak Up guardians, grievances, etc.

Yes

If yes, please provide further details on what comparison your organisation has undertaken::
DHCFT's Workforce Race Equality Standard (WRES)
Equality Delivery System 2 (EDS2)
Bullying and harassment complaints via Datix
Freedom to Speak Up Guardian
Staff Stories of lived experience for learning purposes.

25 Please summarise any actions taken to reduce harassment, bullying and abuse in relation to Disabled staff:

Please summarise any actions taken to reduce harassment, bullying and abuse in relation to disabled staff::
- Work with the Disability & Wellness Network to reduce harassment, bullying and abuse of disabled colleagues.

- Harassment and Bullying Booklet was launched in July 2019 for circulation across the Trust based on the learning achieved by a series of workshops conducted in 2019.

- The implementation of a Person-Centred Culture ('Just Culture') at DHCFT will encourage managers to treat staff involved in a patient safety incident in a consistent and fair way. It supports a culture of openness, fairness and learning in the NHS by making staff feel confident to speak up when things go wrong rather than fearing blame.

- Work with the newly appointed Freedom to Speak Up Guardian (F2SUG), to look at developing F2SU Champions, whose role will incorporate an aspect of

supporting colleagues dealing with bullying and/or harassment.

Metric 5 - Career promotion and progression

26 Are there any issues with the data for this Metric?

Are there any issues with the data for this Metric?:

27 Does your organisation provide any targeted career development opportunities for Disabled staff?

Yes

If yes, please provide further details::
Disability & Wellness Network provides development opportunities.

Metric 6 - Presenteeism

28 Are there any issues with the data for this Metric?

Are there any issues with the data for this Metric?:

29 Does your organisation provide any targeted actions to reduce presenteeism i.e. feeling pressured to come to work when not feeling well?

Yes

If yes, please provide further details::
- The Trust has a Reasonable Adjustments Passport which was produced by People Services in 2018. It is a voluntary agreement between the disabled colleague and their manager.
- Our Trust has a Wellbeing Strategy
- Flexible working options, and employees are made aware of our Flexible Working Policy which is accessible via our intranet.
- Self-referral to our Trust's Employee Assistance Programme (Resolve).
- Health and Attendance Policy
- At sickness review meetings, staff are not pressured to come to work when they are feeling unwell.
- The contents of the Trust's Sickness Absence training for managers covers presenteeism, including the Health and Attendance Policy.
- Employees are able to raise any issues at the Disability & Wellness Network or with the Executive Sponsor for disability equality.

Metric 7 - Staff satisfaction

30 Are there any issues with the data for this Metric?

Are there any issues with the data for this Metric?:

31 Does your organisation provide any targeted actions to increase the workplace satisfaction of Disabled staff?

Yes

If yes, please provide further details::
- Work with the Disability & Wellness Network to develop an effective Action Plan based on the WDES data to close the gaps between the experiences of disabled staff and non-disabled staff at the Trust.
- The Disability & Wellness Network is a platform through which targeted actions can be initiated to increase workplace satisfaction for disabled staff.
-'Mental Health Awareness' training was provided for our Trust's Employee Relations Advisors/Managers and staff side colleagues.
- Our Trust subscribes to a 24-hour Employee Assistance Programme (Resolve) accessible to all employees, including disabled staff, at no cost to them.
-Appropriate use of a Reasonable Adjustments Passport for disabled staff is encouraged. Our Trust has well-established guidelines on this.
-Availability of a menu of flexible working options.
-Staff Forum
-Equality Forum
-Staff Stories at key Board meetings.
-Provision of classroom-based training to complement online based options via our e-learning portal to meet individual requirements.

Metric 8 - Reasonable adjustments

32 Are there any issues with the data for this Metric?

Are there any issues with the data for this Metric?:

33 Does your organisation have a reasonable adjustments policy?

Yes

34 Are costs for reasonable adjustments met through centralised or local budgets?

Local

35 Has your organisation taken action to improve the reasonable adjustments process?

Yes

If yes, please provide further details::
We have a Chronic Health Condition(s)/Disability Policy and Procedure, to which the Reasonable Adjustments Passport is appended.

In addition, our Trust offers a menu of options such as:
- referral to our Occupational Health & Wellbeing Services.
- workplace risk assessments
- stress risk assessments
- flexible working patterns
- peer support through the Disability & Wellness Staff Network
- health-related redeployment, phased return to work for employees, returning to work from long-term sickness absence.
-signposting employees to the Access to Work scheme run by the Department for Work and Pensions.
-Our Trust has a Health &Wellbeing Strategy

- Provision of classroom-based training as a form of reasonable adjustment to complement online-based options via our e-learning portal.

Metric 9 - Disabled staff engagement

36 Are there any issues with the data (9a) or evidence (9b) for this Metric?

No

If yes, please provide details::

37 Does your organisation have a Disabled Staff Network (or similar)?

Yes

Not Answered

If you answered yes to the above, please give details of the expected timescale.:

Metric 10 - Board representation

38 Please describe any challenges that your organisation has experienced in collecting and reporting data for this Metric:

Please describe any challenges that your organisation has experienced in collecting and reporting data for this Metric::
Declaration rates require improvement.

39 Does your Board have a champion for disability equality?

Yes

If yes, with their permission, please provide name and position of the Board/Executive champion/sponsor::
Amanda Rawlings, Director of People and Organisational Effectiveness.
She is also the Executive Sponsor for the Disability & Wellness Network and for disability equality.

Derbyshire Healthcare NHS Foundation Trust
Report to the Trust Board – 3 September 2019

Learning from Deaths - Mortality Report

Purpose of Report

The 'National Guidance on Learning from Deaths' requires each Trust to collect and publish specified information on a quarterly basis. This current report covers the financial year from 1 April 2018 to 31 March 2019.

Executive Summary

This end of year report covering the financial year 1 April 2018 to 31 March 2019 outlines the progress to date.

The approach to serious incident investigations and mortality reviews has been developed over the last 12 months.

Emphasis is put on appreciative learning, looking at ways of improving our systems and processes.

Generally the reviews are giving assurance through a lack of concern but are constrained by the lack of a cause of death in many cases. We are not able to obtain the information from NHS Digital. The Medical Director has escalated this to Dr Alan Fletcher, National Medical Examiner.

Although there is an absence of concern in most individual cases there is an assumption based on national data that our patients will be dying at a premature age due to comorbid physical illnesses, particularly related to cardio vascular risk factors. The Trust is introducing the LESTER tool which will enable our clinicians to monitor these risk factors and identify where intervention is required. This will become a focus of mortality reviews from October 2019.

Cigarette smoking carries a particularly high risk of morbidity and mortality and the current policy of inpatient prohibition is not working and a new policy is in place.

Learning from deaths has been triangulated with a gap analysis of our physical healthcare strategy and information supplied to the Mental Health Act Committee.

In inpatient services the EPR system has been developed to aid recording and interpretation of results and we move to the new nationally agreed Early Warning System in the autumn.

In the community physical health clinics have been developed in the north and south and there have been enhancement of community teams, particularly in areas that lie outside of clinic catchment.

LESTER tools have been embedded in the EPR and compliance dashboards will be

available from September 2019. A minimum physical healthcare check has been developed for all patients not just those at enhanced risk.

There are some risks of course that are specific to mental health services:

The Trust has reviewed the clinical pathway for Emotionally Unstable Personality Disorder patients and agreed that this is a top priority for investment and development. Recruitment has started.

Substance misuse services have a notoriously high premature death rate. Analysis of data has indicated that if too much emphasis is directed towards driving recovery there is a high relapse rate and paradoxically increased death rate through accidental overdose, particularly of opiates and alcohol. The thresholds for recovery versus maintenance have therefore been adjusted. A research project is under development to look at big data to further understand the profile of high risk service users and to inform intervention. There is also a very active screening and vaccination campaign focussed on Hepatitis.

The suicide prevention strategy is being taken forward and developed in tandem with safety plan development with an increasing focus on specific safety plan development for individual services which will be linked to the use of suicide prevention assessment tools underpinned with accredited training.

In forensic services there are projects underway to improve closer working with prisons / Ministry of Justice / local authority. Our approach to the management of Section 37/41s has been strengthened.

In learning disability services patients can die prematurely from treatable illnesses. We are connected to the national LeDER system and they regularly share information with the mortality group which to date has included:

- Sepsis information for patients with a learning disability
- An easy guide to bowel cancer screening for people with LD
- Advice regarding treatment of constipation

In eating disorder services a proposal has been made to the CCG's clinical reference group for improved physical health screening in primary care and there have been meetings with acute hospitals to improve liaison with gastroenterology.

In old age services we are developing themes around the best management of frail patients with acute hospitals and regarding the threshold of admission to our challenging behaviour wards. The development of compassion focussed care on the Cubleys has been linked to safety and was presented in a Board Development session.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	X
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	

Assurances

- This report provides assurance that the Trust is following recommendations outlined in the National Guidance and the development of a Safety Culture.
- From April 2018 to 31 March 2019, the Trust has received 2,029 death notifications of patients who have been with our service within the previous six months. 218 (10.7%) were reported through our DATIX system of which 51 (2.5%) warranted further investigation.
- All inpatient deaths are reviewed and quarterly reports received by the Executive Leadership Team (ELT) in addition to coroner's inquest updates. Medical availability for mortality reviews has improved.

Consultation

This report was received and discussed at the Quality Committee.

Governance or Legal Issues

The Care Quality Commission Regulations - this report provides assurance as follows:

- Outcome 4 (Regulation 9) Care and welfare of people who use services
- Outcome 14 (Regulation 23) Supporting staff
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
- Duty of Candour (Regulation 20)

Public Sector Equality Duty & Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

People suffering from a mental illness and/or substance misuse problem or who have a mental disorder or leaving difficulty have a reduced life expectancy compared to the general population without these characteristics. Actions to mitigate these risks are described in the executive summary.

Recommendations

The Board of Directors is requested to accept this Mortality Report as assurance of our approach and note that it is required to be published on the Trust's website in line with national guidance.

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

Report prepared by: **Dr John R Sykes**
Medical Director

Rachel Williams
Lead Professional for Patient Safety and Patient Experience

Louise Hamilton and Nosheen Asim
Mortality Technicians

Learning from Deaths - Mortality Report

1. Background

It has been over two years since the National Quality Board published a new national framework for NHS Trusts - 'National Guidance on Learning from Deaths[1]'. The purpose of the new framework was to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which would lead to better quality investigations and improved embedded learning.

The Guidance outlined specific requirements in relation to reporting requirements. From April 2017, the Trust was required to collect and publish each quarter, specified information on deaths. A paper was produced and was and continues to be a Board item at the Public Board meeting in each quarter. The Trust met the targets to set out the Trust's policy and approach (by end of Q2) 2017-2018 and publication of the data and learning points by Quarter 3 2017/18. The Trust does include the total number of inpatient deaths and those deaths that the Trust has subjected to case record review in each paper. Of these deaths, subject to review, we have considered how many of these deaths were judged more likely than not to have been due to problems in care.

The Trust has met all of the requirements outlined above within the timescales required.

This report outlines data for the previous financial year from April 2018 to March 2019.

2. Current Position and Progress

- Two years on, there has been little progress to accessing a national database for cause of death, our application for NHS Digital continues, and the Trust is currently awaiting an outcome. This continues to be a slow process, to ensure that the Trust meets all of NHS Digital legal requirements.

- The Mortality Review Group continues to undertake regular case note reviews and there have been improvements in medic availability since the implementation of a rota for attendance from the North consultants.

- Regular audits continue to be undertaken to ensure compliance with policy and procedure and any necessary changes made.

[1] National Guidance on Learning from Deaths. National Quality Board. March 2017

3. Data Summary of all Deaths

Note that inpatients and patients with a Learning Disability (LD) are based upon whether the patient has an open inpatient or LD referral at time of death.

Month	2018-04-01	2018-05-01	2018-06-01	2018-07-01	2018-08-01	2018-09-01	2018-10-01	2018-11-01	2018-12-01	2019-01-01	2019-02-01	2019-03-01
Total Deaths Per Month	165	187	141	182	133	138	197	173	192	226	146	149
Inpatient Deaths	1	0	2	1	0	0	1	0	1	1	0	1
LD Referral Deaths	2	5	0	5	4	1	5	0	2	1	0	1

The table above shows information for the last financial year 01/4/2018 – 31/3/2019.

Correct as at 17.5.2019

1 April 2018 to 31 March 2019, the Trust received 2,029 death notifications of patients who have been in contact with our service.

Initially, the Trust recorded all deaths of patients who had contact within the last 12 months, but this was changed after discussion with Commissioners to contact within the last 6 months. This took effect from 20 October 2017.

An inpatient death is recorded as a patient who has died on Trust premises whilst an inpatient on one of the wards. The inpatient death data does not include any patients that may have been transferred to an acute hospital where they then have died.

4. Review of Deaths

1 April 2018 to 31 March 2019:

Total number of Deaths from 1 April 2018 – 1 March 2019 reported on Datix	218 (of which 169 are reported as "Unexpected deaths"; 37 as "Suspected deaths"; and 12 as "Expected - end of life pathway")
Number reviewed through the Serious Incident Group	217 (1 was not required to be reviewed by SI group and 0 pending for a review).
Number investigated by the Serious Incident Group	51 (155 did not require an investigation and 12 pending for a review)
Number of Serious Incidents closed by the Serious Incident Group?	179 (27 currently opened to SI group and 12 pending for a review, as at 31/3/2019)

The Trust has recorded 8 inpatient deaths April 2018 to 31 March 2019, of all which have been reviewed under the *Untoward Incident Reporting and Investigation Policy and Procedure*. None of these deaths have been due to problems in care.

Only deaths which meet the criteria below are reported through the Trust incident reporting system (Datix) and these are also reviewed using the process of the *Untoward Incident Reporting and Investigation Policy and Procedure*;

Any patient open to services within the last 6 months who has died, and meets the following:

- Homicide – perpetrator or victim.
- Domestic homicide - perpetrator or victim
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatient who died within 30 days of discharge from a DHCFT hospital
- Death following an inpatient transfer to acute hospital
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLs) authorisation
- Death of patient following absconsion from an inpatient unit
- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family / carer / The Ombudsman, or where staff have raised a significant concern about the quality of care provision
- Death of a child (this will also be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death

Death of a patient with historical safeguarding concerns, which could be related to the death:

- Death where a previous Coroners Regulation 28 has been issued
- Death of a staff member whilst on duty
- Death of a child under the age of 18 of a current or previous service user who has died in suspicious circumstances
- Where an external organisation has highlighted concerns following the death of a patient whether they were open to the Trust at time of death or not

5. Learning from Deaths Procedure

From the 1 April 2018 to 31 March 2019, the Mortality Review Group case note reviewed 130 deaths. These reviews were undertaken by a multi-disciplinary team and it was established that of the 130 deaths reviewed, 127 have been recorded as not due to problems in care. 3 were referred to the Serious Incident Group where 2 required no further action, and a further 1 is currently under further investigation and is been monitored by the Patient Safety Team.

The Mortality Group reviewed the deaths of patients who fall under the following 'red flags' from April 2018 – November 2018

- Patient on end of life pathway, subject to palliative care
- Anti-psychotic medication
- Referral made, but patient not seen prior to death
- Death of patient on Clozapine

From November 2018 to March 2019

- Patient referred to services, then assessed and, discharged without referral onto other mental health services (including liaison team)
- Patient diagnosed with a severe mental illness
- Patient only seen as an Outpatient
- Patient taking an Anti-psychotic medication

We have received 31 causes of death since April 2018, of these, initial analysis of death notification information shows the most prevalent causes of death are:

- Bronchopneumonia
- Heart disease
- Dementia

Undertaking Case Note Reviews was very difficult initially and a number had to be cancelled due to lack of medic availability. However since the implementation of a medic rota, the number of case note reviews has improved and fewer are having to be cancelled.

The Trust as well as taking action when the standard of care could have been improved, it is important that good practice is highlighted and commended.

To date the weekly case note reviews have largely highlighted areas of good practice across the organisation and there has been evidence of person centred care.

During a recent review the CPN involved was noted to have provided exceptional care for the patient and the reviewers identified the CPN demonstrated excellent practice. Throughout the record the clinical care provided by the CPN was of a high standard. There is evidence of regular consultation with the patient's carers and other parties involved. At times when the CPN was advised of concerns by the patient's carer, planned visits were expedited in order that the patient's needs could be assessed sooner. There is detailed documentation clearly demonstrating compassionate, person-centred care and this is noted to be consistent in the 3 years the CPN worked with the patient.

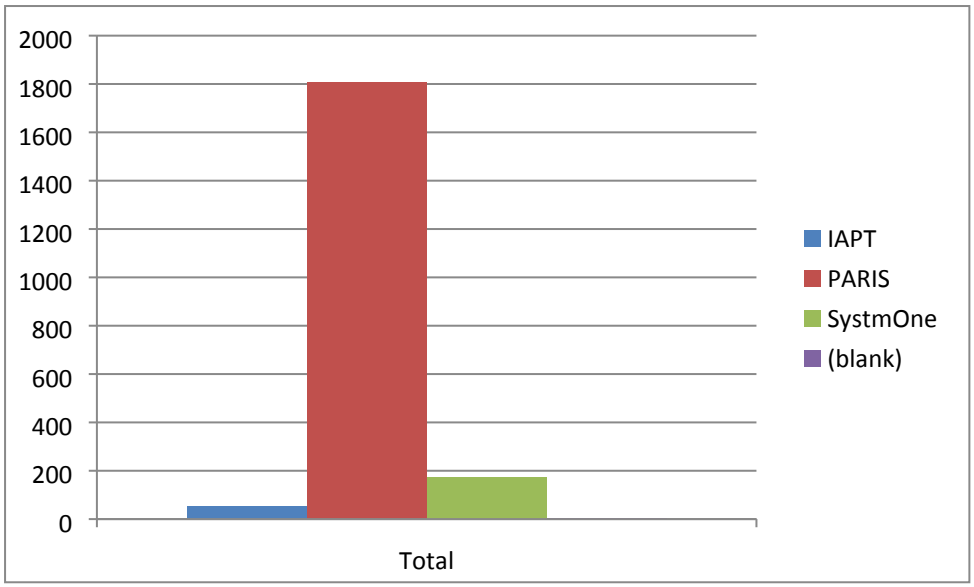
The reviewers felt there is a real sense in the record that the CPN genuinely cared for his patient; "I have also been and sat with him after his lunch, where he was sat in his favourite spot by the fish tank".

When the patients physical health was noted to have deteriorated prior to his death the care home sought advice from the patients CPN concerning where the patient should be cared for as he had no known relatives and the CPN had been involved for some time. This was felt by the reviewers to be testament to the considerate care the patient had received.

The CPN has been provided with feedback following this case note review and nominated for a DEED.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 April 2018 to 31 March 2019

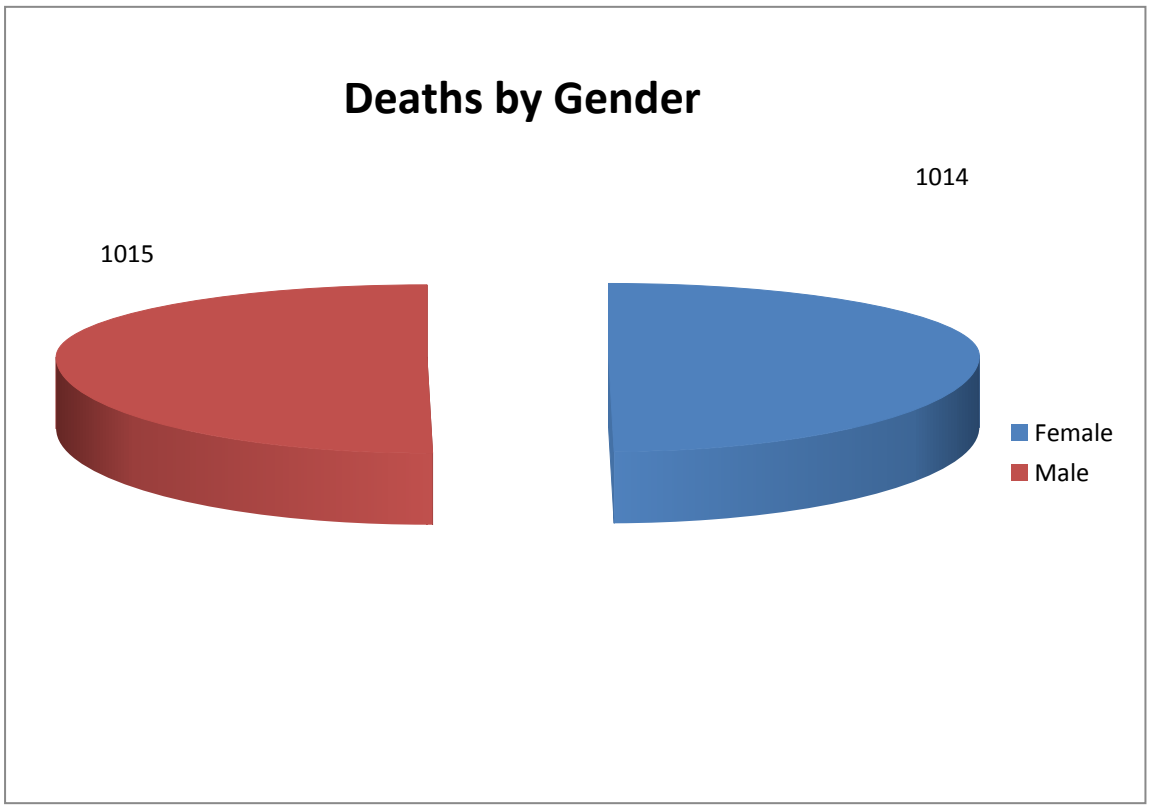


	IAPT	PARIS	SystmOne	Grand Total
Count	51	1806	172	2029

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from PARIS. This clinical record system is aligned to our largest population of patients and a population at greatest risk of death due to the proportion of older people in our care. 172 death notifications were extracted from SystmOne and 51 death notifications were extracted from IAPT.

6.2 Deaths by Gender since 1 April 2018 to 31 March 2019

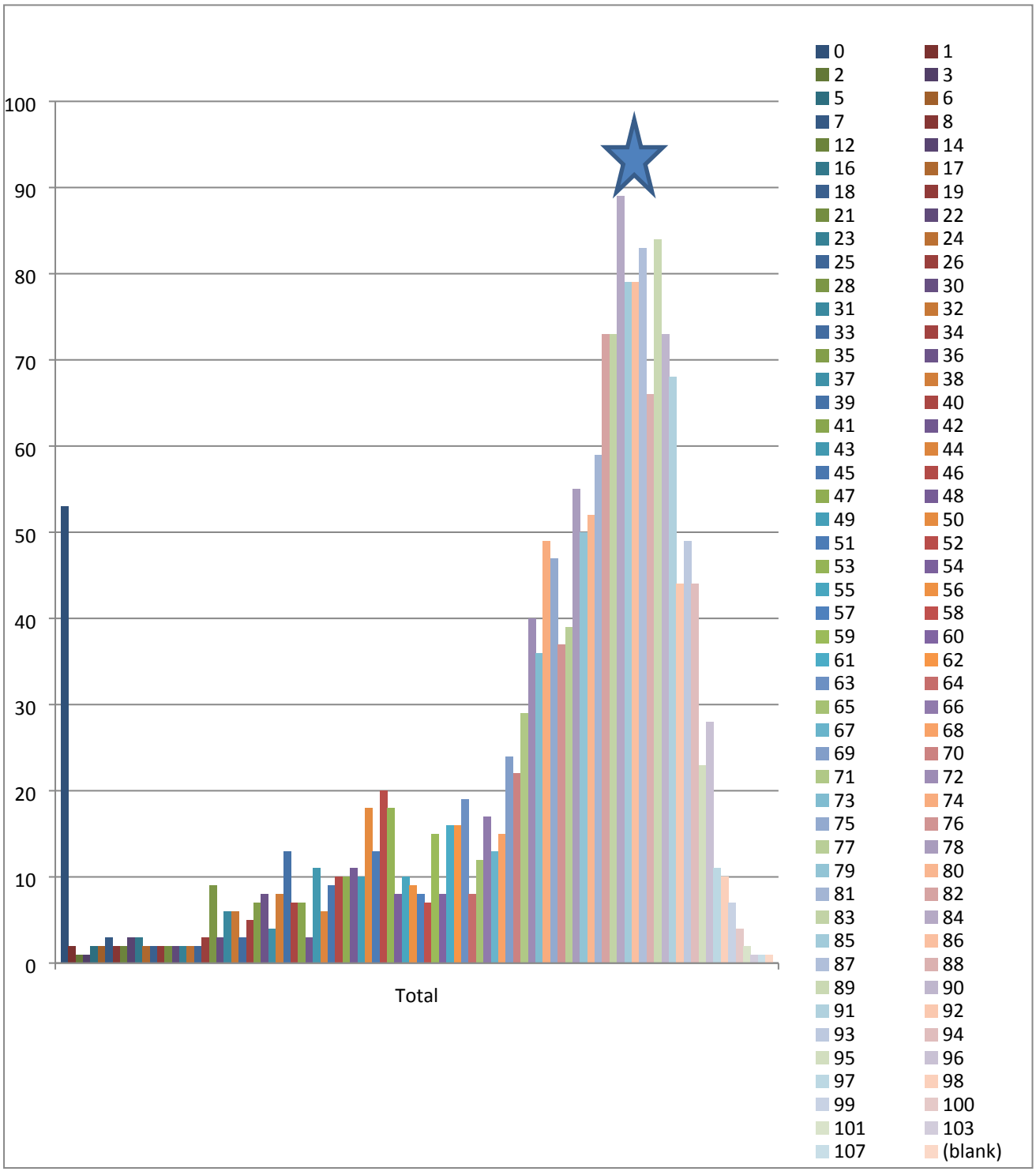
The data below shows the total number of deaths by gender 1 April 2018 to 31 March 2019. There is very little variation between male and female deaths; 1015 male deaths were reported compared to 1014 female.



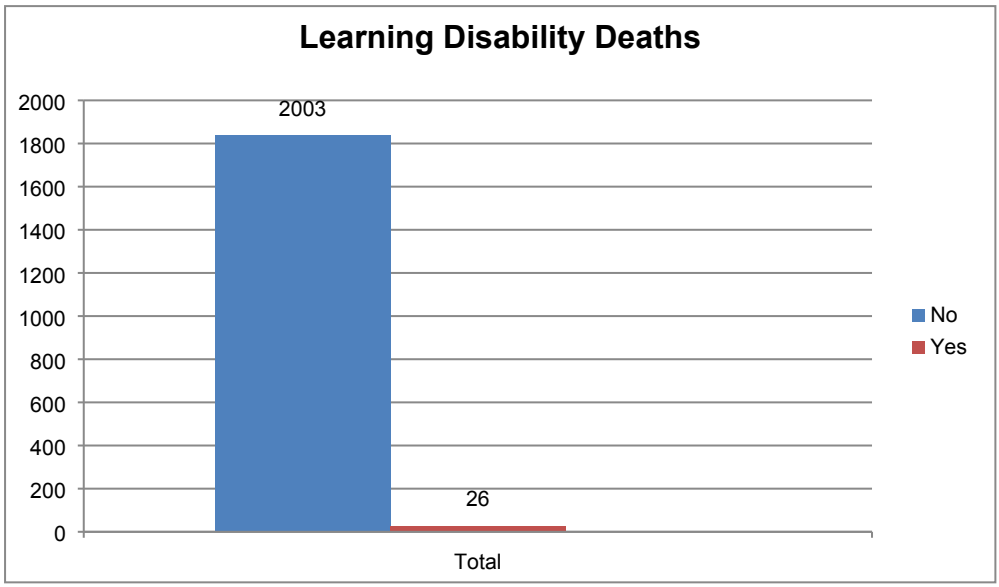
	Female	Male	Grand Total
Count	1014	1015	2029

6.3 Death by Age Group 1 April 2018 – 31 March 2019

The youngest age was classed as 0, and the oldest age was 107 years. Most deaths occur within the 84-87 age groups (indicated by the star).



6.4 Learning Disability Deaths since 1 April 2018 to 31 March 2019



The Trust reviews all deaths relating to patients diagnosed with a Learning Disability. The Trust also currently sends all Learning Disability deaths that have been reported through the Datix system to the Learning Disabilities Mortality Review (LeDeR) Programme. However, we are unable to ascertain how many of these deaths have been reviewed through the LeDeR process, as LeDeR only looks at a sample of overall deaths. Currently the Lead Professional for Patient Safety and Experience is working closely with LeDeR so that the Trust can be involved moving forward in the review process. The Trust is now sharing relevant information with LeDeR. Since April 2018, the Trust has recorded 26 Learning Disability deaths.

The Trust now receives a quarterly update from LeDeR which highlights national good practice and identified learning; this report is shared and discussed at the monthly Mortality meeting.

6.5 Death by Ethnicity 1 April 2018 to 31 March 2019

White British is the highest recorded ethnicity group with 1511 recorded deaths, 360 deaths had no recorded ethnicity assigned, and 16 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Ethnicity	Count
White - British	1511
Not Known	360
White - Any other White background	44
Other Ethnic Groups - Any other ethnic group	42
Not stated	16
Caribbean	13
Indian	12
White - Irish	11
Asian or Asian British - Pakistani	6
Pakistani	3
Mixed - Any other mixed background	3
Asian or Asian British - Indian	2
Mixed - White and Asian	2
Mixed - White and Black Caribbean	3
Asian or Asian British - Any other Asian background	1
Grand Total	**2029**

7. Recommendations and Learning

Below are examples of the recommendations that have been undertaken following the review of deaths either through the *Untoward Incident Reporting and Investigation Policy and Procedure* or *Learning from Deaths Procedure over the previous financial year.* These recommendations are monitored by the Patient Safety Team and are allocated to a specific team, and individuals to be completed. This is not an exhaustive list

7.1 Action Log

- Options to improve the cohesiveness of working with the Chesterfield Royal Hospital and accessing expert medical opinion for mental health patients whilst they are inpatients on the Hartington Unit.

- Further consideration required by the Trust Medical Director in discussing this case with the GP and his Responsible Officer in the spirit of learning and quality improvement. This is in relation to professional practice and continual learning.

- The Trust to discuss progress with Commissioners the possibility of establishing an older people In-Reach and Home Treatment Team in the North of Derbyshire or an alternative model of home treatment for individuals with PDs care profile.

- Trust Medical Director and Chair of the Physical Health Care Committee to risk assess the benefits of routine Serum C reactive protein levels in inpatient areas.

- The Trust to discuss this case with the Clinical Commissioning Group in the spirit of quality improvement and learning. This is in relation to the Care and Treatment Review referral process and ongoing management in relation to the patients care.

- The Section 136 Joint Policy to be reviewed with relevant external agencies in-line with the outcome of this investigation. This is to ensure effective communication and a consistent approach following the outcome of a Section 136 assessment.

- Further consideration by the Trust in discussing this case with Social Care. This is in relation to the patient's journey from referral to allocation of a Social Worker.

- A Learning Review using this case to be undertaken Trust wide with Social Services to be offered the opportunity to participate. (The CCG have offered support with this in terms of Social Care review)

- Development of a staff resource detailing the Serious Incident process and what to expect following an untoward serious incident.

- Review of the Trust guidelines for the management and treatment of opiate use with consideration to the inclusion of a withdrawal scale assessment tool

- To develop a procedure on options and decision making in Criminal Justice Team which includes advice for out of hours Doctors on what to do out of hours and how to communicate with colleagues.

- Consideration of formal management training for development, support and use of IT systems to inform operational decision-making

- Review of policies-blood-borne virus policy, seclusion policy

- Audits- safety box, relapse prevention plans with community mental health teams, standards of practice for patients on a community treatment order

- Discussion with commissioners regarding specific services / pathways for individuals with a diagnosis of personality disorder

- Review the number of funded care programme approach co-ordinators in community teams benchmarked against comparable trusts per hundred thousand population

- Education/information on the referral process to IAPT for inpatient areas

- To consider developing new / incorporating within training already provided a module about the Mental Health Act paperwork linked to seclusion, including seclusion exception reporting and the seclusion policy

- To share with commissioners, the impact and access of community based psychological therapy for interfamilial child trauma

- Where there are co morbid complex physical health issues in someone with a severe mental illness, their care plan safety plan must reflect any concerns or risk related to the management of that physical health need. This includes any concerns around medication.

- To identify the threshold for Forensic Service input and method of referral and dissemination of information

- Development of a Safeguarding Protocol which would include details regarding how to access safeguarding advice and support which would complement information already available via the Safeguarding Connect web page.

- The Process for managing Front Door Presentations to Psychiatric Units needs to be clarified and reviewed.

- There is a waiting list for psychological therapy, for EMDR. Review with commissioners solutions to reduce the waiting time

- A team awareness raising session regarding the frequent revisiting of a service user's decision to withhold information from family and carers using the 'Advanced Planning for People with Bipolar Disorder Guide' from the East Midlands Academic Health Science Network and also the 'Sharing information with family and carers' booklet and the 'Advance Statement about information sharing and involvement of family carers'.

- To review the MDT documentation processes with regard to the decision making actions when there are patient safety concerns. This should take into account the immediate action taken by the medics, care co-ordinators and supervisors.

- For DHCFT staff who work in out of hours services (mental health triage hub, Crisis team) to have access to IAPTUS notes as read only

- Trust to ensure development of clinical standards for personality disorder and a robust Personality Disorders Pathway and appropriate training for staff and teams

- Review of the CPA policy in terms of transfer between secondary services to provide clarity. Transition policy to be updated in include process in the event of a dispute between services in transition Clarity required for services regarding dispute resolution in transition

- Discuss the importance of using the analgesic ladder to manage pain in older people with dementia. Review use of pain management tools.

- The Eating Disorder team to facilitate a reflective session with the Neighbourhood teams in relation to managing Eating Disorder patients and timely referrals.

- Eating Disorder Service to raise with MARSIPAN Lead and Derby Hospitals Mental Health Steering Group the need to establish joint protocols for patients to be directed to appropriate support/ services, and joint clinics and / or regular review meetings for high

- Discuss with the multidisciplinary team the importance of adopting a broader approach to advanced decision making which is discussed in conjunction with DNAR decisions.

- Where Social Care are involved with a client, an multi-disciplinary team and multi-agency meeting should be arranged once a year or more frequently if required due to significant change in accordance with CPA guidelines. CPA Review to be multi-disciplinary and multi-agency where relevant.

- Develop the role of end of life link workers or champions on the ward, to promote a culture of positive end of life care.

- To request commissioners to review contracts to include direction as to the expected level of discharge information and the timeliness of the communication from private providers.

- Observation Policy and Procedure to be reviewed.

- Medication changes which are likely to impact upon the risk of falls should be recorded in the Multi-Disciplinary Team process and care plans updated accordingly.

- To develop standard operating policy/procedures for Hepatitis A, B and C, HIV testing and vaccinating against Hepatitis A and B.

- The consideration of relapse reduction model including relapse signature to be a continuous quality improvement priority for mental health service in 2018.

- Clarify protocols with NHS England surrounding gatekeeping assessments for low secure services.

- Collateral information should be sought from families wherever possible to add to the clinical assessment and understanding of the presentation.

- A clinical supervision framework that ensures clinicians have routine access to professionals with clinical expertise in forensic care.

- Site visits to be organised for junior doctors during induction.

- Community Team Learning Disability Teams to review Triangle of Care action plans with Multi-Disciplinary Team members & carers champions.

- Non-recent sexual abuse reporting process to be discussed with ward staff and all staff to be forwarded link to the Trust procedures.

- Development of a new standard operating procedure in the acute care pathways in the North and South for all complex case clinical reviews.

- To consider the Clinical Safety Plan becoming part of the main PARIS tree index so that it is more easily accessible to all agencies involved.

8. Mortality prevention work undertaken by the Trust;

8.1 Research Project Title: Investigating all-cause mortality in the substance misuse treatment population

Chief Investigator: Jennifer Ness, Lead Health Services Researcher
Project Team: Martin Smith, Recovery Lead; Laura Dunkley, Research Project Manager

Summary

In England, the number of people dying from drug poisoning or misuse is the highest it has ever been, with rates increasing by a third since 2010 (ONS, 2018). These figures do not include the elevated mortality of drug users from other complex health and social issues, from chronic diseases (Mathers et al, 2013) to homicide (Pierce et al, 2015), and so the actual mortality rate will be much higher. This research will extend the findings of the annual ONS report by looking at epidemiology, clinical outcomes and risk factors for premature mortality (not restricted solely to drug overdose). In this regard, the aim of the project is to gain a better understanding of substance misuse services, in the context of the national drug strategy, and to consider what broader lessons can be learned for prevention.

8.2 Summary of Acute Liaison work – Dental day case only – The Royal Derby Hospital

NHS Choices outlines the importance of good oral health and the implications to health,

The state of someone's teeth affects their overall health, with gum disease linked to lots of serious health problems in other parts of the body and increasing risk to other health complications, including stroke, diabetes and heart disease. Gum disease has even been linked with problems in pregnancy and dementia.

The dental day cases are held every other Wednesday for essential assessment and treatment if necessary, for individuals where it is apparent that primary health care services would not be able to meet the needs of this group of people. These sessions offer:

- Case by case situations. Organised visits to the dental day case clinic if required as part of any **desensitisation programme**
- Many service users require accessible **information** around coming into hospital which is issued prior to admission.
- Service users are **met upon arrival** at hospital, and are provided with an offer of **support during any outlined procedure**, including administration of anaesthetic / treatment. This support is available throughout the whole process, not just 'booking in'.

- Support is provided in a variety of ways and is tailored to the needs of the individual.

Supporting post–operatively and the discharge process is also invaluable within the dental day case. Whilst it is essential that observations are monitored post-operatively, these can be extremely distressing to some individuals. Being able to support adjustments within this can be of extreme benefit in the recovery process / procedure. Use of an iPad has at times, provided distraction and focus during periods of high anxiety.

Offering this type of **bespoke** service in hospital enhances the positive outcomes for many, as essential treatment is unlikely to be achieved through primary health care services alone.

8.3 Working with Chesterfield FC: a short history of 'Active Spireites' Summary

In 2013, in a chance meeting, the chair of the Chesterfield FC Community Trust (John Croot) was at a networking meeting which included clinicians from the Trust. The two organisations decided to meet to explore opportunities to develop a joint Mental Health Strategy. The Trust was already working on a Healthy Body Healthy Mind programme that ran with Public Health, looking at how people with severe mental health problems improved their physical health. As part of our recovery approach, the Trust wanted to collaborate with the football club to run sessions targeting improving fitness and mental wellbeing using the motivation of football as that therapeutic tool.

In the five years since the initial meeting, several programmes have developed and the Core Active Spireites programme continues on a rolling basis.

Associated projects have included:

- Healthy lifestyle course at the stadium co-facilitated by mental health Occupational Therapists, football coaches and volunteer Peer Supporters (The Core Active Spireites Programme)
- A similar programme targeted particularly at people with substance misuse problems
- Football coaching sessions & competitive football matches facilitated by Chesterfield FC community Trust & Peer Supporters
- Walking for health project
- In-reach work to acute mental health unit from Chesterfield FC Community Trust
- 'Time to change' match events at Chesterfield FC stadium (Twice a year)
- Establishing links with national projects promoting football and mental health projects and presenting details of the programme at national meetings

8.4 Community Treatment Order Learning Event

On 17 January 2019 Dr John Sykes, Medical Director, and Bhavnita Bunawah, Investigation Facilitator undertook a Learning event in relation to CTO's (Community Treatment Orders) at the Doctors Academic Meeting in the North. The original recommendation from a serious incident had been specific to the individuals involved in that case however it later transpired there was wider learning around the CTO process which culminated in the learning event.

In addition to the CTO activity from the Mental Health Act office, data was derived from Datix in relation to the incidents that have involved an issue with the CTO process. The attendees were advised of the number of incidents categorised between Insignificant to Catastrophic over past 3 years and the specific themes. This allowed for a discussion of individual experiences but also highlighted where the predominant areas errors in relation to CTO are made thus the greatest learning.

The group were introduced to the Untoward Reporting and Investigation policy and procedure process where the recommendations in relation to CTO from serious incidents were discussed after which they were presented with a serious incident case study on the topic of CTO's. During a breakout session the group were asked to consider the main issues and how lessons are learnt. The attendees were also asked to reflect on what the recommendations would be before the findings of the case and the subsequent action plan were shared.

The feedback received was very positive. The attendees reported the event had provided "clarity on CTOs/ CTO legality", provided a "good opportunity to discuss the challenges of CTO" and learning in relation to the "Investigation process". In addition a number of aspects were identified that attendees reported they would utilise in their own practise including "communication between community and in-patient teams", "importance of filing in current paperwork and "Duty of Candour".

A further CTO Learning Event has been arranged for the South Doctors Academic Meeting in June. It is envisaged moving forward these events will be extended to include other clinical staff who are involved in this process and contributions from AMHP's from Social Care.

9. Achievements

- Following the publication by NHS Resolution in to Learning from suicide-related claims, the Trust was highlighted for its excellent practice. Below is the excerpt from the publication

  Derbyshire NHS Foundation Trust have led the way in developing a family liaison service with which to support bereaved families through an SI investigation and the inquest process if necessary. The model is based on the concept of family inclusive practice and the knowledge gaps in engaging with families in all aspects of mental healthcare. The model was created on behavioural family intervention concepts developed in the Lambeth Early Intervention Services in 2001 by the Trust's director of nursing and influenced

by direct experience of meeting siblings who had not wanted to engage with mental health services due to historical experiences and loss through completed suicide.

Following bereavement, the family is offered the services of a family liaison officer (FLO). The FLO acts as the link between the Trust and the family, keeping them informed as to the progress of the SI investigation and supporting them through the inquest process. The service was designed in 2014 and became operational in 2015. When naming the service, police service terminology was used to retain consistency across organisations.

The Trust does not have a full evaluation of their service – emerging evidence and analysis is required. Early feedback suggests that there has been a substantial reduction in family complaints about not being involved in investigations, reductions in other family complaints, and increase in staff confidence. There is now a formal process and assurance that every family is offered support in all unexpected deaths.

The service offers families full involvement in investigations (including robust governance and compliance around this process), offers of direct referral to psychological services including Improving Access to Psychological Therapy services (IAPT) and family therapy work, including working with bereaved children and siblings. This all occurs within existing trust resources and, it should be noted, contributes to service pressures. The Trust has supported many other organisations, both acute and mental health trusts, with access to their videos, service model, clinical policies and job descriptions. This has resulted in other trusts modelling this practice.

- Following the CQC inspection in July 2018, where the processes and procedures for Learning from deaths were reviewed. There were no recommendation's made, only positive comments by the reviewing inspectors.

- The Care Quality Commission produced a report :Learning from deaths ;a review of the first year of NHS trusts implementing the national guidance. In this guidance the Trust

  Although Derbyshire Healthcare NHS Foundation Trust was rated as requires improvement overall in September 2018, it had strong processes in place for engaging with bereaved families and carers. Feedback from families about support received from the family liaison team was overwhelmingly positive. The family liaison role has evolved in line with learning from the national learning from deaths guidance. The family liaison team works with families where there has been a serious incident or unexpected death as reported through the trust's reporting system. They also work with families on referral through the process for learning from deaths, serious incident process and the complaints process where concerns have been highlighted about care. The team start engaging with families after the death of their loved one has been identified. A single point of contact is established, initial condolences are given and the duty of candour, where applicable, is applied at the first point of contact, which can include providing the clinical team with advice.

Engagement with families is individualised and person-centred, and families are invited to contribute to the investigation's terms of reference and outline any specific questions they want answered about their relative's care and treatment. Monitoring of these actions is done through the Serious Incident Group (SIG) and the family liaison team who can review and see if the report answers the family's questions. Families are invited to feedback on the care and treatment of their family member, and the family liaison worker meets with the family at the end of the investigation process to explain the outcome of the investigation. The family liaison team will support the family for as long as they need them up until the inquest, then work towards closure. Any additional needs are met through arranging activities such as referral to independent advocacy or psychological services. There is also a range of information shared with families including details about the Samaritans, Public Health England's 'Help is at Hand' booklet, WAY Widowed and Young (if under 50), details of local support groups, and The Compassionate Friends leaflet. The information that is sent to families depends on the circumstances around the death of their loved one.

Derbyshire Healthcare NHS Foundation Trust
Report to the Trust Board – 3 September 2019

Infection Prevention & Control Annual Report 2018/19

Purpose of Report

This paper summarises the activity over the preceding twelve months of work related to infection control.

Executive Summary

This report was presented to the Quality Committee in July 2019. The information was scrutinised and reviewed. The Quality Committee scrutinised, confirmed and endorsed the report and the required duties under the Health Act.

- The Trust continues to provide a consistent level of performance against infection control standards and related management activities.
- The number of reported cases of key alert organisms is very low.
- As in the previous years the Trust has seen very little interruption to service delivery due to infection control matters, although a contained flu outbreak did lead to a ward closure at the Hartington Unit despite staff coverage of flu inoculation was very high in the service.
- Inspection of clinical areas remains of a good standard and PLACE (Patient-Led Assessments of the Care Environment) scores continue to show that the Trust is performing at a higher than national average level with some improvements on last year's scoring.
- Clinical staff compliance with training has reduced which is a focus for improvement. Whilst this is a reflection of other training compliance, it is below the Trust's accepted standard.
- The framework for mentoring CPE (carbapenemase-producing Enterobacteriaceae) is due for update. We remain vigilant and abreast of changes and developments.
- The Trust has maintained its five star rating for kitchen cleanliness awarded by the local authority.
- A SEPSIS (septicaemia) policy has been introduced and work is taking place with the regional group to improve the recognition, treatment and communication between providers for this group of people.
- Clinical staff have received feedback on cleanliness and tidiness in the acute pathway of storage rooms at the end of the financial year 2018/19 and this has been rectified.

Overall this has been a solid year for the Infection Prevention and Control within the organisation which provides significant assurance of the system and processes in place within the Trust. There is a clear work plan for further improvement.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	

Assurances

- A review of the current audit programme against National infection control guidance has been carried out and the Trust is contemporaneous and compliant.
- There are evidently robust cleanliness measures in place.
- There continues to be robust oversight of infection control incidents or outbreaks.
- Updated terms of reference have been revised for the Physical Health Care and Infection Control Committee (PHCIC). This Committee has has an executive steering group attached which meets bi-monthly off set against the bi-monthly main meeting.
- All infection control policies are in date.

Consultation

Internal Trust operational groups

Reviewed and scrutinised at Quality Committee July 2019

Governance or Legal Issues

- Health and Social Care Act 2008: code of practice on the prevention and control of infections
- This paper brings an update on regulatory aspects – around standards which may form part of a CQC inspection or enquiry. These would be around patient safety, leadership, responsiveness and effectiveness. Standards are set in the Healthcare Associated Infections Code of Practice for Infection Prevention and Control 2015.
- The law states that the code must be taken into account by the Care Quality Commission when it makes decisions about registration and that providers must have regard to the code when deciding how they will meet the regulations.
- Legislation and regulations that relate to the control and prevention of infection include the Health and Safety at Work Act (HASAWA), the Control of Substances Hazardous to Health (COSHH) and the Reporting of Injury, Disease and Dangerous Occurrences Regulations (RIDDOR).

Public Sector Equality Duty & Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

- Ongoing monitoring of compliance data for training; this is being monitored on an ongoing basis with support from operational colleagues.
- Revised Infection Control training packages (electronic and taught) are being explored through the training department.
- Diabetes care and management is an area of focus for the Physical Health Care and Infection Control Committee as this has associated infection control risk and susceptibility.
- Developing improved training for SEPSIS recognition and management with training department for 2018/19.
- Implementation of SEPSIS Policy and associated roll out of NEWS2.
- Alignment with regional policy and procedures and partner in development of regional training aids and support systems.
- Infection Control Committee has combined with Physical healthcare Committee and the revised meeting has been increased in frequency to bi-monthly to enable issues to be dealt with more swiftly and to widen attendance and representation.

Recommendations

The Board of Directors is requested to:

1) Note the reporting of key areas, such as surveillance of healthcare associated infections – alert organisms, outbreaks of infection, staff training.
2) Receive significant assurance on standards of cleanliness of clinical areas and food preparation areas
3) Receive and approve this report in public session to assure the community on the Trust's infection control standards

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

Report prepared by: **Richard Morrow, Assistant Director of Public & Physical Health**
Julie Carvin, Infection Prevention & Support Nurse
Liz Bates, Deputy Head of Facilities

Infection Prevention & Control
Annual Report – 2018/19

Report prepared by Richard Morrow Assistant Director of Public and Physical Health (lead for Infection Prevention and Control) on behalf of Carolyn Green, Director of Nursing and Patient Experience and Director for Infection Prevention and Control.

1.0 Introduction

1.1 Preventing the spread of infection has been a key focus in healthcare for a good number of years, with a statutory requirement to fulfil mandated standards for all healthcare providers. The Health and Social Care Act 2008 enabled a code of practice to be established with standards which are overseen by the Care Quality Commission (CQC).

1.2 The Code of Practice: Prevention and Control of Healthcare Associated Infections (2015) provides the framework for the standards we are required to achieve, and this report will detail the actions and on-going work which underpins the achievement of this. The regulation of this activity falls as part of the inspection programme undertaken by the CQC. Infection Prevention and Control considerations are part of the ongoing framework of improvements undertaken by the organisation.

1.3 Preventing the spread of infection is an integral aspect of both patient safety and patient experience, providing assurance and a visible marker of standards and the quality of care service users should expect to receive. Derbyshire Healthcare NHS Foundation Trust is proud of the high standards we continue to achieve and the comparatively low rates of infection we see.

1.4 We are beginning to see changes to monitoring frameworks and greater attention paid to communicable infections, particularly those where increasing anti-biotic resistance is flagged as a containment and treatment risk. CPE is an example of an anti-biotic resistant infection which is under review to introduce and embed a more whole system focussed approach.

Health and Social care Act Standards	
Systems in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.	• PHCIC meeting has been improved, meeting more frequently, significant improvement in membership and attendance. • Review and update of local policies and inclusion of revised and updated national guidance. • Regular incident reviews through SI and DATIX flags. • Tissue viability and infection control support network (internal champions, and link to regional and national networks). • Annual training updates and policy and procedure updates. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	• PLACE annual reviews. • Head of nursing walk arounds and cleanliness and estates checks. • Supportive and responsive estates and facilities teams.
Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	• Updated guidance reviewed when circulated and policies adjusted. Focus on CPE for 2019 alongside increased vigilance against hospital acquired infections. • Annual audit plan and report in regards to antibiotic stewardship
Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	• Updated and accessible policies are available through trust intranet site. • Infection control link nurses and support nurse to discuss / assess and liaise with colleagues in regards to advice updated techniques or unusual or unclear presentations. • Support to develop management plans to compliment care planning around the holistic needs of service receivers.
Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	• a VTE assessments are carried out as an assessment baseline when people come into our in-patient services. • Prophylactic prescribing is in place to ensure that risks are mitigated where possible. • EPR enables alerts to be flagged for conditions where transmission or susceptibility is identified on a medium or long term basis. • Trust links into Public Health England leads to ensure national or regional concerns are responded to appropriately.
Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	• DHCFT has regularly reviewed updated and accessible policies and procedures. • Al staff has access to PPE and alcohol based hand cleaning products. • Blended model of e-learning and face to face training. • Post incident analysis and shared learning following infection control incidents. • Signage in high traffic and vulnerable areas.
Provide or secure adequate isolation facilities.	• Individual rooms available with bathroom facilities where required. • Cohort Nursing facility available if required.
Secure adequate access to laboratory support as appropriate.	• PHE and regional IPC support available. • National network and support system linked in to NHSI / E available,
Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	• Developing individual management plans using physical health management tool guidance. • Monitoring of changes to infection control guidance.
Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	• DHCFT have an established relationship with Occupational Health provision locally. • Swift access to assessment and advice is available. • Feedback to managers and colleagues is provided to ensure swift resolution to concerns and adjustments can be made,

2.0 National context

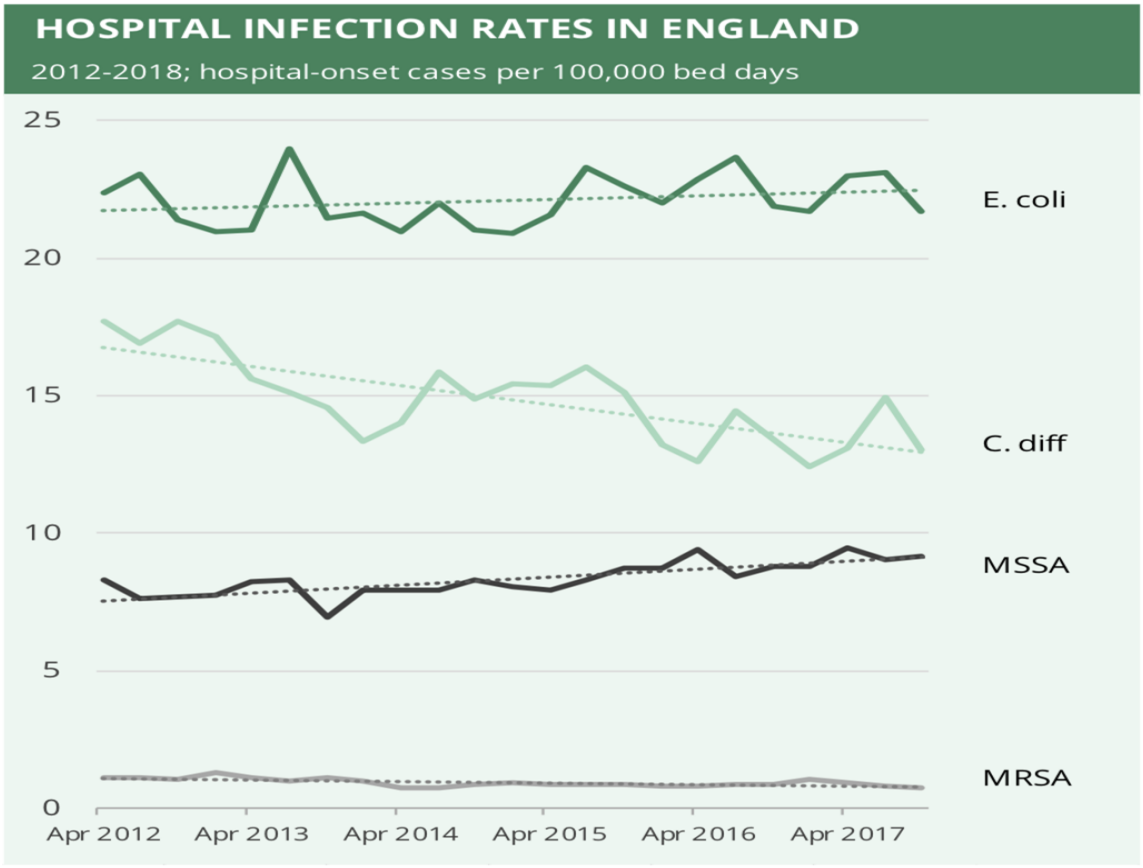
2.1 Over recent years, through sustained progress against challenging expectations, the rates of healthcare associated infection reported nationally have continued to fall (source Public Health England 2014, updated 2016). Cleanliness in healthcare facilities remains a high priority, with the well-established links between poor environmental standards and rates of infection. The emphasis on the speciality and related work is now much more proactive, rather than reacting to events after the fact. This has seen a considerable focus now on 'zero tolerance' of healthcare associated infections, with healthcare associated infection now being seen as largely preventable. There is ongoing focus by NHS England on pandemic influenza preparedness.

The term HCAI covers a wide range of infections. The most well-known include those caused by meticillin-resistant *Staphylococcus aureus* (MRSA), meticillin-sensitive *Staphylococcus aureus* (MSSA), *Clostroides difficile* (C.diff) and *Escherichia coli (E. coli)*. HCAIs cover any infection contracted:

- as a direct result of treatment in, or contact with, a health or social care setting
- as a direct result of healthcare delivery in the community
- as a result of an infection originally acquired outside a healthcare setting (for example, in the community) and brought into a healthcare setting by patients, staff or visitors and transmitted to others within that setting (for example, norovirus).

HCAIs pose a serious risk to patients, clients, staff and visitors to health and social care premises. They can incur significant costs for the NHS and others, and cause significant morbidity and mortality for those infected.

Statistically overall case numbers are falling as shown in the following table from the parliamentary debate paper from 2018 to raise standards of infection control (raising standards of infection control) the focus and concern is shifting to the treatment resistant variants nationally. This is underpinned by an ongoing push to focus on basic principles of infection control containment and management to prevent cross contamination and spread of infections.



Recent focus on the impact of healthcare associated infection has now shifted somewhat from MRSA bacteraemia and *Clostroides difficile* to looking now at other emergent resistant organisms such as *Escherichia coli,* and the significant impact the communicable conditions such as Norovirus have on delivering health care.

3.0 Structures within Derbyshire Healthcare NHS Foundation Trust

3.1 The Chief Executive holds the responsibility for overall standards; however the Trust is required to designate a director lead for Infection Prevention and Control (DIPC), this is undertaken by the Director of Nursing and Patient Experience.

3.2 The Assistant Director of Public and Physical Health is responsible for the day to day delivery of the plan of work and ensuring this meets the required standards. This role is both strategic and also involved in delivery of training, clinical advice and planning.

3.3 Since September 2013, an Infection Control Support Nurse (currently 0.8 wte, increased hours from last year) has been in post to assist the Assistant Director of Public and Physical Health in the delivery of clinical support, advice, training and audit of standards.

3.4 The Head of Estates and Facilities oversees the maintenance, cleanliness and support services which are vital aspect of meeting high standards.

3.5 The programme of work has been previously devised and delivered by the Infection Control Committee, which formed a key component of the Governance structure. This committee has been reporting via the Divisional Clinical Operational Assurance Teams (COAT) as required.

3.6 For 2018/19 the infection Control Committee and the Physical Healthcare Committee were combined in order to make better use of clinician's time and also to broaden the attendance of infection control Committee. The combined meeting will still report to the divisional COAT meetings and Trust Management team (TMT) as before.

3.7 In addition to this the meeting has support and oversight from an executive committee formed to support the delivery of the wide reaching agenda of the Physical health Care and Infection Control Committee (PHCIC). This meets bi-monthly as an adjunct to the main clinical PHCIC meeting.

4.0 Key achievements of 2018/19

4.1 Continued investment in the capital programme has seen sustained improvement in the care environment in a number of locations, through a dedicated capital expenditure allocation for Infection Control in 2018/19.

- Replacement furniture and flooring within the in-patient units as part of a rolling programme of upgrade and improvement
- Furniture and equipment has been provided for newly established physical health monitoring clinics in Community.
- Flooring and fittings upgrades have taken place in the PFI sites on Kingsway site.
- Physical health monitoring equipment from OxeHealth is being installed currently; this enables remote monitoring of patients with elevated physical health risks or those recovering from episodes of ill-health to be monitored in an unobtrusive manner to promote rest without compromising clinical safety.
- Radbourne Unit have had some furniture replaced and some work to the section 136 suite to improve the quality and standards of the facility.
- Ward 1 and the older adult wards at Kingsway site are currently having some replacement furniture delivered.
- Implementation of SEPSIS policy and coalition with regional SEPSIS best practice implementation group.

4.2 Continued delivery of a training programme for those clinical and support staff identified as requiring the training (2491 staff in the target group in April 2019) saw a compliance position on 24/04/17 of 73.51%. This is exactly the same position as the previous year. Training sessions are largely delivered as either 'face to face' taught session, in a variety of locations via the 'block' training methodology, There is also an e-learning option for staff to access. This is being actively promoted as this level of compliance is below what we regard as an acceptable standard.

4.4 In February we had a Flu strain A outbreak on one of our acute in-patient ward at Hartington Unit. (Major incident in DATIX summary table)

- Staff were encouraged to have flu vaccination across the unit if they haven't already had it.
- The affected patients were nursed in dormitories, one male and one female.
- All patients who were safe to manage were encouraged to take leave.
- Signage was displayed alerting visitors, relatives and carers
- Everyone visiting, staying and working on the ward was continually advised in regards to hand washing and reducing traffic on and off the ward.
- The outbreak was contained to one ward with no spread to other areas.
- NHSE and CCG were kept informed as per winter pressures and contractual guidance.
- A post incident review was conducted and many positive lessons learnt in regards to good communication and prevention of cross contamination.
- The estates team were responsive and enhanced cleaning off hand rails etc. was pivotal in managing cross contamination risks.
- Patients on the ward were also vaccinated.

For future incidents we have been exploring sharing PPE resources with fellow providers in the event of an outbreak to increase responsiveness but reduce potential costs and waste.

4.5 Surveillance of healthcare associated infections (HCAI alert organisms) have seen no cases of MRSA bacteraemia acquired within the trust between April 2018 – March 2019 – this has been the case for six consecutive years.

4.6 A C.diff carrier was identified on Ward 1 in January 2019, anticipatory cleaning protocols were instigated and no cross contamination or outbreak ensued. The infection control support nurse was able to support the infection prevention control link nurse and advise on clinical management strategies.

4.7 Cleaning scores, measured against the national standards of cleanliness, have continued to meet the nationally defined 'excellent' standard in clinical areas across the year (see detailed performance in the section 'Assurance').

4.8 Cleaning schedules remain consistent with national guidance, and are held at ward level for access by staff and patients / visitors.

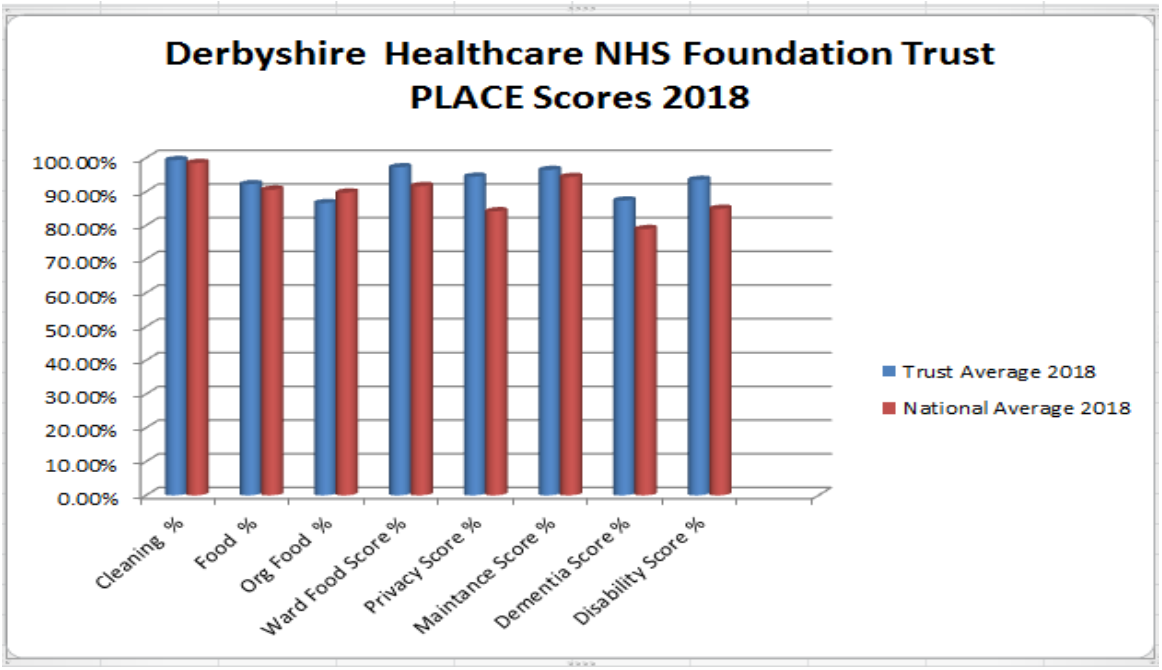
4.9 Patient Led Assessment of the Care Environment (PLACE) inspections took place in Spring 2018and results released later in the year, with continued strong performance. The 2019 inspection programme has yet to begin at the time of writing this report as PLACE are reviewing their inspection framework. The results will not be available until later in the year so will feature in next year's report. The teams undertaking PLACE typically consist of Service User representatives, Estates, Nursing and Domestic Services as well as Infection

Control representation. An action plan is drawn up after the assessments, which then feed into the allocation of capital funds, support for larger capital bids and inform backlog maintenance priorities.

4.10 Continued development of the skills and leadership of the Infection Control Link Nurses programme brings a strong focus of clinical leadership and a conduit for information between the specialist team and clinical level. The infection control audit has been reviewed as the safety of sharps was highlighted last year by the infection control link nurses. The audit is derived from a national safety standards audit and is undertaken annually by all in-patient areas. The 2018 audits are uploaded centrally for assurance and accessibility and this year's schedule is well underway and due to concluded in August 2019. This year we have identified new infection control link nurses as existing staff have moved into other roles within the organisation.

5.0 Assurances

5.1 The Facilities team continue to deliver high standards of cleanliness. This means we remain in the 'excellent' range which is supported by the findings in this year's PLACE inspections. The highest standards and greatest cleaning services input are delivered in inpatient wards and patient facilities.



The Hotel Services and Estates teams continue to undertake visits to the Community Mental Health unit's premises to ensure all environmental standards and being met and to check that all planned maintenance is in accordance with the proposed works schedule. A number of improvements have been made following these visits and new flooring, replacement of carpets and furniture have improved the environment and reduced potential infection control risks.

The food score for the 2018 was the only area below national average however we are conversely proud that the reason is not one of quality.

The comment from the Estates and Facilities Manager sums up the reason that the score is reduced;

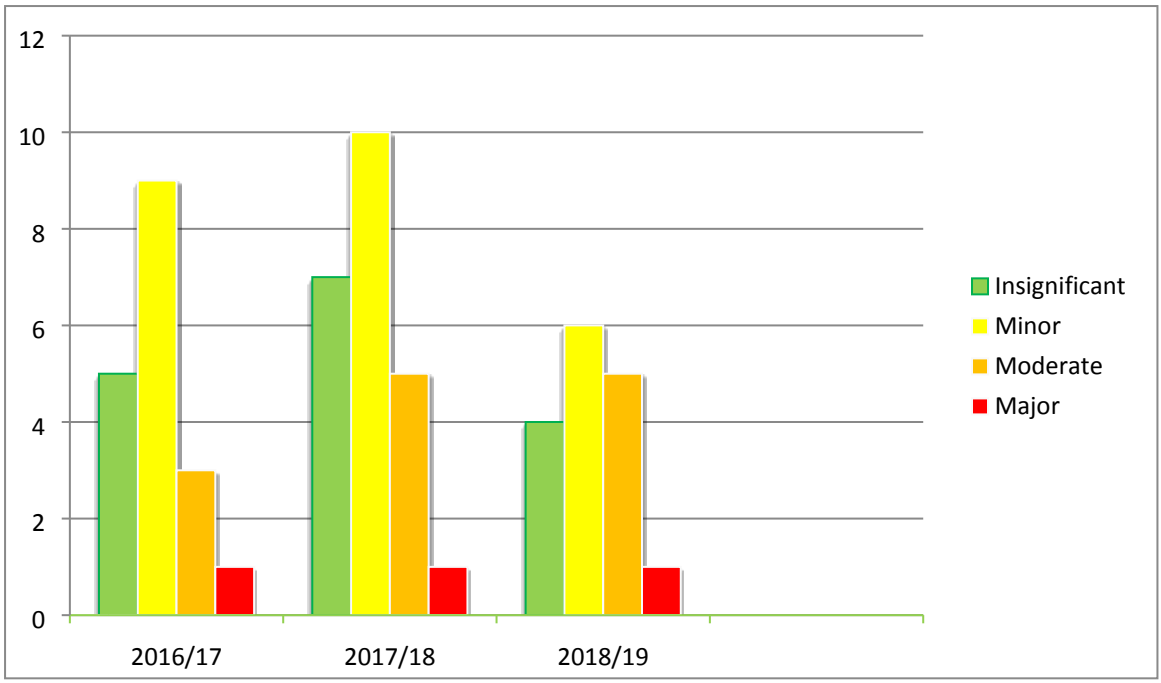
"Food & Organisation Food section, this is not the food that patients eat (Ward Food section). This section is about things such as, having a cooked breakfast every day, if we serve hot desserts at every main meal and do patients receive snacks three times a day. Things like having a cooked breakfast every day, hot desserts at each main meal we do not do, or three snacks, this is at the choice of the patients, clinical staff and dieticians and is a considered choice to promote a healthy diet. we hope that following the National Catering Standards release, PLACE will alter these questions, we have given feedback in regards to this previously. We also loose marks for not having an a la carte menu - a 24 hour menu that never changes and the patients can pick from 16 or so choices for each course. For patients that are in hospital for several days or more this very quickly becomes repetitive. We operate a four week menu which gives a much larger variety but impacts upon our scores. I do raise this annually as well and it was pleasing to hear that the Dietetic association have also been raising this."

It will be interesting to see if the 2019 PLACE framework reflects this as we believe we are addressing patient choice and health needs with the deviation from national guidance.

5.2 The Heads of Nursing rounds have continued to provide assurance of key standards in the inpatient wards, where on a twice yearly basis, representatives from Infection Control, and Hotel Services join the Heads of Nursing to inspect the clinical areas from an environmental quality perspective. This provides a proactive way of looking at the environment, anticipating maintenance and quality issues at an early stage (and ensuring action is taken) and also the opportunity to seek informal feedback from patients on the wards as to the comfort and cleanliness of the wards. We are currently reviewing this to see if a more frequent review would be of benefit given the pressures and increases in activity and incidents in some of in-patient areas.

5.3 Healthcare associated infection (HCAI) surveillance demonstrates our performance, as reported to the Commissioning organisation. We continue to show consistent performance here, with clinical focus on anticipation of possible infection risks and a swift, appropriate response, for example to suspected diarrhoeal illness. This has seen a significant emphasis on prevention of cross infection, and rising confidence in staff to deal with potential infection risks as they arise.

Table summarising infection control incidents recorded on DATIX:



5.4 During 2018/19, there has been one ward closure as a result of diarrhoeal illness (suspected Norovirus). This was short in duration and once identified no new cases arose within the 48 hour monitoring period.

All infection control issues are reviewed and there have been no outbreaks of MRSA bacteraemia and Clostroides difficile. As in previous years learning from Physical Health Care and Infection Control Committee (PHCIC) learning points are also distributed via the Infection Control link nurses and via clinical training. These two committees have combined for 2018/19.

The catheter passport was introduced last year and has been evaluated to have been a success. The infection control support nurse has been working with colleagues to increase awareness / confidence and skills related to catheter care.

5.5 Clinical audit specifically to infection control is focussed on two key areas during the year:

- Infection control general standards (hand hygiene, sharps, decontamination equipment). Thematic review of the general infection control audit saw areas of work needed in regards to the storage of equipment.
- Last year an audit of toy cleaning highlighted some challenges for the clinical team in evidencing after each play contact that toys had been cleaned. This has been amended in the current protocol to show that toys are being cleaned in accordance with the policy but recorded weekly.

5.6 Clinical compulsory training continues to take place for those staff who are required to attend, as identified as part of the training framework, and administrated via the training passport system. Compliance is monitored via

the Physical Health Care and Infection Control Committee at a strategic level, and attendance is managed by each of the Divisions. Frequency of attendance is currently agreed as every 2 years, and these are largely taught sessions via the ‘block training’ method. The compliance ‘as at’ 31 April 2019 was 73.51%, this is consistent with last year’s figures. This remains a focus for 2019/20.

5.7 An influenza vaccination campaign was delivered for staff and patients who met the criteria. The final staff uptake figures remain low but significantly increased to 54% (was 50.2% in previous year).

As in previous years we adopted a peer vaccinator model for the majority of vaccinations provided. For the 2019/20 campaign we are taking a significantly different approach and moving away from a centralised support model to a divisionally led approach. Whilst the Peer support model remains central, the approach is to build ownership and momentum within the Division and continue to promote a staff, patent, family safety initiative.

The target set by the organisation is 85% this year, a significant step change from last year.

The following table outlines the approach being developed:

Role of General Manager	• Successfully deliver a divisional flu inoculation target
Role of Divisional Flu Lead	• Named Flu lead to attend Divisional meetings • Named lead to report to the Divisional on Performance • Attend trust wide flu inoculation meeting • Deliver flu inoculation target of 85% • Ensure each team has a peer vaccinator
Role of Team Manager / Senior Nurse	• Successfully deliver a team Flu inoculation target of 85% • Allocate a peer vaccinator in each team • Ensure every team member is asked to consider the flu inoculation and ensure time to be released to attend a flu clinic or receive an inoculation in the team
Role of team Flu lead / peer vaccinator	• Successfully deliver a team Flu inoculation target of 85% • Be a positive role model for the public health benefits of flu inoculation and the pt safety and protection benefits of flu inoculation.
Receive a team – reward. On behalf of the trust for achieving this level of clinical safety to our staff and patients in a team	

5.8 Hotel services continue to provide assurance on key service delivery areas, such as food hygiene, pest control, laundry and linen supplies, and the duty of care audits required under the NHS Waste Management regulations. A full review of the laundry contract has taken place as a joint venture, with a single provider in place. The kitchens at Kingsway and Radbourne sites have had had environmental health inspections and were once again awarded 5 star ratings by Derby City Council. This is a very public method of demonstrating quality, as it is used across all food preparation establishments. We continue to gain additional assurance by using an independent Environmental Health officer to undertake inspections and guidance, as well as the local authority inspections. Pest control contractors call outs have reduced this year and the estates and facilitated department have arranged for replacement bins and refuse collection vessels to reduce pest control incidents.

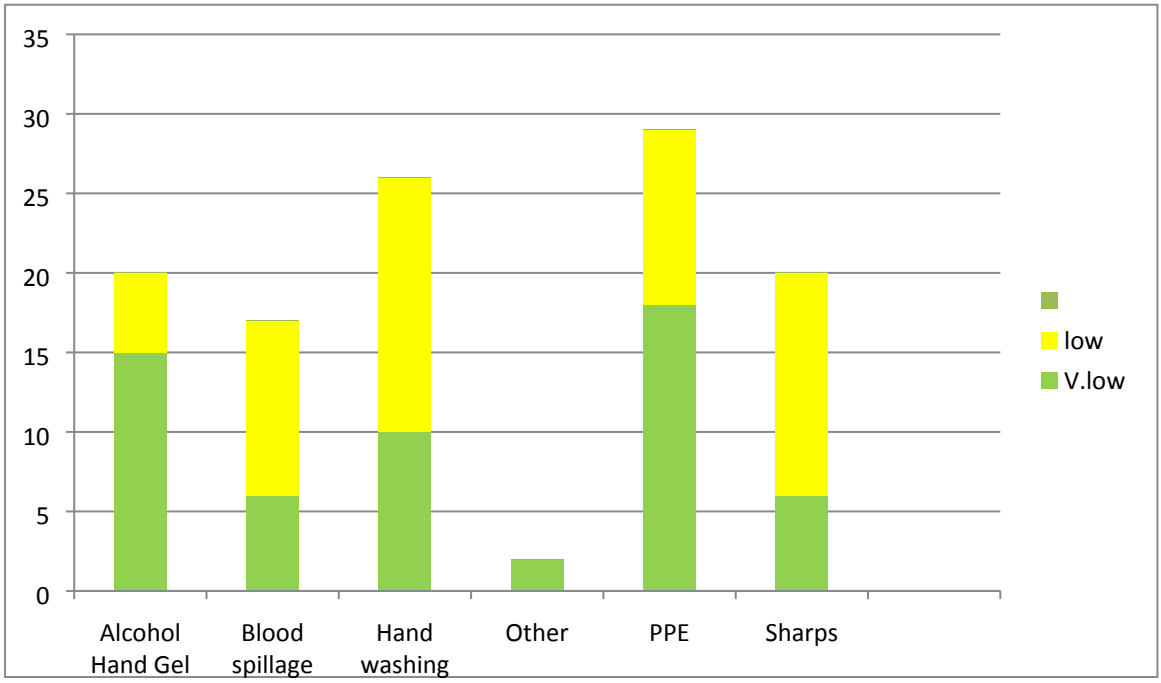
Planned inspections of kitchen areas taking place as a preventative measure measures this year and the estates team have been very proactive in dealing

with the small number of incidents reported in order to ensure that issues are addressed quickly and effectively to maintain confidence from the people who access and work with our services.

5.9 Estates continue to provide a monitoring system and maintenance programme to maintain safe water quality. Focussed work in ensuring proactive flushing records are maintained have been a recent focus of the Estates planned, proactive management. A water safety group is established with focussed prevention of Legionella and also other issues with potable water such as Pseudomonas.

5.10 Risks relating to infection control are recorded on the DATIX risk register against each Ward/Team in line with the Risk Assessment Policy and Procedures. This identifies a number of 'required' risk assessments that wards/teams must complete and review at least annually.

There are currently 114 risks on DATIX relating to infection control, all of which are currently rated as low or very low risk (**see table below**)



6.0 Next steps and priorities

6.1 The organisation continues to place prevention of infection, along with prevention of harm, as a central feature of clinical service delivery. A focus on continuing to equip the workforce is pivotal to this. The delivery of a compulsory training requirement means that staff are equipped to deliver care in a way that prevents the spread of infection, and provides them with the clinical leadership to seek advice where required. Audit and ownership of the results by clinical teams through the infection control leads is a key part to improve safety and encourage curiosity in emerging areas such as antimicrobial resistance.

6.2 Continued focus on strong, visible clinical leadership will continue to see practice at the highest standards, with staff empowered to seek advice and support where needed. Strong leadership also brings consistency of standards.

6.3 Continued commitment in capital expenditure on the Estate will ensure that environmental risk is kept to a minimum (for example on-going replacement schedule for furnishings), upgrade of ward and community facilities reduces the risk of poor environment and enhances patient experience. Work is underway and requires continued commitment to support safe practice. Monitoring of external contracted services ensures the highest standards are achieved on our behalf. This is an important aspect of quality assurance.

6.4 On-going support for the delivery of high standards of hotel services, and specialist infection control advice when needed.

6.5 Commitment to working with other providers, to ensure we play our part as a health economy in reducing the burden of healthcare associated infections, such as CPE, Norovirus, *Clostrioides difficile* and MRSA. In addition we are also looking at regional and national guidance related to SEPSIS and we are engaged in the regional implementation of revised SEPSIS guidelines.

6.6 There is ongoing support for the developmental work undertaken to meet Nutritional standards, much of which is reported via the Physical Care and Infection Control Committee, but crosses over with this work plan due to governance of food preparation and storage. There remains a strong focus is on improving diabetes care and management.

6.7 A continued commitment to the provision of high standards of cleanliness in our premises with the ability to have highly trained and flexible staff helps us meet clinical need.

6.8 Implement CPE guidelines once clear instruction has been received from NHSE/I and PHE.

CPE

- Overview of national guidance changes has identified areas for focus for 2018/19 for CPE (Carbapenemase Producing Enterobacteriaceae). Community / Non-acute toolkit has been in situ since June 2015 and there is pending release of action framework for England by Public Health England (July 2019).

What is CPE?

Enterobacteriaceae are bacteria that usually live harmlessly in the gut of humans. This is called 'colonisation' (a person is said to be a 'carrier'). However, if the bacteria get into the wrong place, such as the bladder or bloodstream they can cause infection.

Carbapenemase-producing Enterobacteriaceae (sometimes abbreviated to CPE) are a type of bacteria which has become resistant to carbapenems, a group of powerful antibiotics. This resistance is helped by enzymes called carbapenemases, which are made by some strains of the bacteria and allows them to destroy carbapenem antibiotics. This means the bacteria can cause infections that are resistant to carbapenem antibiotics and many other antibiotics. PHE, February 2019.

The focus on managing these infections has arisen as they are becoming increasingly resistant to treatment and they are known to survive outside of a host so infection control measures, good antibiotic stewardship and robust cross contamination procedures cannot only reduce the spread but also reduce the risks across the health economy.

- DHCFT are working with PHE to ensure that we are compliant with National guidance changes and contribute to reduce and eradicate the risk where possible.
- DHCFT had a reported case of CPE in July 2017 Please see attached, we have had one case of CPE in a service user's urine he was admitted from RDH after living in Thailand where he contracted Pneumonia and on return to Derby had delirium; this was in April 2017. He was barrier nursed on Cubley Male, then treated and cleared but unfortunately passed away July 2017. He was screened for CPE in the bowel as per protocol in the non-acute and community toolkit.
- The case was detected using the non-acute toolkit released in June 2015. Whilst we have not had further cases reported within the organisation we remain vigilant as the impact on service users, families and providers of care of treatment resistant infections is rising.

7.0 Potential risks in delivery

7.1 Operational support for the infection control support nurse role is pivotal in the ability to deliver the programme of work and level of clinical support and responsiveness needed to meet clinical demand. Given the current demands to increase training compliance it is helpful to continue with increased hours (0.8 wte).

7.2 The relatively low uptake of the influenza vaccination by staff should be considered as a key protective and public health responsibility of the organisation, and requires continued support to improve uptake.

7.3 Continued operational support to achieve compliance with compulsory training.

7.4 Any impact on ability to deliver cleaning services to the current high standard in the inpatient areas and clinical bases would have an impact on existing infection control standards.

7.5 The organisation needs to ensure that we maintain monitoring of externally provided contracts, such as laundry, cleaning (north county units), pest control and maintenance to ensure that that standards are not allowed to slip in challenging operating environments.

7.6 The organisation needs to remain focussed that Hotel Services remain equipped to be able to continue to maintain the high standards of cleanliness we currently achieve.

Richard Morrow
Assistant Director of Public and Physical Health Care
1 July 2019

Derbyshire Healthcare NHS Foundation Trust

Board Committee Assurance Summary Report to Trust Board
Quality Committee meeting held 9 July 2019

Key items discussed

- **BAF Risks for Quality Committee**
  Nothing noted

- **Quality Dashboard**
  Investigations by PHSO Parliamentary and Health Service Ombudsman (clarity is being sought about the detail of these cases). Safeguarding Children Level 3 training performance and how it is below compliance target. People and Culture Committee is monitoring performance and has endorsed the support being provided to inpatient areas to release staff to attend training. We noted that we are moving towards Statistical process control (SPC) charts which we hope will resolve some questions about specific data points. With regards to outstanding Serious Incident actions these were not considered to be high impact actions. Also discussed seclusion data, and if this needs to include number of seclusions and also the number of people this applies to. Committee recognised the importance of focusing on the themes in the serious incident report

- **Acute Care Pathway Monthly Update**
  There was an update re short term and longer term options to address privacy and dignity issues on our wards, options being presented by Mark and Carolyn to the rest of the Executive Team next week. This will then be discussed by the Board in confidential session in August. National and Regional Estates lead has been asked to quality assure estate plans. Significant assurance received that the plan is being developed. Committee discussed if additional staff will be required when accommodation has less visible sight lines due to the intended move from dormitory stock single room ensuite facilities. COO explained that this is being considered.

  Mandatory training is a challenge, but over the last two weeks the trajectory has all been achieved (staff have been able to attend training that they have been booked on to). Recruitment and retention – there are some opportunities identified for the acute pathway for how we approach this, to be taken to the unions this week. Discussed how staff have requested a shift from a CQC action plan to a transformation plan. Limited assurance, and to note the continued hard work of Trust Staff.

- **Smoke Free Model - Tobacco Dependence Policy Update**
  The policy is very well written. We discussed if there could be potential risks from our recommendations of e-cigarettes, recognising that there isn't long term evidence of safety as yet and some emerging evidence of concern. Assurance discussed that this is in line with NICE Guidelines but e-cigarettes are referred to in their guidelines (they refer to this lack of evidence but are not as yet raising concerns). Subject to this approved, with the recognition that this is a harm reduction strategy, and it was a decision on balance of risk. Agreed to keep the policy under review pending emerging research about any harm from e-cigarettes

- **Infection Control - Annual Report**
  Significant assurance. However, we also made reference to how in our most recent CQC inspection there were some cleanliness challenges on one particular ward, and we wondered how this aligns with the PLACE assessments

- **Quality Improvement Strategy – progress update**
  Limited assurance. Future reports would benefit from clearer timescales and impact, together

with timelines of expected outcomes. However, we noted the change in culture that was evident from the narrative and also from conversations elsewhere that are now more improvement focused. Discussed how we might embed this into core business plans, and help the strategy be more visible as our approach.

- **Serious Incidents - Bi-monthly report and Annual Report**
  Appreciated the thematic approach, the learning events were very positive, learning from good practice as well as bad. Concerns raised around 12 hour breaches and discussed the process and agreement for reporting. Significant assurance as to the process, very reassured as to the learning events, limited assurance as to the impact of the learning from serious incidents.

- **Learning From Deaths/Mortality Report**
  Discussed our awareness of whether or not in our locality, are people dying early at the same rate as in the broader population. The committee suggested that a request is made of the Mortality Review Group to review a sample of people who died under the age of 65. Full assurance as to the approach being taken.

- **Clinical Research - Annual Plan**
  Contents noted. Significant assurance.

- **NICE Guidelines Update**
  Discussed areas of improvement in our review of our alignment of NICE guidelines together with continued areas of challenge. Limited assurance but recognise that it is good progress being made (Darryl will take to the CLSD group for discussion).

- **Reducing Restrictive Practice Policy**
  Approved

Assurance/Lack of Assurance Obtained

- **Acute Care Pathway Monthly Update** - limited assurance was obtained on current progress

- **Control of Infection Report** - significant assurance on standards of cleanliness of clinical areas and food preparation areas

- **Quality Improvement Strategy** - received limited assurance with respect to the outline plan

- **Serious Incidents - Bi-monthly report and Annual Report** - significant assurance from the process and learning obtained but received limited assurance from the impact of learning, although it was recognised that it will take time for evidence of learning to emerge

- **Learning From Deaths/Mortality Report** - full assurance from the approach being taken to review learning from deaths

- **NICE Guidelines Update** – Committee took limited assurance from the report but recognised the good progress that has been made in taking a clinically relevant approach to reviewing NICE guidelines.

Meeting Effectiveness

- Effective, whilst missing Carolyn and John but welcoming of Mark's and Darryl's contributions.

- Concerns as to the size of the agenda will be addressed by the Committee Chair and Executive Lead

Decisions made • Covered under key items discussed above	
Escalations to Board or other committee • Acute Pathway is due to be discussed by the Board at an Extraordinary Board meeting to be held in confidential session on 7 August. • Training is already scrutinised and addressed by the People and Culture Committee	
Committee Chair: Margaret Gildea	**Executive Lead: Carolyn Green, Director of Nursing & Patient Experience**

Derbyshire Healthcare NHS Foundation Trust

Board Committee Summary Report to Trust Board
Audit & Risk Committee – Meeting held 11 July 2019

Key items discussed

- Annual Clinical Audit Report and Impact of Clinical Audit
- Report on Data Quality (to be cross reference to IA report and other reports on data quality)
- Board Assurance Framework Issue 3
- BAF Risk 2a Deep Dive "Risk that the Trust will not be able to retain, develop and attract enough staff to protect their wellbeing to deliver high quality care"
- Implementation of Internal and External Audit Recommendations Progress Report
- Corporate Governance Framework – verbal
- Freedom to Speak Up Report Self Review Update Report
- Progress report on 2018/19 Audit & Risk Committee Objectives
- Report on Conflicts of Interest and Declarations of Interest
- Standing Financial Instructions Waiver Report
- Review of changes to Standing Financial Instructions and any changes to Accounting Policies
- Annual Audit Letter and Progress Report
- Internal Audit Progress Report
- Head of Internal Audit Opinion – Stage 1
- Internal Audit charter
- Counter Fraud Annual Report and Progress Report
- Revised Claims Handling Policy and Procedures
- 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 confirmed it was satisfied that the Trust's External Auditor, Grant Thornton, had met all their deliverables for 2018/19 and received full assurance from their Annual Audit Letter.
- Significant assurance was obtained from the 2018/19 Clinical Audit annual report. The Committee welcomed that clinical audit will be moving away from standalone audits to a programme of quality improvement that will be linked to the Trust's strategic objectives, therefore improving the impact of clinical audit.
- The Committee noted the positive impact of clinical audit at the Trust. The self-assessment showed that clinical audit is contributing directly to health care improvements and significant assurance was obtained by the report.
- A comprehensive update was received from the Chief Operating Officer showing the significant improvements in data quality. The most recent audit had achieved a positive rating. The Chair

of the Committee added that the Board and the Board Committees can have confidence in the information contained within the reports they receive. Assurance was given that validation reports will confirm the process of reporting to ensure data quality procedures are understood and followed through. The latest validation exercise would focus on the national mental health data set and would be reported to the August Finance and Performance Committee.

- The Committee took significant assurance from the IM&T activity that is ensuring that data follows the rules of validation and was satisfied that this process was acceptable. Due to the complexity of data quality, the Committee agreed that it could only obtain limited assurance on the work that had been undertaken by the Trust since the first internal audit was undertaken in 2017.
- Significant assurance was received on the process of the review, scrutiny and update of the Board Assurance Framework (BAF) in seeking to identify and mitigate risks to achieving the Trust's strategic objectives.
- Limited assurance was received from the deep dive review of BAF risk 2a *there is a risk that the Trust will not be able to retain, develop and attract enough staff and protect their wellbeing to delivery high quality care*. due to the difficulty in managing the elements of this risk.
- Significant assurance was received on the progress of actions resulting from internal and external audit reports.
- Significant assurance was received on continuing progress with the actions to address development areas arising from the Freedom to Speak up self-review.
- Limited assurance was received from the action plan set in place to ensure effective implementation of the Conflicts of Interest policy but noted the next steps to continue to increase the volume of declarations.
- Significant assurance was received on the process followed to approve and record waivers of the Trust's Standing Financial Instructions.

Key risks identified

- The Committee considered that the narrative contained in the BAF relating to risks associated with lack of commissioning to deliver a full service should be improved to include detail concerning waiting lists.

Decisions made

- Agreement that the Committee will continue to receive an annual report on the adequacy of systems in place for clinical audit.
- Agreement and approval of the third issue of the BAF for 2019/20, agreement that Risk 1a be increased from high to extreme risk. It was also agreed that the risk rating of risk 2a should remain rated as extreme.
- Agreement that the Corporate Governance Framework will be submitted to the October meeting following agreement on the Board Committee structures.
- Approval of the updated Standing Financial Instructions.
- Approval of the revised Claims Handling Policy and Procedures.

Escalations to Board or other Committee

- None

Committee Chair: Geoff Lewins **Non-Executive Director**	**Executive Lead: Justine Fitzjohn** **Trust Secretary**

Derbyshire Healthcare NHS Foundation Trust

Board Committee Assurance Summary Report to Trust Board
Finance & Performance Committee – Extraordinary Meeting held 12 July 2019

Key items discussed

Progress update on CIP Delivery and Continuous (Quality) Improvement Delivery Programme

- CIP planning gap closed - but risks to delivery are still significant in places
- CIP delivery is only part of the overall financial plan delivery. Other cost reductions still required (even if not labelled as 'CIP')
- Discussed pipeline progress, some examples of Quality Improvement ideas like nurse led clinics and the ongoing review of assumptions such as for sickness absence scheme
- Discussed the need for more focussed, triangulated, quantified information eg sickness hotpot teams and their wellbeing offer take up, as well as levels of compliance with appropriate policy.
- Discussed delivery risks and the governance of oversight of delivery
- IAPT re-procurement – latest notification and increased financial risk

2019/20 Financial Performance – Month 3 and forecast for the year

- Discussed key risk issues and assumptions in revenue and capital terms
- Majority of discussion focussed on the run rate and the reported aggregated mitigated forecast, compared to what the component parts of an unmitigated position would be – to be discussed at next Confidential board
- Discussed the perceptions and messaging of reporting CIP achievement whilst having a lot of delivery risks and emergent risks both in the CIP plan and the wider financial position
- Also discussed the ability to achieve the adjusted plan surplus of £1.8m v the control total of £1.4m and the difference in governance / Regulator view of not meeting plan v not meeting control total

Any Other Business

- Discussed the status of the system risk sharing - partner response collation for discussion at CEO/FD and future JUCD Board in the context of quarter one actual positions.
- UHDB end of year accounting issues and if any potential to adversely impact system

Assurance/lack of assurance obtained

- CIP - Limited assurance
- Financial position – Limited assurance (at best)

Key risks identified

- High risk to delivery of planned financial position overall given level of known and emergent risks

Decisions made

- Unmitigated downside scenario to be discussed at Confidential board

Escalations to Board or other committee

- As described above

Committee Chair: Richard Wright	**Executive Lead: Claire Wright, Deputy Chief Executive and Director of Finance**

Derbyshire Healthcare
NHS Foundation Trust

Board Committee Assurance Summary Report to Trust Board
Finance & Performance Committee – Meeting held 15 August 2019

Key items discussed

Minutes from meeting held on 21 May and extraordinary meeting on 12 July 2019

- System Risk Share : regular progress update required from system via execs

IAPT verbal update

- Discussion on latest procurement information (commercially sensitive).

Operational Performance and KPI Achievement

- Discussed new style reporting and focused on out of areas and the read-across between reports. Care coordination numbers waiting reducing, average wait to be seen increasing. Risk Management for patients discussed.
- Considered the BME and ethnicity breakdown provided and reverse commissioning

CAMHS wait time paper

- Discussed the challenges over time and the updated clinical model to try to optimise resource use in pathway
- Wait-times discussed at length.
- Commissioning landscape discussed.
- People-related issues compounding the waits (recruitment, sickness, turnover)

CIP Delivery and Continuous (Quality) Improvement Delivery Programme

- Discussed need to consider CIP and wider efficiency together in the round
- Discussed the level of completion of schemes and progress with future planning and innovation taking place
- Use of Resources paper trailed in September Board. Discussed some ideas for innovation
- Discussed sickness absence in detail, including need to know take up and impact of the increased wellbeing offer as well as (compassionate) compliance with policy in managing sickness.

Delivery of Estate Strategy - update

- Same presentation as Board Development session in order to formalise the aims, vision and principles agreed ahead of November Board documents. Discussed need to have more sight of sustainability and environment, co-production, new-build ambition and capital availability.

Data Quality Validation

- Excellent MHMDS compliance against 57 measures – Quality of processing

2019/20 Financial Performance

- Noted the capital plan changes
- Financial risks and 'Bridge' discussed in detail
- Concern about CQUIN and estates cost risks – not yet quantifiable and not yet included in forecast
- Assurance is limited and has reduced since previous discussion.

Reference Cost Update

- Noted

Review of 2019/20 Forward Plan – noting the Committee objectives for the year

- Will be updated for 6 monthly update on REGARDS data, November – Community Paediatrics and EPRR 6 month and H&S 6 month compliance additions

Assurance/lack of assurance obtained

- Operational Performance and KPI Achievement - Limited
- CAMHS and Paediatrics waiting times - Limited
- CIP Delivery and Continuous (Quality) Improvement Delivery Programme - Limited
- Delivery of Estate Strategy update – not possible to give assurance level at this stage
- Data Quality validation - Significant assurance on the information presented
- Finance – Limited assurance (reduced confidence)

Key risks identified

- Financial plan delivery and cost reduction requirements.
- The level of financial risks that are emergent and/or not yet quantifiable

Decisions made

- Referrals to other Committees (see section)

Compliance discussions

- Discussed future naming of Committee, terms of reference amendments (to add EPRR and Health Safety) and timing of next updates thereof.

Escalations to Board or other committee

- To Quality Committee – the patient impact and risk management of the people waiting and the average wait to be seen
- To People and Culture Committee – the people-related issues (recruitment, sickness, turnover) that are reported as affecting the CAMHS wait times performance
- To Board – to highlight the ongoing financial performance risk and the reducing levels of assurance/confidence

Committee Chair: Richard Wright	**Executive Lead: Claire Wright, Deputy Chief Executive and Director of Finance**

Board Committee Assurance Summary Report to Trust Board
Safeguarding Committee – 16 July 2019

Key items discussed

Safeguarding Children and Adults at Risk Annual Report

- Change to equalities section to make wider improvements and clarity in the mitigation plan
- Intercollegiate document – safeguarding children / issues explained in full to the reader of the annual report to ensure individuals who are not appraised of the legal statutory duties are aware of our legislative duties
- Gap in controls to be articulated with specific improvement plan. In this case acute improvement plan specifically training to gain the required Trust standard. Limited assurance.
- Adjust and clarify the specific Joint Targeted Inspection and multi-agency work improvements and Trust only actions, in the context of the multi-agency inspection
- Improvement areas / and assurance to the Trust
- Significant assurance with one gap in control, with a mitigation plan in place that was scrutinised and confirmed

Safeguarding Children Position Statement

- Equalities issues and protected characteristics improvement areas to be improved
- Section 11 audit outcome was positive and action plan gave assurance to the Committee
- Three serious case reviews are on trajectory and in place
- Recruitment of a safeguarding children doctor, is now required following retirement of previous post holder
- Significant assurance obtained with safeguarding children

Looked after Children Annual Report

- Equalities section requires improvement and is to be strengthened
- Improvements to be made to the executive summary to include explicit connections of the service model and how the looked after children service reduces the inequalities gap
- Significant assurance obtained on the service and its outcomes

Safeguarding Adults Position Statement

- Equalities section to be improved
- Challenge on when the families and carers strategy and improvement work will commence
- CQC information on sexual safety was detailed and positive
- Limited assurance on Safeguarding Adults and improvement.

Learning and effectiveness

- Improvement required on equalities sections of papers and working through Level 3 gaps in assurance and operational uptake to ensure operational compliance and improvement is achieved.

Consideration of BAF Risks related to Safeguarding Committee

- An addition of Level 3 Safeguarding Adults and Children's Training until the expected standard is met.

Meeting Effectiveness

- Healthy critical challenge on equalities assurance and the improvements needed.

Assurance/lack of assurance obtained

- Safeguarding Children and Adults at Risk Annual Report, significant assurance with one gap in control with regard to the operational management and up-take of Safeguarding Children and Safeguarding Adult Children.

- Safeguarding Children position paper, first two quarters significant assurance with improvements in training uptake, across areas with a trajectory for improvement.

Key risks identified

- Training compliance and ensuring operational performance against the Trust's standard.

Decisions made

- Annual reports were of high quality and specific requirements following this detailed scrutiny and improvement areas these reports were agreed for the reports to be submitted to the Trust Board in October.

Escalations to Board or other committee

- Executive Leadership Team is fully appraised of the gap in assurance for training compliance - executive action to reduce the gap continues.

Committee Chair: Anne Wright	**Executive Lead: Carolyn Green. Executive Director of Nursing and Patient Experience**

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 (such as national policy and BREXIT) which could impact on its ability to effectively implement its strategy								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	Freedom to Speak Up Guardian Report (six monthly)					X					X
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 info)	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		X						
GH	Clinical Strategies 2019-22 - Oct: Older Adult , Working Aged Adult - Nov: Eating Disorders, Perinatal - Dec: Forensic and Rehab, Substance Misuse, LD, Children's						X	X	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 information on death) Apr/Jul/Oct/Feb/Apr	X				X		X		X	
JS	Guardian of Safe Working Report			X			X		A		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 – 3 September 2019

Report from the Council of Governors Meeting held on Tuesday 2 July 2019; the Extraordinary Council of Governors Meeting held on 6 August 2019

Report from the Council of Governors Meeting held on Tuesday 2 July 2019

The Council of Governors met on Tuesday 2 July 2019 at the Centre for Research and Development, Kingsway Hospital site, Derby. The meeting was attended by 18 governors.

Verbal update on Joined Up Care Derbyshire – including the impact of the Long Term NHS Plan

Ifti Majid gave a verbal update on the latest activities within Joined Up Care Derbyshire (JUCD) which included:

- An Independent Chair will be appointed for the JUCD and a recommendation had been sent to Simon Stevens, Chief Executive of NHS England.
- The system continued to experience significant financial pressures; including on delivery of CIP (cost improvement) schemes. JUCD partners had been asked to sign up to a risk share agreement towards a system control total.
- Additional funding of £1 million had been received – this is new money associated with the Long Term NHS Plan.

Refresh of Trust Strategy

Ifti Majid updated the Council of Governors on the changes that have been made to the Trust Strategy, which were also discussed and signed off in the Board meeting, which took place earlier in the day. Significant engagement with colleagues and groups across the Trust had been undertaken and positive feedback had been received.

The update achieves its two key aims:

1) To make sure that the Trust Strategy is relevant to addressing local/national challenges of the day
2) To be simpler and easily accessible to staff, who can relate the strategy to their areas of work.

The update also included clarification of the Trust's "people first" value and how this applies to colleagues. Governors noted that the Trust Strategy now outlines refreshed strategic objectives, alongside a set of detailed building blocks setting out how these priorities are to be achieved. The Council of Governors supported the refreshed Trust Strategy.

Presentation of the Annual Reports and Accounts 2018/2019

Claire Wright, Deputy Chief Executive and Director of Finance presented a summary on the financial performance of the Trust during 2018/19. Claire was pleased to announce that despite continuing pressures, both locally and nationally, the Trust met the control total of £2.3 million. As a result of this the Trust received additional Provider Sustainability Fund (PSF) income from NHS Improvement, which further

increased the surplus to £3.8 million. Cost improvement savings of £4.5 million were also achieved.

Grant Thornton, the Trust's External Auditors, delivered a presentation on the Trust's Annual Audit Letter, summarising the key findings of the audit.

Non-Executive Director deep dive
Geoff Lewins, Non-Executive Director and Chair of the Audit and Risk Committee 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 May 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.

South Liaison Team presentation
Lesley Fitzpatrick and Fiona White from the Liaison Team Service delivered a presentation on the South Liaison Team – governors had asked for information in order to gain a better understanding on how this service works.

Report from Governors' Nominations and Remuneration Committee and Council of Governors approvals
Caroline Maley, Trust Chair gave an update from the Governors' Nominations and Remuneration Committee meetings which were held on 22 May and 21 June 2019 respectively. The Committee received confirmation that Julia Tabreham, Margaret Gildea and Richard Wright have agreed to take on a further three year term as Non-Executive Directors. The Trust Chair fully supported the re-appointments which were approved by the Council of Governors.

The Committee had set up a working group to review the Terms of Reference. The revised Terms of Reference were presented to the Council of Governors for approval. The main changes related to the membership (composition) and quoracy. The Council of Governors approved the revised Terms of Reference and the required changes to the Trust Constitution, as outlined in the report.

Discussion took place regarding the proposal for an additional Non-Executive Director post. It was agreed this would be referred to the Governors' Nominations and Remuneration Committee and then on to the Council of Governors for approval.

Caroline Maley advised that Julia Tabreham will be leaving her post as Deputy Chair and therefore there is a vacancy for a Deputy Chair. This would come back to the Council of Governors in due course.

Annual Members' Meeting (AMM) update
Roger Kerry, updated the Council of Governors on the on the progress of the AMM preparations. 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.

Governance Committee Report
Kelly Sims, Chair of the Governance Committee presented a report of the meeting held on 12 June 2019. Governors were encouraged to complete the Governor Engagement Log which has been produced and developed to enable governors to log issues and feedback from Trust members and the public about the Trust. The information will help governors to identify common themes/issues relating to the Trust to raise with Non-Executive Directors and on which to hold them to account.

The Committee were updated on the forthcoming elections which will be held in Derby City West and Erewash. Nominations run from 12 July and close on 9 August.

The Committee ratified the appointment of Lynda Langley as Lead Governor. Lynda will begin the appointment in September when John Morrissey stands down.

Report from the Extraordinary Council of Governors meeting held on 6 August 2019

The Council of Governors met on Tuesday 6 August 2019 in Albany House, Kingsway Hospital site, Derby. The meeting was attended by 14 governors.

Proposal for a sixth Non-Executive Director Post and re-allocation of Deputy Trust Chair
Caroline Maley, Trust Chair presented a report that set out the rationale for creating a sixth Non-Executive Director post on the Board of Directors. The Council of Governors unanimously approved the proposal to create a sixth Non-Executive Director post on the Board of Directors and supported the proposal for a temporary appointment while the formal process is running.

Caroline Maley explained that during the review of NED commitments, Julia Tabreham had asked to stand down from the Deputy Chair role. Expressions of interest were sought and Richard Wright had come forward. Caroline Maley recommended the appointment to the Council of Governors. The Council of Governors approved the appointment of Richard Wright as Deputy Chair of the Trust, with backdated effect from 1 August 2019.

Thanks were extended from the governors to Julia Tabreham, who has been the Trust's Deputy Chair since November 2016. It was noted that Julia will continue as a Non-Executive Director for a further term of office.

The Council noted the financial implications for the additional NED role, the pro-rata temporary appointment and the transfer of the fee for the Deputy Lead Governor role.

Derbyshire Healthcare NHS Foundation Trust

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

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
CRS	Commissioner Requested Services
CSF	Commissioner Sustainability Fund
CTO	Community Treatment Order
CTR	Care and Treatment Review

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
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	
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
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 Disabilities
LHP	Local Health Plan
LHWB	Local Health and Wellbeing Board
LOS	Length of Stay
M	
MARS	Mutually Agreed Resignation Scheme
MAU	Medical Assessment Unit
MAS	Memory Assessment Service
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists 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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
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
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
SBS	Shared Business Services
SEND	Special Educational Needs and Disabilities
SI	Serious Incidents
SIRI	Serious Incident Requiring Investigation
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