Derbyshire Healthcare
NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust
Board of Directors

Conference Rooms A and B, First Floor, Centre for Research & Development, Kingsway Hospital
4 September 2018 09:30 - 4 September 2018 12:15

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Derbyshire Healthcare
NHS Foundation Trust

NOTICE OF PUBLIC BOARD MEETING – TUESDAY 4 SEPTEMBER 2018
TO COMMENCE AT 9:30 AM IN CONFERENCE ROOMS A&B
FIRST FLOOR, CENTRE FOR RESEARCH & DEVELOPMENT, KINGSWAY HOSPITAL

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks, apologies for absence and Declarations of Interest Register	Caroline Maley
2.	9:35	Minutes of Board of Directors meeting held on 3 July 2018	Caroline Maley
3.		Matters arising – Actions Matrix	Caroline Maley
4.		Questions from governors or members of the public	Caroline Maley
5.	9:45	Chair's Update	Caroline Maley
6.	9:55	Chief Executive's Update	Ifti Majid
OPERATIONAL PERFORMANCE, QUALITY AND STRATEGY			
7.	10:05	Integrated Performance and Activity Report	Claire Wright/Amanda Rawlings/Carolyn Green/Mark Powell
8.	10:25	Quality Report - Responsive	Mark Powell
11:00 B R E A K			
9.	11:15	Equality Delivery System 2 & Workforce Race Equality Standard Submission	Amanda Rawlings
10.	11:25	Pulse Check Results and Staff Survey Plan	Amanda Rawlings
11.	11:35	Board Assurance Framework Update Issue 2	Sam Harrison
12.	11:45	Board Committee Assurance Summaries and Escalations: Quality Committee 10 July, Audit & Risk Committee 17 July, People & Culture Committee 24 July, Finance & Performance Committee 24 July, Quality Committee 21 August 2018 *(minutes of these meetings are available upon request)*	Committee Chairs
13.	12:00	Report from Council of Governors meeting held 3 July 2018 (for information and noting)	Sam Harrison
CLOSING MATTERS			
14.	12:05	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Board Forward Plan - Meeting effectiveness	Caroline Maley
FOR INFORMATION			
Glossary of NHS Acronyms			

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

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

The next meeting will be held at 9.30am on 2 October 2018 at St Thomas Centre, Chatsworth Road, Brampton, Chesterfield, Derbyshire S40 3AW

Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.
Participation in meetings is at the Chair's discretion

Derbyshire Healthcare
NHS Foundation Trust

Our vision

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

Making a positive difference

Our values

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

Our Trust values are:

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

Declaration of Interests Register 2018/19

NAME	INTEREST DISCLOSED	TYPE
Margaret Gildea Non-Executive Director	• Director, Organisation Change Solutions Limited • Non-Executive Director, Derwent Living	(a, b) (a)
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, Woodhouse May Ltd • Director, Arkwright Society Ltd	(a, b) (a)
Ifti Majid Chief Executive	• Board Member NHS Confederation Mental Health Network • Kate Majid (spouse) Chief Executive of the Shaw Mind Foundation which is a global mental health charity	(e) (a, d)
Caroline Maley Trust Chair	• Director – C D Maley Ltd • Trustee – Vocaleyes Ltd. • Governor, Brooksby Melton College	(a, b) (a, d) (a, d)
Mark Powell Chief Operating Officer	• Chair of Governors, Brookfield Primary School, Mickleover, Derby	(e)
Amanda Rawlings Director of People and Organisational Effectiveness (DHCFT)	• Director of People and Organisational Effectiveness, Derbyshire Community Healthcare Services (DCHS) • Co-optee Cross Keys Homes, Peterborough	(e) (e)
Dr Julia Tabreham Deputy Trust Chair and Non-Executive Director	• Non-Executive Director, Parliamentary and Health Service Ombudsman • Director of Research and Ambassador Carers Federation • Member of Sir Alex Allan's Parliamentary and Health Service Ombudsman's Clinical Advice Service Review	(a) (d) (a)
Dr John Sykes Medical Director	• Undertakes paid assessments of patients at the request of the local authorities under the Mental Health Act and Mental Capacity Act and acts likewise for solicitors representing patients.	(e)
Richard Wright Non-Executive Director	• Executive Director, Sheffield Chamber of Commerce • Chair Sheffield UTC Multi Academy Trust • Board Member, National Centre of Sport and Exercise Medicine Sheffield	(a) (a) (d)

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

(a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those dormant companies).
(b) Ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
(c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
(d) A position of authority in a charity or voluntary organisation in the field of health and social care.
(e) Detail 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&B
Research and Development Centre, Kingsway, Derby DE22 3LZ

Tuesday 3 July 2018

MEETING HELD IN PUBLIC

Commenced: 9.30 Closed: 12:00

PRESENT	Caroline Maley	Trust Chair
	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
	Dr John Sykes	Medical Director
	Mark Powell	Chief Operating Officer
	Carolyn Green	Director of Nursing & Patient Experience
From item DHCFT2018/102	Samantha Harrison	Director of Corporate Affairs
	Amanda Rawlings	Director of People & Organisational Effectiveness
	Gareth Harry	Director of Business Improvement & Transformation
IN ATTENDANCE	Anna Shaw	Deputy Director of Communications & Involvement
	Sue Turner	Board Secretary
For item DHCFT2018/091	Adam Chilcott	Health Facilitator, Learning Disability Service
For item DHCFT2018/091	Jackie Fleeman	Lead Strategic Health Facilitator Learning Disability Service
For item DHCFT2018/091	Debbie Edwards	Acute Liaison Nurse, Learning Disability Service
For items DHCFT2018/102- 103	Kully Hans	Freedom to Speak Up Guardian
VISITORS	Sandra Austin	Trust Volunteer
	Andrew Beaumont	Trust Member
	Rosemary Farkas	Public Governor, Surrounding Areas
	Jo Foster	Staff Governor (Nursing)
	Dr Jason Holdcroft	Staff Governor (Medical and Dental)
	John Morrissey	Lead Governor & Public Governor – Amber Valley
	Al Munnien	Staff Governor (Nursing)
	April Saunders	Staff Governor (Allied Professions)
	Kelly Sims	Staff Governor (Staff Administration and Allied Support Staff)
APOLOGIES	Dr Julia Tabreham	Deputy Trust Chair and Non-Executive Director
	Margaret Gildea	Senior Independent Director

DHCFT 2018/090	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** The Trust Chair, Caroline Maley, welcomed all to the meeting. Apologies for

	absence were noted as above. Director of Corporate Affairs, Sam Harrison, will join the meeting once the interview being conducted by the CQC on the Trust's Well-Led processes has concluded. The Declaration of Interests register, as included in the Board papers, was noted.
DHCFT 2018/091	**<u>TREAT ME WELL CAMPAIGN</u>** Lead Strategic Health Facilitator from the Learning Disability Service, Jackie Fleeman, attended the meeting along with her colleagues Adam Chilcott, Health Facilitator and Debbie Edwards, Acute Liaison Nurse from the Learning Disabilities (LD) service and gave a presentation on the national campaign led by MENCAP called Treat Me Well. Jackie gave an overview of the Treat Me Well Campaign. Her presentation contained two videos that highlighted the work of the Treat Me Well campaign and showed how making reasonable adjustments in hospitals and community services can make to access healthcare easier for people with LD. The Board heard how Adam has advocated the easy reading material that is now available and how Jackie's and Debbie's work has improved the way services are accessed not just by people with LD but also improved access to our healthcare services such as Children's and Substance Misuse services. Chief Executive Ifti Majid was interested to know how primary care and local family doctors are reacting to the need for reasonable adjustments and was informed that a good response had been received from doctors. Information made available to patients has been made easier to read and understand and more time is allocated to appointments. These improvements have all been put in place as a result of the training doctors receive in making reasonable adjustments for people with LD. Ifti was pleased to hear that Adam had helped other organisations improve their services and asked him to help the Trust champion the cause of LD people in the Trust's services and ensure that our information material is easy to read and access. Director of Nursing and Patient Experience, Carolyn Green, referred to her paper on the Treat Me Well campaign and asked the Board to support the cause of LD people in the Trust's services and ensure that their voice is heard. Staff will be trained on making reasonable adjustments through awareness videos. Having understood the Treat Me Well campaign and its connection with new revised clinical standards in LD services the Board endorsed the necessity to raise the profile of people with LD and autism to meet their needs and agreed to sign up to the campaign so that system plans associated with this group of people are improved. It was proposed that Carolyn Green would take the lead on the Treat Me Well campaign on behalf of the Board. The Quality Committee would monitor the implementation of the campaign and provide a report to the Board in July 2019 to provide assurance that the Trust has honoured its pledge to ensure that information supplied for its care pathways is easy to understand and can be accessed by everyone. The Treat Me Well Campaign would also be taken forward by the Executive Leadership Team (ELT). **ACTION: Quality Committee to monitor the implementation of the Treat Me Well Campaign and provide a progress report to the Board in July 2019**

	ACTION: Treat Me Well Campaign to be taken forward by the Executive Leadership Team **ACTION: Board Forward Plan for 2019/20 to include report on the Treat Me Well campaign** **RESOLVED: The Board of Directors:** **1) Received the paper on the Treat Me Well campaign and understood the connection with new reviewed clinical standards in LD services in all settings** **2) Received significant assurance that the LD services are in receipt of the new standards and this is working its way through governance groups to assess against the new standards** **3) Understood the connection between the Treat Me Well campaign and the newly issued standards and would await further intelligence from the Quality Committee and sub-structures on current levels of assurance against new standards and improvement plans to meet any gaps in service standards** **4) Agreed to sign up to the Treat Me Well campaign and gave due regard to the Board's role in influencing and representing the voice of individuals with LD in wider system changes to accept its leadership responsibilities as a large provider of this care pathway for Children's and Adult services.**
DHCFT 2018/092	**MINUTES OF BOARD OF DIRECTORS MEETING HELD ON 5 JUNE 2018** Having reviewed the minutes of the previous meeting held on 5 June 2018, Non-Executive Director, Anne Wright, requested that an additional paragraph be included in item DHCFT2018/082 Update on Joined Up Care Derbyshire to reflect the discussion she held with Chief Executive, Ifti Majid and STP Director, Vikki Taylor during the meeting. The minutes were therefore accepted as a correct record of the meeting along with the inclusion of the following paragraph: "*Anne Wright, Non-Executive Director, Ifti Majid and Vikki Taylor discussed how the prevention and early intervention that was in the STP two years ago needs more emphasis as this appears to have a lower prominence in current plans and programmes than previously set out and that prevention and early intervention is essential to the achievement of sustainability."*
DHCFT 2018/093	**MATTERS ARISING – 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 2018/094	**QUESTIONS FROM GOVERNORS OR MEMBERS OF THE PUBLIC** A question had been received prior to the meeting from one of the Trust's Governors relating to minute item DCHFT2018/062 of the meeting held on 1 May challenging the additional incentive funding the Trust received from the over achievement of the control surplus.

	Richard Wright, Non-Executive Director and Chair of the Finance & Performance Committee responded by explaining that the control total is the amount set by our regulators NHS Improvement (NHSI) at the beginning of the financial year and is the surplus amount that we are required to achieve. At the end of the year the total surplus was £3.428m against the agreed surplus required by NHSI and resulted in an over achievement of £663k. Because we over achieved our agreed surplus we then were allocated some 'incentive' funding from NHSI of £2.329m after year end finances were submitted to them. This meant that overall the total surplus was £5.757m, before technical adjustments, and is the remaining surplus reported in the Trust's 2017/18 annual report and accounts which is to be presented to this afternoon's meeting Council of Governors. Richard Wright clarified that services were not reduced in order to generate the additional surplus reported at 2017/18 year end. The £663k initial surplus was made possible because of a one-off historical land sale proceed of £950k. This helped us partly offset some of the additional patient-care related costs that we had been managing during the year. When we receive the additional 'incentive' funding it can only be spent on capital, not running costs. However, these capital projects create assets that support the delivery of patient care and treatment which is invested in providing buildings, equipment and technology. The Trust is currently working with staff to identify where this funding may be used to benefit most effectively patient care and to support our staff. Chair of the Audit & Risk Committee Non-Executive Director, Geoff Lewins, added that the Audit & Risk Committee was fully aware of the surplus and the 'incentive' funding when it reviewed the 2017/18 Annual Report and Accounts and was assured that this surplus had not been achieved at the expense of patient care. It was pointed out that scheduled governor training on NHS and Trust finances covers the understanding of the reported position and wider NHS finances along with regulatory requirements for providers and all governors are encouraged to attend this session. It was agreed that this question would also be answered to at the meeting of the Council of Governors taking place at 2pm that afternoon.
DHCFT 2018/095	**<u>CHAIR'S UPDATE</u>** Caroline Maley provided her report on her activity with and for the Trust since the previous Board meeting held on 5 June 2018, highlighting the following areas. Caroline had signed the Dying to Work Charter with Ifti Majid on 15 June. This event was witnessed by Pauline Latham, MP, Jacci Woodcock and Rob Johnstone from the TUC and a number of governors and Staffside representatives. She was very pleased to have been able to make this commitment on behalf of the Trust to its staff. Caroline had visited the LD team and Older Adults Community team in Swadlincote and was impressed by the passion and commitment that staff have for the work they do with service users and carers. It also gave her the opportunity to reflect on the specialist nature of the skills of staff who look after patients with really challenging needs. She was concerned about how long it takes to train people to take on these roles and has raised with the Executive

	Leadership Team (ELT) the need prepare for our services of the future to ensure that we have a pipeline of training for staff to be able to deliver these services as staff with longer tenure retire. The Mental Health Act Committee met on 7 June and considered how the Associate Hospital Managers (AHMs) are to be supported and trained. Caroline looks forward to seeing a new structure being developed for the AHMs and the outcome of the development work that is taking place to support these people to do the best for our service users. Caroline also gave a brief overview of the quarterly meeting of NHS Providers' Chiefs and Chairs that she attended on 19 June when discussions took place on values, purpose, behaviour, staff engagement, collaboration and culture of learning, openness and transparency, all of which are the values we are endorsing here at the Trust. The CEO of NHS Providers also gave his perspective on the NHS financial settlement that was announced on 17 June. Although this money would help, it was not yet known if it would be enough. **RESOLVED: The Board of Directors noted the activities of the Trust Chair throughout the month of June**
DHCFT 2018/096	**<u>CHIEF EXECUTIVE'S UPDATE</u>** The Chief Executive's report provided the Board of Directors with an update on developments occurring within the local Derbyshire health and social care community. The report also updated the Board on feedback from external stakeholders such as commissioners and feedback from staff. Ifti Majid's report included detail of the five year funding settlement for the NHS. He highlighted the key points that are intended to give the service growth of more than 3% over the next five years. Mental health was playing a strong part in the narrative associated with the Prime Minister's announcement and Ifti would welcome the opportunity to see how the Trust would be involved in the ten year plan that the NHS has been tasked with developing and intended for the Trust to influence and talk to NHS England (NHSE) about the more longer term based plans for mental health prevention based measures. Pressure was starting to be felt due to the deficit position of trusts. 44% of trusts finished the year in deficit and the pressure being felt in acute trusts is expected to spread to community and mental health services. Ifti talked about the 8% staff vacancy rate across the NHS and the impact this had on the services the Trust has to deliver and looked forward to discussing this further during the Integrated Performance Report agenda item. The Joined Up Care Derbyshire (JUCD) Board met on 21 June. Ifti referred to the £508,000 that Derbyshire had been allocated to provide new models of workforce to support the required transformation. He had expectations that this would focus on areas such as extended roles, apprenticeships, promoting prevention and health and wellbeing. Ifti also mentioned the wave 4 capital bids that had been prioritised by Derbyshire in association with updating the Trust's local Estates strategy, the top three priorities being Buxton Community Hub, Bakewell Community Hub and Shirebrook Joint Service Centre. Ifti also talked about reverse mentoring. He was pleased to report that early indicators have shown positive feedback from these sessions which have been

	led not by the Executive but by the BME Mentor and are an exciting and alternative way to hear the voice of BME colleagues within our organisation. Attention was drawn to the Executive engagement events taking place through individual Director visits and the *Ifti On the Road* events. A number of themes have emerged from these sessions and feedback from each visit is being logged on an engagement spreadsheet with actions allocated and shared with the Trust's Freedom to Speak Up Guardian. In response to Non-Executive Director, Richard Wright, asking how the five year funding settlement for the NHS might affect NHS contracts and the NHS as a whole, Ifti considered that block contracts might be an area that will start to encompass how to reduce bureaucracy and waste through NHS contracts and he expected this would be addressed through partnerships within the Sustainability and Transformation Partnership (STP). He also thought that as part of the ten year programme there will be expectations on healthcare targets and was concerned that 18 week wait times could start to be felt across the system and emphasised the need to apply leverage to ensure targets were meaningful and would bring long term outcomes for our service users. Caroline Maley asked if there was any indication within the scope of the ten year plan. Director of Finance, Claire Wright, advised that although nothing has yet been issued, an expectation has been set for the NHS pay award although plans at individual organisation level have not yet been shared. **RESOLVED: The Board of Directors scrutinised the Chief Executive's update, noting the risks and actions being taken**
DHCFT 2018/097	**<u>INTEGRATED PERFORMANCE AND ACTIVITY REPORT</u>** Chief Operating Officer, Mark Powell, presented the Integrated Performance Report (IPR) and provided the Board with an integrated overview of performance as at the end of May 2018. The focus of the report is on workforce, finance, operational delivery and quality performance. The Trust continued to perform well against many of its key indicators. The body of the report showed that maintenance and/or improvement continues across many of the Trust's services. The Regulatory Compliance dashboard showed a positive performance although there were still some challenges to be faced around sickness absence, staff appraisal levels and compliance with mandatory training. The Strategy Performance dashboard showed a stronger position with improvements being seen in Delayed Transfers of Care (DTOC) and neighbourhood waiting times moving in the right direction. Attention was drawn to recruitment levels. Anne Wright referred to the previous meeting when the Board heard that the national issue of rejection of visas had impacted on the recruitment of consultants and asked if this had been resolved. Director of People and Organisational Effectiveness, Amanda Rawlings, advised that tier two visa applications had improved and this should enable the Trust to generate a future pipeline of consultants and make it easier to recruit doctors and nursing staff. She also hoped that the NHS campaign focussing on getting 14 to 18 year olds interested in nursing would have the desired effect. She welcomed this campaign as it would help position the NHS as a place to work for young people and she undertook to keep the Board updated as to how this campaign progresses. During this discussion it was proposed by Ifti Majid that

	the IPR should reflect the underlying vacancy rate and the changes since investment was made from the contracting round and the impact this would have on the Trust's services. This would be explained in the IPR and discussed at the next meeting in September. In response to Richard Wright asking how the Trust could ensure that students return to work within the organisation following their placement, Amanda Rawlings assured him work is taking place to make sure the Trust retains students who have worked here on their placement and that the Trust is their employer of choice and that the People and Culture Committee would receive more detail about this initiative. Carolyn Green was pleased to report that the Trust has retained all its nurses since facilitators had been brought in to support staff at the Radbourne Unit and Hartington Unit. This was a positive achievement and she was also pleased to see that nurses from the south of England are applying for positions at the Trust. Mark Powell reported that the level of agency spend was falling because it is becoming difficult to engage agency workers. This had created additional risks which were currently being managed. He hoped that once the new workforce model is in place this will help reduce agency spend. Non-Executive Director, Geoff Lewins, referred to the Delayed Transfers of Care (DTOC) data contained in the report. Mark Powell put this into context with the most recently published national data of all organisations for delayed transfer bed days. Eighteen months ago the Trust was set a much higher target when each trust had their targets adjusted. He explained that because the Trust's DTOC has always been low its target was set much lower than most trusts. This is the target the Trust has been rated on which is why the chart shows we have a lower indicator to measure against. Work is progressing to ensure patients are not waiting any longer than necessary and we have performed well in trying to avoid DTOC. Ifti Majid observed that the report showed an improving situation in Child and Adolescent Mental Health Services (CAMHS). He noted that the city has seen a significant rise and the neighbourhoods in the south of the county have shown a slight increase. Despite this rise, people are still being seen within ten weeks which must put teams under significant pressure and he asked for assurance that the developed action plans are being effective and asked what the escalation process will be. Mark Powell responded that the Quality Committee has taken oversight of the neighbourhood review and the outcomes of this review will be available in September. In addition to this a risk mitigation plan is being updated. This is being overseen by the Quality Committee and no escalations have been raised to date by the Quality Committee to the Board. Ifti Majid asked if current mitigations were robust enough and whether the neighbourhood was working sufficiently well to address these issues. Mark Powell assured him that one of the objectives of the review is to reframe the current model to manage patients at risk. One of the themes of the review might show that the Trust is able to provide a level of service to some patients and not others and will be based on individual need. There would also be further discussions about how the new model could be reframed to serve all patients within the Trust's care. Carolyn Green added that new roles of nursing associates were being

	developed for high risk groups which would support pressures within the community teams. This was being monitored by the Quality Committee to ensure staff were being focussed on correctly within the teams. These were key measures that affect people within our services which are underpinned by the risks on the Board Assurance Framework (BAF). Claire Wright raised a point of clarification on the finance position regarding the distance from plan metric that worsens to 2 in the forecast position. She clarified that this is a result of the forecast income increasing since the plan was set whilst the control total remained constant. The resulting margin percentage is reduced by a very small amount but any reduction results in a reduced score. **ACTION: IPR to reflect the underlying vacancy rate and the recent changes since investment from the contracting round and discussed at the next meeting in September** **RESOLVED: The Board of Directors considered the Integrated Performance Report and obtained limited assurance on current performance across the areas presented.**
DHCFT 2018/098	**<u>INFECTION PREVENTION AND CONTROL ANNUAL REPORT</u>** This paper, presented by Medical Director, John Sykes, was previously received by the Quality Committee in June 2018 and summarised the activity over the preceding twelve months of work related to infection control. The Health Act 2009 requires that NHS bodies must, in accordance with regulations made by the Secretary of State, publish in respect of each reporting period a document containing prescribed information relevant to the quality of Infection Prevention and Control in the Public domain therefore this annual report is formally made in public in addition to the responsible committee, which in this case is the Quality Committee. John Sykes confirmed that the Quality Committee had obtained significant assurance with the infection control systems and processes across the Trust and that performance has been stable and met the required standard. The Board acknowledged the significant amount of work that had contributed to the high standards achieved over 2017/18 related to infection control and accepted the report. **RESOLVED: The Board of Directors** **1) Received and accept the annual report and recommendations of the Quality Committee.** **2) Noted the reporting of key areas, such as surveillance of healthcare associated infections – alert organisms, outbreaks of infection, staff training.** **3) Received assurance on standards of cleanliness of clinical areas and food preparation areas.**
DHCFT 2018/099	**<u>LEARNING FROM DEATHS – MORTALITY REPORT</u>** This report presented to the Board by John Sykes is produced in order to meet requirements set out in the 'National Guidance on Learning from Deaths' which outlines that the Trust is required to collect and publish on a quarterly basis

	specified information on deaths. In line with the CQC's recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a national framework for NHS trusts - 'National Guidance on Learning from Deaths'. The purpose of the framework is to introduce a more standardised approach to the way NHS trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and improved embedded learning. The report included the progress achieved from 1 April 2017 to 29 May 2018 and provided assurance that the Trust was following recommendations outlined in the national guidance. This report had previously been received by the Quality Committee on 12 June where challenges had been raised with undertaking case note reviews of all deaths as outlined in the national guidance within available time and the impossibility of carrying this out without substantial additional resource. Ifti Majid was concerned that the report showed that as of 29 May a total of 80 deaths should be under review. John Sykes reported that two deaths underwent investigation through the Serious Incident process and nothing untoward was discovered and no areas of concern could be found by the Mortality Review Group. Anne Wright who is also the Mortality and Learning from Deaths NED made the point that staff should not be distracted from front line care to review deaths. It was noted that the strategy for reviewing deaths is to be explored by the Quality Committee and the Committee's report would be submitted to the Board along with the next quarterly Mortality Report. Claire Wright referred to the section of the report regarding Public Sector Equality Duty and Equality Impact Risks and requested that this be expanded in forthcoming reports to include reference to the ethnicity information contained in the report. The Board accepted this Mortality Report and noted that it had been published onto the Trust website prior to end of June 2018, as per national guidance. **ACTION: The next iteration of the report to include data relating to ethnicity and deaths in Public Sector Equality Duty and Equality Impact Risks section** **ACTION: Report on the strategy for reviewing deaths to accompany the next Mortality Report to the Board** **RESOLVED: The Board of Directors accepted the Mortality Report as assurance of our approach, and noted that the report is required to be published on the Trust website prior to end of June 2018, as per national guidance.**
DHCFT 2018/100	**<u>CQC INSPECTION UPDATE</u>** Ifti Majid provided the Board with a verbal briefing on the CQC inspection visits made to core teams that took place over the last two weeks within the Trust. He reported that he had been impressed with the level of openness and transparency that staff have displayed when engaging with the CQC inspectors.

	The Board was made aware of the issues around the timeliness of the recording of patient observations on some inpatient wards. Formal feedback is not expected to be received from the CQC until September. The sequence of inspections would conclude with a series of Well-Led interviews that are taking place with members of the Board from 11 – 13 July. **RESOLVED: The Board of Directors noted the verbal update on the CQC Inspections**
DHCFT 2018/101	**<u>REVALIDATION OF DOCTORS ANNUAL REPORT</u>** This report provided the Board with an overview of medical appraisal and revalidation and provided the necessary assurance that the Trust has fully achieved all the standards stated in the statement of compliance required by NHS England (NHSE) by 28 September. Key points included the following: • 100% of available doctors completed appraisals or had approved postponement. • Major reason for deferment – new starters • Quality of appraisals is improving • Appraiser numbers are healthy Claire Wright observed that it would have been helpful to have seen reference to correlations with known information around people with protected characteristics for example our Workforce Race Equality Standard (WRES) information, gender pay gap and staff survey results in the report. The Board noted that the report had previously been received by the Quality Committee on 10 June and it contained detail of recruitment checks to support the signing of the compliance statement by the Trust Chair as the higher Responsible Officer for submission to NHS England by 28 September. **ACTION: Data in medical appraisal compliance charts to be assessed for accuracy to ensure that reporting is accurate to both NHSE and within ESR** **ACTION: Trust Chair to sign the statement of compliance required by NHSE for submission by 28 September** **RESOLVED: The Board of Directors:** **1) Accepted the report and noted it will be shared along with the annual audit with the higher Responsible Officer** **2) Approved the Statement of Compliance for submission to NHS England in September 2018**
DHCFT 2018/102	**<u>FREEDOM TO SPEAK UP GUARDIAN REPORT</u>** Freedom to Speak Up Guardian (FTSUG), Kully Hans, joined the meeting and presented the first of the scheduled six-monthly updates to the Board on the work of the FTSUG. The report contained both quantitative and qualitative information, case studies and other information which enabled the Board to obtain a good oversight of

	Freedom to Speak Up (FTSU) matters as well as an understanding of issues being identified and areas for improvement. The following areas were highlighted. The Raising Concerns/Speaking Up at Work Policy has been updated to ensure that the process to manage concerns raised is clearly defined. A log is maintained of concerns that are received and these concerns are raised by individuals directly to FTSUG or through the Senior Independent Non-Executive Director, Margaret Gildea, who works closely with the FTSUG role. Kully Hans gave an overview of the type of concerns that have been raised relating to attitudes, bullying and harassment. Some concerns have also been raised around policies and procedures and health and safety matters. The work of the FTSUG is communicated to staff through the FTSUG Newsletters and all FTSUG are required to report quarterly to the National Guardian's Office on the numbers and types of concerns that are raised. The National Guardian's Office works closely with the CQC and NHSI. Caroline Maley asked if managers have found it difficult to work with staff who have raised concerns. Kully responded that terms of reference have sometimes been requested for cases but overall she has found that it has become easier for managers to respond to staff who have raised concerns. Ifti Majid welcomed the number of concerns that have been raised as this showed that the culture of our organisation supports people to feel able to raise concerns. The Board understood that the next step would be to carry out a pulse check survey to gain an understanding of how the role of the FTSUG has been realised within the Trust. The next six month report received by the Board will show the learning from the FTSUG work and how this is being taken forward as well as the number of cases that have been closed off and some of the actions and learning from cases. Kully was thanked for her commitment to this role and for the progress she has made in this first six months of taking up this role. **RESOLVED: The Board of Directors:** **1) Noted the first report from the Freedom to Speak up Guardian** **2) Received assurance that the role is effective within the Trust, with a clear framework of policies, procedures and personal support to further develop this work** **3) Noted the planned work of the Freedom to Speak up Guardian as a key element of the Trust's aims to put People First and engender a culture of openness, transparency and learning.**
DHCFT 2018/103	**<u>FREEDOM TO SPEAK UP SELF-ASSESSMENT</u>** The self-review was completed by the Director of Corporate Affairs, Sam Harrison, the Executive Lead for (FTSU) on behalf of the Board, with contribution from the Freedom to Speak Up Guardian and the Governance lead. The report outlined the Trust's position following completion of the self-review of FTSU as required by NHS Improvement (NHSI). Sam Harrison took the Board through the key areas and highlighted how the

	self-review work overlaps with work already underway arising from wider governance reviews. The aim of the self-review is for trust boards to consider the leadership and governance arrangements in relation to FTSU and reflect on any areas to develop and improve. Completion of the self-assessment will act as a benchmark for our work. There have been additional actions that have been identified to take this work forward. This includes having a Board Development Session to explore further areas of concerns that have been raised. Further development of the continuous improvement agenda and learning is an organisational priority and will encompass identifying and sharing learning from concerns raised. Both Executive and Non-Executive Directors are also encouraging discussion within individual teams during quality visits. This has been extended from *Ifti's On the Road Campaign* through to other Directors. Development of our continuous improvement agenda will ensure ongoing promotion and awareness activity of FTSU work and will enable organisation wide learning from concerns that are raised. Learning from case reviews from the National Guardian's Office will be included in reports to the Audit and Risk Committee and People and Culture Committee. The Board considered this to be a very comprehensive piece of work and noted that the self-review confirmed that a great deal of work had been completed across all the areas of FTSU agenda and that the baseline assessment was overall very positive. There were no areas where we could not provide evidence of assurance. The increasing profile of the Freedom to Speak Up Guardian in developing leaders' focus on learning and continual improvement is key to this work. Much work had already been completed and embedded and there is further improvement planned. An audit of FTSU is proposed to be included on the internal audit programme for later in the year. The Audit and Risk Committee will continue to receive updates on progress against these additional actions as part of the regular report by the Freedom to Speak Up Executive Lead. **RESOLVED: The Board of Directors:** **1) Reviewed the outcomes from the self-review of Freedom to Speak Up** **2) Received significant assurance from the evidence outlined and ongoing reporting and oversight of established practice** **3) Agreed the future development work identified from the self-review to be completed for oversight by the Audit and Risk Committee as lead Committee for ensuring robustness of implementation of the Trust's Raising Concerns /Speaking up at work (Whistleblowing Policy).**
DHCFT 2018/104	**<u>BOARD COMMITTEE ASSURANCE SUMMARIES AND ESCALATIONS</u>** Assurance summaries were received from the Board Committees below, and highlights provided by the respective Non-Executive Chair. **People & Culture Committee – provided by Amanda Rawlings in the absence of Margaret Gildea** Learning Beyond Registration (LBR) is reduced for 2018/19. This matter was escalated to Board so that the Board is sighted on this change. A paper would be submitted to the Executive Leadership Team (ELT) to address how this levy will be distributed to staff in order to provide for the workforce for the future.

	Mental Health Act Committee – Anne Wright The Committee had commissioned a piece of work in respect of the recruitment, appraisal and management of Associate Hospital Managers (AHMs) and the infrastructure to support this governance process. There is a high risk of breach of new Section 136 waiting times given the difficultly of accessing beds for CAMHS, LD/Autism cases and Psychiatric Intensive Care Unit (PICU) places. This is being updated in the Board Assurance Framework (BAF) and commissioners have been asked by the Chief Executive to look at this pathway and we are currently waiting for their feedback. **Quality Committee – provided by Carolyn Green in the absence of Julia Tabreham** A substantial level of revisions arose from the meeting that will be required for updating in the BAF. Additional detail has been requested by the Committee to be included in the BAF. These include the improvement work required for the PARIS system and ligature assessments. A deep dive on BAF Risk 1a on safety and quality standards will take place at the July meeting. **RESOLVED: The Board of Directors received and noted the Board Committee Assurance Summaries**
DHCFT 2018/105	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK** No issues were highlighted in the meeting for update or inclusion in the Board Assurance Framework.
DHCFT 2018/106	**MEETING EFFECTIVENESS** Attendees and visitors were thanked for their attendance and were informed that plans were in place to progress with a sound system that will be used at future Board meetings. The Board considered that papers received at today's meeting were of a good standard and that sufficient time had been spent discussing issues that directly impact on people who use the Trust's services which was prioritised while discussing the IPR.
DHCFT 2018/107	**2018/19 BOARD FORWARD PLAN** The forward plan was noted by the Board and would be updated to include the campaigns the Board has signed up to in recent months.

There will be no meeting of the Board held in August. The next meeting of the Board to be held in public session will take place at 9.30 on Tuesday 4 September 2018.

The location will be Conference Rooms A & B, Centre for Research & Development, Kingsway, Derby, DE22 3LZ

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - AUGUST 2018			
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
28.2.2018	DHCFT 2018/024	Deep Dive – Joint Eating Disorders Service	Carolyn Green	**Transferred to Quality Committee Actions Matrix** Introduction of a combined initiative with specialist areas to be captured in the new Eating Disorders Strategy	Nov-18	A revised eating disorder strategy will be submitted to the Quality Committee within a six month delivery date - scheduled for October 2018. **Action transferred to Quality Committee and captured on Quality Committee actions matrix. Quality Committee to confirm when action is complete (due November 2018).**	Yellow
28.3.2018	DHCFT 2018/042	Board Assurance Summaries and Escalations	John Sykes Ifti Majid	**Transferred to Quality Committee Actions Matrix** Age discrimination breach within the Equalities Act to be raised with commissioners on behalf of the Quality Committee	~~1.5.2018~~ 3.7.2018	Letter regarding age discrimination breach within the Equalities Act has been sent to commissioners and will be progressed through the Quality Committee and will also be addressed by ELT. Upate from Quality Committee (John Sykes) 3.7.2018: Commissioners have confirmed that they will invest in crisis teams this year and that an ageless service is essential to comply with the law. They wish to engage with the Trust to determine the priority of this development against others that have been identified. Action is complete from the Board's perspective. **Quality Committee to confirm when action is complete**	Green
3.7.2018	DHCFT 2018/091	Treat Me Well Campaign	Carolyn Green	**Transferred to Quality Committee Actions Matrix** Quality Committee to monitor the implementation of the Treat Me Well Campaign and provide a progress report to the Board in July 2019	4.9.2018	Quality Committee to receive report on Treat Me Well in June 2019 prior to report being submitted to Board in July 2019 (timeline for reporting captured in Quality Committee Forward Plan and Board Forward Plan	Green
3.7.2018	DHCFT 2018/091	Treat Me Well Campaign	Carolyn Green	Treat Me Well Campaign to be taken forward by the Executive Leadership Team	4.9.2018	Carolyn Green has held a planning meeting with the team and allocated a budget with key priorities. Further updates will be provided to the Quality Committee	Green
3.7.2018	DHCFT 2018/091	Treat Me Well Campaign	Board Secretary	2019/20 Board Forward Plan to include report on the Treat Me Well campaign	3.7.2018	Treat Me Well Campaign update report scheduled for July 2019 in 2019/20 Forward Plan	Green
3.7.2018	DHCFT 2018/097	Integrated Performance Report (IPR)	Mark Powell Amanda Rawlings	IPR to reflect the underlying vacancy rate and the recent changes since investment from the contracting round and discussed at the next meeting in September	4.9.2018	IPR report to September meeting will reflect the underlying vacancy rate and changes made since investment was received from the contracting round	Yellow
3.7.2018	DHCFT 2018/099	Learning from Deaths Mortality Report	John Sykes	The next iteration of the report to include data relating to ethnicity and deaths in Public Sector Equality Duty and Equality Impact Risks section	4.9.2018	Mortality Report due at October meeting	Yellow
3.7.2018	DHCFT 2018/099	Learning from Deaths Mortality Report	John Sykes	Report on the strategy for reviewing deaths to accompany the next Mortality Report to the Board	4.9.2018	Strategy for reviewing deaths will accompany the next Mortality Report due at October meeting	Yellow
3.7.2018	DHCFT 2018/101	Integrated Performance Report (IPR)	John Sykes	Data in medical appraisal compliance charts to be assessed for accuracy to ensure that reporting is accurate to both NHSE and within ESR	4.9.2018	Dr Edward Komocki, Medical Appraisal Lead has agreed a system and a format for inclusion in IPR	Green

3.7.2018	DHCFT 2018/101	Revalidation Of Doctors Annual Report	John Sykes Caroline Maley	Trust Chair to sign the statement of compliance required by NHSE for submission by 28 September	4.9.2018	Statement of compliance signed	Green

Resolved	**GREEN**	6	60%
Action Ongoing/Update Required	**AMBER**	0	0%
Action Overdue	**RED**	0	0%
Agenda item for future meeting	**YELLOW**	4	40%
		10	100%

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 4 September 2018

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 3 July 2018. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

1. I have made 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 4 July I attended a CAMHS (Child and Adolescent Mental Health Service) team meeting at Century House. In these meetings, members of the team have the opportunity to raise concerns for team input to difficult and challenging cases. For me it was clear how important the relationship with social services is, and how difficult it is for our staff when there is a gap in support from the local authority, largely arising due to the cuts they have faced. I was also able to get an insight into how the team works with service users in tier 4 beds hosted by Nottinghamshire Healthcare. I was made very welcome by the team, and will take my observations forward with the discussions in Joined Up Care Derbyshire and the Mental Health Workstream.

3. On 10 July I visited the Memory Assessment Service at Dovedale Day Hospital where I was able to observe lead nurse Julie Sheppard confirming diagnosis for three very different patients. This was done in a calm and caring way, and I was able to observe how we work with voluntary organisations who signpost to various support options in the community. I was made aware that there have been reductions by commissioners in the early cognitive support and cognitive maintenance we are able to give service users.

4. On 26 July I observed a ward round in Ward 34 at the Radbourne Unit, including the handover from one team to another before the ward round began. Dr Jason Holdcroft and Dr Abbassi welcomed me to the ward round and made me very comfortable with the patients that we were seeing. I was assured of the compassion and care shown for patients and how patient and family centred the approach was. I was delighted at the end of the meeting to be shown an electronic handover system "Nick Knack" which has been developed by Dr Nick Ting whilst a trainee on the ward. It is a great piece of innovation and helps very much in the handover process each day.

5. On 31 July in the morning I visited the Substance Misuse Services in Ripley and was able to meet and talk briefly to a number of staff who were in the office. Heather Walker gave me a tour of the building which has its quirks! This team

was a great example of collaborating across a number of specialisms – and I was pleased to hear of the skill developments for staff to be able to work across drug and alcohol misuse. Again there were good examples shown of service user care and support, including innovation around employment helping to overcome personal challenges.

6. In the afternoon on 31 July I visited the health visiting team at the Rosehill Children's Centre where Marie White took me out to visit two families. I was very impressed at how the team operates and how child and family centred the care was in a very challenging area of Derby. I was also delighted to meet a number of students who work for the service and to hear first-hand how good their training and development by Marie and the Trust has been.

7. 28 August I will be visiting the Bolsover team and will cover this in my report next month.

Council of Governors

8. On 26 June I welcomed new governors following elections recently held to the Trust as a part of the induction we provide. I was impressed by the range of skills and enthusiasm that they bring to their roles and I look forward to working with them in the future. On 2 August we carried out a further induction meeting for new staff governors.

9. On 3 July the Council of Governors met following the Public Board meeting in the morning. It was good to see so many governors attend the Board meeting, and feedback in the afternoon confirmed that governors find it useful to observe the Board meeting and see the NED (Non-Executive Director) challenge that takes place. We also welcomed a number of governors to their first Council meeting following elections.

10. I met with public governor Gillian Hough on 2 August in advance of the Governance Committee of the Council of Governors. Deputy Trust Chair, Julia Tabreham, joined me at this meeting as she deputised for me at the Governance Committee on 21 August. Gillian Hough has come to the end of her term as Chair of the Governance Committee, and I thank her for the work that she has done as Chair of this committee. A replacement as Chair of this committee has yet to be appointed, and Carole Riley, Deputy Lead Governor has agreed to Chair the meeting for the next three months.

11. On 2 August I had a quarterly catch up with staff governors, despite holidays and family pressures reducing the number who could attend. The purpose of this meeting is to ensure that staff governors are able to carry out their role as a governor with the support from the Trust.

12. The Governance Committee of the Council of Governors met on 21 August. The Committee was chaired by Gillian Hough, and they are doing a lot of work to address the means of engagement with the community, and holding NEDs to account, in terms of framing the questions that they need answers for. Julia Tabreham deputised for me as I attended a Good Governance Institute /NHSI

(NHS Improvement) meeting in Birmingham that day.

13. On 26 June, 17 July and 22 August I met with John Morrissey and Carole Riley, Lead and Deputy Lead Governors, as part of our regular one to one meetings. These are important meetings to ensure that we share information and that there are no surprises.

14. The next meeting of the Council of Governors will be on 4 September following the Public Board meeting. The next Governance Committee takes place on 17 October.

Board of Directors

15. On 11 July Board Development focussed on the CQC (Care Quality Commission) Well Led process and preparation, as well as taking time to discuss the shape and content of the new Integrated Performance Report.

16. On 24 July, I attended the Finance and Performance Committee to observe how it has developed as an assurance committee. I am confident that it is on the right path to deliver its objectives.

17. Contact with Avtar Johal, our NeXT director, has been light since the last Board meeting. The initial placement period of six months will be coming to an end at the end of September, and I will be working with NHSI to report back on the experience that we have had and to provide feedback to Avtar himself. I will be considering with NHSI whether there is another candidate ready for a placement that meets our criteria of extending support to those from a BAME (Black, Asian, and minority ethnic) background who wish to gain experience as a NED.

18. I continue to meet with Non-Executives on a one to one basis quarterly. I met with Anne Wright and Richard Wright.

System Collaboration

19. The JUCD (Joined Up Care Derbyshire) Board meeting took place on 19 July, and I attended this along with Ifti Majid. A substantial presentation was given by Newton, a consultancy, on the Derbyshire System Flow Diagnostic, seeking ways to improve flow, reduce delays and ensure that the system is ready for winter. The aim of this was to look at demand and capacity planning for winter.

    Unresolved at the time of writing this report is the recruitment of a small central team to support the recently appointed Director for the STP (Sustainability and Transformation Partnership), Vikki, Taylor and the workstream leads. As a Trust we have offered to host this small central team.

    Once again there was a focus on the financial gap that the system has in the current financial year and a briefing on the actions that are being taken to minimise these. The Estates Strategy for the system was noted. More detail will be included in the CEO report to this Board.

20. On 30 July I visited The Park Medical Practice with Mark Powell to attend a GP practice meeting at which a large area of focus was mental health. It was really useful to be able to set out for them the challenges that we face and to hear some of their challenges. I was grateful for Mark's attendance as he was able to deal with many of the day to day issues that were raised.

Regulators: NHS Providers and NHS Confederation and others

21. Our CQC well led inspection will be covered elsewhere, but I would like to record my thanks to all who supported and took part in this important process for the Trust. At the time of writing my report we are awaiting the draft of our reports for factual accuracy checking and completion.

22. On the 18 July, with Geoff Lewins I attended the NHS Providers Governance Conference in London. The focus on the conference was on system wide governance and the role of the sovereign organisation in the system.

23. On 25 July I attended the quarterly meeting of the Midlands and East Chairs networking event, preceded as before with the power hour for the chairs of the mental health trusts. Areas of interest for the mental health trust chairs included STP governance and CQC well-led reviews and the common learnings from the new style inspection. In the main meeting, apart from the usual regional update from Dale Bywater, there was a presentation on the vision for talent management being led by NHSI, and I know that Director of People Services and Organisational Development, Amanda Rawlings is engaged in this for our Trust. We also heard from the Chair of Nottingham University Hospitals on the reflections of taking part in the BBC Hospital programme screened earlier this year.
24. On 21 August 2018, I attended a Board Development session sponsored by NHSI and hosted by the Good Governance Institute (GGI) entitled Well Led for the Future. At this session there was an emphasis on data, and using data across the system to have one source of truth informing system decision making. We also received a short presentation on the relevance of King IV Report on Corporate Governance published in 2016 and its relevance to the NHS. Included in the handouts was a useful linking of the NHS Key Lines of Enquiry (KLOE) to the King principles.

Beyond our Boundaries

25. Julia Tabreham attended the University of Derby Graduation on 19 July with Faith Sango, as unfortunately I had a funeral to attend that day. Julia reported to me that the graduation was particularly warm and friendly. It was good to be able to fly our flag at the ceremony, given the important of the university in our student recruitment pipeline.

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

Assurances

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

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

None

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

This report reflects a wide range of activities across the Trust, and consideration relating to ensuring inclusion is embedded in operational work of the Trust. The specific services visited provide support to those with protected characteristics by the nature of their work – such as learning disability services, memory assessment services and acute, mental health support and substance misuse.

With respect to our work with Governors - we work actively to encourage a wide

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

Demonstrating inclusive leadership at Board level

Through the Trust's involvement in the NeXT Director scheme, hosting a placement for Avtar Johal, we are supporting the development of those who may find it more difficult to be appointed as a NED in the NHS. This placement will run to the end of September, when we will review the effectiveness of our support for Avtar and the scheme before deciding on our next steps.

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

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.

National Context

1. As I mentioned as part of my last Board report, in March, the Prime Minister committed to a "sustainable long term plan" for the NHS backed by "a multiyear funding settlement". She expanded on this in June, confirming a new funding settlement for the NHS of an average of 3.4% real terms increase over the next five years. Mrs May also tasked the NHS with producing a ten year plan in return for the increase in funding, setting out how the service intends to deliver major improvements. The timing of the plan's publication is expected to coincide with the autumn Budget, where the funding uplift, and how it will be funded, will be formally set out. The broad timeline associated with the development of the 10 year plan is roughly suggested to be:

    - Structure and themes announced early August
    - Working groups confirmed over the course of August (directly relating to our service portfolio, I understand there is likely to be a mental health working group led by Claire Murdoch, a Learning Disability group led by Ray James and a long term conditions, a dementia group led by Caroline Abrahams and a healthy childhood and maternal health group led by Sarah-Jane Marsh)
    - Engagement takes place throughout September – It is understand this will include:
        - Bespoke engagement by each of the working groups
        - NHS Improvement and England engagement with the sector through regional forums and roundtables
        - Stakeholder engagement, both with the working groups and with the ALB (arm's-length body) leadership
        - Engagement with staff, patients and the public (likely to take place through STPs (Sustainability and Transformation Partnerships)
        - Engagement through NHS Improvement's CEO advisory group
    - At the end of September, there will be a joint NHS England and NHS Improvement board meeting to discuss the plan
    - During October, the working groups will refine their outputs and their collective work will be brought together in the plan

- The plan will be published in early November

- Following the publication of the plan NHS England and NHS Improvement will establish the NHS Assembly to oversee the delivery of the plan

Alongside the ten year plan a delivery plan is being developed covering the first few years of the ten year plan. At this point it is not clear how separate this will be from the ten year plan and how it will relate to the expected planning guidance that the arm's-lengths bodies currently want to publish in late September. NHS Improvement Chief Executive, Ian Dalton has identified a number of issues that he wants to address through this planning guidance/delivery plan including:

- Productivity levels – providers are likely to be expected to achieve more than last year, with the expectation around Get It Right First Time (GIRFT) as well as "transformation projects, and further cuts to agency, procurement, back office and corporate costs" as further savings opportunities

- Sector deficit – the national bodies may have to consider writing off some of the trust sector debts

- Control totals – these will be replaced with a new financial architecture from April 2019, with Ian Dalton commenting that the current approach to control totals encourages non-recurrent savings rather than a focus on underlying financial sustainability

- Fines and sanctions – these are likely to be reviewed (including the marginal rate for emergency care)

- Tariff – the gap between tariff prices and costs of provision needs to be addressed

- Provider Sustainability Fund – will be reviewed as "the distributional effects of that have again not necessarily been equal across the system"

On 29 August I am attending a NHS Confederation Mental Health Network session with Claire Murdoch as part of the mental health working group engagement outlined above.

2. NHS Improvement has announced the appointment of six Non-Executive Board members which includes the re-appointment of Lord Ara Darzi and Lord Patrick Carter. The 4 new Board members who we may be less familiar with are:

    - *Sir Andrew Morris* — Lead for the Frimley Health & Care Integrated Care System and former chief executive of Frimley Health NHS Foundation Trust

    - *Wol Kolade* — chairman of the Guy's and St Thomas's Charity and managing partner of the private equity firm, Livingbridge. Mr Kolade is also an Emeritus Governor of the London School of Economics and Political Science and former chairman of the British Private Equity and Venture Capital Association

    - *Laura Wade-Gery* — member of the Government Digital Service Advisory

board, as well as non-executive director of the John Lewis Partnership, non-executive director of property development and investment company British Land, and non-executive director of biotechnology company Immunocore. Ms Wade-Gery is also the former chief executive of Tesco.com

- *Tim Ferris MD* — chief executive of the Massachusetts General Physicians Organisation and was formerly the senior vice president of Population Health Management at Partners Healthcare in Boston, USA

3. During July I was proud to be involved in the launch of the *'We are the NHS'* recruitment campaign. The purpose of the campaign is to increase positive perceptions of and pride in working for the NHS. In doing so it aims to motivate target audiences to undertake careers in the NHS and help fill vacancies in the workforce. In the first instance this was focussed on nursing vacancies. A new TV advert was released along with coverage on radio and newsprint media. As part of the campaign I was interviewed as a nurse, and BME (black and minority ethnic) senior leader by BBC Radio with the interview being aired by BBC Derby, BBC Manchester, BBC West, BBC Stoke and BBC Sheffield. In addition it was a privilege to have been quoted (with photo) in a wide range of print and online Asian and South Asian news media related to the recruitment campaign.

Local Context

4. The Joined up Care Derbyshire (JUCD) Board met on 19 July. Key issues discussed included:

- Feedback from a company called NewtonEurope relating to activity efficiencies within the Southern Derbyshire acute care system. Some significant opportunities around IV (intravenous therapy) treatment, admission avoidance, 24/7 treatment and hospital discharge were reported. Extrapolations from this southern focussed work can be made into the northern acute care pathway and this will form the focus for work led by the urgent care Board going forward.

- Vikki Taylor was confirmed as the STP Director and is due to commence work full time from October. Her post along with other STP core posts will be hosted by our Organisation. This meeting was Joy Hollister's last meeting before her retirement and it was confirmed the Place workstream will be led in the interim by Pervez Sadiq from Derby City Council before being picked up longer term by Helen Jones who is Joy's replacement as Strategic Director for Adults in Derbyshire County Council.

- The Derbyshire STP Estates Strategy was approved along with agreement on priority investment for the next round of NHS capital bids that centre around the development of community hubs in Buxton, Bakewell and Shirebrook.

- We approved an elective care transformation plan that by national requirement focussed on the setting out of plans to develop a pilot site for First Contact Practitioner (senior qualified practitioners placed at the front of a care pathway as an alternative to seeing a GP) and the development of an Ophthalmology high impact interventions plan.

5. It was a great privilege to take part in the NHS 70 celebrations at Westminster Abbey in London along with Scott Lunn and Rachel Kempster as my guests for the event. There were many moving tributes but the one that most resonated was a young

survivor of the Manchester bombings who spoke about the care and treatment she had received. On the same day Caroline Maley hosted Shirley Houston and Simon Rose at York Minster for a similar celebratory event. We held our own NHS 70 'T' celebration as part of the Summer Fayre at Kingsway on 7 July. It was very positive that a number of local dignitaries such as the Mayor of Derby and Margaret Beckett MP were able to join us.

In addition during the week of 20 August we held two further NHS 70 events – Team Derbyshire Healthcare Bake Offs. I had the privilege of judging the fantastic array of cakes at the Hartington Unit and Caroline Maley had a similar pleasure down at Kingsway. A fantastic turnout and some very talented bakers I have to say!

Within our Trust

6. Week commencing 9 July saw the CQC on site completing their well led assessment as part of our comprehensive review. My thanks to all colleagues who were involved in the visit either directly being interviewed or providing the bundles of evidence we needed to submit – a real team effort. We hope to receive the full CQC report including the well led component week commencing 27 July following which we have ten days to make any factual accuracy changes before the report is made public likely to be mid-September.

7. On 20 July I met with some 30 nursing students who were currently on placement in our Trust. It was a great opportunity to get some feedback about the culture students experience in our Trust as well as to have some conversations about the NHS, mental health and what the future may well hold from a service provision perspective. The students universally talked about how welcoming we were as a Trust and it being friendly and open which was great to hear. They also spoke of the importance of ensuring mentors had time to spend with students to support them, the need for computers as students access can be down prioritised in a busy team and this had become more clear as all clinicians need to use computers for the electronic records. We also were able to discuss the sort of things that would attract the students to work for us, interestingly money was not top of the list but personal development and shift patterns that linked to their non-working lives were really important.

8. Board members will have noticed that more housing on the Kingsway site is now occupied. This is a great opportunity for developing relationships with local residents, tackling stigma and for seeing our hospital and services as part of the community. There are also risks that we have to manage for example we have had a number of

incidents reported such as children cycling through the area near the apple, people walking their dogs around the site and alarmingly the putting up of a rope swing on a tree on our site. To support management of these risks fencing has been erected to delineate the hospital boundary and I have written to all local residents assuring them of our desire to work together but reminding them of the need to respect the privacy and dignity of people using our services. The response to my letter was generally positive and it was helpful that a number of residents whilst recognising and supporting the points I raised also mentioned how our staff and patients smoking outside their property and parking in the street (Derby Teaching Hospital staff) was causing some frustration for them as well. To help the ongoing relationship development and to facilitate further discussion and mutual understanding it is my intention to hold a local public meeting during November on the Kingsway site

9. As a Trust and nationally the adult mental health pathway remains under intense pressure. As can be seen from our integrated performance report later in the Board meeting, our bed occupancy remains very high with a significant number of patients needing to receive bedded care outside of Derbyshire. In addition there have been occasions when there were no adult mental health beds in the Country in either the NHS or private sector. Whilst this is often something that attracts scrutiny from regulators due to it being a cause of 12 hour A&E breaches as a Board we should be more concerned about the impact that it has on patients who are in the Community who need a bed when one isn't available. I have attached a very powerful note (that has been anonymised) that I received that demonstrates the pressure one such person felt whilst awaiting a bed. The Board can take assurance that there is much work going on within our Trust practically and operationally to look to manage capacity more effectively such as the 100 day plan, the bed optimisation project and further development of red to green. In addition it is something that forms part of the mental health STP workstream and more strategically something that is being flagged with NHS England by the Mental Health Network, however testimonies like the one attached clearly evidence this is an area the Board needs to remain sighted on to ensure progress is made at pace.

10. It has been a quieter time for ward and team visits since the last Board with the CQC visit and then summer holidays both for Executives but also being conscious that teams are also managing increased leave. That said the quality visit programme has continued along with *Ifti on the Road* engagement events and pre-ELT (Execut5ive Leadership Team) drop ins at:

    - Corbar View, Buxton
    - Ashbourne Centre, Kingsway

    Key themes that emerged from these sessions included:

    - Pace around recruitment (subsequently sorted out) and also an interesting and helpful discussion about autonomy and freedom for local managers to act

    - Challenges with being able to attract bank staff prepared to work in the furthest reaches of county rather than just main towns/Derby

    - The importance of ensuring that when one area/department delivers efficiencies there are no in adverted knock on impacts into other teams

    - Importance of maintaining relationships with other providers who look after patients from Derbyshire eg Stepping Hill particularly where differing models

such as Acute Hospital Liaison exist

- Parking on the Kingsway site remains problematic with some encroachment into the areas at the back of the kitchens causing delivery issues (immediate action taken to rectify)

In addition Gareth Harry visited the Derby Mission who are a voluntary organisation covering a partnership of a number of churches across the city and provide services to homeless and vulnerable people in the community. He had a helpful conversation about their need for specific training for working with people with mental health needs, the difficulty in accessing primary care services and their links to our services, including ongoing difficulties with tackling dual diagnosis issues.

Feedback from each visit has been logged on our engagement spreadsheet, actions allocated and shared with our freedom to speak up guardian.

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

Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

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

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

That said some of the reports both nationally and within the Derbyshire system have the potential to have an adverse impact on people with protected characteristics for example the work looking at current estate utilisation and prioritisation of some locality buildings over others whilst increasing access in some areas could by definition reduce access for some users of our service. There is a risk that the issues within the Kingsway site could result in difficulties for people to access services due to stigma and the financial pressure the NHS is under could result in changes to services that adversely affect one or more local communities adversely and this is something we would locally review by carrying out our own equality impact assessment regardless of any national directive.

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

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

The specific focus within the recruitment campaign on people from Asian or Southern Asian communities demonstrates not just a desire to have a representative and inclusive workforce but that specific action is being taken to promote all roles in local 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.

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

IT'S BREAKING ME HARD NOT HAVING ABED!!
I FEEL LIKE IM FEEZING AWAY BIT BY BIT;
DO NOT FEEL LIKE DOING JABS, SHOWERING,
TEETH, MEDS ETC.

NOT GETTING HELP NEEDED
I OLDING IN PAIN

MOST OF THE TIME IM FEELING UNCOMFORTABLE
(NO WHERE TO BE)
IM TRYING SO HARD TO ENGAGE BUT THIS
IS DIMINISHING IM [redacted]
NATURALLY COMING AWAY. EYE BALLING
BECOMING NONE EXISTANT AT TIMES.
DIFFICULT TO SEE EVERYONES A HUMAN
JUST LIKE ME.

I CANNOT COMPREHEND
ANYTHING.
MY SENSES ARE BECOMING MORE ACUTE
LIGHT, SOUND, TASTE, DECISIONS MADE
HARDER.
I MOAN AND SCREAM TO THE TOPS 'GLUE
ME HELP' [redacted] 'GLUE
ME HELP'.

PUT YOUR SELF DOWN [redacted] IT JUST TAKES
ONE DRUNK [redacted] LIKE A HUMAN WALL OR A
PET JUST PUT YOUR SELF AWAY.

ABED
WAITING FOR HEALING [redacted] IS LIKE
WAITING FOR YOUR NEXT HIT. (SCORE
YOUR CRACK)

A LIVING NIGHTMARE!!!
WORSE

IT'S LIKE BEING BURIED ALIVE

WHERE CAN I PUT THIS? OH GOD!

I'M GOING TO EXPLODE SOON

I AM SCARED!!!

THE DRUG/POISON RUNS THROUGHOUT MY BODY AT TIMES AND WHEN IT DOES IT MEANS BUSINESS.

(SCREAMING & SHOUTING HERPS) PARTLY.

EVERYONE AT THE HUBB ARE AMAZING. I CANNOT FAULT THEM. THEIR TREATING ME WELL!! I WILL CONTINUE GOING AT THE BEST OF MY ABILITY!!!

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 September 2018

Integrated Performance Report Month 4

Purpose of Report

This paper provides the Trust Board with an integrated overview of performance as at the end of July 2018. The focus of the report is on workforce, finance, operational delivery and quality performance.

Executive Summary

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

A number of areas where performance is below Trust standards or trends are showing an overall change in performance. In order to ensure that there is a focused discussion on key issues these have been listed below.

1. Regulatory Compliance dashboard

- Agency Spend
- Care Programme Approach (CPA) 7 day follow up
- Sickness absence
- Appraisals
- Mandatory Training
- Out of Area placements

2. Strategy Performance dashboard

- Cost Improvement Plan
- Agency Spend
- Delayed Transfers of Care (DTOC)
- Neighbourhood waiting times
- Number of patients with a Length of Stay (LOS) greater than 50 days
- Quarter 1 Pulse Check results

At the end of the report further information is provided regarding some aspects of data quality assurance.

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

Assurances

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

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

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

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

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

Recommendations

The Board of Directors is requested to;

1. Confirm the level of assurance obtained on current performance across the areas presented.
2. Determine whether further assurance is required and 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:	**Peter Charlton, General Manager, IM&T**
	Rachel Leyland, Deputy Director of Finance
	Liam Carrier, Workforce Systems & Information Manager
	Rachel Kempster, Risk and Assurance Manager
	Peter Henson, Performance Manager

Integrated Performance Report Month 4

1. Regulatory Dashboard

Finance	Finance Score	Finance Scorecard	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Capital Service Cover	YTD	2	2	G	→		
			Forecast	2	2	G	→		
		Liquidity	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Income and Expenditure Margin	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Income and Expenditure variance to plan	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Agency variance to ceiling	YTD	1	1	G	→		
			Forecast	1	2	R	→		
	Single Oversight Framework	Agency costs as % of total pay costs	YTD	2.9%	2.9%	G	→		
			Forecast	2.9%	3.2%	R	→		
		NHS I Segment	YTD	N/A	2		→		
Quality and Operations	KPIs	CPA 7 Day Follow-up (M)	Jul, 2018	95.00%	92.98%	R	↓		
			Jun, 2018		98.21%	G			
		Data Quality Maturity Index (DQMI) - MHSDS Data Score (Q)	Jul, 2018	95.00%	96.12%	G	→		
			Jun, 2018		96.53%	G			
		IAPT RTT within 18 weeks (Q)	Jul, 2018	95.00%	99.86%	G	→		
			Jun, 2018		100.00%	G			
		IAPT RTT within 6 weeks (Q)	Jul, 2018	75.00%	95.82%	G	→		
			Jun, 2018		96.80%	G			
		Early Intervention in Psychosis RTT Within 14 Days - Complete (Q)	Jul, 2018	53.00%	84.00%	G	→		
			Jun, 2018		85.00%	G			
		Early Intervention in Psychosis RTT Within 14 Days - Incomplete (Q)	Jul, 2018	53.00%	94.12%	G	↑		
			Jun, 2018		90.91%	G			
		Patients Open to Trust In Employment (M)	Jul, 2018		10.17%	G	→		
			Jun, 2018		10.40%	G			
		Patients Open to Trust In Settled Accommodation (M)	Jul, 2018		57.88%	G	↓		
			Jun, 2018		59.25%	G			
		Under 16 Admissions To Adult Inpatient Facilities (M)	Jul, 2018	0	0	G	→		
			Jun, 2018		0	G			
		IAPT People Completing Treatment Who Move To Recovery (Q)	Jul, 2018	50.00%	58.32%	G	→		
			Jun, 2018		58.73%	G			
		Physical Health - Cardio-Metabolic - Inpatient (Q)							
		Physical Health - Cardio-Metabolic - EI (Q)							
		Physical Health - Cardio-Metabolic - on CPA (Community) (Q)							
		Out of Area - Number of Patients Non PICU (M)	Jul, 2018		13		→		
			Jun, 2018		13				
		Out of Area - Number of Patients PICU (M)	Jul, 2018		13		↓		
			Jun, 2018		24				
		Out of Area - Average Per Day Non PICU (M)	Jul, 2018	7.9	6.2	G	↓		
			Jun, 2018	9.7	7.2	G			
		Out of Area - Average Per Day PICU (M)	Jul, 2018	23.7	7.9	G	↓		
			Jun, 2018	24.6	14.2	G			
		Written complaints – rate (Q)	Q1 2018/19		0.02		↓		
			Q4 2017/18		0.03				
		Staff Friends and Family Test % recommended – care (Q)	Q4 2017/18		73%		→		
			Q2 2017/18		73%				
		Occurrence of any Never Event (M)	Jul, 2018	0	0	G	→		
			Jun, 2018		0	G			
		Patient Safety Alerts not completed by deadline (M)	Jul, 2018	0	0	G	↓		
			Jun, 2018		2	G			
		CQC community mental health survey (A)	2017		7.3/10		↑		
			2016		7.0/10				
		Mental health scores from Friends and Family Test – % positive (M)							
		Potential under-reporting of patient safety incidents (M)							
Workforce and Engagement	KPIs	Turnover (annual)	Jul, 2018	10.00%	10.29%	G	→		
			Jun, 2018		10.30%	G			
		Sickness Absence (monthly)	Jul, 2018	5.04%	6.48%	R	↑		
			Jun, 2018		5.21%	R			
		Sickness Absence (annual)	Jul, 2018	5.04%	TBC	R	↓		
			Jun, 2018		5.35%	R			
		Vacancies (funded fte)	Jul, 2018		11.74%		→		
			Jun, 2018		12.27%				
		Appraisals All Staff (number of employees who have received an appraisal in the previous 12 months)	Jul, 2018	90.00%	79.45%	R	→		
			Jun, 2018		79.25%	R			
		Medical Appraisals (number of medical employees who have received an appraisal in the previous 12 months)	Jul, 2018	90.00%	97.00%	G	↓		
			Jun, 2018		100.00%	G			
		Compulsory Training (staff in-date)	Jul, 2018	90.00%	82.61%	A	→		
			Jun, 2018		82.36%	A			
		NHS Staff Survey (A)	Work		60.92%				
			Treatment		72.77%				

Key:
Period Current Month / Previous Month

Achieving target
Not achieving target
Within tolerance
No Target Set

Target

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

1.1 Finance Position

The overall score of a '1' is in line with plan year to date and forecast outturn.

All metrics are forecast to achieve their planned outturn with the exception of agency variance to ceiling - this is forecast at '2' which is worse than the plan of '1'.

Comparing the actual expenditure on Agency to the ceiling, we are below the ceiling value by £37k (3.7%) at the end of July. This generates '1' on this metric within the finance score. Agency expenditure is forecast to be above the ceiling by 10.9% which is generating a score of '2' which is worse than the plan. Agency expenditure is forecast to be above the ceiling by £330k. (This includes contingency costs estimated at £400k.)

1.2 Agency cost as percentage of total pay

The plan of 2.9% reflects the ceiling of £3.030m as a percentage of the total pay budget. The agency expenditure is forecast to be higher than plan but the total pay expenditure is forecast to be less than the plan.

The forecast agency expenditure equates to 3.2% of the pay budgets (3.2% last month). National NHSI (NHS Improvement) benchmarking information from 2017/18 showed agency expenditure at 4.5% of pay budgets with Midlands and East region at 5.2%.

1.3 CPA (Care Programme Approach) 7 day follow up

During July a small number of patients were not followed up in seven days following their discharge. One patient was placed within a 24 hour care situation and contact was made with the home and not the patient direct, one patient was discharged out of area and was followed up locally and two patients were unable to be contacted within the time frame despite numerous attempts to do so

A further case related to a communications error which has been followed up with the respective team to avoid this happening again.

1.4 Sickness Absence

Staff attendance remains a significant challenge to the Trust with an annual sickness absence rate of 5.35% however compared to July 2017 the annual sickness absence rate has reduced by 0.04%. In July 2018 the sickness absence rate for the month was 6.48% which is 1.27% higher than the previous month and 1.21% higher than the same period last year (June 2017).

A main area of focus continues to be the Radbourne Unit where dedicated HR resource has been deployed to support managers in reviewing sickness absence. The table below shows the main areas of concern.

Sickness Absence July 2018	HC	% *
RDH Ward 36 Adult Acute Inpatient IP	27	32.37%
County South Early Intervention	10	22.88%
High Peak and Dales CRHT	10	22.58%
Enhanced Care Ward IP	30	20.16%
Cherry Tree Close Residential Rehab IP	22	17.22%
City & County South CRHT	34	16.73%
Hope & Resilience Hub	22	16.00%
RDH Ward 33 Adult Acute Inpatient IP	26	14.47%
Catering MH	20	13.25%
RDH Ward 35 Adult Acute Inpatient IP	25	13.11%
Sth DD Neighbourhood - Adult	23	11.51%
Hartington Unit Tansley Ward Adult IP	26	10.69%
Kingsway Cubley Court OP Female IP	37	10.55%
Erewash Neighbourhood - Adult	17	9.81%
Derby City Drug Team	17	9.77%
RDH Ward 34 Adult Acute IP	22	9.44%
KillNthCfld Neighbourhood - Adult	24	9.18%
Kingsway Cubley Court OP Male IP	42	9.11%
Audrey House Residential Rehabilitation IP	21	8.92%
Criminal Justice Liaison Team	21	8.88%

A new attendance guide has been written and is currently being discussed with the unions regarding attendance. It is proposed that First Care (sickness management system) will send this out with their first letter.

1.5 Appraisals

There has been an increase of 0.20% in appraisal completion, now running at 79.45% against a target of 90%.

Medical staff appraisal completion is currently 97% under the Medical appraisal system process (this is the "rolling month-by-month figure" of all the doctors eligible to be appraised who have been appraised within the required 12 month period)

The new People Services, divisional people managers will be taking a lead with services to look at hot spots and provide support and guidance, new training is to be rolled out as part of the leadership strategy which will raise the profile and importance of a good appraisal.

1.6 Training

The table below shows the main mandatory training hotspot service areas for May.

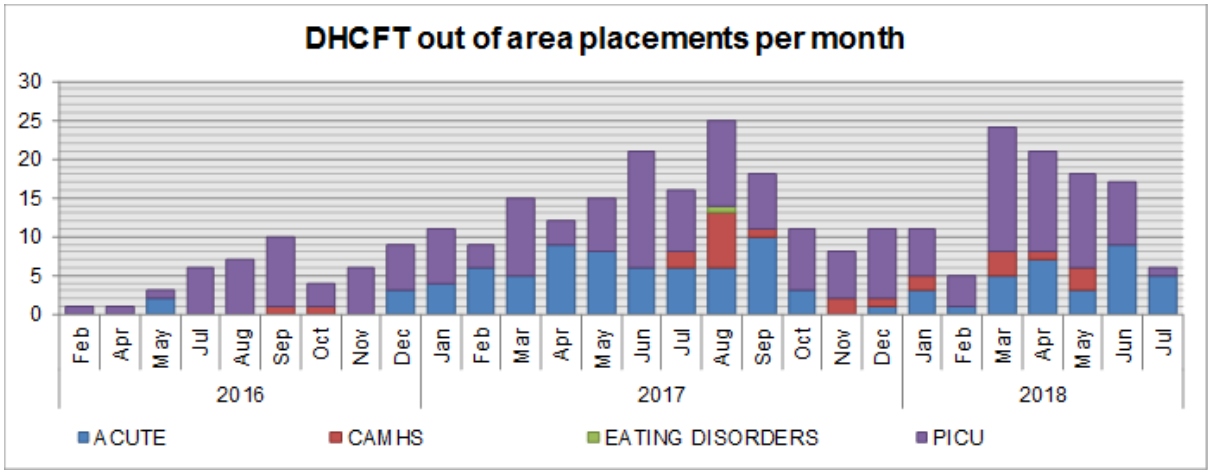
Compulsory training compliance is running at 82.61% against a target of 90%.

In addition, now that People Services are in place colleagues are now available to work alongside operational colleagues to understand and address any barriers to completion. Moreover, supportive sessions are being conducted across the organisation to engage with staff and in particular bank staff to understand ESR and undertake eLearning.

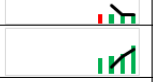
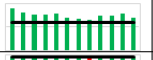
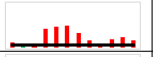
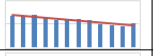
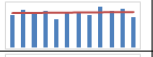
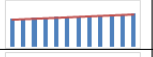
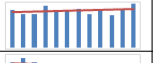
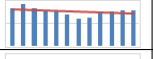
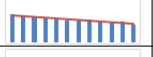
1.7 Out of Area Placements

Over the last two months there has been an increase in the number of patients who have required an adult acute psychiatric bed. This has been as a result of the Trust not being able to provide a bed when needed due to being at full capacity.

Some of the actions in the 100 day urgent care plan seek to improve the efficiency of patient pathways and therefore we expect to see an improvement in these over the next three months.



2. Strategy Delivery

Finance Scorecard	Finance Scorecard	YTD	1	1	G	→	
		Forecast	1	1	G	→	
	Control Total position £000	YTD	555	631	G	↑	
		Forecast	2331	2331	G	→	
	CIP achievement £m	YTD	1.566	1.399	R	↑	
		Forecast	4.871	4.871	G	→	
		Recurrent	4.871	2.345	R	↓	
	Agency £m	YTD	1.012	0.975	G	↑	
		Forecast	3.030	3.360	R	→	
	Cash £m	YTD	22.584	26.028	G	↑	
		Forecast	21.608	21.908	G	→	
Quality and Operations Scorecard	RTT Incomplete Within 18 Weeks (%)	Jul, 2018	92%	94.0%	G	↓	
		Jun, 2018		95.6%	G		
	CPA Review in last 12 Months (on CPA > 12 Months)	Jul, 2018	95%	95.2%	G	→	
		Jun, 2018		95.7%	G		
	Delayed Transfers of Care (%)	Jul, 2018	0.8%	1.9%	R	→	
		Jun, 2018		2.5%	R		
	North Neighbourhood Average Wait (weeks)	Jul, 2018		8.3		↑	
		Jun, 2018		8.2			
	North Neighbourhood Current Waits (number)	Jul, 2018		2009		↑	
		Jun, 2018		1956			
	City Neighbourhood Average Wait (weeks)	Jul, 2018		6.7		↓	
		Jun, 2018		8.5			
	City Neighbourhood Current Waits (number)	Jul, 2018		1448		↑	
		Jun, 2018		1344			
	South Neighbourhood Average Wait (weeks)	Jul, 2018		10.9		↑	
		Jun, 2018		10.1			
	South Neighbourhood Current Waits (number)	Jul, 2018		1783		↑	
		Jun, 2018		1766			
	CAMHS Average Wait (weeks)	Jul, 2018		9.5		↑	
		Jun, 2018		8.5			
	CAMHS Current Waits (number)	Jul, 2018		358		↑	
		Jun, 2018		357			
	Community Paediatrics Average Wait (weeks)	Jul, 2018		17.3		↑	
		Jun, 2018		14.4			
	Community Paediatrics Current Waits (number)	Jul, 2018		811		↓	
		Jun, 2018		929			
	Number of Adult Acute Inpatients (Hartington and Radbourne) LoS > 50 Days	Jul, 2018		80		↑	
		Jun, 2018		73			
Workforce and Engagement Scorecard	RETAIN - Staff engagement score	2017 Annual	To see an improvement in the staff engagement score	3.740	G	↑	
		2016 Annual		3.690			
		Q1 Jun 2018		72%	G	→	
		Q4 Mar 2018		72%			
	DEVELOP - Recruitment of preceptorship staff	2017/18	Number of students recruited into preceptorship	31	R	↓	
		2016/17		46			
	ATTRACT - Retention of preceptorship staff	2017 Annual	Number of students recruited into preceptorship who stay for at least one year	91%	G	→	
		2016 Annual		91%			
	LEADERSHIP & MANAGEMENT - Employee relations cases	Q1 Jun 2018	To see a reduction in the number of cases	40	G	↓	
		Q4 Mar 2018		48	R		
		Q3 Dec 2017		45	R		
		Q2 Sep 2017		37			

Key:

Period Month
Previous Month

Achieving target
Not achieving target
No Target Set

Target
Trend

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

2.1 Control Total position

The surplus in the month of £171k was £19k above plan, so the year to date favourable variance has increased to £76k. The forecast remains to achieve the control total at the end of the financial year.

We currently anticipate that in order to do so we will need to use all 'reserves'. There remain financial pressures to manage in order to achieve the control total, in particular the costs of adult out of area placements.

The likely full impact of the AfC pay award is still being assessed and is undergoing enhanced predictive analysis.

2.2 Cost Improvement Programme (CIP)

At the end of July £4.2m of CIP has been assured in the ledger (£1.4m YTD) which leaves an unassured gap of £660k. There are several schemes still to be actioned which are forecasting further savings of £508k, leaving an unidentified gap of £152k.

Of the forecast savings 48% is to be saved recurrently.

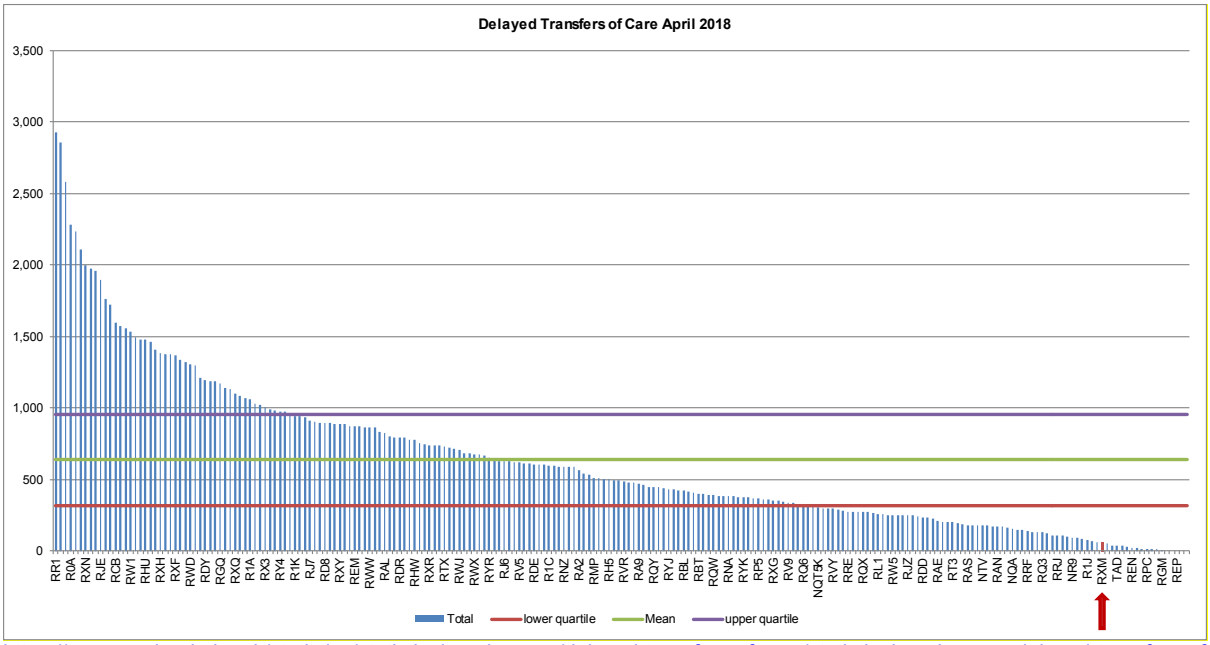
2.3 Delayed Transfers of Care (DTOC)

DTOC has increased but is still below national average. Individually the patients registered under DTOC are followed up with robust discussion with social care.

There were seven delayed transfers in May, two of which have now been resolved.

From a system wide perspective we have noted an increase in Derby City DTOCs where currently we do not have designated hospital social workers. We are in negotiation with social care regarding ring fencing this role and obtaining further support to address this issue.

We continue to be one of the lowest reporters of DTOCs nationally currently eighteenth of all organisations for delayed transfer bed days.



https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/statistical-work-areas-delayed-transfers-of-care-delayed-transfers-of-care-data-2018-19/

2.4 Neighbourhood Waits

There has been an increase in demand in Derby City neighbourhood over the last three months, predominantly for community mental health services.

Since the last Board of Directors meeting the waiting list policy has been agreed, which sets out the need for colleagues to communicate effectively with referrers and those on the waiting list. This is in turn being underpinned by having a consistent approach to managing waiting lists.

In the South Derbyshire, City and Amber Valley team we continue to experience difficulties with obtaining consistent locum cover for the vacant consultant post. This is continuing to affect capacity resulting in clinics being cancelled/rearranged at short notice. The Older Peoples Medical Team is particularly pressured at the moment resulting in reduced community capacity in order to ensure adequate cover for the inpatient areas.

The review of neighbourhood services continues to be undertaken with specific outcomes seeking to address current issues across community mental health services. This work is highlighting areas where activity is currently being completed by the neighbourhood Teams which hasn't been commissioned (e.g. Personality Disorder, ASD (Autism Spectrum Disorder) and ADHD (Attention Deficit Hyperactivity Disorder). Further internal analysis will be required prior to dialogue with commissioners about how we address this issue.

2.5 Number of patients with a LOS (Length of Stay) greater than 50 days

The pattern relating to patient length of stay over longer periods demonstrates peaks and troughs and clearly during peak periods there is an impact on out of area bed use.

The Hartington Unit have for some time had a system in place of weekly clinical review of exceptional LOS including Consultants and Heads of Nursing. This is currently being systematically established at the Radbourne Unit and also aligns to the red to green process.

It is recognised this is a high priority for clinical and management focus but there is currently a background of management absence across all levels at the Radbourne Unit. This has been supported by redeployment of staff from the Hartington Unit but it needs to be recognised that there has been a lack of continuity which is currently being addressed.

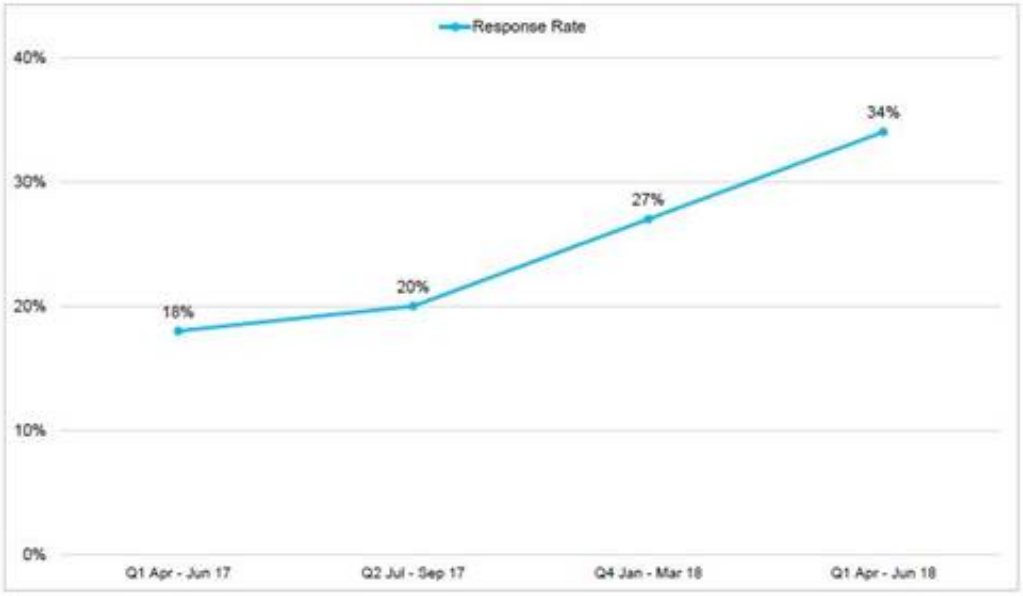
The patients with longer length of stays have complex needs and are often waiting for specialist placements or specialist accommodation and there are sometimes legal complications with disagreement about the way forward with carers and patients. Strategy meetings are held to plan ways forward and promote resolution.

The Urgent Care Clinical Lead post has just been recruited to and has started in post. This post will take a key role in facilitation of action planning and implementation of clinical models which will have an impact upon avoiding the development of unnecessary long inpatient stays.

2.6 Workforce and engagement measures

Q1 Pulse Check – April – June 2018 results - 34% of the workforce completed the Q1 Pulse Check – our best response rate to date.

National Friends and Family Test Response Rate



Base: Q1 Apr-Jun 17 n = 412, Q2 Jul-Sep 17 n = 465, Q4 Jan-Mar 17 n = 650, Q1 Apr-Jun 18 n = 811

The organisational level results can be found in the chart and table below. Whilst there is not an improvement in all of the questions, the focus of encouraging more colleagues to respond shows a better accurate picture of how staff are feeling; there were more positive responses in four out of the ten questions and three showed no change.

We are very aware, however, that there is more to do. Managers have been sent a breakdown of the pulse check results for each area, and are being urged to discuss the results in teams and make changes as a result.

Staff Friends and Family Test questions

National Friends and Family Test (FFT) Scores

Q1. How likely are you to recommend this organisation to friends and family if they needed care or treatment?
Q2. How likely are you to recommend this organisation to friends and family as a place to work?

Base: Q1 Apr-Jun 17 n = 412, Q2 Jul-Sep 17 n = 465, Q4 Jan-Mar 17 n = 650, Q1 Apr-Jun 18 n = 811

Additional questions

Question	Q4 Jan – Mar 2018	Q1 Apr – June 2018	% change
Care of patients/service users is the Trust's top priority	80%	77%	-3%
I am able to make suggestions to improve the work of my team/department	78%	79%	+1%
There are frequent opportunities for me to show initiative in my role	74%	73%	-1%
I am able to make improvements happen in my area of work	67%	67%	N/A
I think that it is safe to speak up and challenge how things are done	62%	61%	-1%
I look forward to going to work	61%	61%	N/A
I am enthusiastic about my job	73%	75%	+2%
Time passes quickly when I am working	78%	80%	+2%

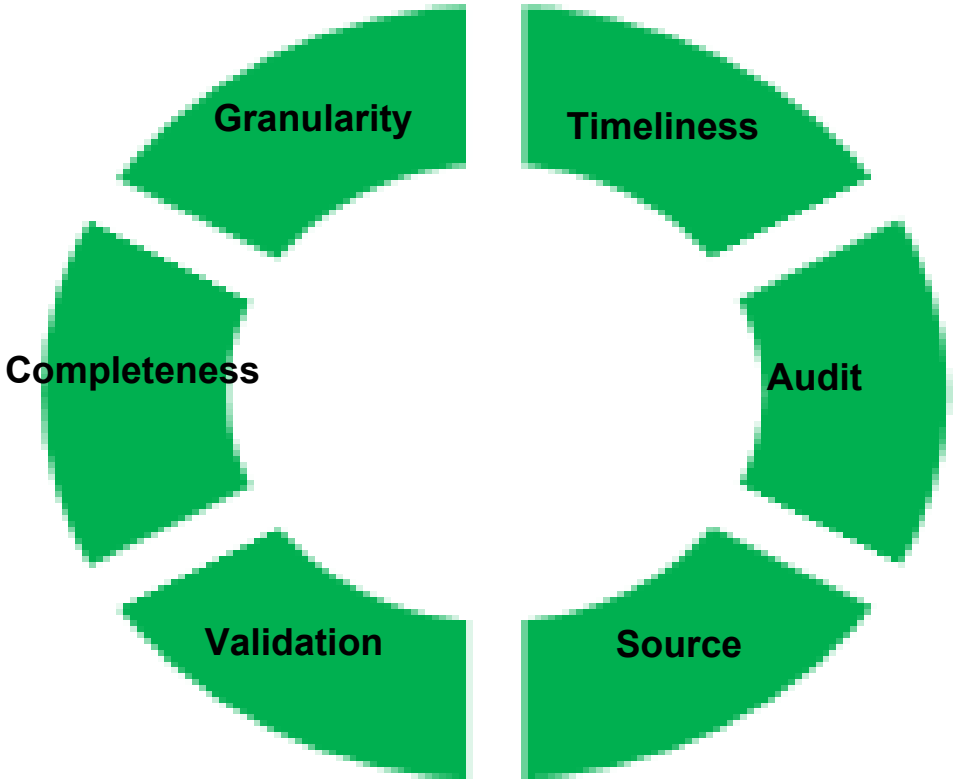
The quarter 2 Pulse Check is set to launch to all staff on Monday 3 September 2018.

Data Quality Kitemark

Background

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

Approach



The Trust has adopted this Data Quality Kitemark. The assessment of each domain will be based on the following criteria;

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

Data Quality Indicator	Definition	Not yet assessed	Sufficient	Insufficient
Validation	Prior to publication, is the data subject to validation, e.g. spot checks, random sample checks, involvement of a clinician, the associated service or approval by Executive Director?	Not yet assessed	The data is validated against a secondary source. The indicator owner can assure the data is a true reflection of performance, supported by a sign off process and underlying information.	No validation has taken place. The information owner cannot assure that the data truly reflects performance. A random sample may reveal errors.
Source	Is the source of the data fully documented and understood?	Not yet assessed	All users understand how to extract the data in line with the indicator definition. The data source is well documented in the event that there is a change in personnel producing the indicator.	The data source is poorly documented and could be inconsistently extracted.
Completeness	Is the indicator a reflection of the complete performance of the Trust	Not yet assessed	All the appropriate activity has been included within the indicator	A material amount of activity has not been included within the indicator that may alter the Trust level performance.
Granularity	Can the data be disaggregated into smaller parts? E.g. evaluated at a division or ward level as well as a Trust level.	Not yet assessed	Data can be drilled down to a division or ward level in order to understand and drive performance improvement.	Data is only available at a Trust level.

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

KPI Data Quality Reviews

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 September 2018

Quality Report - Responsiveness

Purpose of Report

This paper provides Trust Board with a focused report on service responsiveness as part of wider reporting relating to CQC domains.

As it is a new report it also provides Board members with an opportunity to discuss whether this type of report gives the necessary content to facilitate a strategic discussion about our services and provide assurance at the same time and/or whether further development work is needed.

Executive Summary

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

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

The report has been split into a number of sections;

1. Introduction – this section provides national context to help inform and focus our discussion on strategic issues.

2. 'Responsiveness' performance in a number of service areas – this section provides detailed data and information about the responsiveness of a number of Trust services.

3. External feedback on service responsiveness – this section provides detailed data and information from a number of external sources about Trust services.

It should be noted that this report does not include data or information for all Trust services. However, Board members do receive evidence and information about many of the services not included in this report. For example, Early Intervention, CAMHS, Neighbourhood teams, referral to treatment times (RTT) and serious incidents are provided in the Integrated Performance Report and/or via numerous other reports that are provided and reviewed at Board Committees.

The aggregation of the information in this report and from other Board Committee reports is intended to facilitate a discussion by Board members on strategic issues associated with the responsiveness of Trust services.

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

Assurances

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

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

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

Consultation

This paper has not been considered elsewhere.

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

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

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

Recommendations

The Board of Directors is requested to;

1. Discuss the content of the report and provide feedback on whether it meets the intended purpose.
2. Confirm the level of assurance obtained on current performance across the areas presented.
3. Update Board Assurance Framework where necessary.

Report prepared and presented by:	**Mark Powell** **Chief Operating Officer**

Quality Report - Responsiveness

1 Introduction

1.1 Policy and regulatory requirements linked to responsiveness

NHS Improvement (NHSI)

The NHSI Single Oversight Framework contains several performance requirements related to responsiveness in the NHS, two of which are applicable to the Trust:

- People with a first episode of psychosis begin treatment with a NICE recommended care package within two weeks of referral.
- 75% of people wait six weeks or less from referral to entering a course of talking treatment under Improving Access to Psychological Therapies (IAPT) and 95% of people wait 18 weeks or less.

Care Quality Commission (CQC)

The CQC inspection of providers includes a key line of enquiry to establish whether or not services are responsive to a patient's needs, in line with the legal requirement under Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9.

The outcome of the last inspection in 2016 was that the Trust was rated as "requires improvement" for responsiveness, for the following reasons:

- Long waiting lists for psychological therapies
- Dormitory style bays on acute wards that did not promote the privacy and dignity of patients.
- High levels of patients requiring access to a psychiatric intensive care unit bed being placed out of area
- Poor recording of discharge planning on older people's wards

Mental Health 5 Year Forward View (MH5YFV)

The MH5YFV contains a number of requirements to improve responsiveness in mental health services, with the ones relating to the Trust outlined below.

- An additional 49,000 children and young people receive treatment from NHS-commissioned community services in 2018/19 nationally (32% increase)
- By 2020/21, evidence-based community eating disorder services for children and young people will be in place in all areas, ensuring that 95% of children in need receive treatment within 1 week for urgent cases, and four weeks for routine cases.
- Continue to increase access to specialist perinatal mental health services, ensuring that an additional 9,000 women access specialist perinatal mental health services and boost bed numbers in the 19 units that will be open by the end of 2018/19 so that overall capacity is increased by 49%.
- By 2020/21, there will be increased access to psychological therapies, so that at least 25% of people (or 1.5 million) with common mental health conditions access services each year. The majority of new services will be integrated with physical healthcare. As part of this expansion, 3,000 new mental health therapists will be co-located in primary care, as set out in the General Practice Forward View. Meet 50% IAPT recovery rate; meet 75% of people accessing treatment within six weeks IAPT waiting time; and meet 95% of people accessing treatment within 18 weeks IAPT waiting time.
- Ensure that 53% of patients requiring early intervention for psychosis receive NICE concordant care within two weeks.

- Increase investment for crisis resolution and home treatment (CRHT) teams (CRHTTs) to meet the ambition of all areas providing CRHTTs resourced to operate in line with recognised best practice by 2020/21.
- Continue to work towards the 2020/21 ambition of all acute hospitals having mental health liaison services that can meet the specific needs of people of all ages including children and young people and older adults; and deliver Core 24 mental health liaison standards for adults in nearly 50% of acute hospitals subject to hospitals being able to successfully recruit.
- By 2020/21, all NHS-commissioned mental health providers will have armed forces champions and a specific named clinician with an expertise in military trauma. There will be a network of specialist collaborative providers that have been co-commissioned with CCGs (Clinical Commissioning Groups) to provide accessible bespoke care for the armed forces community. This will include accessible services for complex post-traumatic stress disorder and other complex presentations that are bespoke for the armed forces community.
- Support delivery of (Sustainability and Transformations Partnership (STP) level plans to reduce all inappropriate adult acute out of area placements by 2020/21. Review all patients who are placed out of area to ensure that they have appropriate package of care.
- By 2020/21, NHS England should lead a comprehensive programme of work to increase access to high quality care that prevents avoidable admissions and supports recovery for people who have severe mental health problems and significant risk or safety issues in the least restrictive setting as close to home as possible. This should seek to address existing fragmented pathways in secure care, increase provision of community-based services and trial new co-commissioning funding and service models.
- By 2020/21, there will be evidenced improvement in mental health care pathways across the secure and detained settings. Access to liaison and diversion services will be increased to reach 100% of the population, whilst continuing to ensure close alignment with police custody healthcare services.
- By 2020/21, inpatient stays for children and young people will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible to avoid inappropriate out of area placements. Inappropriate use of beds in paediatric and adult wards will be eliminated.

1.2 Trust strategy related to responsiveness

The Trust Strategy (2018-21) contains a commitment to transform our services through working in more joined-up pathways of care which are easy to understand, which should result in easier access to care, new pathways developed as part of the Five Year Forward View and services developed using evidence and feedback from a variety of sources to ensure we meet people's diverse needs.

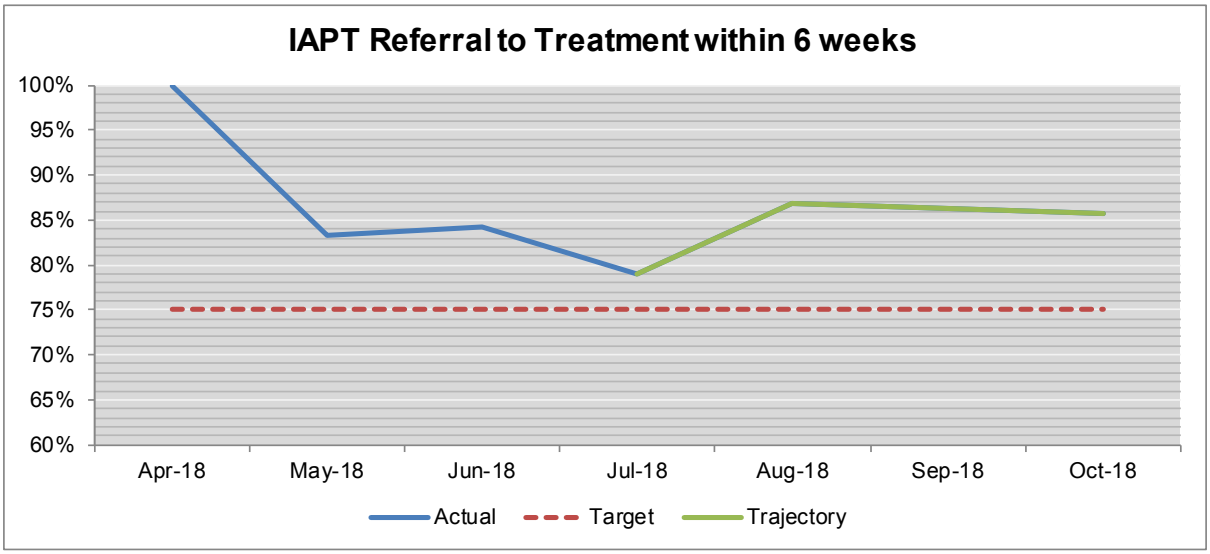
It also contains a commitment to meet operational targets, thereby ensuring access to care in a timely manner.

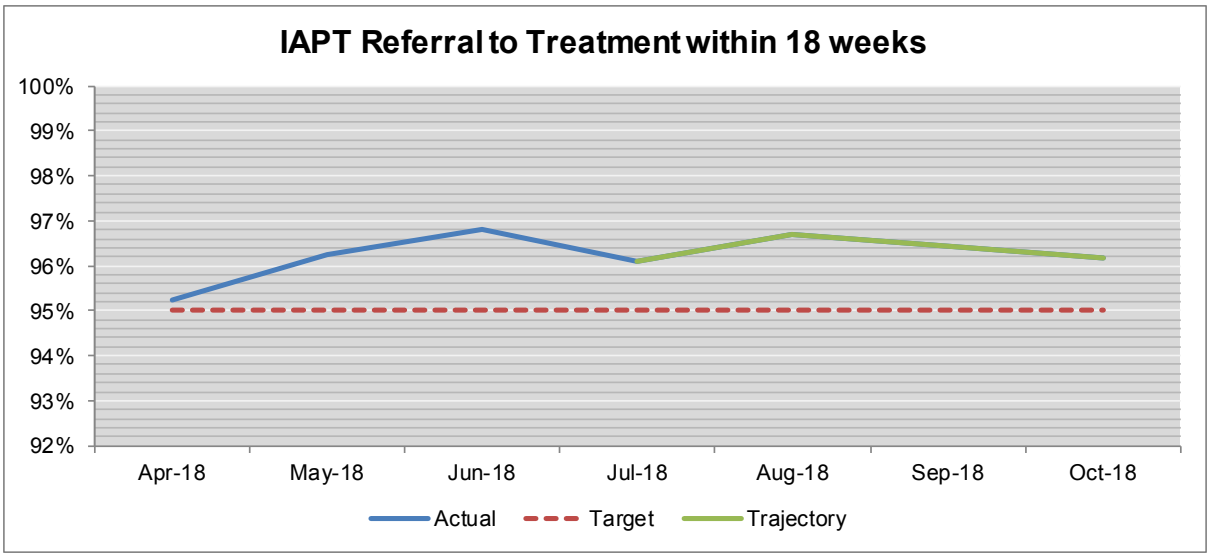
2 Performance on key service areas

Note – not all Trust Services are provided in this report and Board members will observe some duplication across reports. Evidence and information about many of our services such as Early Intervention, CAMHS, Neighbourhood teams and referral to treatment times (RTT) is provided in the integrated performance report and several other reports which are received at Board Committees.

2.1 Psychological therapy waiting time - IAPT and Secondary Care

Current performance





In the most recently published national data, 89.4% of people waited less than 6 weeks and 98.9% waited less than 18 weeks to enter treatment. DHCFT were in the top 32% of performers for the 6 week target and joint top performer for the 18 week target.

We continue to exceed all referral to treatment targets. Waiting lists are monitored regularly to ensure the targets are met.

2.2 Liaison Psychiatry

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

Current Performance

Liaison Team (RAID) – Quantitative and Qualitative Outcomes 2017 Percentage of patients (%)													
	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Compliance 1 Hour Wait	95.38%	97.79%	93.18%	94.85%	98.17%	99.00%	100.0%	100.0%	90.83%	93.04%	97.76%	93.33%	95.04%
Compliance 24 Hours Wait	98.45%	100.0%	98.25%	99.52%	99.42%	100.0%	100.0%	100.0%	100.0%	99.40%	97.19%	97.46%	99.49%

2.3 Neighbourhood assessment waits

Current performance

Service	Team	Number Waiting	Average Wait (Weeks)
Derby City	Derby City	93	4
North Derbyshire	Bolsover & Clay Cross	63	4
North Derbyshire	Chesterfield Central	14	5
North Derbyshire	High Peak & North Dales	21	2
North Derbyshire	Killamarsh & North Chesterfield	103	7
South Derbyshire	Amber Valley	3	5
South Derbyshire	Erewash	3	3
South Derbyshire	South Derbys & South Dales	13	1

The NHS Benchmarking Network (2017) found that nationally 40% of patients referred to community mental health teams were seen within four weeks of referral:

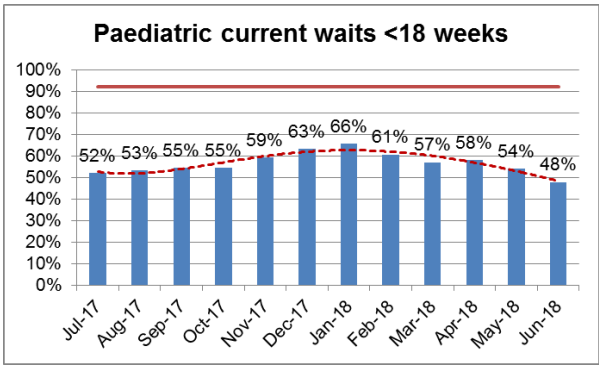
The review of neighbourhood services continues to be undertaken with specific outcomes seeking to address current issues across community mental health services. The conclusion of this work is expected after the summer period.

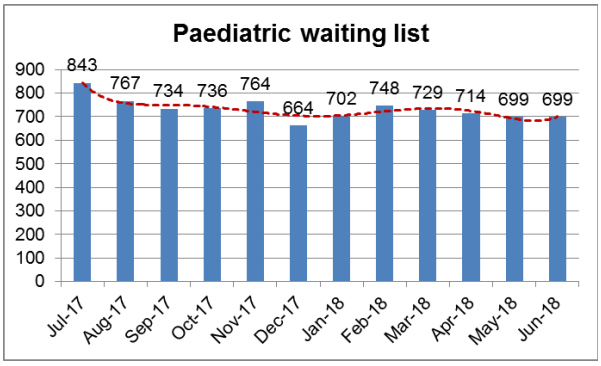
2.4 Paediatrics

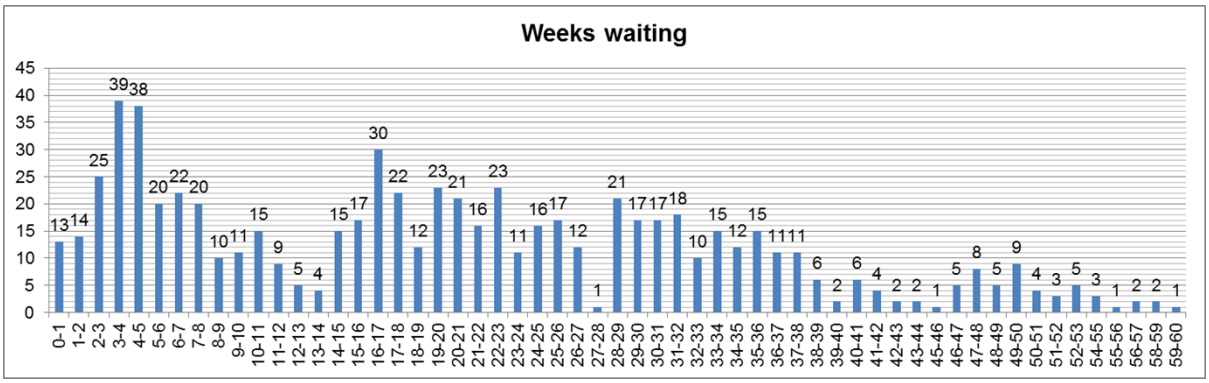
Although over the last few years there has been significant improvement, the number of new referrals received each month continues to exceed capacity. The effect on the waiting list is an increase in the number of children currently waiting to be seen who have been waiting longer than 18 weeks (currently stands at 52%). There are currently 14 children who have been waiting over a year to be seen.

A national study (Royal College of Paediatrics and Child Health, 2017) found that community paediatric referral to treatment waiting time ranged from 6-33 weeks with an average wait of 14.6 weeks. In contrast the Trust's average wait in 2017/18 was 33 weeks.

Current performance







The Trust has recently recruited to one of the vacant posts in Community Paediatrics and hope to have completed recruitment in the coming weeks. This leaves 1 vacant Speciality Doctor post which is being re-advertised. Recruitment remains challenging in this specialist field, we have re-engineered the post to maximise the potential for recruitment and also to help meet our other statutory obligations.

We continue to undertake recruitment processes to try to attract candidates. We will then work to ensure equitable provision across localities, especially where we have the longest waiting times. Negotiations with the CCG are underway regarding the service specification to ensure clarity and resource for the activity required in the localities.

The neurodevelopmental pathway will be launched in early September to coincide with the new academic year, which will help ensure correct allocation of referrals which have traditionally come to Community Paediatrics but may be better suited in other services.

Cases who are more appropriate to Clinical Psychology have been identified and we have agreement to transfer cases to their care. The appointment of a neurodevelopmental co-ordinator will ensure timely response, waiting lists management and ensuring clinical information has been gathered in advance of the appointment.

2.5 Out of Area placements

Over the last 12 months, the Trust has had to place an average of 15 patients per month into out of area beds.

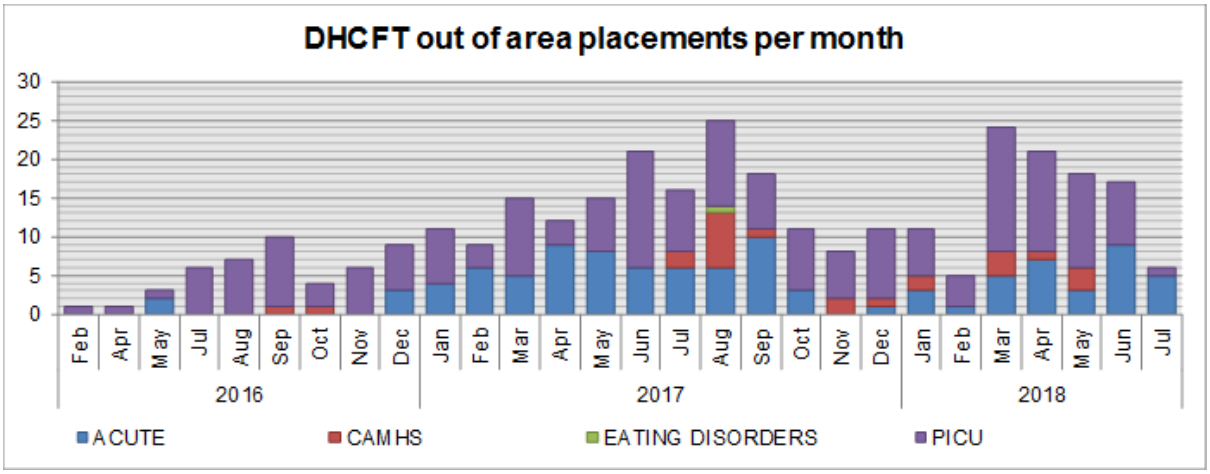
Predominantly this has been a result of a commissioning gap: there has been no commissioning of local mental health inpatient beds for Child and Adolescent Mental Health Services (CAMHS), or for Psychiatric Intensive Care (PICU).

At times there is also a need for acute adult mental health out of area placements owing to lack of bed availability on our wards.

Current performance

Table 6: OAP activity over the period due to unavailability of bed: by Region
England, 1 to 30 April 2018

Area	OAPs active at period end	OAPs started in period	OAPs ended during period	Number of OAPs by duration[4] 1-7 nights	8-14 nights	15-30 nights	31+ nights
England	*650*	*645*	*650*	*200*	*115*	*195*	*140*
London	90	95	80	40	15	15	10
Midlands and East	200	165	170	50	25	60	35
North	175	215	240	75	40	70	55
South East	90	95	85	20	20	30	15
South West	85	60	60	15	10	15	20
Unknown	10	5	20	5	5	5	5



The national policy drive to reduce out of area placements to zero by 2021 is going to be a challenge for all Providers. Our 100 day urgent care improvement plan sets out a number of key objectives that will positively impact on the Trust's requirement for out of area beds. It will though require significant change in practice across the whole health and social care sector and then sustained effort to meet this goal.

2.6 Autism Spectrum Disorder (ASD)

Current performance

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

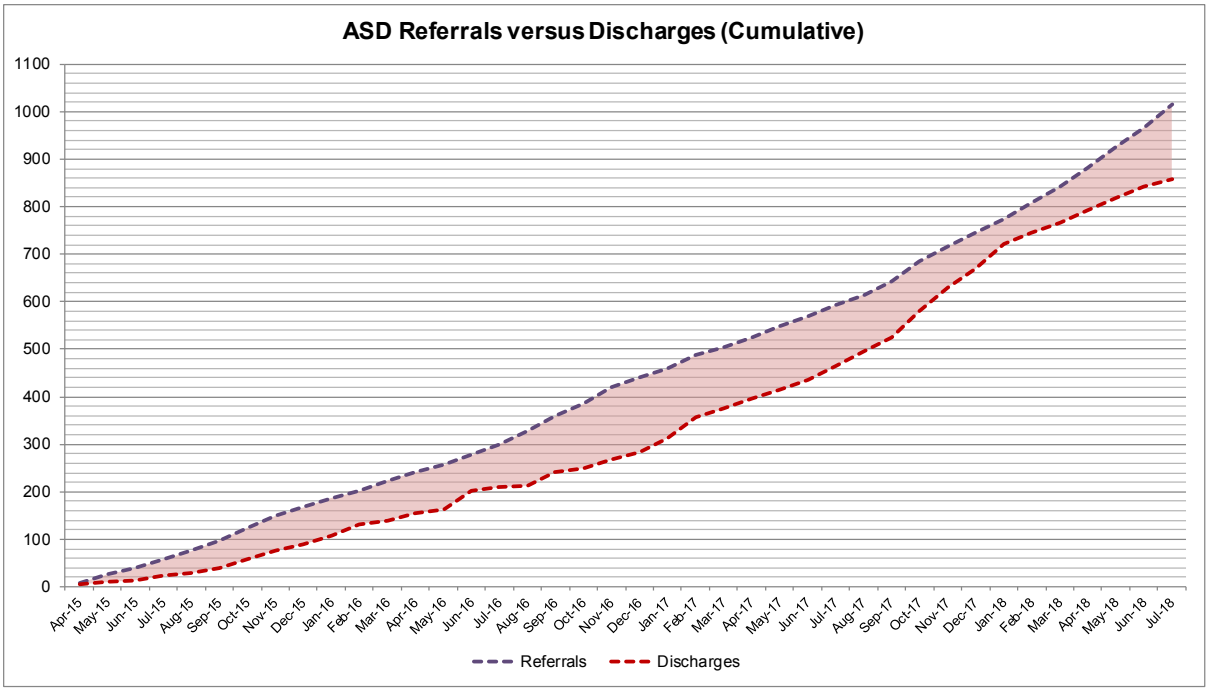
As the data shows below demand for ASD assessment continues to exceed capacity. The number of referrals received per month consistently exceeds the number of discharges.

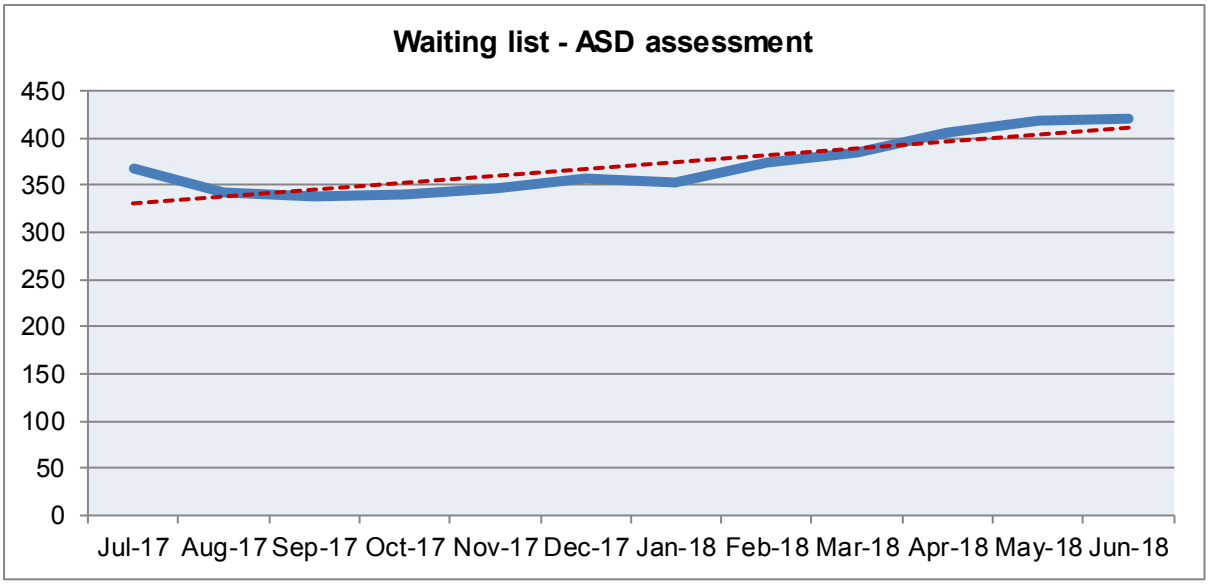
Staff retention continues to be a challenge owing to the "assessment only" nature of the roles.

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

Staff also provide consultation and advice on complex cases and have engaged in limited direct work for those having significant complexity (which again enables the staff to practice and therefore retain their specialist skills).

Wait from referral to diagnosis	number	%
0-5 Weeks	52	9%
5-10 Weeks	44	8%
10-15 Weeks	49	10%
15-20 Weeks	42	9%
20-25 Weeks	36	9%
25-30 Weeks	40	11%
30-35 Weeks	37	11%
35-40 Weeks	29	10%
40-45 Weeks	33	12%
45-50 Weeks	23	10%
50-55 Weeks	19	9%
55-60 Weeks	32	16%
60-65 Weeks	37	22%
65-70 Weeks	47	37%
70-75 Weeks	25	31%
75-80 Weeks	12	21%
80-85 Weeks	3	7%
85-90 Weeks	2	5%
90-95 Weeks	3	8%
95-100 Weeks	1	3%
> 100 Weeks	3	9%





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

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

3 External feedback on service responsiveness

This part of the report provides information from external sources about the Trust's responsiveness.

3.1 Patient survey – community and inpatient

The patient satisfaction survey published in November 2017 resulted in the following results that provide evidence of patients' views of how responsive our services are:

Section score for	Our Trust	Lowest score achieved	Highest score achieved
Health and Social Care Workers	7.7	6.4	8.1
Organising Care	8.7	7.8	9.0
Planning Care	7.1	6.0	7.5
Reviewing Care	7.7	6.2	8.3

3.2 Patient complaints and compliments

Through day to day running of clinical services we receive a number of complaints about access to our services.

From the three categories of subject of complaints that we felt best covered responsiveness the data shows that Neighbourhood services North, South and City had most complaints raised. This is based on the complaints made and not the findings from the investigation.

Unfortunately we do not capture compliments in a way that we can pull out information about responsiveness without reading each entry, which would be too time consuming.

Appointments (e.g. delays and cancellations)	21
Neighbourhood Services - North	7
Bolsover & Clay Cross Locality	4
Chesterfield Central	2
Killamarsh & Chesterfield North	1
Neighbourhood Services - South	**6**
South County and South Dales	4
Amber Valley	1
Early Interventions Team - Derby City	1
Neighbourhood Services - City	**4**
Resource Centre - Outpatient Dept.	4
Community Paediatrics	**2**
Paediatrics - Derby City	1
Paediatrics - Southern Derbyshire	1
Psychological Therapies, Perinatal & Performance/Training/Admin	**1**
Talking Mental Health Derbyshire	1
Learning Disabilities Services	**1**
Amber Valley CLD Team	1

Availability of Services / Activities / Therapies	44
Neighbourhood Services - North	**14**
Killamarsh & Chesterfield North	5
Chesterfield Central	4
High Peak & North Dales	3
Bolsover & Clay Cross Locality	2
Neighbourhood Services - South	**10**
South County and South Dales	6
Amber Valley	2
Erewash	1
Early Interventions Team - Derby City	1
Campus - Assessment Services	**5**
Crisis - Chesterfield	2
Crisis - City & County South	1
RAID Liaison Team - North	1
RAID Liaison Team - South	1
Neighbourhood Services - City	**4**
Resource Centre - Outpatient Dept.	2
Derby City (C)	1
Derby City (B)	1
Community Paediatrics	**3**
Derby City	2
Southern Derbyshire	1
Campus - Radbourne Unit	**2**
Ward 33 Adult	1
Ward 35 Adult	1

Availability of Services / Activities / Therapies	44
Child and Adolescent Mental Health Services (CAMHS)	**2**
County South Derbyshire	1
Derby City	1
Substance Misuse Services	**1**
Derbyshire Recovery Partnership (drugs service)	1
Psychological Therapies, Perinatal & Performance/Training/Admin	**1**
Talking Mental Health Derbyshire	1
Children's Therapies & Complex Needs	**1**
Neuro Developmental Team	1
Neighbourhood Services - Admin & Management	1
Medical Secretaries	1
Number of complaints about responsiveness	
Number of compliments about responsiveness	

Waiting Times	8
Neighbourhood Services - City	**3**
Resource Centre - Outpatient Dept.	2
Derby City (A)	1
Neighbourhood Services - South	**2**
Amber Valley	2
Neighbourhood Services - North	**2**
Killamarsh & Chesterfield North	2
Campus - Assessment Services	**1**
Crisis City & County South	1

3.3 Friends and family test feedback with responsiveness component

The Trust is fortunate to receive feedback from friends and family of service users. Whilst the feedback represents a small proportion of those that we provide services to, it does give rich information for us to reflect on, often correlating with other feedback that the Trust receives.

All responses July 17 to July 18:

Likelihood of recommending Trust	number	%
Extremely likely	421	53%
Likely	253	32%
Neutral	83	11%
Unlikely	21	3%
Extremely unlikely	10	1%
Grand Total	**788**	**100%**

Responses with feedback about responsiveness:

Extremely Likely (n=3)

"After waiting for a long time to access services I was desperate. When you eventually get an appointment you're so grateful. Access to these services should come into play quicker because anyone that needs these services has been in a very black hole."
(Derby City Outpatients)

"Helen is a good therapist. Sadly with mental health issues on the rise there isn't enough funding and waiting time is long. Helen is very caring and excellent at her job. She goes above and beyond just a basic duty of care. All the reception staff at St Andrews House are friendly and caring."
(Derby City Community)

"The team who came in came in at all hours of the day. They supported not only the client but the staff. They provided excellent advice and strategies. They offered advice on the phone."
(Dementia Rapid Response Team)

Likely (n=10)

"Because they responded quickly and visited several times without rushing me."
(Chesterfield Crisis Assessment and Home Treatment Team (CRHT))

"Shorter waiting to be seen after referral. Someone to answer the phone during opening hours. Have tried several times to ring before 3pm and have been given answer machine saying reception is closed."
(Community Paediatrics)

"They worked hard to achieve the patients' needs and were very professional/compassionate. Would listen to what carers had to say."
(Dementia Rapid Response Team)

"Care has been sporadic - but we do have accessible numbers."
"Shortage of staff in the CMHT means many people without support they need, but I recommend people seek help"
(Derby City Outpatients)

"Due to the promptness of support I have received via The Hub and Psychiatry Outpatients."
"Long wait for appointments"
"Require more regular appointments and times"
"The wait is so long and it's hard to get seen"
"There is not a lot of care to access in mental health services. While your service is not perfect - appointments are hard to obtain - it is helpful."
(Resource Centre Outpatients)

Neutral (n=5)

"I don't see anyone and it has taken me months to get an appointment"
"I feel like that the waiting time is too long when feeling like I do. But very good support when getting to see someone."
"I had to rearrange my appointment and couldn't get an appointment for months and even then rearrange my appointment again so it has been over 6 months to be seen."
"Lack of continuity/seeing same consultant at appointments it is impossible to assess a patient fully in 10-15 minutes"
(Derby City Outpatients)

"I have been struggling for some time now and I asked for an appointment to be seen; that was in October 2016 I have not heard from you until now."
(Resource Centre Outpatients)

Unlikely (n=8)

"It's very difficult to be seen regularly."
"Unable to get a regular CPN."
"Always running late."
"Don't feel listened to."
(Bolsover & Clay Cross Outpatients)

"The phones are never picked up. Then CAMHS are all annoyed because you have not rang up with plenty of notice to cancel an appointment. You are not even able to leave a message on an answer machine. So disappointing and stressful all round. Plus the additional worries of not knowing when your son can be seen and will it be before he runs out of medicine."
(Child & Adolescent Mental Health Services (CAMHS))

"Found treatment disjointed but mainly because under 2 teams at first. Got better once under just CRHT but the fact that saw a lot of different staff which wasn't helpful."
(Chesterfield CRHT)

"My appointments are made far too infrequently no relationship with psychiatrist as it is a different consultant every time."
(Derby City Outpatients)

"Poor support services. Should have follow up appointments every 2 months not 5 months. Only seen today because I asked for an urgent appointment."
(Resource Centre Outpatients)

Extremely unlikely (n=2)

"I feel let down by this admission it was different to last time. The doctor has made several appointments to see me and has never kept them. When I have asked for anything in ward round the doctor has done the opposite. I feel like I had lost faith in the staff and find it hard to trust them."
(Hartington Unit, Tansley Ward)

"Very disappointed with the treatment & service (except the prescribers who have all been very nice) Currently will not have seen drug worker for 10 weeks even though have been feeling high risk and asked for fortnightly meetings. Normally see drug worker every 4 weeks but need more support. Appointments can range from 3 minutes to 45 minutes and never know what it will be inconsistent as what I think we will be discussing seems to be forgotten by the next meeting. No structure as care plan objectives and tasks are not fulfilled so lose incentive e.g. to discuss my thought sheets at next appointment then it doesn't happen. Sometimes just given script at reception and all topics that were previously arranged to be discussed are forgotten as had no proper appointment. Letters received on plain paper not headed notepaper showing no telephone number even though it says to contact the number below in case cannot attend!!! Difficult to find out protocols on treatments, medication and appointments and even Ripley staff cannot give the information I require. The phone seems to be answered by whoever is passing when it rings. Not only is communication between service user and drug worker inadequate but seems to be poor between the staff themselves. Disorganised had to sign disclosure form twice in a month as first one lost.
(Substance Misuse Service, Matlock)

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 September 2018

Workforce Race Equality Standards (WRES) 2017/18 and Equality Delivery System2 (EDS2) Update

Purpose of Report

The annual Workforce Race Equality Standards (WRES) 2017/18 reporting template and summary is presented for consideration and approval prior to sharing with lead commissioners and publishing on our website by 24 September, 2018.

An update on Equality Delivery System 2 (EDS2) grading process 2018 is provided and a refreshed REGARDS (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation) wheel poster is presented for approval.

Executive Summary

1. The Workforce Race Equality Standard (WRES) annual submission

The WRES and EDS2 are welcomed by the Trust and consider it as a mechanism to identify and reduce any disparities that arise in relation to experience and outcomes for staff, applicants and patients.

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.

The WRES takes a small number of indicators (9) and requires NHS organisations to close the gap between the BME and white staff experience for those indicators. Organisations will be 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.

The WRES data is submitted electronically into a central system called UNIFY which uses formulas to generate percentages and ratios. Key findings from indicators 5 - 8 which are taken from the most recent staff survey form part of the submission. The data is used to drive improvement and to undertake deep dives in order to better understand how the results occur and what would be effective in addressing these.

Our current position and the steps we are taking to improve our performance are summarised in attached WRES documents, which incorporate the action plan and identify the streams of work to close the gaps across the 9 indicators .Please refer to WRES reporting template (Appendix 1) and WRES summary (Appendix 2) for further detail. In summary, there is considerable work to be done to address the variations in experience, workforce representation, progression and development.

Compliance

National/central reporting : The WRES UNIFY excel spreadsheet populated by People Information & Systems Team and approved by Director of People & Organisational Effectiveness was sent on time to the national WRES Team, NHS England on 10 August 2018.	Completed
Local reporting: The draft annual WRES summary and reporting template for 2017/18 is attached for discussion and approval prior to publishing on our external website and sharing with lead commissioners as part of the Quality Schedule reporting by 24 September, 2018.	On track
The Workforce Race Equality Standard Action Plan 2017: Helping our BME Staff to succeed was previously presented to the Board on 1st May 2018. The attached WRES reporting document incorporate the action plan and identifies the streams of work to close the gaps across the indicators. The annual BME Colleague Network Conference & AGM took place on the 15th May, 2018 –where members of the network and senior leaders took the opportunity to scrutinise by each AfC Band, by ethnicity to help identify where barriers to staff progression, treatment and experience may be occurring, and to consider the action to address these barriers. The WRES action plan was further refined to ensure that this year's theme 'recruitment and progression' will be progressed through key work streams. This is set out and was shared in the BME Network conference report. The NHS WRES technical guidance (2018) is being used to apply good practice across the different work streams https://www.england.nhs.uk/wp-content/uploads/2017/03/wres-technical-guidance-2018.pdf Reverse mentoring is progressing well, with positive feedback from both parties. We are sharing good practice and learning at mental health workforce conference on the 6th September, 2018	In progress

EDS2 and the WRES will complement each other, since EDS2 complements WRES data, and the WRES data can feed into EDS2 evidence.

2. **Equality Delivery System 2 Implementation Plan 2018** – EDS2 is currently undergoing refresh by the national team and in the interim we are starting to prepare for this year's annual grading.

   EDS2 Patient experience and outcomes goals 1 & 2 - discussions are taking place to prepare for our annual grading process. The Head of Equality, Diversity & Inclusion is working with the Deputy Director of Operational Services and Director of Nursing & Patient Experience to finalise details and which specific service will be undertaking equality deep dive. A provisional date has been set aside for Thursday 15 November, 2018 at the R & D Centre Kingsway pending agreement with senior accountable officers.

3. **Board Equality, Diversity, and Inclusion Action Plan 2017-2019** the detailed version was reviewed at a recent Equality Board Development session (May 2018). The action plan comprising of the top 6 equality objectives set out below will be refined and refreshed as part of our annual EDS2 grading to gain assurance of progress and evidence of embedding Goal 4* within the Trust core business and performance processes.

   *EDS2 Goal 4: Inclusive Governance /leadership (*leaders, showing strong and sustained commitment to promoting equality within and beyond organisation. Engaging and responding to the needs of the diverse REGARDS groups)*

   Top 6 Equality objectives:

   1. Completion of data (*across the nine protected characteristics/PCs/REGARDS) for services and b) workforce
   2. Developing engaging and inclusive leadership
   3. Allocate corporate resources to progress the equality and inclusion agenda within DCHFT
   4. Demonstration of 'due REGARDS' relating to strategy, policy and decision-making (Equality Impact Analysis) key committees
   5. Develop refined community engagement mechanisms (particularly reaching out to seldom heard/traditionally excluded groups)
   6. EDS2 assessment – continuous improvement across the 4 Goals/18 outcomes

4. **A refreshed REGARDS wheel** poster reflecting the new values and brand is attached at Appendix 3. Working with 'Due REGARDS' and respect because everyone matters was developed at recent Equality Board Development session and the draft artwork is presented for approval and printing of posters.

   "Due regard" in this context refers to:

   - REGARDS acronym to help us remember to include the different equality strands.
   - Legal definition under the Equality Act (case law commonly known as Brown principles) due regard referring giving proportionality, relevance and sufficient attention to implementing the findings of the WRES, Workforce Disability and other standards to ensure equity and tackling discrimination..
   - Giving due regard is also about 'positive unconditional regards' which is an asset based human rights approach which reflects our values around putting the human being at the centre, being compassionate and inclusive in our approach

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

Assurances

The Board and Chief Executive / BME Champion will continue to provide leadership and ongoing support for the delivery of the WRES.

Consultation

WRES metrics and action plan is shared 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.

Governance or Legal Issues

As above.

The WRES is a mandatory requirement embedded within the NHS Contract to ensure effective collection, analysis and use of workforce data to address under-representation of BME staff across the NHS. The WRES has clear links with the EDS2 which also became mandatory for NHS Trusts, including CCGs from April 2015.

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).

Quality Schedule 4 of the Main Contract: NHS Equality Delivery System (EDS2) evidence / progress reporting / assessment grades.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks –

The WRES is a tool which identifies variations/inequalities and between BME and White staff experiences in the workplace this is measured through a set of metrics. Our current position (see WRES findings for the specific data analysis) clearly highlights under-representation, variations in experience, treatment and progression for colleagues from BME communities. The document sets out the steps we are taking to improve our performance in the actions section. The attached WRES document incorporates the action plan and identifies the streams of work to close the gaps across the indicators. In closing the gaps this will achieve tangible progress in tackling race inequalities and discrimination experienced by our BME workforce.

Research has shown that improving the diversity of the workforce will lead to better healthcare outcomes for our patients where the workforce is representative of the community it serves. The Trust is committed to being 'positively diverse and inclusive' and building a compassionate and inclusive workplace where all staff feel valued, have the opportunity to be themselves, flourish, succeed and free from discrimination.

Recommendations

The Board of Directors is requested to:

1) Note findings against the nine performance indicators and approve the WRES reporting template and summary.
2) Note the EDS2 Implementation plans 2018.
3) Discuss and approve the refreshed REGARDS poster.

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

Report prepared by: **Harinder Dhaliwal**
Head of Equality, Diversity & Inclusion

Appendices:

1. WRES reporting template
2. WRES summary
3. Refreshed REGARDS wheel poster.

Response ID ANON-DH32-FNKW-7

Submitted to **Workforce Race Equality Standard (WRES) reporting template - 2017**
Submitted on **2018-08-24 08:35:25**

Introduction

1 Name of organisation

Name of organisation:
Derbyshire Healthcare NHS Foundation Trust

2 Date of report

Month/Year:
August 2018

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

Name and title of Board lead for the Workforce Race Equality Standard :
Ifti Majid, Chief Executive

4 Name and contact details of lead manager compiling this report

Name and contact details of lead manager compiling this report:
Harinder Dhaliwal
Head of Equality, Diversity and Inclusion

5 Names of commissioners this report has been sent to

Complete as applicable::
David Gardner, Assistant Director of Procurement & Commissioning - David.Gardner@hardwickccg.nhs.uk

Workforce Race Equality Standard reporting template

6 Name and contact details of co-ordinating commissioner this report has been sent to

Complete as applicable.:
David Gardner, Assistant Director of Procurement & Commissioning - David.Gardner@hardwickccg.nhs.uk

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

Unique URL link on which this Report and associated Action Plan will be found:
http://www.derbyshirehealthcareft.nhs.uk/standards/equality-diversity/wres/

8 This report has been signed off by on behalf of the board on

Name::
Ifti Majid, Chief Executive,

Date::
4th September 2018

Background narrative

9 Any issues of completeness of data

Any issues of completeness of data:
121 (4.85%) BME staff not stated ethnicity

10 Any matters relating to reliability of comparisons with previous years

Any matters relating to reliability of comparisons with previous years:

Self reporting

11 Total number of staff employed within this organisation at the date of the report:

Total nuber of staff employed within this organisation at the date of the report:
2494

12 Proportion of BME staff employed within this organisation at the date of the report?

Proportion of BME staff employed within this organisation at the date of the report:
314 (12.59%)

13 The proportion of total staff who have self reporting their ethnicity?

The proportion of total staff who have self–reported their ethnicity:
12.59%

14 Have any steps been taken in the last reporting period to improve the level of self reporting by ethnicity?

Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity:
All Ethnic Origin Data is provided by the employee or applicant. Staff who have been recruited into the organisation through TRAC will have provided their Equalities Data online which will then filter through into ESR. For any staff that are recruited without using NHS Jobs, often Doctors, starter paperwork is populated in conjunction with the Medical Staffing Team which is then populated in ESR when they start or paper copies of data validation forms are sent out to them to complete. We have also, every so often, asked current staff members to check and update their information if necessary

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

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 to staff to encourage completion. Ethnicity self reporting promoted via BME Colleague Network.

Workforce data

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

What period does the organisation's workforce data refer to?:
01 April 2017 - 31 March 2018

Workforce Race Equality Indicators

17 Percentage of staff in each salary range of £10k compared with the percentage of staff in the overall workforce. Very Senior Managers (VSM) salaries generally begin at £100k (including executive Board members). Organisations should undertake this calculation separately for non-clinical and for clinical staff.

Data for reporting year:
Clinical staff (exc medical): White 56.06% & BME 7.14%
Non-Clinical Staff: White 23.42%, BME 3.25%
Not stated 4.85%

Data for previous year:
Clinical staff: White 56.34% & BME 6.99%
Non-Clinical staff: White 23.52% & BME 2.76%
5.11% not stated

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:
The data indicates a decrease for White staff group : Clinical staff 0.28% and non-clinical 0.1%. An increase for BME staff group - Clinical 0.15% and Non-clinical 0.49%. Implications for succession planning and identification of BME talent pipeline. Detailed breakdown for the different Agenda for Change bandings data shows under representation of BME talent, particularly in the senior leadership pool.

Board Equality Action Plan priority to drive cultural change and demonstrate senior leadership commitment and productive drive in achieving improvements for BME staff treatment experience and progression. Executive team working with BME Colleague Network to understand potential barriers and close the gaps to ensure fair recruitment and progression. Annual EDS2 grading by staff and BME Conference incorporate honest conversations, sharing triangulated data to understand evidence and proportionate interventions to drive improvements. Aligned to Trust People Strategy, Workforce Development Plan and Leadership Strategy to ensure BME talent identified and growing BME pool and pipeline. This year's theme Recruitment & Progression will be progressed through a number of work streams and interventions supported by the BME Colleague Network.

18 Relative likelihood of staff being appointed from shortlisting across all posts.

Data for reporting year:
Relative likelihood of White staff being appointed from shortlisting compared to BME staff 1.57 greater

Data for previous year:
Relative likelihood of white staff being appointed from shortlisting compared to BME staff 1.47 greater

The implications of the data and any additional background explanatory narrative:
A figure above “1” would indicate that White candidates are more likely than BME candidates to be appointed from shortlisting. The data indicates an increase 0.1

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:
Board Equality Action Plan priority to drive cultural change and demonstrate senior leadership commitment and productive drive in achieving improvements for BME staff treatment experience and progression. Executive team working with BME Colleague Network to understand potential barriers and close the gaps to ensure fair recruitment and progression. The Board Equality Action Plan includes a top high level equality objective to increase BME workforce representation. WRES action plan 'Helping BME people to succeed' has been developed Annual EDS2 grading by staff and BME Conference (May 2018)incorporated honest conversations, sharing triangulated data to understand evidence and proportionate interventions to drive improvements. Aligned to Trust People Strategy, Workforce Development Plan and Leadership Strategy to ensure BME talent identified and growing BME pool and pipeline. This year’s theme Recruitment & Progression will be progressed through a number of work streams and interventions supported by the BME Colleague Network.
Work stream 1: BME Recruitment Project group and plan developed and sponsored by Chief Executive/BME champion. Progress will be monitored by the BME Colleague Network and Equality Forum through regular reporting by the Head of People Resourcing (project officer) leading this work stream. Interview panels for senior posts -will have a designated Inclusion Guardian on the panel – someone whose sole role is to ensure we support people from all protected characteristics have the best opportunity at being successful and that processes are followed.

19 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.

Data for reporting year:
Relative likelihood of BME staff entering formal disciplinary process compared to White staff is 3.03 greater

Data for previous year:
Relative likelihood of BME staff entering formal disciplinary process compared to White staff is 1.60 greater

The implications of the data and any additional background explanatory narrative:
A figure above “1” would indicate that BME staff members are more likely than white staff to enter the formal disciplinary process.
This data indicates increase of 0.56 from previous year in the likelihood of BME staff entering formal disciplinary process compared to White staff.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:
To ensure proportionality for all disciplinary processes and outcomes. The Director of People Services and Organisational Effectiveness and one other Director will seek assurance that all potential disciplinary cases are conducted in accordance with the Trusts disciplinary policy at all times without bias or discrimination.

20 Relative likelihood of staff accessing non-mandatory training and CPD.

Data for reporting year:
Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff 1.53 greater

Data for previous year:
Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff 0.97

The implications of the data and any additional background explanatory narrative:
A figure below “1” would indicate that white staff members are less likely to access non-mandatory training and CPD than BME staff.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:
This data indicates an increase 1.43 in the likelihood of White staff accessing non-mandatory training and CPD compared to BME staff.

This data indicates an increase 1.43 in the likelihood of White staff accessing non-mandatory training and CPD. The BME Colleague Network is sponsored by CEO/BME Champion and will continue to be supported and strengthened in terms of impact of actions (using feedback, data and feedback to drive improvements) and development opportunities to flourish and succeed. Continue to ensure BME staff feel valued, supported and engaged in the work of Trust and have an impact. Continue to promote and track training opportunities at BME Network and positive action interventions.
The BME Network have commissioned Work stream 2: BME Progression and development lead by the Head of Workforce to look at barriers to progression and opportunities for exposure and development to enable BME people to progress.
Reverse mentoring programme is in place and action research is running concurrently with University of Nottingham. ReMEDI is a learning opportunity which enables senior leaders to gain insight from colleagues who are junior than themselves into what it is like to work within our organisation. It supports the development of inclusive leadership, cultural competence, capability, inclusive culture and environment. We wanted to make a difference and have a positive impact on culture and behaviours through understanding/learning from the lived experience of our BME colleagues, reduce potential systematic and individual barriers and biases. BME mentors have also benefitted from improved visibility, knowledge of the organisation and enhanced their mentoring skills.

Workforce Race Equality Indicators

21 KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

White:
25%

BME:
27%

White:
27%

BME:
29%

The implications of the data and any additional background explanatory narrative:
A 2% decrease for both White staff and BME staff experiencing bullying, harassment or abuse from patients, relatives or public has occurred since the previous year. However, BME staff experience still remains higher than White staff experience (2% higher).

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:
A multi-disciplinary Zero Tolerance Harassment & Bullying Work stream lead by Director of People & organisational Effectiveness in partnership with BME Colleague Network, staff side, staff governors. Action plan developed using triangulated data and expertise of group to drive improvement.

22 KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

White:
22%

BME:
28%

White:
22%

BME:
21%

The implications of the data and any additional background explanatory narrative:
Data for White staff experiencing bullying, harassment or abuse from staff has remained same as previous year, whereas BME staff have reported a 7% increase since last year and report 6% higher than white staff.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:
As above Indicator 5 : K25
Reaffirm at regular intervals the Trust position statement on zero tolerance issued by the CEO. Inclusive leadership Team Leaders learning event 2/11/2018 leaders and BME Network working together to address the inequalities identified by BME Network & WRES action plan. Use opportunities including NHS Diversity and Human Rights week, Black history month, inclusion week, refugee week, multi-faith experiential learning tours, hate crime and Pride to promote Trust stance on abuse

23 KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.

White:
80%

BME:
56%

White:
75%

BME:
73%

The implications of the data and any additional background explanatory narrative:
A 5% increase reported by White staff believing the trust provides equal career opportunities since previous year, however a 17% decrease from BME staff with the overall difference that 24% of BME staff believe this less than White staff.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:
BME Colleague Network supported by CEO/BME Champion and senior leadership, strengthened and impact to make a difference.
Executive team working with BME Colleague Network to understand potential barriers and close the gaps to ensure fair recruitment and progression. Annual EDS2 and BME Conference incorporate honest conversations, triangulated data to understand evidence and proportionate interventions to drive improvements. Aligned to Trust People Strategy, Workforce Development Plan and Leadership Strategy to ensure BME talent identified and growing BME pool and pipeline. This year's theme Recruitment & Progression will be progressed through a number of work streams and interventions supported by the BME Colleague Network. Reverse Mentoring for Equality, Diversity & Inclusion is a learning opportunity which enables senior leaders to gain insight from colleagues who are junior than themselves into what it is like to work within our organisation. It supports the development of inclusive leadership, cultural competence, capability, inclusive culture and environment. BME mentors have also benefitted from improved visibility, knowledge of the organisation and enhanced their mentoring skills.

24 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:
6%

BME:
14%

White:
6%

BME:
10%

The implications of the data and any additional background explanatory narrative:
Data for White staff experiencing discrimination from management or colleagues has remained same as previous year, whereas BME staff have reported a 4% increase since last year and report 8% higher than white staff.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:
A multi-disciplinary Zero Tolerance Harassment & Bullying Work stream lead by Director of People & organisational Effectiveness in partnership with BME Colleague Network, staff side, staff governors. Action plan developed using triangulated data and expertise of group to drive improvement.
To better understand the issues confronted by our BME staff which will inform the one-day manager training and underpin our WRES action plan.

Workforce Race Equality Indicators

25 Percentage difference between the organisations' Board voting membership and its overall workforce.

White:
8.3%

BME:
-3.5%

White:
9.1%

BME:
-4%

The implications of the data and any additional background explanatory narrative:
This data indicates the percentage of BME Voting Board Members is 9.1% compared with the Trust 12.6% , which is difference of - 4.3

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:

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

Are there any other factors or data which should be taken into consideration in assessing progress?:
Board Equality Action Plan priority to drive cultural change and demonstrate senior leadership commitment and productive drive in achieving improvements for BME staff treatment experience and aspirations. Executive team working with BME Colleague Network to understand potential barriers and close the gaps to ensure fair recruitment and progression. Annual EDS2 and BME Conference incorporate honest conversations, sharing triangulated data to understand evidence and proportionate interventions to drive improvements. WRES action plan is aligned to Trust People Strategy, Workforce Development Plan and Leadership Strategy to ensure BME talent identified and growing BME pool and pipeline. This year's theme Recruitment & Progression will be progressed through a number of work streams and interventions supported by the BME Colleague Network.

27 Organisations should produce a detailed WRES action plan, agreed by its board. It is good practice for this action plan to be published on the organisation's website, alongside their WRES data. Such a plan would elaborate on the actions summarised in this report, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other workstreams agreed at board level, such as EDS2. You are asked to provide a link to your WRES action plan in the space below.

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.:
The WRES action plan which has been developed in partnership with the BME Colleague network is integrated within this reporting template. Action plan and conference report can be located on the Trust external website via the Equality & Diversity page.
This WRES action plan is owned by the CEO on behalf of the Board of Directors

Workforce Race Equality Standard

REPORTING TEMPLATE (Revised 2016)

Template for completion

Name of organisation

Derbyshire Healthcare NHS Foundation Trust

Date of report: month/year

July 2018

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)

Hardwick CCG

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

David Gardner, Assistant Director of Procurement & Commissioning - David.Gardner@hardwickccg.nhs.uk

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

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

Ifti Majid, Chief Executive, Board Meeting 4th September, 2018

Publications Gateway Reference Number: 05067

Report on the WRES indicators

1. Background narrative

a. Any issues of completeness of data

121 (4.85%) staff not stated ethnicity

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

All Ethnic Origin Data is provided by the employee or applicant. Staff who have been recruited into the organisation through TRAC will have provided their Equalities Data online which will then filter through into ESR. For any staff that are recruited without using NHS Jobs, often Doctors, starter paperwork is populated in conjunction with the Medical Staffing Team which is then populated in ESR when they start or paper copies of data validation forms are sent out to them to complete. We have also, every so often, asked current staff members to check and update their information if necessary

2. Total numbers of staff

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

2494

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

314 (12.59%)

3. Self reporting

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

12.59%

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

ESR Self Service continues to give staff the ability to view their own ethnicity and update their own protected characteristics.All Ethnic Origin Data is provided by the employee or applicant. Staff who have been recruited into the organisation through TRAC will have provided their Equalities Data online which will then filter through into ESR. For any staff that are recruited without using NHS Jobs, often Doctors, starter paperwork is populated in conjunction with the Medical Staffing Team which is then populated in ESR when they start or paper copies of data validation forms are sent out to them to complete. We have also, every so often, asked current staff members to check and update their information if necessary

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

4. Workforce data

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

01 April 2017 - 31 March 2018

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.	Clinical staff (exc medical): White 56.06% BME 7.14% Non-Clinical Staff: White 23.42% BME 3.25% Not stated 4.85%	Clinical staff: White 56.34% & BME 6.99% Non-Clinical staff: White 23.52% & BME 2.76% 5.11% not stated.	The data indicates a decrease White staff group : Clinical staff 0.28% and non-clinical 0.1% An increase for BME staff group - Clinical 0.15% and Non-clinical 0.49%. Implications for succession planning and identification of BME talent pipeline. Detailed breakdown for the different AfC data shows under representation of BME talent particularly in senior leadership pool	Board Equality Action Plan priority to drive cultural change and demonstrate senior leadership commitment and prodfuctive drive in achieving improvements for BME staff treatement experience and aspriations. Executive ve team working with BME Colleague Network to understand potential barriers and close the gaps to ensure fair recruitment and progression..
2	Relative likelihood of staff being appointed from shortlisting across all posts.	Relative likelihood of white staff being appointed from shortlisting compared to BME staff 1.57 greater	Relative likelihood of white staff being appointed from shortlisting compared to BME staff 1.47 greater	A figure above “1” would indicate that white candidates are more likely than BME candidates to be appointed from shortlisting. The data indicates an increase	As above .Work stream 1: BME Recruitment Project group and plan developed and sponsored by Chief Executive/BME champion. Progress will be monitored by the BME Colleague Network and Equality Forum through regular reporting by the Head of People Resourcing (project officer) leading this work stream. Interview panels for senior posts -will have a
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.	Relative likelihood of BME staff 3.03 greater	Relative likelihood of BME staff entering formal disciplinary process compared to White staff 1.60	A figure above “1” would indicate that BME staff members are more likely than white staff to enter the formal disciplinary process. This data indicates increase of 0.56 from previous year in the likelihood of BME staff entering formal disciplinary process compared to White staff .	To ensure proportionality for all disciplinary processes and outcomes. The Director of People Services and Organisational Effectiveness and one other Director will seek assurance that all potential disciplinary cases are conducted in accordance with the Trusts disciplinary policy at all times without bias or discrimination.
4	Relative likelihood of staff accessing non-mandatory training and CPD.	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff 1.53 greater	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff 0.97	This data indicates an increase 1.43 in the likelihood of White staff accessing non-mandatory training and CPD compared to BME staff.	The BME Colleauge Network is sponored by CEO/BME Champion and will continue to be supported and strengthened in terms of impact of actions (using data and feedback to drvie improvments) and development opporutnties to flourish and succeed. Continue to ensure BME staff feel valued, supported iand engaged in the work of Trust and have an impact

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 25% BME 27%	White 27% BME 29%	A 2% decrease for both White staff and BME staff experiencing bullying, harassment or abuse from patients, relatives or public has occurred since the previous year. However, BME staff experience still remains higher than White staff	Workstream 3 : Zero Tolerance Harassment & Bullying Work stream lead lead by Director of People & organisational Effecvtiveness in partnship with BME Colleauge Netwrok, staff side and staff governors. Understanding, triangulating
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White 22% BME 28%	White 22% BME 21%	Data for White staff experiencing bullying, harassment or abuse from staff has remained same as previous year, where as BME staff have reported a 7% increase since last year and report 6% higher than white staff.	As above Reaffirm at regular intervals the Trust position statement on zero tolerance issued by the CEO. Inclusive leadership Team Leaders learning event 2/11/2018 leaders and BME Network working
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.	White 80% BME 56%	White 75% BME 73%	A 5% increase reported by White staff believing the trust provides equal career opportunities since previous year, however a 17% decrease from BME staff with the overall difference that 24% of BME staff believe this less than White	As above. BME Colleague Network supported by leadership, strenghened and impact to make a difference. Reverse Mentoring for Equality, Diversity & Inclusion is a learning opportunity which enables senior leaders to gain insight from
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 6% BME 14%	White 6% BME 10%	Data for White staff experiencing discrimination from management or colleagues has remained same as previous year, where as BME staff have reported a 4% increase since last year and report 8% higher than white staff.	As above To better understand the issues confronted by our BME staff which will inform the one-day manager training and underpin our WRES action plan.
	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.	White 9.1% BME -4.3%		This data indicates the percentage of BME Voting Board Members is 9.1% compared with the Trust 12.6%	

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 refer to the WRES Technical Guidance for clarification on the precise means for implementing each indicator.

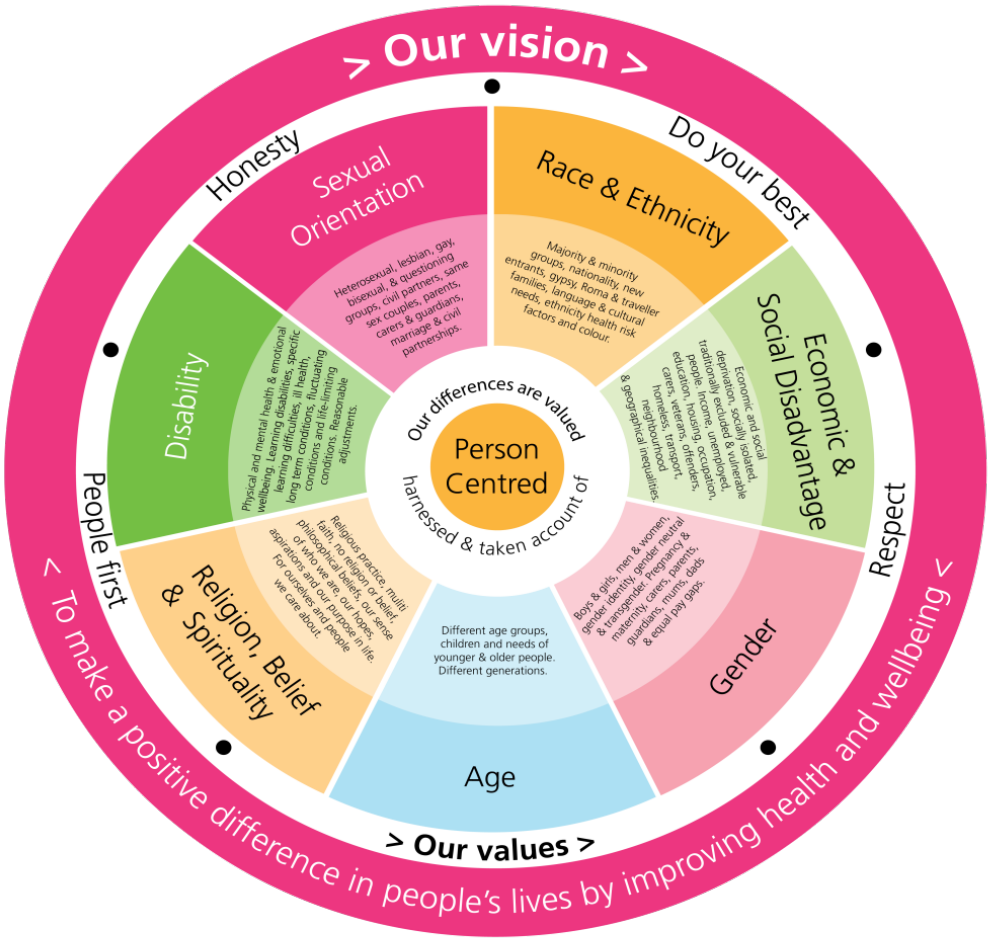
6. Are there any other factors or data which should be taken into consideration in assessing progress?

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

Appendix 3: Refreshed REGARDS poster September 2018

Working with 'Due REGARDS' and respect because everyone matters.



We are all unique and deserve to be treated individually, fairly and with compassion. It is not about trying to treat all people the same but ensuring that everyone receives equal quality and same level of respect, dignity and sensitivity, in a way that meets their own needs. We want everyone to feel confident to be themselves and have a voice.

Using the **REGARDS*** wheel helps us to ensure that we take our values seriously, where diversity is respected, that our behaviours reflect our intent and that our colleagues and our local communities can hold us to account.

For further information please contact: harinder.dhaliwal1@nhs.net

***REGARDS & Protected characteristics** defined under the Equality Act 2010: Race/Ethnicity, Gender/Sex, Gender Reassignment, Age, Religion or belief, Disability, Sexual Orientation, Marriage, Civil Partnership, Pregnancy and Maternity.*

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 September 2018

Staff Engagement: NHS Staff Survey and Pulse Checks

Purpose of Report

The purpose of this paper is to:

- Highlight to the Board of Directors where we are now in relation to the staff feedback received over the past nine months
- Share progress against the focus areas for action for the current year, based on the key themes identified in both the 2017 NHS Staff Survey and Q4 Pulse Check
- Set out the plan for the 2018 NHS Staff Survey
- Present the Board of Directors with the Q1 Pulse Check results and an update in terms of local engagement across services
- Provide an opportunity for the Board of Directors to discuss the above.

Executive Summary

NHS Staff Survey

An update on what has happened/is happening since the 2017 NHS Staff Survey has been included in appendix 1 – which includes highlights around the focus areas: visibility of the Board, raising concerns, staff development and involvement in organisational decisions.

The provisional launch date for our 2018 NHS Staff Survey is on Monday 24 September and will run until midnight on Friday 30 November by our independent contractor Picker Europe. Derbyshire Healthcare will run a full census this year – via mixed mode (mainly electronic, with some staff groups opting for paper surveys).

There have been a number of changes to the national survey this year; however the main one being around the reporting indicators – losing the 32 key findings and replacing them with 10 themes – see report for more details.

Pulse Check

Whilst we have seen a steady incline in some areas, including response rates, there is always work to be done to continue to improve quarter by quarter. Our results show that, over time, we are making gradual but steady improvements in the percentage of people who would recommend the Trust as a place to work and to receive care. Similarly, 3 of the 8 additional questions this quarter show more positive responses, while 2 are unchanged.

During Q1 and Q2 the Organisational Effectiveness Team's main focus has been around the 'engagement pilot' group and identifying and targeting teams which have

never had an engagement score due to a lack of responses. There has also been a focus on increasing the participation rate in low performing teams through understanding barriers, introducing bespoke action plans, with alternative delivery methods, and supporting change and improvement.

Next steps

- Communication and promotion of the latest 'What's happened since the 2017 NHS Staff Survey?' update to all staff
- Launch of the Q2 Pulse Check survey on Monday 3 September – including the additional questions to help inform our Zero Tolerance to Bullying & Harassment initiative
- Ongoing work in service with the 'engagement pilot' plus other bespoke/targeted teams, supported by the new Divisional People Lead role
- Confirm final plans for the 2018 NHS Staff Survey
- Revision of the Pulse Check programme for 2019 to time the quarterly surveys more appropriately, so we have more time to listen to feedback and act on results before the next survey.

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

Assurances

- Ongoing updates to the NHS Staff Survey areas for focus for the year ahead communicated and shared
- Gradual but steady improvements in the percentage of people who would recommend the Trust as a place to work and to receive care
- Increased response rates in both the NHS Staff Survey and quarterly Pulse Check survey
- Plan of action for both organisational and local focus for 2018, including future surveys.

Consultation

We engaged with staff via the Staff Forum and Staff Engagement Group in order to help inform the key focus areas for 2018. Whilst engaging with services to determine the 'engagement pilot' group.

Governance or Legal Issues

The NHS Staff Survey and Staff FFT are NHS England requirements.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks N/A

Recommendations

The Board of Directors are requested to:

1) Receive and review where we are now in relation to the staff feedback received over the past 9 months, including the NHS Staff Survey and Pulse Check results, where key themes have been identified, and are being acted on
2) Approve suggestions (in terms of survey mode) for the 2018 NHS Staff Survey plan
3) Take assurance from next steps and both the organisational and local engagement work happening across the Trust.

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

Report prepared by: **Clair Sanders**
Organisational Effectiveness Lead

Staff Engagement: NHS Staff Survey and Pulse Checks

Section 1 – Background

Engaged staff think and act in a positive way about the work they do, the people they work with and the organisation that they work in. It is also evidenced that staff feedback is associated with patient feedback across a range of measures (Raleigh et al., 2009).

Engaged staff experience a blend of job satisfaction, organisational commitment, involvement in the direction of their own job and a feeling of empowerment. They have a desire to improve the way things are in their organisation, both for themselves, their colleagues and the outcomes of the organisation itself.

Evidence of high staff engagement may also include: improved patient experience, lower accident rates, higher productivity, fewer conflicts, more innovation, lower staff turnover and reduced sickness rates (Powell et al., 2014).

Section 2 – NHS Staff Survey

2017 NHS Staff Survey

Based on a number of avenues – engagement with staff via the Staff Forum, the NHS England data, triangulation with free text comments and the Q4 Pulse Check results – the Trust made every effort to get behind the data this year, listen to what staff are telling us and identify key themes from the results. Following discussion at ELT (on 14 May 2018) it was agreed that the organisation will focus on the following 4 key areas:

1. Visibility of the Board and TMT – particularly in clinical areas
2. Staff feeling confident to raise concerns and that they will be acted on – through multiple channels
3. Fair and equal opportunities for development – via learning/training, promotion/recruitment etc.
4. Staff involvement in decisions made at Derbyshire Healthcare – organisationally and locally

These focus areas were used to inform and develop a bottom-up action plan that sits comfortably with staff and resonates with their priorities of what will make Derbyshire Healthcare the best place to work.

It was suggested that there would be no mandatory organisational requirement for each service to submit an action plan to address the focus areas. Instead, the Organisational Effectiveness Team engaged with GMs/service leaders to ensure they understood the areas of focus and have local plans in place to address them. We believe that ‘one size does not fit all’ so localised planning is the best way to make improvements.

This year communication of updates to the action plan relating to the key focus areas as we progress will be labelled under the following:

- You said, we did…
- You said, we are doing…
- You 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).

Please see appendix 1 for the: *'What has happened since the 2017 NHS Staff Survey?' update*

2018 NHS Staff Survey

The provisional launch date for our NHS Staff Survey is on Monday 24 September and will run until midnight on Friday 30 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.

The following survey modes have been suggested:

Localities (as per ESR)	Survey mode*
Campus	Electronic/paper mix
Central Services	Electronic/paper mix
Centre for Research + Development	Electronic
Children's Services	Electronic/paper mix
Clinical Serv Management	Electronic
Corporate Affairs inc. Comms & Involvement	Electronic
Estates	Electronic
Facilities Group	Paper
Finance & Capital Projects	Electronic
Governance	Electronic
IT, Information Management & Patient Records	Electronic
Medical	Electronic
Neighbourhood	Electronic
Nursing	Electronic
Nursing Management	Electronic
Operations Management	Electronic
Pharmacy	Electronic
Procurement & Contracting	Electronic
Safeguarding	Electronic

Please note –

- There have been further changes to the NHSE Coordination Centre's guidance this year with regards to the confidentiality of reporting and providing response rate updates – 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 few 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.

NHS England questionnaire/reporting changes

Following work from the 2016 and 2017 surveys, there have been changes to the questions relating to morale. These questions now ask about stress and if you are thinking about leaving.

The main change however is to how the national data is presented this year, with an updated set of indicators. The previous 32 key findings will be replaced by 10 themes (below), all of which will be scored on a 0-10 scale.

1. Appraisals & support for development
2. Equality & diversity
3. Health & wellbeing
4. Immediate managers
5. Morale
6. Quality of care
7. Safe Environment - Bullying & harassment
8. Safe Environment - Violence
9. Safety culture
10. Staff engagement

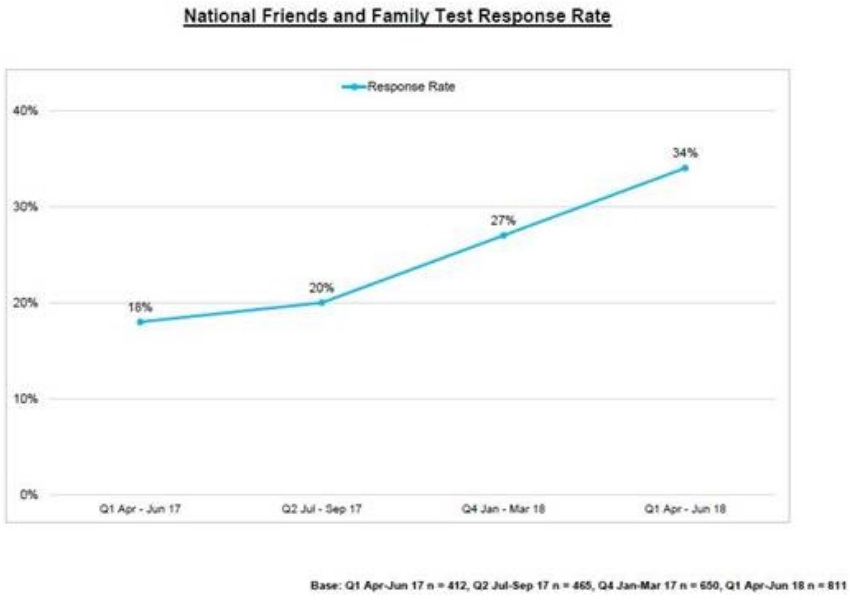
In terms of ongoing communications throughout the survey period - a weekly response rate email will be circulated to all people managers on Mondays, and a headline response rate with any key updates will be included to all staff in the Weekly Connect email.

Section 3 – Derbyshire Healthcare Pulse Check

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 11 – Sunday 30 June 2018, with 34% of our staff completing the survey – our best response rate to date.



Whilst we have seen a steady incline in some areas, including response rates, there is always work to be done to continue to improve quarter by quarter. Our results show that, over time, we are making gradual but steady improvements in the percentage of people who would recommend the Trust as a place to work and to receive care. Similarly, 3 of the 8 additional questions this quarter show more positive responses, while 2 are unchanged (see the table below). This is encouraging – however we are very aware that there is more to do.

Question	Q4 2017/18: Jan – Mar 2018	Q1 2018/19: Apr – Jun 2018	% change
Care of patients/service users is the trust's top priority	80%	77%	-3%
I am able to make suggestions to improve the work of my team/department	78%	79%	+1%
There are frequent opportunities for me to show initiative in my role	74%	73%	-1%
I am able to make improvements happen in my area of work	67%	67%	-
I think that it is safe to speak up and challenge how things are done	62%	61%	-1%

Question	Q4 2017/18: Jan – Mar 2018	Q1 2018/19: Apr – Jun 2018	% change
I look forward to going to work	61%	61%	-
I am enthusiastic about my job	73%	75%	+2%
Time passes quickly when I am working	78%	80%	+2%

Staff Engagement Scores (SES)

The SES is a new measure for Derbyshire Healthcare and will be included each quarter going forward. It is calculated as an average of the three categories below, each of which are each made up of 3 questions from the survey:

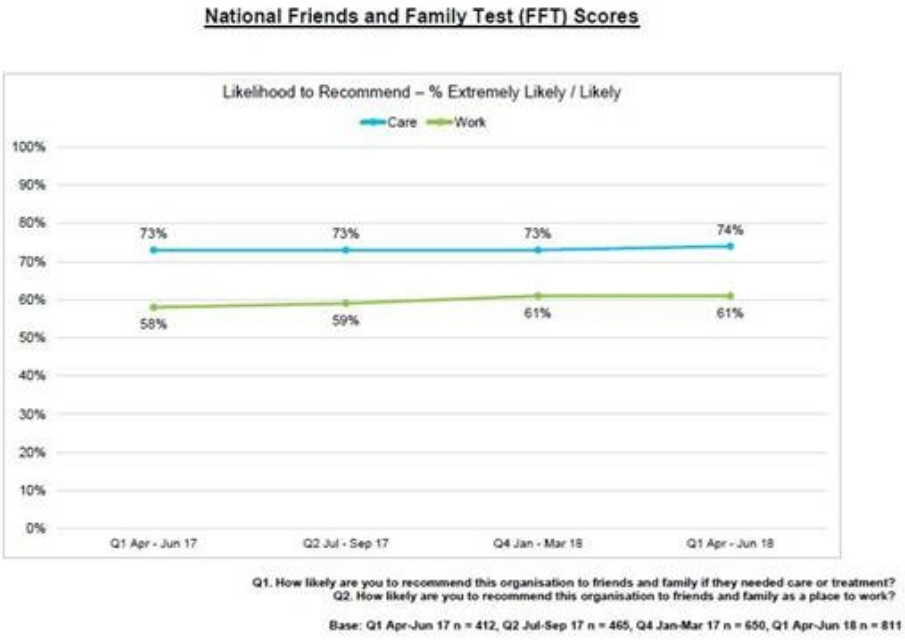
- Advocacy – speak highly of Derbyshire Healthcare
- Involvement – how involved you feel in what happens in your team/department/Derbyshire Healthcare
- Motivation – how much you enjoy your job and being part of the organisation

	Q4 2017/18: Jan – Mar 2018	Q1 2018/19: Apr – Jun 2018
SES	72 (out of 100)	72 (out of 100)

Staff Friends and Family Test (FFT) results

The Staff FFT results focus on 2 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?



Please see appendix 2 for the: *Q1 organisational results summary*
Please see appendix 3 for the: *Q1 detailed breakdown of all questions for all localities*

The Q2 Pulse Check will open on Monday 3 September and run for 3 weeks, closing at midnight on Sunday 23 September 2018. There will be a number of additional questions in this survey, asked as a one-off, focusing on Bullying & Harassment, that we can use as a baseline measure for the Zero Tolerance to Bullying & Harassment initiative we are working on, set to launch on Monday 1 October 2018.

During Q1 and Q2 the Organisational Effectiveness Team have initially been identifying and targeting teams which have never had an engagement score due to a lack of responses, but do have the team number to be able to produce results in theory. There has also been a focus on increasing the participation rate in low performing teams through understanding barriers, introducing bespoke action plans, with alternative delivery methods, and supporting change and improvement.

Local engagement initiatives

The Organisational Effectiveness Team undertook a thorough analysis to identify the 10 most (METs) and least (LETs) engaged teams in the organisation (according to the Q4 Pulse Check data). The first step was to work with the LETs in Q1 to utilise technology to increase response rates to get a true picture of feeling across these teams; then use the latest results to establish if the engagement in these areas still correlates when we had a fuller picture via the whole team responding.

It was suggested that these 20 targeted teams remained anonymous to the wider organisation, and were just be referred to as part of an engagement pilot. It is worth noting that these scores are based on the number of staff who answered the survey in those areas.

Please see appendix 4 for the: *most and least engaged teams (METs and LETs) Q1 update*

A comprehensive triangulation exercise is now underway to help us better understand the areas and begin to work with the Divisional People Leads (DPLs – formally HR Business Partners) to target, create and executive our staff engagement plan, including targeted OD interventions, to work with and support these teams (if still appropriate) over the remainder of the financial year. Immediate next steps in process are:

- Working with the Workforce Systems & Information Team to triangulate data against teams' sickness absence, retention and training compliance etc.
- OE Team to meet individually with the 10 LETs to firstly understand the results through a series of focus groups, then work with the GMs and DPLs to develop action plans - targeted OD interventions, supported by the Staff Wellbeing Team – for the remainder of the financial year
- Work with the METs to understand what they do well to share best practice across the organisation via engagement initiatives such as: case studies (paper, online and vlog).
-

Section 4 – Next Steps

The Organisational Effectiveness Team will work closely with services over the next 6 months and monitor progress at set touch points throughout the year using the Pulse Check and Staff FFT surveys.

Both organisational and local themes will now also be triangulated with wider feedback from other staff engagement channels captured via the Communications and Involvement Team, so we have a fuller picture of what's happening across the Trust.

Immediate actions –

- Communication and promotion of the latest 'What's happened since the 2017 NHS Staff Survey?' update to all staff (appendix 1)
- Launch of the Q2 Pulse Check survey – including the additional questions to help inform our Zero Tolerance to Bullying & Harassment initiative
- Ongoing work in service with the 'engagement pilot' plus other bespoke/targeted teams, supported by the new Divisional People Lead role
- Confirm final plans for the 2018 NHS Staff Survey – provisionally due to launch to all staff across Derbyshire Healthcare on Monday 24 September
- Revision of the Pulse Check programme for 2019 to time the quarterly surveys more appropriately, so we have more time to listen to feedback and act on results before the next survey.

It is proposed that progress on all action areas is reported bimonthly to People and Culture Committee, then fed through to the Trust Management Team.

Appendix 1: NHS Staff Survey – 'What has happened since the 2017 NHS Staff Survey?' update

Appendix 2: Pulse Check – Q1 organisational results summary

NHS
Derbyshire Healthcare
NHS Foundation Trust

Staff Friends and Family Test

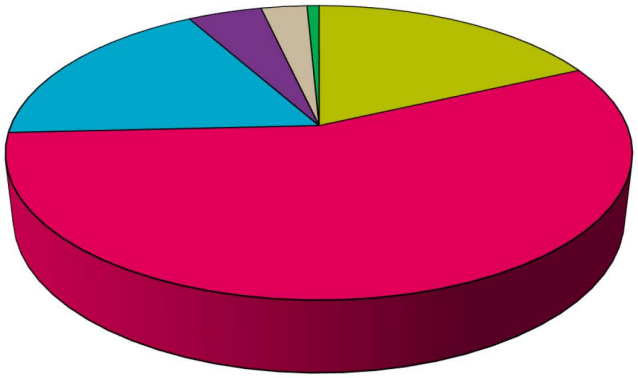
Q1 2018/19

Derbyshire Healthcare NHS Foundation Trust

Picker

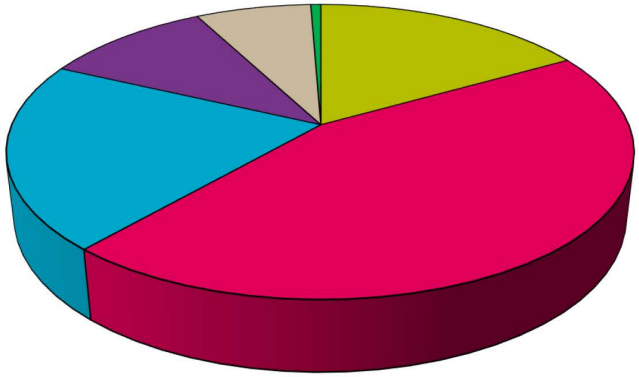
How likely are you to recommend your organisation to friends and family if they needed care or treatment?

Base	811	
Extremely Likely*	147	18%
Likely*	455	56%
Neither likely nor unlikely	143	18%
Unlikely	37	5%
Extremely Unlikely	23	3%
Don't Know	6	1%



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

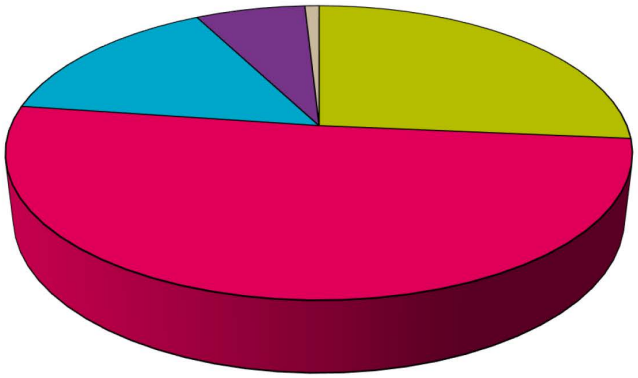
Base	804	
Extremely Likely*	135	17%
Likely*	359	45%
Neither likely nor unlikely	165	21%
Unlikely	83	10%
Extremely Unlikely	57	7%
Don't Know	5	1%



Picker

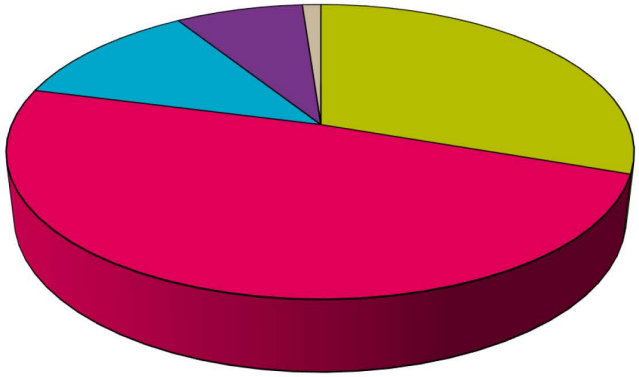
Care of patients/service users is Derbyshire Healthcare NHS Foundation Trust's top priority.

Base	799	
Strongly agree*	211	26%
Agree*	406	51%
Neither agree nor disagree	121	15%
Disagree	54	7%
Strongly disagree	7	1%



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

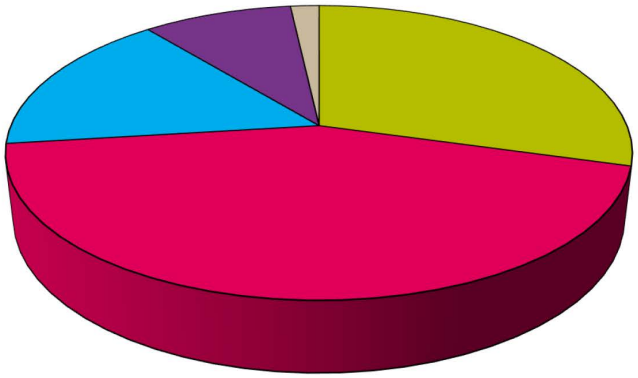
Base	792	
Strongly agree*	240	30%
Agree*	386	49%
Neither agree nor disagree	95	12%
Disagree	62	8%
Strongly disagree	9	1%



Picker

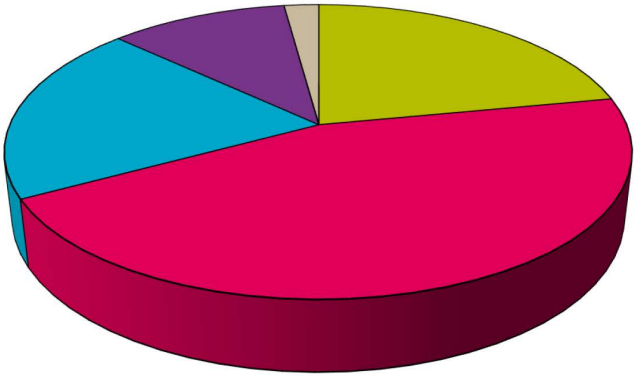
There are frequent opportunities for me to show initiative in my role.

Base	794	
Strongly agree*	233	29%
Agree*	347	44%
Neither agree nor disagree	127	16%
Disagree	73	9%
Strongly disagree	14	2%



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

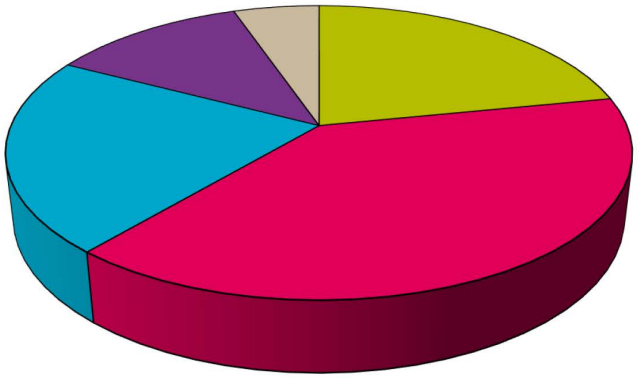
Base	796	
Strongly agree*	175	22%
Agree*	359	45%
Neither agree nor disagree	158	20%
Disagree	87	11%
Strongly disagree	17	2%



Picker

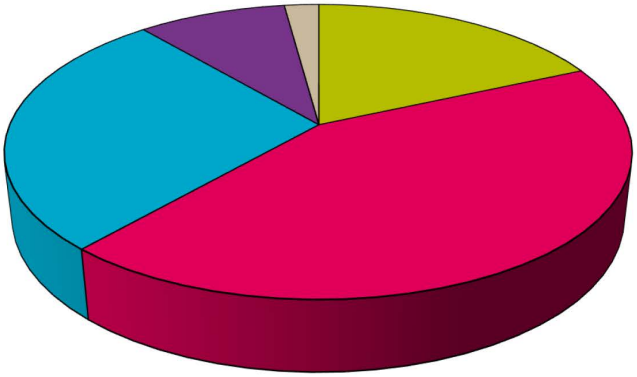
I think that it is safe to speak up and challenge how things are done

Base	796	
Strongly agree*	174	22%
Agree*	313	39%
Neither agree nor disagree	171	21%
Disagree	96	12%
Strongly disagree	42	5%



I look forward to going to work.

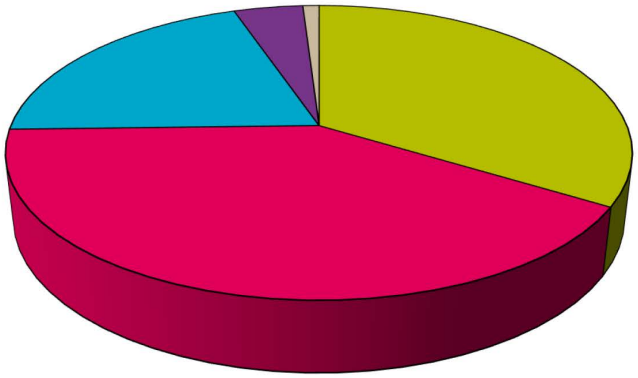
Base	803	
Always*	147	18%
Often*	346	43%
Sometimes	219	27%
Rarely	73	9%
Never	17	2%



Picker

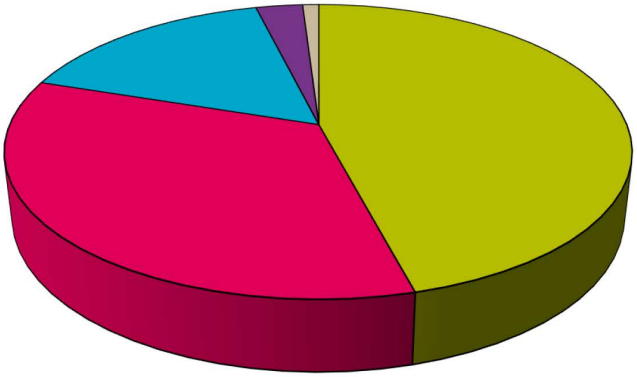
I am enthusiastic about my job.

	Base	799	
	Always*	269	34%
	Often*	327	41%
	Sometimes	161	20%
	Rarely	34	4%
	Never	8	1%



Time passes quickly when I am working.

	Base	802	
	Always*	368	46%
	Often*	274	34%
	Sometimes	129	16%
	Rarely	23	3%
	Never	8	1%



Picker

Appendix 3: Pulse Check - Q1 detailed breakdown of all questions for all localities

Locality 1

	Responses	Response Rate	How likely are you to recommend your organisation to friends and family if they needed care or treatment?	How likely are you to recommend your organisation to friends and family as a place to work?	Care of patients/service users is Derbyshire Healthcare's top priority.	I am able to make suggestions to improve the work of my team / department.	There are frequent opportunities for me to show initiative in my role.	I am able to make improvements happen in my area of work.	I think that it is safe to speak up and challenge how things are done	I look forward to going to work.	I am enthusiastic about my job.	Time passes quickly when I am working.
Derbyshire Healthcare NHS Foundation Trust	811	34%	74%	61%	77%	79%	73%	67%	61%	61%	75%	80%
Campus	130	21%	66%	57%	74%	73%	66%	61%	48%	52%	69%	73%
Capital Projects	4	80%	*	*	*	*	*	*	*	*	*	*
Central Services	150	37%	69%	57%	71%	78%	68%	62%	50%	57%	72%	74%
Centre for Research + Development	8	44%	88%	75%	100%	75%	88%	75%	50%	63%	88%	63%
Children's Services	128	33%	77%	63%	83%	80%	69%	64%	63%	61%	71%	83%
Clinical Serv Management	18	62%	83%	89%	89%	100%	94%	100%	83%	83%	83%	94%
Communications & Involvement	5	83%	100%	80%	80%	100%	80%	80%	80%	80%	80%	100%
Corporate+ Legal Affairs	16	89%	100%	75%	94%	88%	88%	80%	81%	75%	94%	94%
Estates	6	29%	67%	50%	50%	33%	33%	33%	33%	50%	33%	67%
Facilities Group	36	25%	97%	71%	91%	63%	73%	64%	74%	74%	82%	88%
Finance (L3)	18	82%	89%	83%	94%	100%	100%	100%	94%	78%	89%	89%
FM Group	1	100%	*	*	*	*	*	*	*	*	*	*
Governance	16	62%	63%	56%	75%	93%	88%	81%	63%	69%	75%	81%
IT, Information Management & Patient Records	32	84%	78%	72%	84%	87%	84%	78%	72%	66%	81%	81%
Medical	8	35%	38%	88%	63%	88%	86%	63%	38%	75%	100%	100%
Neighbourhood	187	34%	74%	59%	74%	79%	76%	68%	60%	61%	75%	80%
Nursing	6	86%	83%	83%	100%	100%	100%	100%	83%	67%	83%	100%
Nursing Management	7	54%	86%	86%	86%	100%	100%	86%	86%	86%	86%	86%
Operations Management	4	100%	*	*	*	*	*	*	*	*	*	*
Pharmacy	18	53%	61%	28%	56%	50%	33%	39%	41%	50%	61%	78%
Procurement & Contracting	10	91%	80%	44%	70%	90%	90%	70%	78%	60%	90%	90%
Safeguarding	2	40%	*	*	*	*	*	*	*	*	*	*
Workforce OD	1	100%	*	*	*	*	*	*	*	*	*	*

Appendix 4: Pulse Check - most and least engaged teams (METs and LETs) Q1 update

TEAMS			RESPONSE RATES			STAFF ENGAGEMENT SCORES			LOCALITY INFORMATION	
Most Engaged Team	Eligible	Completed	Q4 2017-18	+/-	Q1 2018-19	Q4 2017-18	+/-	Q1 2018-19	Locality 1	Locality 2
Trust Board (CORP) (G63101)	7	7	100%	⇨	100%	98	↓	89	Corporate+ Legal Affairs	Corporate+ Legal Affairs (L4)
Specialist Services Management (OSER) (G61801)	8	6	75%	↓	67%	96	⇨	96	Clinical Serv Management	Clinical Serv Management (L4)
Liaison Team North (OSER) (G61389)	20	7	35%	↓	32%	94	↓	90	Campus	Assessment Services (L4)
UPC Management (OSER) (G61151)	15	9	60%	↑	69%	90	↓	87	Clinical Serv Management	Clinical Serv Management (L4)
Health & Safety (N&Q) (G62505)	7	6	86%	⇨	86%	87	↓	78	Governance	Governance (L4)
Finance (FIN) (G63201)	23	21	91%	↓	82%	87	↑	91	Finance (L3)	Finance + Pfi (L4)
IAPT (OSER) (G61465)	79	22	28%	↑	33%	87	↓	84	Central Services	Psychological Therapies
Nursing and Operations Management (N&Q) (G62476)	12	6	50%	↑	58%	83	↑	89	Nursing Management	Nursing Management (L4)
LRCH Ward 1 OP 'IP' (OSER) (G61726)	34	10	29%	↓	18%	81	↓	69	Campus	Kingsway Campus
Information Technology Department (OSUP) (G62027)	24	17	71%	↑	82%	81	↑	82	IT, Information Management & Patient Records	IT, Information Management & Patient Records (L4)

Least Engaged Team	Eligible	Completed	Q4 2017-18	+/-	Q1 2018-19	Q4 2017-18	+/-	Q1 2018-19	Locality 1	Locality 2
RDH Ward 35 Adult Acute Inpatient 'IP' (OSER) (G61108)	32	5	16%	↓	15%	20	↓	0	Campus	Radbourne Campus
Sth DD Neighbourhood - Adult (OSER) (G64029)	22	7	32%	↑	36%	41	↑	50	Neighbourhood	County South Neighbourhood
Human Resources Dept (WODC) (G62000)	20	12	60%	-	-	53	-	-	Human Resources	Human Resources (L4)
Early Access (OSER) (G61448)	22	8	36%	↓	22%	54	↑	56	Children's Services	CAMHS
Kingsway Cubley Court OP Male 'IP' (OSER) (G61731)	40	13	33%	↓	10%	56	↓	0	Campus	Kingsway Campus
Kingsway Cubley Court OP Female 'IP' (OSER) (G61734)	37	6	16%	↑	24%	57	↑	61	Campus	Kingsway Campus
Patient Records (OSUP) (G62035)	8	7	88%	↑	90%	59	↑	71	IT, Information Management & Patient Records	IT, Information Management & Patient Records (L4)
Pharmacy (OSUP) (G62750)	36	18	50%	↑	53%	60	↓	51	Pharmacy	Pharmacy (L4)
Kedleston Low Secure Unit 'IP' (OSER) (G61053)	40	13	33%	↓	19%	61	↑	77	Campus	Kingsway Campus
Psychology Neighbourhood (OSER) (G64009)	32	16	50%	↑	53%	62	↑	67	Neighbourhood	Neighbourhood (L4)

References

- *Raleigh, V. S., Hussey, D., Seccombe, I., and Qi, R. (2009). Do associations between staff and inpatient feedback have the potential for improving patient experience? An analysis of surveys in NHS acute trusts in England. Quality and Safety in Health Care. 18 (5), p347–354.*

- *Powell, M., Dawson, J., Topakas, A., Durose, J., & Fewtrell, C. (2014). Staff satisfaction and organisational performance: evidence from a longitudinal secondary analysis of the NHS staff survey and outcome data. Southampton (UK): NIHR Journals Library.*

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 September 2018

Board Assurance Framework (BAF)
Second issue for 2018/19

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the second issue of the BAF for 2018/19.

Executive Summary

- The headline risks for the 2018/19 BAF, considered by the Board in March 2018, have been fully worked up by Executive Directors and now detail assurances and controls, gaps and actions.

- Eleven risks are currently identified in the BAF for 2018/19.

- Two risks continue to be rated as extreme in terms of risk to achievement of the Trust's strategic objectives. These are: 18_19 3a Delivery of financial plan; and 18_19 4a Retention, development and attraction of staff. The remaining nine are currently rated as high risk.

- There have been no changes formally agreed by the relevant Board Committees in relation to the overall rating of BAF risks since the first issue of the BAF to Board in March 2018. However there is a continuing focus on ensuring appropriate actions to mitigate risks are identified and to scrutinise, evaluate and challenge risk ratings. It is the expectation that completion of identified actions will result in reduced risk ratings and we continue to work with Executive Leads to ensure appropriate mitigating actions are identified with timeframes and milestones for delivery.

- Due to the gap between the BAF being considered by the Audit and Risk Committee and Board, the following items have been discussed in relevant committees and subject to formal scrutiny and challenge, will be included in the next iteration of the BAF.

    - Risk 1b was reviewed by the Mental Health Act Committee Operational Group in August 2018. They have proposed to the Mental Health Act Committee taking place in September 2018 that the risk be reduced from high to moderate, due to the significant progress with increasing compliance, evidenced through audits and compliance checks and improved training compliance

    - Following discussion at ELT (Executive Leadership Team) in July 2018 regarding recent operational issues including increased use of out of area beds, the Chief Operating Officer will consider if the risk rating for BAF risk 4d (patient flows) should be increased in Issue 3. This will be discussed by

the Finance and Performance Committee as part of its review of BAF risks.

- In the BAF oversight report to the Quality Committee in August 2018, emerging risks were identified in relation to impact of change of the redesigned learning disability pathway on the existing workforce; and lack of connectivity from some children's teams with Trust Board and Trust communications.

- In addition, the BAF will be revised to include the 100 Day Improvement Plan.

All will be considered as part of the next cycle of review of BAF risks for Issue 3 of the BAF.

- Due to the timing of this issue of the BAF being presented to Board, the formal review of the risks with the relevant Executive Directors was undertaken back in June 2018 so some of the review dates for actions are showing as passed. This will be addressed with the BAF risk review meetings with Directors arranged for early September 2018.

- A recommendation (3) of the Deloitte phase 3 Well Led governance review was to expand the BAF to include information on mitigating actions for all high and extreme rated operational risks. This detail has therefore been included in this second issue of the BAF and as per the recommendation, will be included again in issue four. Where updates have been included on Datix since the BAF was last considered by the Audit and Risk Committee, this detail has been included.

- The Deep Dive programme for review of risks by Board Committees has been developed and agreed with Executive Directors. This programme is included for information.

- The BAF risks for the responsible Board Committees continue to be presented at the start of each agenda in order to drive the Committee agenda. Reflection of any required changes to the BAF, following discussion of agenda items, remains as a standing item.

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

Assurances

This paper provides an update on all Board Assurance risks and provides assurance on the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives

Consultation

Individual Executive Directors – during May/June 2018

Executive Leadership Team – 25 June 2018

Audit and Risk Committee – 17 July 2018

Governance or Legal Issues

Governance or legal implications relating to individual risks are referred to in the BAF itself.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

Specific elements within each BAF risk and associated actions are addressed by the relevant lead Executive Director in taking forward, for example clear policies and procedures are in place to ensure equality of access in all recruitment processes as outlined under Risk 18_19 4a (retain, develop and attract). As part of the review cycle for the BAF (issue 3) we are to focus on impact on those with protected characteristics to further evidence and provide assurance that any barriers are identified and addressed.

Recommendations

The Board of Directors is requested to:

1. Agree and approve this second issue BAF for 2018/19 and the significant assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives
2. Agree the inclusion of the summary of mitigation for current high/extreme

operational risks and the format presented in response to the Deloitte Well Led recommendation
3. Agree the plan for completion of BAF 'Deep Dives' during 2018/19.

Report presented by: **Samantha Harrison**
Director of Corporate Affairs

Report prepared by: **Samantha Harrison**
Director of Corporate Affairs

Rachel Kempster
Risk and Assurance Manager

Board Assurance Framework

Second issue for 2018/19

The Board Assurance Framework (BAF) is a high level report which enables the Board of Directors to demonstrate how it has identified and met its assurance needs, focused on the delivery of its objectives and subsequent principal risks. The BAF provides a central basis to support the Board's disclosure requirements with regard to the Annual Governance Statement (AGS), which the Chief Executive signs on behalf of the Board of Directors, as part of the statutory accounts and annual report.

This is the second formal presentation of the Board Assurance Framework to the Board of Directors for 2018/19.

1) Overview and movement of risks 2018/19

A summary of all risks currently identified in the 2018/19 BAF is shown below. Movement of these risks will be added as the year progresses

BAF ID	Risk title	Director Lead	Risk rating Q1	Risk rating Q2	Risk rating Q3	Risk rating Q4	Direction of movement
18_19 1a	Failure to provide safety and quality standards	Director of Nursing and Patient Experience	HIGH (4x4)	HIGH (4x4)			
18_19 1b	Failure to provide full compliance with the Mental Health Act (MHA) and the Mental Capacity Act (MCA)	Medical Director	HIGH (4x4)	HIGH (4x4)			
18_19 1c	Failure to develop systems and processes to deliver physical health care for patients	Medical Director	HIGH (4x4)	HIGH (4x4)			
18_19 1d	Failure to redesign the Care Programme Approach processes	Director of Nursing and Patient Experience	HIGH (4x4)	HIGH (4x4)			
18_19 2a	Risk that we do not engage our workforce to experience aims and values of the Trust	Director of People and Organisational Effectiveness	HIGH (4x4)	HIGH (4x4)			
18_19 3a	Delivery of financial plan	Director of Finance	EXT (4x5)	EXT (4x5)			
18_19 3b	Failure to influence Joined Up Care Derbyshire	Director of Business Improvement and Transformation	HIGH (4x4)	HIGH (4x4)			
18_19 4a	Unable to retain, develop and attract staff in specific teams	Director of People and Organisational Effectiveness	EXT (4x5)	EXT (4x5)			
18_19 4b	Failure to gain confidence of staff re the electronic patient record	Chief Operating Officer	HIGH (4x4)	HIGH (4x4)			
18_19 4c	Unable to introduce new workforce models and provide training to reskill staff	Director of People and Organisational Effectiveness	HIGH (4x4)	HIGH (4x4)			
18_19 4d	There is a risk that the Trust will not improve the flow of patients through our services	Chief Operating Officer	HIGH (4x4)	HIGH (4x4)			

There have been no changes to the overall current rating of BAF risks since the first issue of the BAF in March 2018.

2) Deloitte phase 3 recommendation

The Deloitte report[1] raised that the Trust has a Risk Assurance and Escalation report received by the Senior Assurance Group, Trust Management Team, Audit and Risk Committee and Quality Committee and that this is helpful in describing divisional risk profile, new high scoring risks and detail of risks rated high and extreme, but that it is unusual that the Board does not receive this alongside the BAF to provide a greater focus on mitigating actions.

The recommendation from the report is for the Trust to:

> 'Expand the existing Risk Assurance and Escalation Report so that information on mitigating actions is included for all open high and extreme-rated risks. This report should be received by the assurance committees alongside the BAF, and also by the Board (for information) on a six-monthly basis.'

To meet this requirement the previously summarised operational risk information included at the bottom of each BAF risk has been expanded to include a details of controls, mitigating actions and the date the risk is next due for review. This is to allow a line of sight between risks being raised by operational services through the Datix risk register, and the risks to achievement of strategic objectives identified by the Board, which are detailed in the BAF. It is recognised that some operational risks relate to a number of BAF risks, but to prevent repetition they are only included once in the attached BAF document.

There are currently three operational risk rated as extreme:

- 21223 in relation to dysphagia referrals
- 21274 in relation to staff levels on Ward 36. This has recently been increased from a high to extreme risk
- 21459 in relation to inadequate staffing in the City and South County Crisis Resolution and Home Treatment Team. This new risk was added to Datix on 30/07/2018, so has not been included on Issue 2 of the BAF document itself.

The Trust has a mechanism in place to ensure all risks are reviewed regularly. An update date (when the last review of the risk was undertaken) and a summary of progress are shown for each risk.

In line with the Deloitte recommendation, it is proposed that this level of detail be included again alongside the Fourth Issue of the BAF.

3) Deep dives 2018/19

'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

[1] DHCFT Review of Governance Arrangements. Deloitte. 12 January 2018

2018/19, agreed with Executive Directors, is shown below. The deep dive for risks with a residual risk rating of extreme will continue to be undertaken by the Audit and Risk Committee. The responsible committee for these risks is also shown (in brackets).

The current plan for BAF Deep Dives for 2018/19 is shown below. Those that have been completed are highlighted:

Risk ID	Subject of risk	Director Lead	Committee
18_19 1a	Safety and quality standards	Carolyn Green	Quality Committee July 2018 Completed
18_19 1b	MHA/MCA Compliance	Dr John Sykes	Mental Health Act Committee: September 2018
18_19 1c	Physical healthcare compliance	Dr John Sykes	Quality Committee September 2018
18_19 1d	CPA approach	Carolyn Green	Quality Committee October 2018
18_19 2a	Staff engagement	Amanda Rawlings	People and Culture Committee October 2018
18_19 3a	Financial plan	Claire Wright	Audit and Risk Committee (Finance and Performance Committee) January 2019
18_19 3b	Influence 'Joined Up Care Derbyshire'	Gareth Harry	Finance and Performance Committee September 2018
18_19 4a	Staff retention, recruitment and development	Amanda Rawlings	Audit and Risk Committee (People and Culture Committee) July 2018 Completed
18_19 4b	Electronic Patient Record	Mark Powell	Quality Committee December 2018
18_19 4c	Workforce model and training to reskill staff	Amanda Rawlings	People and Culture Committee December 2018
18_19 4d	Improve flow of patients	Mark Powell	Finance and Performance Committee January 2019

Guidance on contents for deep dive presentations has been reviewed and recirculated to all Executive Directors.

Summary Board Assurance Framework Risks 2018/19. Issue 2.3

Ref	Principal risk	Director Lead	Current rating (Likelihood x Impact)
Strategic Objective 1. Quality Improvement			
18_19 1a	There is a risk that the Trust will fail to provide standards for safety and quality required by our Board, as set out in the Health and Social Care Act 2009 and measured through the CQC's regulatory process	Executive Director of Nursing and Patient Experience	HIGH (4x4)
18_19 1b	There is a risk that the Trust will fail to provide full compliance with the Mental Health Act (1983) and Mental Capacity Act (2005)	Medical Director	HIGH (4x4)
18_19 1c	There is a risk that the Trust will fail to develop systems and processes to deliver safe and effective physical health care for patients	Medical Director	HIGH (4x4)
18_18 1d	There is a risk that the Trust will fail to redesign the Care Programme Approach processes, which may impact upon the quality of care provided to patients and their carers	Executive Director of Nursing and Patient Experience	HIGH (4x4)
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 & wellbeing of staff which may affect the safety and quality of patient care	Director of People and Organisational Effectiveness	HIGH (4x4)
Strategic Objective 3. Financial Sustainability			
18_19 3a	There is a risk that the Trust fails to deliver its financial plans	Executive Director of Finance	EXTREME (4x5)
18_19 3b	There is a risk that the Trust fails to influence Joined Up Care Derbyshire (the 'system') to effectively engage in enhancing service models for children, and people with mental health problems, learning disabilities, or issues with substance misuse	Director of Business Improvement and Transformation	HIGH (4x4)
Strategic Objective 4.Operational Delivery			
18_19 4a	There is a risk that the Trust will not be able to retain, develop and attract enough staff in specific teams to deliver high quality care	Director of People and Organisational Effectiveness	EXTREME (4x5)
18_19 4b	There is a risk that the Trust will fail to gain the confidence of staff to maintain a modern and effective electronic patient record system	Chief Operating Officer	HIGH (4x4)
18_19 4c	There is a risk that the Trust will be unable to meet the needs of patients by not introducing new workforce models and provide sufficient training to reskill staff.	Director of People and Organisational Effectiveness	HIGH (4x4)
18_19 4d	There is a risk that the Trust will not improve the flow of patients through our services	Chief Operating Officer	HIGH (4x4)

Board Assurance Framework Risks 2018/19 v 2.3

Strategic Outcome 1. Quality Improvement

Principal risk:

Risk: **There is a risk that the Trust will fail to provide standards for safety and quality required by our Board, as set out in the Health and Social Care Act 2009 and measured through the CQC's regulatory process**

Impact: May lead to harm, 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

BAF ref:	**Director Lead**: Carolyn Green, Executive Director of Nursing and Patient Experience	**Responsible Committee**: Quality Committee	Datix ID:
18_19 1a			21287

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 – Quality governance structures, teams and processes to identify quality related issues; Implementation of Safe Wards programme; Induction and mandatory training; 'Duty of Candour' processes; clinical audits and research, health and safety audits and risk assessments.

Detective – Quality dashboard reporting; Quality visit programme (including commissioner involvement); Incident, complaints and risk investigation and learning - including monitoring actions plans; Annual Training Needs Analysis; HoNoS clustering; FSR compliance checks; mortality review process

Directive – Quality Framework (Strategy) outlining how quality is managed within the Trust. New Quality Improvement Strategy. Policies and procedures available via Connect; CAS alerts

Corrective – Board committee structures and processes ensuring escalation of quality issues; Annual skill mix review; CQC and GIAP action plans; Incident investigation and learning; 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):

Operational risk information extracted from Datix 18 06 18_updated 13 08 18

Board Assurance Framework Risks 2018/19 v 2.3

Quality dashboard Scrutiny of Quality Account (pre-submission) by committees and governors	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 and 12/58 for effectiveness CQC comprehensive review identified 4 services rated as 'good' for safety KPMG 2016/17 and 2017/18 BAF and Risk Register Reviews - Schedule 4/6 analysis and scrutiny by commissioners

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Fully implemented quality priorities and Quality Improvement Strategy	Roll out of actions in relation to the current quality priorities and Quality Improvement Strategy including a training needs analysis and full implementation plan [ACTION OWNER: DBI&T]	30/09/2018	Quality priorities are required outcomes of quality visits, programme commenced to be completed by Sept 2018. Full training needs analysis in development, to be completed by Aug 2018. Quality Improvement ELearning now available. Implementation plan for Quality Improvement Strategy commenced.	Medium
Commissioner commitment to invest in mental health and children's services. Role of primary care models underdeveloped in Derbyshire.	Commissioner lobbying and provision of evidence to support need to increase funding or to provide an alternative strategic plan [ACTION OWNER DON]	31/12/2018	Position statement on PLACE based care in development with Commissioners, anticipated for Aug 2018.	Low ⇩
Lack of effective forensic clinical service pathway following prison release. Release of IPP prisoners (indeterminate imprisonment for public protection) increases risks.	Recruit to and operationalise community forensic team, following funding settlement [ACTION OWNER:COO] Recruit to and operationalize additional investment in Neighbourhoods and Crisis service [ACTION OWNER:COO]	30/09/2018	Recruitment of community forensic team underway, team to be in place by Sept 2018. Neighbourhood staff in place. Recruitment of crisis staff underway, to be operational by Sept 2018.	Low ⇩
Non commissioned services for Derbyshire based PICU beds and CAMHS Tier 4 beds	Improvement plan with commissioners in place for CAMHS rise and HTT model [ACTION OWNER COO]	30/09/2018	Recruitment underway, to be in place by Sept 2018.	Medium ⇩
Early warning signs of service failure and independent service modelling	Implement QUESTT. Explore and commission remodelling exercise of community mental health services and inpatient beds [ACTION OWNER DBI&T]	31/07/2018	Mapping underway, final hierarchy to be agreed by July 2018.	Medium
Fully embedded Clinical and Operational Assurance Teams	Embed CPD and complete development work for COATs [ACTION OWNER COO]	31/07/2018	Training plan to be rolled out by July 2018. Leadership and Management Development Strategy developed. Wider organisational involvement to follow, with plan for priorities to be agreed for 2018/19 by end July 2018	Medium
Gap in knowledge and competence in relation to treatment of autism and support in complex cases	Implement clinical quality improvements as identified in Schedules 4 and 6 in autism treatment during 2018/19 [ACTION OWNER DON]	31/07/2018	Lead psychologist identified to lead the development of a clinical strategy for autism	Medium ⇩
Clinical buy in to review NICE guidelines	To be evidenced through compliance with quality priorities assessed during Quality Visit programme	31/10/2018	NICE Steering Group to oversee results from Quality Visit programme with respect to compliance with NICE	Medium

Operational risk information extracted from Datix 18 06 18_updated 13 08 18

	[ACTION OWNER DON]			
Full compliance with Trust strategy to be 'smoke free'	Further develop improvement plan with ward teams to prevent smoking on inpatient wards to reduce risks of potential fire if smoking in undesignated areas [ACTION OWNER DON]	30/09/2018	Fire officer and FRESH committee to work on safety improvements to ensure staff feel safe and confident to challenge smoking in ward areas safely and effectively. Impact monitored through incident reporting processes.	Medium
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Effective plan for comprehensive re-inspection 2018 and embedding any learning and findings	Lead Trust wide plan and fully implement CQC actions plan established in 2018, with subsequent plan to raise all services identified as requires improvement [ACTION OWNER DON]	31/10/2018	Remaining two actions completed. CQC 2018 new actions following Cubley Male inspection are in design with the team and corporate services and connect with PARIS record keeping and capital investment in equipment. Funding confirmed report on progress planned for July 2018 Quality committee	High ⇧
Effective plan to ensure ability to achieve quality priorities, CQUIN and Non CQUIN targets including 'Sign Up to Safety' and 'Always Events' campaigns	Implement CQUIN action plan for 2018/19, and action plans for 'Sign up to safety' and 'Always Event' campaigns [ACTION OWNER DON]	31/07/2018	Further success achieved against Q4 17/18 target. Quality and financial plan to be realigned as a result. 2018/19 milestones are continuation of previous year, A&E repeat attenders target already improved.	Low ⇩
Lack of clinical strategies with Divisional areas.	Recovery and enablement, substance misuse and Co-existing substance misuse and then Eating Disorders [ACTION OWNER DON]	30/09/2018	First planning meeting with clinical leads. Expecting substance misuse clinical strategy to be in place by Sept 2018.	Medium
Evidence to support sexual safety of patients is maintained across inpatient areas	Identify issues re sexual safety of patients in inpatient areas and develop a plan to improve where gaps are identified [ACTION OWNER DON]	30/09/2018	Scoping and developments paper considered by Safeguarding Committee May 2018. Further analysis of incidents underway. Sexual safety strategy and improvement plan to follow by Sept 2018	Medium
Compliance with NQB Learning from Deaths guidance, particularly in relation to capacity of Trust to undertake timely case record reviews	Increase availability of medical staff to complete case record reviews. Agree and submit application for access to NHS Digital. Build dashboard to monitor learning from deaths [ACTION OWNER MD].	30/09/2018 30/09/2018 Complete	Deputy Medical Director leading work to increase medical availability through reviews of job planning, and use of higher trainee doctors Application submitted April 2018. Legal basis for access being negotiated with NHS Digital. Dashboard built and in place on Connect with limited confidential access and Trust facing data summary available to all staff.	Low
Full compliance with safe use of medicines, with breaches still continuing to be identified.	Improvement plan in place to deliver compliance with medicines management code, including implementation of the Medicines Optimisation Strategy [ACTION OWNER MD]	30/09/2018	Implementation plan for Medicines Optimisation Strategy due to ELT Sept 2018. TMT to receive updated dashboard every quarter from Sept 2018. Analyse learning from breaches and share across the trust to reduce errors and improve compliance.	Medium
Achievement of required levels of compliance with mandatory and role specific training	Increase compliance with mandatory and role specific training requirements [ACTION OWNER COO]	30/09/2018	TMT overseeing performance improvement	Medium
Timely completion of actions following serious incidents and complaints	Increase focus on completion of outstanding actions led by operational managers {ACTION: COO]	31/08/2018	Plan to ensure completion of outstanding actions being led by Chief Operating Officer	Medium

Operational risk information extracted from Datix 18 06 18_updated 13 08 18

			Process review in Datix completed to improve clarity around managerial ownership of actions	

Related operational high/extreme risks:

ID	Division	Title	Description	Controls in place	Mitigating actions	Date of next review
3385	Neighbourhood Services	Waiting Times for Psychological Assessment and Intervention	Long waits across areas of the neighbourhood for psychological assessments.	Use of waiting list policy and prioritisation of urgent cases. Use of a supervision/consultation model to reduce number of referrals Action from TMT to review number of individual contacts.	05/06/18 update: Actions outlined still in operation. The activity project is underway and due to be completed in July 18 for discussion at TMT. This risk has been reviewed in May 18 COAT and agreed that it should remain with same risk level.	31/08/2018
21106	Children's Services: Universal and Specialist Community Services	Sexual Abuse Referrals	Services for providing an examination service for children who may have been sexually abused were put out to tender with plan for a regional service. Medical college guidance that anyone working in this area should see a minimum of 20 cases per year. Paediatricians struggle to meet this threshold. Team members concerned will be held up in the court as inadequate or un-credible witnesses	Community Paediatricians have been trained Discussion at Peer Review Supportive reflections De-briefing	17/07/18 update. Meetings have been arranged following agreement with the financial envelope:- 1. Consultant's operationalization meeting will take place on 3rd August. 2. Contractual meeting at NUH with contracts and finance departments on 25th July	31/08/2018 (reduced to moderate 17/07/18)
21171	Children's Services: Universal and Specialist Community Services	Medicines fridge in a room too hot/cold	The NHS medicines fridge at St Andrews School is stored in a room that frequently goes above and below the safe guidelines. The medicine storage cupboards are also in this same room. Drugs need storing in safe temperatures. The risk is that the drugs are kept in a room that regularly exceeds the safe limits.	The windows are opened during school opening times to reduce the temperature. When school is shut and the heating is off there is no control over the room temperatures. Even with windows open the temperatures can exceed 30 C	01/08/2018: Update from team manager. Advice has been taken from pharmacy on numerous occasions in relation to keeping blinds and windows closed whilst the air outside the clinic room is hotter than the air inside. She has contacted and sent a letter to the school head teacher to discuss concerns and has discussed the purchase of drug storage cabinets with integrated temperature control.	30/09/2018
21204	Campus: Unit Coordinator Team	Ligature risk assessment	The 136 suite has been fitted to a high anti ligature spec, is only in use under staff supervision and is monitored by CCTV, however there remains a few identified risk areas which are detailed within the attached document	Detailed in supporting detailed risk assessment document	19/03/18 update: Awaiting confirmation that observation window in 136 suite shower area has been fitted. 13/8/18 Risk Manager escalated for action.	31/08/2018

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3035	Pharmacy	Pharmacy staffing	Uncertainty about the future of the DCHS contract for pharmacy services prevents substantive recruitment to some posts and a reliance on locum/bank staff who can leave with no/short notice.	Core functions being prioritised. Cover being provided by existing staff- where possible.	11/06/18 update: Situation remains difficult. Service to DCHS needs to be provided until 31/10/18, however if staff leave they cannot be replaced. All 3 Band 8a pharmacy staff currently off work. Expect improvement from Oct/Nov, when risk should begin to reduce through to Jan 2019 when pharmacist situation expected to improve.	31/07/2018

Operational risk information extracted from Datix 18 06 18_updated 13 08 18

Board Assurance Framework Risks 2018/19 v 2.3

Strategic Outcome 1. Quality Improvement

Principal risk:

Risk: **There is a risk that the Trust will fail to provide full compliance with the Mental Health Act (1983) and Mental Capacity Act (2005)**

Impact: Potentially adverse impact on the patient experience, which may lead to an adverse impact on the CQC overall assessment

Root causes:

a) Complex and dynamic interface between the Mental Health Act and Mental Capacity Act
b) Logistical issues in application of the FSR, compliance reports can be generated but requires further development to be fully fit for purpose
c) Lag in clinical culture catching up with best practice

BAF ref:	**Director Lead**: Dr John Sykes, Medical Director	Responsible Committee: Mental Health Act Committee	Datix ID:
18_19 1b			21288

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 – Comprehensive training plan supported by MCA Training Manual developed by trust clinicians; Good compliance with MCA training; Increased general awareness of issues amongst clinicians with multidisciplinary team approach; Junior doctor training; Single place created in PARIS to record MCA assessments: Lead nurses and practice development and compliance lead now working into both inpatient and community teams

Detective – Rolling compliance checks; Programme of quality improvement audits; Regular compliance checks with feedback to relevant managers; Practice Development and Compliance Lead for MCA and Medical Lead

Directive – MHA and MCA policies and procedures; Lead director accountability and chain of accountability through to consultants and senior nurses; Designated MCA medical lead; MHA Manager and Team; DoLs lead; MHA Committee and Operational group.

Corrective – MHA Committee assurance on MHA/MCA processes with clear lines of responsibility and accountability; Mental Health Act Operational Group scrutiny performance and monitors remedial action

Assurances on Controls (internal):	Positive assurances on Controls (external):
Reporting of training compliance against plan to MHA Operational Group and relevant managers. Good levels of compliance Range of compliance checks and audits agreed by MHA Operational Group with assurance provided to MHA Committee	KMPG audit of Mental Capacity Act 2017/18 (Significant assurance with minor improvement opportunities)

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Improvement in practice and recording made in inpatient areas yet to be made in community settings	Focused workplan for improving compliance in community team with development of relevant guidance and documentation [ACTION OWNER MD]	30/09/2018	Re-audit completed. Reported to the MHA Operational Group Aug 2018. Improving compliance.	Medium ⬇

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Comprehensive training to support application of MHA and DoLs	Develop and implement comprehensive training plan to support application of MHA and DoLs. [ACTION OWNER MD]	30/09/2018	Trajectory of 3 yearly training confirmed to MHA Operational Group Aug 2018. Improved position.	Medium ⬇
Real time feedback to clinicians following rapid tranquilisation	FSR to be developed to enable pharmacists to give clinicians 'real time' feedback following rapid tranquilisation to their patient. Pilot operation now on Enhanced Care Ward [ACTION OWNER MD]	30/09/2018	Monitoring of rapid tranquilisation improved due to developments in the FSR. Real time feedback to clinicians not possible without electronic prescribing. Regular reporting to MHA Operational Group.	Medium
Consistent approach to management of Associate Hospital Managers (AHM's)	Develop a plan to ensure a consistent approach is implemented with respect to recruitment, job descriptions, appraisal, offers of appointment and training for AHM's [ACTION OWNER MD]	30/09/2018	Proposal considered by ELT and MHA Operational Group Aug 2018. Final plan to go to MHA Committee Sept 2018	Medium
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Evidence of actions taken and embedded following CQC mental health act focused related visits	Action matrix to cover all actions from all units, and to highlight those overdue, to be in place by September 2018 as per KPMG recommendation [ACTION OWNER MD]	30/09/2018	Plan to use CQC portal functionality to follow up these actions, and report to the MHA Operational Group and MHA Committee. From Sept 2018.	Medium
Potential breaches of Section 136 waiting times. (Due to reduction in length of time a person can be held in a S136 suite under the new Police and Crime Bill).	Raise at Board level with escalation to Commissioners [ACTION OWNER MD]	Complete	This risk is impacted on by the difficulties accessing CAMHS/learning disability and PICU places. Issue to be escalated through ELT to Board.	Achieved
Related operational high/extreme risks: None specifically identified				

Operational risk information extracted from Datix 18 06 18_updated 13 08 18

Board Assurance Framework Risks 2018/19 v 2.3

Strategic Outcome 1. Quality Improvement

Principal risk:

Risk: **There is a risk that the Trust will fail to develop systems and processes to deliver safe and effective physical health care for patients**

Impact: Morbidity and mortality for people with a serious mental illness (SMI) will continue to be below the national average, people will have longer stays in hospital and the CQUIN for physical healthcare will not be achieved

Root causes:

a) Known links between SMI and other co-morbidities e.g. diabetes, cardiac disease; respiratory disease
b) Increased risk factors in population e.g. obesity, smoking, alcohol and drug misuse and deprivation
c) Lack of secondary care infrastructure to monitor physical health impact of people with SMI
d) Lack of clear processes for communication between primary and secondary care with respect to physical health monitoring

BAF ref:	**Director Lead**: Dr John Sykes, Medical Director	**Responsible Committee**: Quality Committee	Datix ID:
18_19 1c			21289

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 – Range of physical health related training in place i.e. physical health care screening and monitoring , ILS/BLS, infection control, ,
Detective – Physical health care monitoring clinics pilots in various trust services
Directive – Physical Health Care Strategy; Physical Care Committee; Trust Infection Control Committee; Drugs and Therapeutics Committee; infection control and tissue viability link nurses; Policies and procedures support a range of physical health interventions and monitoring; 'Smoke Free' Trust
Corrective – Practice Development and Compliance Lead for physical health care, to support ward/team based best practice

Assurances on Controls (internal):	Positive assurances on Controls (external):
Programme of physical health care related audits and associated action plans	CQC (Cubley Court) feedback report Feb 2018 Safety Thermometer

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Lack of single location on PARIS for recording and monitoring of physical health care	Develop a physical health care tile on PARIS to record in a single place all physical health care related information, initially focused on LESTER Tool compliance [ACTION OWNER MD]	31/12/2018	Physical health care tile being developed in PARIS Play with input from clinical and IT staff. LESTER compliance aspects of this Tile to be in place on PARIS Live from July 2018. Testing and audit/reporting fidelity to be completed Jul – Dec 2018, ahead of national audit reporting due Jan 2019, which supports CQUIN report. Recording of physical health care observations in 136 suites developed as paper form. To be created in PARIS as part of above process.	Medium
Trust led physical healthcare monitoring following initiation of medications	Expand Derby pilot of physical health care monitoring clinics to Chesterfield [ACTION OWNER MD]	30/09/2018	Monies identified, staff being recruited to and clinical model agreed. To roll out from Sept 2018	Medium

Operational risk information extracted from Datix 18 06 18_updated 13 08 18

Uptake of intervention focused training re physical healthcare	Compliance reporting and monitoring of hotspots, to target in specific areas, including resuscitation training [ACTION OWNER MD/COO]	30/09/2018	Significant increase in E-learning uptake to support LESTER tool. May 2018, 48.74% compliance. In order to increase training uptake additional courses, including out of hours are being run. Constant review of capacity to ensure training places are available to match demand (dependant on clinical staff being released).Training and development team exploring with resuscitation lead at DRH, different ways to ensure staff remain competent.	Medium
Gaps in communication with GP practices re awareness of SMI cohort leading to potential gaps in physical healthcare monitoring	Continue to work with GP practices to ensure SMI databases are maintained and kept up to date [ACTION OWNER MD]	31/10/2018	Audit of SMI registers undertaken during Q4 17/18 demonstrated 91% compliance with required information shared with GP's. 2018/19 CQUIN requires defined process across Trust, workplan for Derbyshire agreed with Commissioners and public health. Quarterly meetings in place to monitor progress.	High ⇧
Specific process and training to manage sepsis, in line with national guidance	Review the current infection control policies to ensure information around the identification and management of sepsis, and other high profile infections, are in line with current national guidance and best practice	31/08/2018	Review of policies underway	Medium
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Consistent monitoring and recording of physical healthcare standards across inpatient and community settings	Develop automated compliance checks and audits in PARIS [ACTION OWNER MD]	31/08/2018	Develop compliance report for key areas- 136 assessment, admission, community 1st contacts in addition to CQUIN requirements to be presented at TMT	High
Consistent implementation of the LESTER tool	Scope the implementation of a module in PARIS to enable local teams to receive early notification of patients commencing medication to enable monitoring to be put in place [ACTION OWNER MD]	31/07/2018	Trigger notifications to clinicians involved in a patient's care being developed based on diagnosis to instigate use of LESTER tool. To go live from July 2018. Scoping of implementation of E-prescribing remains underway. Specification and interface issues being explored with development team and CIVICA.	High

Related operational high/extreme risks:

ID	Division	Title	Description	Controls in place	Mitigating actions	Date of next review
21221	Children's Services: Universal and Specialist Community Services	Resuscitation training	Compliance with resuscitation training remains lower than plan. Availability of training problematic due to trainer not being available. Recent course cancellations have occurred.	Monthly exception report to allow local monitoring, this has highlighted the reducing compliance. Monitor at Divisional COAT and operational meetings. Request L&D to provide additional capacity and position statement - received 12/02/18. Additional sessions being provided.	02/05/2018 update. Compliance end April 18 increased to 63%. Escalated to TMT and ELT via COO. Executive team to continue to monitor provision and compliance.	31/08/2018

Operational risk information extracted from Datix 18 06 18_updated 13 08 18

Board Assurance Framework Risks 2018/19 v 2.3

Strategic Outcome 1. Quality Improvement

Principal risk:

Risk: **There is a risk that the Trust will fail to redesign the Care Programme Approach processes, which may impact upon the quality of care provided to patients and their carers**

Impact: Impact upon the effectiveness of clinical service delivery and leading to avoidable errors in care.

Root causes:

a) Homicide investigation identifying failure to implement effective CPA policy and resulting no adherence
b) Staff reporting that process can be bureaucratic and does not always support and enable person centred care
c) Recording processes and pathways require modernisation

BAF ref:	**Director Lead**: Carolyn Green, Executive Director of Nursing and Patient Experience	**Responsible Committee**: Quality Committee	Datix ID:
18_19 1d			21290

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 – Incident and complaint reporting and investigation
Detective – Clinical supervision
Directive – Current CPA policy; Training plans
Corrective – Regular audits of compliance

Assurances on Controls (internal):	Positive assurances on Controls (external):
Existing CPA policy and audit plan	Current performance compliance and included in external submissions

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Current policy not fit for purpose	Redesign CPA Policy and approach [ACTION OWNER DON]	31/07/2018	Phase 1 completed. Phase 2 redesign in process, staff engagement underway	Medium
	Engage and consult with social care colleagues and develop collaboratively.[ACTION OWNER DON]	Completed	Positive feedback received on the concept of redefining policy	
	Engage and consult with colleagues around best approach for implementation [ACTION OWNER DON]	Completed	National CPA associate conference held in DHCFT in June 2018, DoH and National speakers on CPA explored the future direction. This learning will be included in the CPA review, all eLearning included in the next draft of CPA policy.	
	Complete revised V3 of CPA policy	31/08/2018	New draft will include minimum standards of practice, refocused on standards and including monitoring model against key standards. Plan	

Operational risk information extracted from Datix 18 06 18_updated 13 08 18

			to go back out to consultation in August 2018	
	Design and redesign training methodology using experts by experience and carers[ACTION OWNER DON]	31/08/2018	Carers Quality improvement lead assessed knowledge of people currently in in- patient care on CPA. To feed their feedback and involvement into review and training	
	Continual audit of compliance and outcomes., connecting to recovery and enablement strategy.[ACTION OWNER DON]	30/09/2018	Findings from community audit of CPA and safety plan reviewed by COAT and reported to July 2018 Quality Committee.	
	Adopt a learning and scrutiny culture in supervision that reviews the adequacy and meaningfulness of CPA in supervision [ACTION OWNER DON]	31/12/2018	Audit of case files, improvement trajectory for supervision is in place and will continue with increased monitoring until December 2018	
	Embed CPA monitoring into COAT practice and include routinely on compliance and clinical audit programme.[ACTION OWNER DON]	31/12/2018	Findings from community audit of CPA and safety plan reviewed by COAT and reported to July 2018 Quality Committee. Will be reviewed by COAT, at regular intervals and monitored at TMT and performance monitoring	
Compliance with revised policy	Develop and implement audit of compliance over an 18 month period [ACTION OWNER DON]	31/12/2018		Medium
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Related operational high/extreme risks: None specifically identified				

Operational risk information extracted from Datix 18 06 18_updated 13 08 18

Board Assurance Framework Risks 2018/19 v 2.3

Strategic Outcome 2. Engagement

Principal risk:

Risk: **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 & wellbeing of staff which may affect the safety and quality of patient care**

Impact: Negative impact on staff wellbeing which may lead to an impact on quality of care provided and overall staff retention

Root causes:

a. Lack of engaging and participative leaders and managers in an inclusive way
b. Lack of clear leadership expectations
c. Lack of management, leadership, coaching and mentoring development to improve leaders
d. Lack of robust recruitment processes ensuring suitability for role
e. Limited ownership of Staff Survey and Pulse Checks throughout organisation

BAF ref:	**Director Lead**: Amanda Rawlings, Director of People and Organisational Effectiveness	**Responsible Committee**: People and Culture Committee	Datix ID:
18_19 2a			21291

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 – Team Derbyshire leaders events to engage leaders. Ongoing wider engagement activities for all staff
Detective – Management and leadership questions from staff survey, staff survey engagement questions. 'Ifti on the Road' programme
Directive – Leadership development training supporting managers
Corrective – Appraisal and supervision processes

Assurances on Controls (internal):	Positive assurances on Controls (external):
Improvement from staff survey to pulse check evident during 2018 Report in Chief Executive report to Board and Weekend Note to staff highlighting staff engagement and feedback Staff forum feedback Feedback from Quality Visits Planned oversight of implementation of leadership development strategy to People and Culture Committee (as part of People Plan)	Staff Survey (limited assurance) Pulse Checks Friends and Family Test

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Lack of leadership development strategy	Develop leadership and management development strategy to include: management development; leadership development; coaching and mentoring, reverse mentoring. [ACTION OWNER DPOE]	31/07/2018	Leadership and Management Development Strategy developed, and reported to ELT June 2018, People and Culture Committee July 2018. Wider organisational involvement to follow, with plan for priorities to be agreed for 2018/19 by end July 2018.	Medium ⬇

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Required further development to embed and coordinate wider engagement activity	Range of activities are in place including Staff Forum, Team Derbyshire Healthcare Leaders events, team briefing, raising concerns, director/CE visits etc to provide opportunity to engage with staff. Continuing implementation and evaluation of effectiveness to be undertaken including review of feedback captured from all engagement activities. [ACTION OWNER DPOE/DCA]	30/09/2018	Organisation wide staff survey action plan agreed through ELT, PCC and Board completed. PCC to track progress to Sept 2018, when next staff survey commences.	Medium
Lack of response/analysis of feedback from staff	Broad oversight of feedback from all staff engagement to be coordinated and themes identified in order to address these. Ensure response to issues staff raise and promoting 'you said, we did' to encourage further engagement and feedback. [ACTION OWNER DPOE/DCA]	30/09/2018	Staff survey and pulse checks analysed. Plan in place to work with 10 least engaged teams by Sept 2018, to improve staff survey participation rates and overall engagement score.	Medium
Staff awareness and ownership of Trust vision and values	Refreshed Trust strategy, vision and values to be cascaded through Trust and reinforced by staff communication, branding and role modelling from senior leaders. Promotion of examples of positive behaviours in practice to be disseminated and example of this happening in practice celebrated. Ensure staff are aware of what behaviours/practice is not acceptable and how to report this. [ACTION OWNER DPOE/DCA]	30/09/2018	Refreshed Trust Strategy, vision and values cascaded throughout Trust and reinforced through Team Brief, staff magazine and screen saver on Connect. Developing Staff Forum encouraging staff to have a voice and raise issues. Work now underway to develop a set of expectations for staff whilst working in the Trust, led by HR and Communications managers. .	Medium
Required further development to embed and coordinate wider engagement activity	Range of activities are in place including Staff Forum, Team Derbyshire Healthcare Leaders events, team briefing, raising concerns, director/CE visits etc to provide opportunity to engage with staff. Continuing implementation and evaluation of effectiveness to be undertaken including review of feedback captured from all engagement activities. [ACTION OWNER DPOE/DCA]	30/09/2018	Assessment and tracking of effectiveness of the range of activities in place underway. Progress reported to People and Culture Committee June 2018, further update planned for Oct 2018.	Medium
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Staff survey identifying issues with leadership and management.	Identify resources to implement leadership and management development programme [ACTION OWNER DPOE]	30/09/2018	Leadership and Development Strategy written. Priorities being identified and reported to ELT June 2018, People and Culture Committee July 2018. To be costed in line with affordability. Leadership and development manager recruitment underway from June 2018.	Medium ⇩
Staff responses on morale and health and wellbeing questions in staff survey	Address hotspot areas and wider trust actions to address [ACTION OWNER DPOE]	30/09/2018	ELT/TMT/PCC overseeing focused work underway enable by Organisational Effectiveness Lead, to support hotspot areas.	Medium
Related operational high/extreme risks: None specifically identified				

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Strategic Outcome 3. Financial sustainability

Principal risk:

Risk: **There is a risk that the Trust fails to deliver its financial plans**

Impact: Trust becomes financially unsustainable.

Root causes:

a) Non-delivery of internal CIP including back office efficiency
b) 'QIPP' disinvestment by commissioners leaves unfunded stranded costs in Trust
c) Other income loss without equivalent cost reduction (e.g. CQUIN, cost per case activity, commissioner clawback)
d) Costs to deliver services exceed the Trust financial resources available, including contingency reserves.
e) Lack of sufficient cash and working capital or loss due to material fraud or criminal activity

BAF ref: 18_19 3a	**Director Lead**: Claire Wright, Executive Director of Finance	**Responsible Committee**: Finance and Performance Committee	Datix ID: 21292

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating EXTREME	Likelihood 4	Impact 5	Rating EXTREME	Likelihood 4	Impact 5	Direction ⟷	Rating MODERATE	Likelihood 2	Impact 5	Accepted	Tolerated	Not accepted

Key controls:

Preventative – Budget training, segregation of duties, contract with commissioners to reach mutual agreement on QIPP disinvestment, mandatory counterfraud training and annual counterfraud work programme

Detective –Audits (internal, external and in-house); Scrutiny of financial delivery, bank reconciliations; CIP planning and delivery; Contract performance, Local counterfraud scrutiny

Directive – Standing financial instructions; budget control, delegated limits, 'no-PO no pay' rules; Agency staff approval controls; Approval to appoint process; Business case approval process (e.g. back office); CIP targets issued; Invest to save protocol

Corrective – Corrective management action; Use of contingency reserve; Disaster recovery plan implementation; TMT performance reviews and associated support/ in-reach, Programme Assurance Board for CIP delivery

Assurances on Controls (internal):	Positive assurances on Controls (external):
Financial performance reports to Trust Board and Finance and Performance Committee evidence the overall actual performance as well as the forecast performance. Includes several sections covering the efficacy of controls include: - CIP delivery achievement - Agency expenditure (gap in control against 'ceiling' target) - Balance sheet cash value	- Internal Audits– significant assurance with minor learning opportunities for internal audits: 2017/18 Expenditure Data Analytics (3 medium, 1 low risk findings) and 2017/18 Payroll Data Analytics (1 medium, 2 low risk findings) - External Audits – strong record of high quality statutory reporting - Grant Thornton and KPMG audits show good benchmarking for key financial metrics (including liquidity) - NHSI Finance Rating Metrics – shows good performance (gap: agency metric) - National Fraud Initiative – no areas of concern

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Board Assurance Framework Risks 2018/19 v 2.3

The Integrated Performance Report evidences delivery of services, workforce information, quality information set against the financial performance evidencing whether we deliver services within our resources	- Local Counterfraud work – Referrals to KPMG show good counterfraud awareness and reporting in Trust and no material losses have been incurred - Deloitte Well Led review – positive affirmation of the effectiveness of the Finance and Performance Committee

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Agency approvals controls are failing to reduce agency expenditure to under the NHSI ceiling level	Executives continue to have regular meetings and take appropriate actions.[ACTION OWNER: COO] AIM: achieve average £250k per month agency spend (or less)	31/08/2018	Agency controls have led to reduced total agency expenditure and better adherence to capped hourly rates, but ceiling not achieved. Agency spend reduced from c£5m in 1617 to c£4m in 17/18 Trust vision/priorities: Financial sustainability – the leading indicators chosen are achieving agency ceiling and recurrent CIP	Medium
Cost control/Cost improvement – requirement for firm plans for full 18/19 CIP programme (and longer term pipeline of cost and quality improvement)	QIPP and CIP incorporated into the mental health STP workstream [ACTION OWNER DBI] Increased CIP meetings and project scrutiny, management action via PAB {ACTION OWNER – CEO] AIM: full CIP programme, quality assured. Updated PMO and associated structures with new Director Business Improvement and Transformation in place	31/08/2018	CIP and QIPP continue to be part of Mental Health STP Workstream. New Programme Delivery approach planned. Gap remains: full assured programme for 18/19 required. Further action: Additional F&P oversight and scrutiny of continuous improvement/longer term plans for 18/19 and beyond. PAB re-instated chaired by CEO. Continuous cost and quality improvement is a key deliverable in the new Director of Business Improvement and Transformation role Trust vision/priorities: Financial sustainability – the leading indicators chosen are agency ceiling and recurrent CIP	High
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery.
Related operational high/extreme risks: None specifically identified				

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Board Assurance Framework Risks 2018/19 v 2.3

Strategic Outcome 3. Financial sustainability

Principal risk:

Risk: **There is a risk that the Trust fails to influence Joined Up Care Derbyshire (the 'system') to effectively engage in enhancing service models for children, and people with mental health problems, learning disabilities, or issues with substance misuse**

Impact: If not delivered 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) Changing national directives
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

BAF ref:	**Director Lead:** Gareth Harry, Director of Business Improvement and Transformation	**Responsible Committee**: Finance and Performance Committee	Datix ID: 21293
18_19 3b			

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 4	Impact 4	Rating HIGH	Likelihood 4	Impact 4	Direction ⟷	Rating MODERATE	Likelihood 3	Impact 4	Accepted	Tolerated	Not accepted

Key controls:

Preventative - 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

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

Assurances on Controls (internal):	Positive assurances on Controls (external):
- Reports to Board regarding any system wide changes or risks - Regular progress feedback to F&P on system change - Updates and feedback at TMT and ELT in order to update on system change or 'blockers' - Engagement with Governors in order to get feedback and update them on progress - Engagement with staff though managers, staff side, focus groups etc.	NHSE/I agreement of plans Mental Health Delivery Board and checkpoint meetings with central STP team

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Lack of capacity and cohesion across clinical pathways	Transform clinical pathways to provide more joined up care (internal focus)[ACTION OWNER DBI&T]	31/08/2018	Invites to each of eight PLACE Alliances received and Trust representation identified to attend. Meetings diarised for Jul and Aug 2018.	High

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Board Assurance Framework Risks 2018/19 v 2.3

Delivery of 'Five Year Forward View'	Develop new clinical models for service delivery via Mental Health System Board (external focus). Work with commissioners to deliver Mental Health Investment Standard in developing new pathways and services [ACTION OWNER DBI&T]	31/07/2018	Rehabilitation pathway entering implementation phase. Agreement of financial flow from CGG required by July 2018 to enable investment in community teams to continue.	High
Level of influence on system wide childrens and urgent care QIPP schemes	Ensure Trust is actively participating in workstreams for children and urgent care [ACTION OWNER DBI&T]	31/07/2018	Review of attendance at Urgent Care Strategy Board underway, to be completed July 2018. Instigating meetings with childrens commissioners to discuss system approach.	High
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery.
Compliance with Mental Health Investment Standard	NHS England monitoring of CCG's compliance with investment standard [ACTION OWNER DBI&T]	Ongoing monthly	Main contract with CCG agreed April 2018. Contract agreement provided assurance that Mental Health Investment Standard would be met by 2018/19. Monitoring to ensure agreed spend occurs through contract management processes	Medium ⬇

Related operational high/extreme risks:

ID	Division	Title	Description	Controls in place	Mitigating actions	Date of next review
867	Neighbourhood Services	Commissioned Care Co-ordination Capacity within Neighbourhood Teams	Commissioning Gap. Insufficient care co-ordination capacity. Risk applies to all neighbourhood teams. Identified gap in resource requirement has led to significant pressure on care co-ordination capacity. Demand for service over the past 12 months has increased by 16% which has also led to pressure on capacity and waits for care coordination	Shortfall in care co-ordination resource has been raised with the commissioners. Each team has a waiting list management procedure this is implemented as far as is possible. Each team has a duty system to respond to those on the waiting list, and to try and manage their needs and ensure flexible approach to needs led allocation in a timely manner. Waiting lists are reviewed by service managers.	18/06/2018 update: Commissioners have provided funding for an additional 7 Care Co-ordinators for neighbourhood services. The funding can draw down as recruitment takes place.	30/09/2018
21189	Central Services: Mental Health: Eating Disorders Service (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.	Voluntary services exist to offer supportive non clinical interventions. Currently working on proposals to broaden the admission criteria to the ED Service in consultation with Commissioners. Clinical and Operational Leads to meet to devise new access criteria (including implications on capacity/waiting times) and new service specification for commissioners.	04/06/2018 update: Draft business case presented to CCG in relation to increased funding for ED service. Enhanced staffing required to support a wider access criteria. At present additional funding for 18/19 not identified. Priority for any incremental increase in 19/20 to be agreed internally. Operational policy for Eating Disorders to include access criteria and quantify the risk element related to weight reduction not captured in BMI figure.	30/09/2018

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Board Assurance Framework Risks 2018/19 v 2.3

21209	Children's Services: Universal and Specialist Community Services	Contracting and financial risk	Ivy House school nursing service funding and commissioning. Currently operating service at financial deficit and in contract discussion with local authority. Financial discrepancy is circa £90k per annum. Issues with payment of invoices	Raised by Director of Strategy via letter form in several occasions to local authority over preceding months.	30/05/2018 update: Discussions with commissioners have come to an agreement. Credit notes have been issued for previously raised invoices, and a revised invoice has been raised to the school. A meeting with the Head and Board of Governors was successful in identifying additional resource requirements and fleshing out the revised service specification.	30/06/2018
21223	Central Services: Learning Disability: Erewash CLD Team	Exceeded waiting times for dysphagia referrals	SLT LD currently accepts referrals for dysphagia classed as routine and urgent Due to only 1.3 therapists currently available to provide this service, there are 52 people waiting for a service following a telephone screen, with 14 classed as urgent. Recent ISMR's and LeDeR reviews have shown that people who are on the waiting list for this service, have died from aspiration pneumonia whilst awaiting an assessment.	Detailed option appraisal attached to risk assessment.	11/07/18: Currently 77 referrals for dysphagia classed as routine and urgent All urgent referrals have currently breached the 5 day target. This is an inspirational target set locally following a discussion with the Royal College of SLT who don't set a national target These people are at risk of hospital admission linked to their dysphagia	31/08/2018

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Strategic Outcome 4. Operational Delivery

Principal risk:

Risk: **There is a risk that the Trust will not be able to retain, develop and attract enough staff in specific teams to deliver high quality care**

Impact: Risk to the delivery of high quality clinical care including increased waiting times
Exceeding of budgets allocated for temporary staff
Loss of income

Root causes:

a. National shortage of key occupations
b. Future commissions of key posts insufficient for current and expected demand
c. Trust reputation as a place to work
d. Trust seen as small with limited development opportunities
e. Sufficient funding to deliver alterative workforce solutions
f. Retention of staff in some key areas

BAF ref:	**Director Lead**: Amanda Rawlings, Director of People and Organisational Effectiveness	**Responsible Committee**: People and Culture Committee	Datix ID:
18_19 4a			21294

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	⟷	HIGH	3	5			

Key controls:

Preventative – Targeted recruitment campaigns, including through social media – including introduction of microsite
Detective – Performance report identifying specific hotspots and interventions to increase recruitment. Monthly in-depth reporting around recruitment activity. Weekly meeting tracking medical vacancies.
Directive – Implementation of actions to deliver People Strategy, with focus on attracting and retaining staff
Corrective – Recruitment campaign delivered through targeted mobile display and implementation of mobile phone 'pop ups'

Assurances on Controls (internal):	Positive assurances on Controls (external):
Performance report to Executive Leadership Team and People and Culture Committee, includes recruitment tracker Reducing agency spend Reducing vacancy rate	Staff survey Pulse Checks CQC visits identify caring and engaging staff

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Workforce plan to include alternative workforce models both medical and nursing	Develop alternative workforce models for key hard to fill services where have been unable to attract suitable medical staff. [ACTION OWNER MD/DPOE]	30/09/2018	Currently focused on Associated Nurses, NMP and ACP's. Two ACP's are progressing through recruitment process to start in September 2018. Medical Director to work with medical staff across the Trust around introduction of new roles and to develop a plan by Sept 2018.	High

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	Continue to progress, in line with Year 2 of the Workforce Plan, nursing/AHP associates and apprenticeships.	31/07/2018	Plan being revised in line with LBR funding and Levy Funding. To be agreed by ELT July 2018	
Appeal of the trust as a place to work	Further develop multigenerational offer to attract staff for key national occupational shortages, and for development and retention of staff in key areas [ACTION OWNER DPOE] Develop a rotation role and programme across inpatient and community services in order to proactively manage the flow workforce across these areas [ACTION OWNER DPOE/COO]	30/09/2018 30/09/2018	Developing a rotation programme by Sept 2018 across inpatient and community services in order to proactively manage the flow of workforce across these areas. Flexible working offer needs further promotion, in-house bank being expanded Work commencing between people services and operations. Development of a business case to give assurance around the gaps	Medium
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
National funding sources to develop our workforce	Gain funding streams from Learning Beyond Registration (LBR), Apprenticeship Levy and STP funding for Mental Health [ACTION OWNER DPOE]	30/09/2018	LBR funding reduced for 18/19 by over 50%. Review funding streams available including how levy is used, by July 2018	High

Related operational high/extreme risks:

ID	Division	Title	Description	Controls in place	Mitigating actions	Date of next review
2772	Children's Services: CAMHS	Insufficient resources CAMHS workforce	Insufficient CAMHS workforce leading to a lack of care coordination within new pathway model resulting in increased reliance on medical team. Reliance on locum and agency usage.	Active recruitment to Consultant vacancies and short term locum cover. Patients who only require only medication management have been transferred to health hub (nurse prescriber)	17/04/2018 update: Consultant vacancies continue. Recruitment in March 2018 was unsuccessful. Considering: possible conversation of post to speciality doctor, non-medical senior clinical posts. Project commencing May 2018. Risks remain, on call rota continues to cause pressure. Agency locum in place.	03/09/2018

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20993	Children's Services: Universal and Specialist Community Services	Staff shortage Children and Therapies	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). Children known to service already having to wait for reviews – some with physical disabilities may experience harm from lack of timely special equipment reviews.	Identifying children open and inactive to services and discharging some Caseload reviewed to ensure waiting times can be addressed with capacity for throughput. Additional support secured for service engineering facilitated sessions with transformational lead. ASM to monitor the situation and feedback the risks and consequences to senior management.	17/07/18 update: Cover for mat leave covered and B6 post in early years backfilled. New technical instructors for early years and special schools started, but two further resignations received. New staff requiring significant supervision currently. Staffing on more even keel, but recent review has identified service significantly under resourced. Risk likely to remain high for further 6 months, pending discussion with commissioners.	30/09/2018
21124	Neighbourhood Services: Neighbourhood - South County and South Dales	No long term Consultant psychiatrist	The team has a backlog of urgent patients and routine follow ups created by a lack of consultant cover for the past 18 months. No junior doctor cover as no consultant to supervise. Patients mental illness escalating with increasing numbers having had outpatient appointments cancelled on numerous occasions. Negative impact on patient experience. Lack of continuity of medical support Unavoidable admissions.	Locum left post 25/5/2018 with short notice. Consultant cover is on a day to day on call consultant basis. Clinics are being cancelled a week at a time. Temporary staffing are looking for a new locum Permanent job is out to advert. NMP being employed on a pilot with negotiation of Consultant to supervise.	27/07/2018 update: Currently have a locum consultant in place. Risk still on going.	31/10/2018
21238	Neighbourhood Services: Neighbourhood - Derby City	Inability to allocate urgent referrals	* 96 people on waiting list for CPN * Inability to allocate urgent referrals due to staffing levels * In 4 days received requests for 4 urgent allocations, 2 of which require male CPNs but only have 2 x 1wte and 1x 0.4wte male CPNs * Pressure from EI to allocate transfers of care. * CPN sickness requiring cover from the existing team staff.	* Clinical lead providing case load management * Medics to be asked to review case loads with CPNs to try and facilitate discharge from CPN case load to free space. * Service manager regularly reviewing the urgent referrals trying to allocate where possible * Clinical lead working with EI on interface issues	26/07/2018 update: Team currently in process of setting up nurse led clinic to reduce waiting list. 2 over recruitment posts for band 6 care coordination have gone out on TRAC. Risk remains present but reduced (previously rated as extreme)	30/09/2018

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3262	Community Paediatrics Teams	Long waiting lists following reduction in paediatrician staffing levels	Children and young people and their families are not being seen and assessed within a timely and appropriate manner.	Attempts at recruitment are ongoing. Follow up caseload to be transferred to ND Team and there are longer term plans for transformation in some of the areas however this will have an impact in the longer term rather than in the short term. Suitable locum cover has been difficult to obtain and only covers the less specialised aspects of the roles.	17/07/18 update: Interviews for the ND Coordinator have been set for the 24/7/18. This will have a positive impact on the delivery of the ND pathway and coordinated response to referrals. Currently there are 2 vacancies advertised on NHS Jobs for specialty grade doctors. This advert closes on the 20/07 with interviews set for the 31/07	31/08/2018
21315	Children's Services: Universal and Specialist Community Services	Staffing levels	Depleted numbers of staff in neurodevelopment team., affecting: response times to non- urgent calls, clinic cover, capacity to carry out new assessments leading to increased waiting lists. Staff being recruited to, but induction and training of new staff likely to impact on service delivery until Dec 2018.	Communication plans in place between the team admin and clinical staff to minimise concerns from parents. Weekly allocations meetings. Clinical lead building robust case load discussion with staff during supervision.	25/06/18 update: Additional capacity is being sought through the recruitment of a specialty grade medic to support the work with ADHD. Non-medical prescriber has returned from sickness absence but on limited duties. The community paediatric team is working with the ND team to support and help manage some of the review prescribing.	31/08/2018
21274	Campus	Ward 36 staffing	Ward 36 currently have significant staffing deficits: Band 7, 6 and 5 currently not in post. 4.8 Band 5 vacancies 1 Band 5 OT vacancy 2 Band 3 vacancies The ward will therefore be unable to achieve required safer staffing levels 100% of the time with significant impact on patients and staff	Senior Nurse from Ward 33 transferred to Ward 36 for 3 months to support. Robust rota management, this includes block booking of bank staff and staff familiar with the ward. Band 7 and 6's working clinically impacting on operational duties of the ward. Daily unit huddles to identify immediate deficits. Escalation process with ASM and Head Of Nursing.	26/07/18: Review of establishment list is to be reviewed w/c 30/07/18 Staffing Solutions Team actively looking for Bank/Agency staff.	31/08/2018

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Strategic Outcome 4. Operational Delivery

Principal risk:

Risk: **There is a risk that the Trust will fail to gain the confidence of staff to maintain a modern and effective electronic patient record system**

Impact: Information relating to patient care will be fragmented and incomplete due to inconsistencies and duplication in the recording of information on PARIS

Root causes:

a) Historical reliance on papers records
b) Workforce not conversant with a fully electronic record
c) Staff confidence to use computers efficiently
d) Increase in information being recorded in electronic record
e) Recreation of multiple paper templates in the FSR leading to duplication of information being recorded
f) Reporting functionality reliant on specific document structure in PARIS
g) Clinical information being held in the incorrect location on Paris

BAF ref:	**Director Lead**: Mark Powell, Chief Operating Officer	**Responsible Committee**: Quality Committee	Datix ID:
18_19 4b			21295

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 – PARIS training; Bite size courses to support continued learning; Basic IT Training; Provision of equipment to support agile working; PARIS "Play" environment ; Establishment of 'super-user' groups responsive development to Paris concerns, clinical systems lead support to teams.
Detective – Audits and compliance checks; monitoring of Enhancement log requests through CRG; Work with ward and community teams to understand how clinical functions work using patient records
Directive – Clinician led Paris (FSR) Clinical Reference Group reporting to TMT/ELT and Quality Committee in order to review current PARIS functionality and develop a work programme to enhance the FSR based on clinical feedback
Corrective – Engagement with staff to rationalise documentation and improve user interface; Learning based visits to other Trusts using PARIS and other FSR's

Assurances on Controls (internal):	Positive assurances on Controls (external):
Range of clinical audit and compliance checks based using two way data analysis from PARIS including: physical healthcare recoding and monitoring, MCA, seclusion and rapid tranquilisation, care plans, CPA. Identified gaps fed into FSR Clinical reference Group, and relevant COAT for action Concerns from two way data analysis are fed back to the Paris Development team for review	KPMG MCA internal audit report (2018) (positive assurance on recording of information) CQC inspection on Cubley Ward with positive assurance on physical health recording, fluid intake and physical observations recording CQUIN- nearing full compliance re alcohol and tobacco interventions

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:

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Clear specification for improvements required	Develop clear specification of improvements required to PARIS, with project plan, and timeline to meet agreed scope. FSR CRG to develop plan and report back to the Finance and Performance Committee [ACTION OWNER COO]	31/08/2018	Second scoping exercise completed, resulting in four task and finish groups being identified to focus on: physical health care, information flow, well-being plans and clerking in. All meeting by 30/06/18 and to agree work plan for developers and realistic time frame to achievement. Update to be reported to TMT June 18, then onto F&P July 18.	Moderate
Confidence of staff in using the FSR to enhance patient care	-Ongoing support and review from Clinical systems lead -Involve clinicians in the FSR CRG to seek opinion and advice. -Ensure focus is maintained on reducing complexity and number of templates and time taken to complete by staff [ACTION OWNER COO] -Identify medical clinical information officer to develop clinical involvement in PARIS [ACTION:MD]	Ongoing 31/08/2018	 Increased number of clinicians now attending the FSR CRG (5) Four task and finish groups outlined above have been developed in response to areas of highest concern from clinicians and requiring the greatest simplification and redesign.	High
Fragmented recording of physical healthcare information on PARIS	Remapping of physical healthcare health care recording and monitoring on PARIS [ACTION OWNER MD]	31/08/2018	Being progressed by task and finish group for physical health care as outlined above. First meeting held, scoping requirements partially completed.	Moderate
Limited staff engagement with safety planning process	Developing the safety plan framework on PARIS in line with commissioner feedback to include a stepped approach to safety planning and review of the existing form [ACTION OWNER MD]	31/08/2018	Trainers/developers are attending teams for drop in sessions. Positive feedback has been received, for example through quality visit feedback.	Moderate
Too many locations on PARIS to record same information	-Rationalisation and reduction of clinical documents held on PARIS -Conversation of 'forms' to 'locations' to centralise similar clinical information in one place. -Increasing auto population of forms where relevant -Development of tiles to improve access to key information (Care planning/ physical health care/ safety planning [ACTION OWNER COO]	31/08/2018	The FSR CRG has reviewed the enhancement log, rationalised actions and reviewed more complex actions with the staff proposing to clarify request. Number of actions align with actions identified through scoping exercise, so these will be subsumed in task and finish group work plans	High
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Oversight of other Trust development of FSR's	Continue to develop supporting arrangements with other Trusts using PARIS and other EPR's to support learning and development [ACTION OWNER COO]	31/08/2018	Trust colleagues have visited another trust that uses Civica to establish what learning can be transferred to our own trust. Any positive learning is being reviewed at the CRG meeting.	Moderate
Related operational high/extreme risks: None specifically identified				

Operational risk information extracted from Datix 18 06 18_updated 13 08 18

Strategic Outcome 4. Operational Delivery

Principal risk:

Risk: **There is a risk that the Trust will be unable to meet the needs of patients by not introducing new workforce models and provide sufficient training to reskill staff.**

Impact: Risk to the delivery of high quality clinical care
Risk to achievement of financial targets

Root causes:

a. Capability and capacity of managers and clinical leaders to implement change
b. Lack of financial settlement sufficient to retrain staff to new roles
c. Lack of national funding streams for salary support

BAF ref:	**Director Lead**: Amanda Rawlings, Director of People and Organisational Effectiveness	**Responsible Committee**: People and Culture Committee	Datix ID:
18_19 4c			21296

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 – External funding secured
Detective – People and Culture Committee oversight of delivery of workforce plan
Directive – Workforce plan;
Corrective – Year 2 funding plan; Annual Learning beyond registration and STP transformation funding plan

Assurances on Controls (internal):	Positive assurances on Controls (external):
Quarterly updates provided to PCC. PAB progress reports from the medical working group re alternative workforce models	Mental Health workforce plan as part of STP, reviewed and challenged by HEE

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Workforce plan: Oversight of delivery via fully functioning strategic workforce groups. Leadership ownership of the plan with sponsors for introducing new roles	Reshape the strategic workforce group and education group membership. Identify leaders for each new role [ACTION OWNER DPOE]	31/08/2018	Year 2 workforce plan has been agreed. Investment into key roles such as Nursing Associates, Nursing Apprentices and ACP's agreed. ELT and PCC to track progress	Medium
Funding: Ownership across the leadership team to transform current gaps in supply to new posts. Trust and HEEM funding	Executive oversight at ELT to delivery and transformation. HEEM funding – bid for every available work stream [ACTION OWNER DPOE]	30/09/2018	Medical Director has a working group looking at 10 key actions and this includes alternative workforce models to address the medical gaps the trust has. PAB is overseeing the progress of this group	High

Operational risk information extracted from Datix 18 06 18_updated 13 08 18

availability				
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Lack of regular review at ELT and strategic workforce group of workforce plan delivery	Increase the focus on the ELT and Strategic workforce groups quarterly [ACTION OWNER DPOE]	31/07/2018	ELT to receive the training funding plan in July to ensure funding focused on the key areas to delivery transformation	Medium
Related operational high/extreme risks: None specifically identified				

Operational risk information extracted from Datix 18 06 18_updated 13 08 18

Board Assurance Framework Risks 2018/19 v 2.3

Strategic Outcome 4. Operational Delivery

Principal risk:

Risk: **There is a risk that the Trust will not improve the flow of patients through our services**

Impact: This may lead to: poor patient experience and outcomes due to increased length of treatment or stay; increased placements outside of local area; inefficient use of resources; reduced access to services; increased waiting times; financial penalties

Root causes:

a. Average length of stay is above national average
b. Lack of alternative care options
c. System wide resourcing issues

BAF ref:	**Director Lead**: Mark Powell, Chief Operating Officer	**Responsible Committee:** Finance and Performance Committee	Datix ID:
18_19 4d			21297

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:

Detective – TMT/ELT and F&P Committee; Meeting to facilitate bed optimisation across both units; Daily and weekly performance reporting (bed occupancy, length of stay, Red2Green project)

Directive – 'LEAN' based approaches to service change; Coaching support by Programme Assurance Office and Head of Programme Delivery

Corrective – Board reporting on Trust Strategy; Dementia Rapid Response Teams; In-reach to Ward 1; CAMHS home treatment model

Assurances on Controls (internal):	Positive assurances on Controls (external):
Update reports to Quality Committee and TMT on Neighbourhood Review progress Bed status dashboard Red2Green weekly tracker Community Caseload health tracker Monthly Integrated Performance Report to Board	CMHT Community Service Survey

Gaps in control:	Actions to close gaps in control:	Review due	Progress on action:	Risk to delivery:
Increased use of health services by some high risk individuals	Improve packages for high intensity users of health services through projects supporting the acute care pathway [ACTION OWNER COO]	31/08/2018	High intensity users project (JET -Joint Intensity Team) role recruited to work alongside designated police officer to support small cohort of high intensity users of police, mental health, A&E, EMAS. Planned service implementation from Aug 2018.	Moderate
Delayed discharges above specified lengths of stay	Bed optimisation project, including 'Red2Green' project implementation to increase flow in inpatient areas [ACTION OWNER COO]	31/12/2018	Red2Green continues to be undertaken across all wards, data being collated to evaluate impact. A wider review of the Trust's urgent care model is being undertaken. This is being translated into a full	High

Operational risk information extracted from Datix 18 06 18_updated 13 08 18

			programme of work which will include a focus on further reducing lengths of stay. Renewed escalation focus on patients who have stayed in hospital over 50 days.	
High caseloads and long waiting lists in community based mental health teams	Complete Neighbourhood review, to ensure services are meeting commissioned needs in line with 'Joined Up Care Derbyshire' approach [ACTION OWNER COO]	31/10/2018	Neighbourhood review still in progress. Feedback from meetings with all Neighbourhood teams is being integrated to inform the revisions to the clinical model. Care Clustering is being used to support this work and help stratify the patient population	High
Lack of clear Urgent and Emergency Care clinical model	Review Urgent and Emergency Care clinical model to be undertaken to introduce a single inpatient clinical model [ACTION OWNER COO]	31/10/2018	Fortnightly meetings in situ with agreed draft plan in place and further commitment to provide revised clinical model and clinical standards for internal and external use. Urgent Care Strategy group (led by COO) commenced to review development of urgent and emergency care.	High
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Related operational high/extreme risks: None specifically identified				

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

Operational risk information extracted from Datix 18 06 18_updated 13 08 18

Derbyshire Healthcare NHS Foundation Trust

Board Committee Summary Report to Trust Board
Quality Committee – Meeting held 10 July 2018

Key items discussed

- Mortality trend is of concern. This is a worsening position. The Board agreed in July that front line provision should take priority over putting additional time and resource into mortality investigations
- Duty of Candour Policy and Procedures expired policy – agreed
- Deloitte Well Led Framework Review Phase 3 reviewed, committee agreed that it has full oversight of these actions
- Board Assurance Framework was reviewed, Committee agreed: CQC warning notice considered and concerns raised on Autism, Cubley Court and Physical Healthcare. Work to mitigate is underway on all of these. Serious Untoward Incident closure rates continue to be poor and worsening.
- BAF Deep Dive Risk 1a Safety and Quality Standards – new IT equipment discussed. 100 day improvement plan underway.
- Quality Dashboard – Number of incidents of moderate harm and deaths reported has trebled since May. Capacity and resource is required to care for patients.
- Draft Safety Planning Audit in Neighbourhood services - ongoing to be managed through COATs.
- Complaints and Compliments Annual Report – Analysis at the operational level, more valuable to divisions/leads. Format to be reviewed.
- Clinical Research and Development Annual Plan received and ratified.
- Neighbourhood Services Review. Operational pressures and risks noted and discussed. New model expected for September to mitigate these.

Assurance/lack of assurance obtained

- Significant assurance obtained that appropriate action is being taken on BAF Risk 1a
- Limited assurance received on Quality Dashboard due to pressure the teams are under
- Significant assurance on Neighbourhood Service audit and plans to be managed through Neighbourhood COAT
- Limited assurance received on Complaints and Compliments Annual Report and work due to a small number of complaints not responded to with the required 3 days
- Significant assurance received on the Clinical Research Annual Plan and work programme/intentions for 2019
- Significant assurance received that Neighbourhood Review is progressing as intended

Key risks identified • The need to balance front line provision with resource required to investigate SUIs and patient deaths and to improve closure rates • CQC Warning Notice timely and robust action required to close down • Autism commissioning gaps impacting the Trust's patients • Much to do to improve physical healthcare performance	
Decisions made None	
Escalations to Board or other committee • Serious Untoward Incident closure rates	
Committee Chair: Julia Tabreham	**Executive Lead: Carolyn Green**

Derbyshire Healthcare NHS Foundation Trust

Board Committee Summary Report to Trust Board
Audit and Risk Committee – Meeting held 17 July 2018

Key items discussed

- Email analytics IG additional information – the NED challenge confirmed as having been satisfied. (Continue looking at trend at IG group and next report to Committee to include focus on that)

- Annual Report laid before parliament

- BAF – second issue 2 Extreme and 9 High rated risks. No changes to ratings since last meeting. Deep dive programme incorporated into forward plans going forward. Will review measures of success that will move the ratings (picking up on any relevant CQC feedback)

- Deep dive – Risk 4a Retain, develop, attract staff in specific teams. Hotspots are the challenge. Agreed to leave rating as extreme. Successful impact from social media on workforce supply. Microsite portal very successful promoting Derbyshire. Targeted mobile display – promotion with focus on qualified nurses. Need more conversion of microsite hits turning into applications. 'Back office' KPIs discussed: discussed work around the end-to-end review to streamline and improve bottle necks. Integrated innovative workforce models e.g. NMP, ACPs Associate Nurses etc. Discussion about score rating. With regard to recovery plans for hotspots AR expressed high level of confidence. Discussion about innovation such as rotational approach for newly qualified. The multi-generational effects on recruitment and people's career expectations. Learning points from support that is tailored to hotpots. Timeframe for changes: ?6 months to next state for current hotspots (although national supply issues will remain, more generally)

- Audit And Risk Committee objectives were discussed and agreed

- Internal and External Audit Recommendations progress – quarterly update – five new reports issued and the CF risk assessment included. 17 actions from audits and 10 from CF risk assessment. four remain open. Discussion of timeframes and any overdue actions. Discussion of job planning process and system and oversight at ELT.

- Clinical audit progress report – John Sykes (dialled in). Re-audit cycle: to be successful it is important to integrate training and coaching to improve practice. Underuse of benchmarked national audits that we are involved in: scope to improve the effect of tools to improve quality of care – suggestion to do fewer larger national units and fewer team audits. Quality Committee oversight already, so the Committee need to not duplicate with QC remit on clinical audit. Timeliness of completion is improved, process being managed better – increased focus on outcomes and action planning stage to improve impact on clinical care, some cultural changes as part of wider QI framework. 2018/19 focus on national audits and linking clinical audit with QI. Discussed how to measure success. Need strategic view of the resource to have highest impact on quality of care and incorporate any CQC findings.. Need impact summary at Quality Committee then it will come to ARC in year-end report.

- Deloitte Well Led phase 3 update recommendation related to risk (recs 3, 4, and 8). Discussed and agreed the blue forms for three recommendations mitigating actions included reports, updates to risk training and increase in datix capture. Analysis of relevant service areas to look into the type and frequency of risks reported e.g. at Hartington. Looked at staff survey and teams will focus on culture of reporting going forward e.g. by supporting relevant teams by offering bespoke training to support specific areas risks and systems accordingly. Discussion of reporting to Board and Committees.

- Conflict of Interest update. Still relatively low level of declarations particularly of secondary employment – to be captured in supervision, appraisal, induction and sickness absence reporting/monitoring etc. IA discussion and training. Raise profile of secondary employment issues through Team Brief etc.

- Board Committee chairs report resulted in a discussion on the governance status of the Committee Chairs meeting. Needs further clarification discussions.

- Standing Financial Instructions – annual update. Noting secondary employment additions. Approved.

- Waiver log – 6 months of 2017/18. No undue trends. Waiver log – missing columns need to be complete in order to close off as soon as possible (not wait for October meeting). Number 12 confusing – (e.g. '£100,00'). Need assurance have made the right decisions and can't take assurance from process as yet because of incomplete document.

- Internal Audit – progress report, plan delivery across planned audits to November 2018, noting audit timeframes and end of contract. Also the situation of the health sector and component parts therein.

- Counter Fraud update – discussions on secondary employment and sickness absence review commencing next week. Discussion of referrals resulting in system weaknesses being identified but not fraud. NHSCF issued procurement and invoice fraud updates. Discussions of reactive referrals and whether there are any potentially malicious referrals

- External Audit update – Audit Letter published to conclude the 2017/18 audit process. Discussion of sector updates. Includes the Annual Audit Letter that went to Council of Governors

- Closing business. No updates required to BAF as a result of discussions. Forward plan July column to have the SFI cross added. BAF deep dives, lead execs name and where to, to be updated

- Meeting effectiveness – late papers only to be accepted with chair approval agreed (didn't have any). Incomplete paper affected that item. Appropriate time given to agenda items. Duplication of discussion to continue to be cautioned against. Assurance summaries good. Slightly difficult with late notified sickness apology but email brief beforehand supported Chair.

Assurance/lack of assurance obtained

- BAF – Significant assurance
- Audit actions progress – significant assurance
- Deep dive on 4a Recruitment, Retention, Develop – significant assurance on process, limited assurance on the outcome currently. Innovations very well received.
- Clinical audit – significant assurance on arrangements
- Deloitte Well Led completion of recommendations – Full assurance for rec 3 and 4 and significant assurance for recommendation 8 (embeddedness for this one needs periodic review at most appropriate committee – action matrix come back in 6 months unless better to go elsewhere)
- Conflict of interest – Limited assurance
- SFIs – Full assurance on updated document
- Waiver – defer judgement on assurance until receive complete document
- Internal Audit plan – significant assurance with plan to complete to time
- Counter Fraud plan – significant assurance
- External Audit – full assurance
- Confidential session - fully assured on progress with procurement processes and decisions

made to date
Key risks identified • Deep dive – workforce supply (known risk) • Clinical audit – COATs and CRG capacity to appropriately prioritise clinical audit/QI impacts. Pick up that discussion at Quality Committee • Potential duplication of reporting at IPR at board, QC – Execs to consider and clarify. Rachel Kempster to discuss with Sam Harrison
Decisions made • BAF approved • ARC objectives agreed (and review in 6 months) • Adequate overview at Quality Committee and Mental Health Act Committee, annual reporting will to continue to be made to the Audit & Risk Committee • Deloitte Well Led recommendation blue forms accepted. • SFIs – updated document approved • Full set of info required for Waiver log before judgement can be made – needs concluding prior to next meeting
Escalations to Board or other committee Cross reference to Quality Committee: discussion of COATS/CRG capacity to support the progress of using clinical audit in QI plans

Committee Chair: Geoff Lewins	**Executive Lead: Sam Harrison, Director of Corporate Affairs and Trust Secretary**

Derbyshire Healthcare NHS Foundation Trust

Board Committee Summary Report to Trust Board
People & Culture Committee – Meeting held 24 July 2018

Key items discussed

- Minutes of meeting of the People & Culture Committee (PCC) held 5 June 2018 - approved as an accurate account of the meeting.

- Actions Matrix reviewed.

- Matters Arising - the Committee discussed the training compliance and agreed that the focus needs to be at the stage of achieving compliance rates. The Committee was briefed that plans are afoot to improve the delivery model that will improve effectiveness and efficiency.

- The Policy Matrix was noted. A decision is to me made if the Trust needs an Engagement Strategy in light of the range of activities that are underway. Agreement was reached to extend two policies renewal dates - Chronic Health Conditions/Disability Policy Procedure and Employee Performance Improvement Policy and Procedures.

- Staff Story - A member of staff attended the meeting and shared their experience since joining the Trust in 2017 as a Healthcare Assistant after relocating to Derby and focussed on how the use of social media had a positive effective in connecting him to the Trust. He also described the encouraging response received since joining the organisation and how he has been supported to engage in Trust activities and be the voice of staff via becoming a Staff Governor and as a Nurse Ambassador.

- Review of Revised Terms of Reference - Changes to the Terms of Reference were approved. Agreed that PCC members will hold two engagement meetings per year with Staff Side and Staff Governors to share the work programme of PCC.

- Review of Board Assurance Framework (BAF) Risks - BAF risks were reviewed and discussed. Risk 2 – Staff Engagement was discussed to establish whether this was still a red rated (high) risk. It was agreed that this will remain a red risk as People First is a Trust priority and until we have sufficient evidence that staff engagement is improving. Progress is tracked via the pulse check and staff survey results. BAF risk 4c regarding workforce model will come back to the Committee in December through the refreshed Multi-disciplinary workforce plan.

- Deep Dive BAF Risk 4a as presented to Audit & Risk Committee 17 July 2018. BAF risk 4a – Workforce Supply was discussed and Audit and Risk Committee and PCC receive an update. The Committee took assurance on the activity but limited assurance on the ability to move the risk out of the red in the near future.

- Strategic Workforce Report - The Committee received a report on the AFC (Agenda for Change) pay deal, 2018 Junior Doctor terms and conditions, Tier 2 rules, the work the Trust is doing on talent management, the development of a wellness and disability network and zero tolerance to bullying and harassment. Further updates will be

provided to the Committee over future months.

- Mental Health Workforce Plans as part of the STP (Sustainability and Transformation Progamme). The Committee received the STP (Sustainability and Transformation Partnership) Mental Health Workforce Plan which was submitted to HEE (Health Education England) and is waiting to hear about the next steps for funding and education commissioning. This will be included in the Committee's work plan once we hear more on the national direction.

- Mandatory Training for Campus (closing the CQC Actions / Deloitte Well Led Phase 3 Recommendations). Progress noted, action is now merged into the monthly performance reporting and any underperformance managed via the Trust Management Team (TMT), Executive Leadership Team (ELT).

- Recruitment Hotspots. Report was received, it was agreed to track the Radbourne Unit recruitment and retention for success. Lack of assurance at this stage agreed.

- Onboarding Principles. The WARM principles guide was shared with the Committee. The approach was well received for its simplicity and approach. Significant assurance received.

- Flu Campaign plan and approach was discussed

- Access to Staff Support. The Committee supported the recommendation to undertake a review of the range of staff support services available to staff and to understand why the EAP (Employee Assistance Programme) usage is so low. Paper to ELT (Executive Leadership Team) then PCC in October 2018 with suggested way forward.

- Leadership and Management Strategy. PCC members supported the Leadership and Management Strategy.

- Workforce Performance Report. Committee requested the People Resourcing team focus on the staff in the pipeline to speed up staff commencing employment across the Campus teams.

Assurance/lack of assurance obtained

- Positive assurance received for the Staff Story

- Terms of Reference approved

- BAF risks – significant assurance on inputs but limited assurance on the outcomes at this stage

- BAF risk 4a – Deep Dive – Risk was subject to a deep dive at the Audit and Risk Committee. Significant assurance provided on inputs but not on the outcome at this stage

- Mandatory Training for Campus, the Committee received significant assurance from the report and that all future monitoring is included in the workforce performance report

- Recruitment hotspots – limited assurance received

- Onboarding principles - significant assurance received
- Flu campaign plan for 2018/19 received significant assurance
- Workforce performance report - the content was noted but there was lack of assurance on recruitment pipeline and request to expedite the applicants in the process

Key risks identified

- Recruitment pipeline
- Achieving 75% flu vaccination rate to for the 2018/19 CQUIN target
- Current EAP scheme take up rates

Decisions made

- Management and Leadership Strategy was supported
- For ELT and PCC to receive a proposal on staff support services in October 2018
- To ask the People Resourcing Team to focus on the applicants in the pipeline for speedy start dates

Escalations to Board or other committee

- None identified

Committee Chair: Margaret Gildea	**Executive Lead: Amanda Rawlings, Director of People Services and Organisational Effectiveness**

Derbyshire Healthcare
NHS Foundation Trust

Board Committee Summary Report to Trust Board
Finance & Performance Committee – Meeting held 24 July 2018

Key items discussed

- Minutes from meeting held 15 May 2018 – duplicate first para aside from that accepted

- Action Matrix and Matters arising – greens accepted, Civica e-prescribing action close it, data quality discussion closed off by MP update – that needs circulating after meeting

- Policy Matrix – no issues

- Board Assurance Framework – F&P risks for consideration
  Changes being in blue was well received. Deep dive format – needs review of format: Execs to discuss. Committee will review the perceived level of risk for 3b influence of joined up care after relevant discussion on the relevant paper. 4d flow risk will be updated for the 100 day plan impacts

- Commissioning Interface and Contract Update
  Evolving picture with increased risk, meetings with commissioners and compliance with MHIS and perceived 'overinvestment' and CCG aim to rescale investment. Looking to mitigate by addressing growth aspects (cost and income). Mental Health STP workstream to discuss this week. Discussions about PICU budget holding in longer term (and associated factors). CCG view of contractual notice obligations as per discussions at recent CMDG. Correction to the clarification of the definition of MHIS including LD/Dementia.

- Operational Performance and KPI Achievement
  PICU working group with commissioners. Level of adult out of areas is fluctuating. 100 day plan should see positive impact from September although occupancy rates are very high in some areas. Nationally very low availability of beds. Clustering discussed elsewhere. Seven day follow ups and national move to three day target. Outpatient cancellation and DNAs: some improvement and availability. TMT agreement to adopt three week advance notice in two areas to trial. Discharge email summaries now fully automated. DTOCs are variable but very low compared to national. Generally performance is good.

- Progress report on Clustering
  Some pockets of teams that are using clustering effectively and flow through team working well. But generally-speaking not sufficient progress being made. RCI impact: i.e. the services' reference cost index is a function of clustering capture of activity and costs. Continuous improvement example such as Bolsover where it's creating value for practice and continuous improvement, which appears greater in community services compared to inpatient services. Harness good practice to encourage the evidencing of benefit of clustering. Discussions on Leadership approaches and incorporation of various 'stratification' of patient needs/systems/approaches and best practice.

- CIP Delivery and Continuous (Quality) Improvement Delivery Programme
  Plan CIP delivery £145k short of £4.8m. In year £246k behind of phased plan. c£1.4m level of risk within the plan not yet full assured and delivered. PAB wish to see the move towards discussion from risks around completeness of CIP plan to move to describing oversight of risks of the delivery of the financial requirements. QIA rejections discussed 8 rejected at time of report. 30 QIAs accepted. Table 3 columns which are not fully assured and or delivered total

£1.4m and that is the risk level. Focus of assurance activity is on biggest delivery risks. Quality improvement implementation plan described that will go to QC Scale of ambition was noted ie 55% of staff being engaged

- Procurement Exception for Contract Notice and Tenders
  Noted content and progress

- Assurance on delivery of Estate Strategy
  Review against current strategy. List of leases discussed. Different approach for next iteration of the strategy. Future smoothing and improved alignment of usage of buildings across the week discussed. Service user and staff engagement are equally important for the new estate strategy that will be led by the clinical strategy. Carbon usage table reviewed. Building management system evidencing optimisation. Discussion of Derbyshire system estates linkages allied to STP estate strategy. Six facet survey approach discussed e.g. aging backlog requirements against new investments and refurbs and new governance and assurance structures. Forward looking approach in future. Ward 1 and 2 discussions. Next steps: MP will take to ELT to consider next approach, key decision points and key governance. Proposal: November 2018 MP will update on progress with new strategy and approach and then new approach presented for January 2019

- Financial Performance and Planning Update
  As discussed elsewhere in agenda items several risks are increasing, CIP not fully met yet, gap to year end, pay award funding gap. Challenging but is still deliverable with appropriate actions committee to stay informed in between meetings.

- Reference cost sign-off process update – Agreed: ratification of previous agreement ahead of the meeting

- Specific update re: Electronic patient record system discussions were noted.

- Any Other Business – NHSI letter responding to Plan. CM asked CW to circulate to F&P/Board

- Review of 2018/19 Forward Plan – need to add November interim and January fuller Estates updates. Add clustering in November and 6 months another paper.

- Issues to be escalated to Board, Audit and Risk Committee or other Board Committees – none specific

- Confirmation of any updates to F&P Committee BAF risks – in considering the JUCD risk – Committee felt that discussions were live and would be premature to elevate the risk immediately but if £2m issue not resolved then will elevate the impact score of the JUCD risk

- Meeting effectiveness – good meeting, strong papers, meeting room far too hot

Assurance/lack of assurance obtained

- Commissioner interface and discussions around contract value – limited assurance

- Estate strategy – significant assurance in good control of current estate heading into development of new strategy aligned to clinical and operational strategy delivery

- Clustering – Limited assurance

- Performance – Significant assurance

- CIP – Limited assurance

- Financial performance – limited assurance given the level of risks being carried.

Key risks identified

- Commissioner-related risks: their view of MHIS calculation and rescale of investment: risk = of loss of income and impact on forecast. PICU costs if CCG look to transfer insufficient budget. CCG view on notice on the 18/19 contract (noting however the expected mitigation of there being Commissioner Requested Services)
- Cluster buy-in and effectiveness of clustering, lack of progress as it currently stands
- CIP – related risks: non achievement to date is compounded by, and is compounding, the overall worsening of forecast financial performance factors. CCG view of 'share' of future CIPs (QIPP). Level of non-recurrent CIPs.
- Financial performance: forecast year end has worsened due to multiple factors as described.

Decisions made

- Keep members updated of evolving discussions with commissioners in between F&P committees
- Clustering: Given lack of progress, ELT to consider what is the best approach to improve engagement and use and develop a more nuanced approach focussed on community services clustering (incl HONOS and ReQol) in the context of other related evolving reviews (e.g. CPA and payment systems), RCI impact, linking to continuous approach in community services.
- Reference cost sign off process update – Agreed: ratification of previous agreement ahead of the meeting

Escalations to Board or other committee

- None

Committee Chair: Richard Wright	**Executive Lead: Claire Wright, Deputy Chief Executive and Director of Finance**

Derbyshire Healthcare NHS Foundation Trust

Board Committee Summary Report to Trust Board
Quality Committee - meeting held 14 August 2018

Key items discussed

- Medicines Management Committee (MMC) Governance Arrangements presented by John Sykes. Ratified that the MMC should provide assurance reports to the QC, with some suggested amendments around operational input to the committee, namely medical input from Children's and Learning Disability Services, and nursing input from Children's services.

- Serious Incidents Bi-monthly Reporting – it was agreed that this is now part of the 100 day action plan work, with resource review requested from Chief Operating Officer (COO).

- Policy Status Matrix was noted

- Summary of Board Assurance Framework (BAF) risk for Quality Committee. Committee reviewed a reference summary of the BAF risks that would populate the next iteration of the BAF for the Board on 4 September. Also discussed the identification of a NED for children's, or looking at more broadly approaching this via a more balanced team brief. NED role was agreed to be overseen by Anne Wright as Safeguarding NED.

- Quality Dashboard. Concerns around the data in the dashboard around the overdue Serious Incidents and actions, but this data improved within the Serious Incident Report (see below) as this covers a later time period

- Update on CQC Visit to Older Adults Services – verbal update from Deputy Director of Nursing & Quality Governance with regards to our response to the warning notice and progress made.

- Quarterly Risk Assurance Escalation Report Risk and Assurance Manager updated the Committee on our systems and processes, highlighting the most significant quality and clinical risks on the Trust Risk Register. Committee was also updated on the implementation of the Risk Management Strategy that will be taken through the Audit and Risk Committee.

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- Serious Incidents Bi-monthly Report: Overdue actions remain but situation has improved. Report will be reviewed in the autumn, potential of it moving to more of an assurance summary with less operational detail.

- Health and Safety Committee Annual Report covered our performance around Fire, Health & Safety, Moving & Handling and Security Management. Shows the Trust has good grip. Report received and accepted.

- Ligature Risk Reduction Report – now need documented Ligature Risk Assessments for all our community buildings where there is any patient access, whether or not we own the building. Action plan is in place.

- Quality Assurance Group Summary Report showed our process around how any clinical or quality concerns are escalated to our commissioners via the Quality Assurance Group

- Accessible Information Standards Update – update received around our ongoing compliance and work further undertaken in Learning Disability Services. Work currently underway to identify 'hot spots' of service users requesting British Sign Language

- Physical Healthcare Strategy Implementation Plan - verbal update from Medical Director who is

chairing a process of making sure that we have action plans behind each aspect of the strategy. Written report not yet available.

- Update on Safety Needs Assessment and Management of Safety Needs showed current progress, work underway to adapt in line with clinical requirements for different populations, and ongoing feedback from practitioners.

- Recovery Enablement Strategy showed current progress around this together with problems as a result of commissioning changes to the service user and carer involvement structures. Director of Corporate Affairs will flag with Director of People Services & Organisational Effectiveness the connection with Building Better Opportunities. Report approved.

- Update on use of eBurn and Smoking Cessation – verbal update from Director of Business Improvement and Transformation. Implementation of smoke-free continues to bring some difficulties, with some instances of assault on staff. County and City Public Health departments looking to review their policies to support the use of vapes. Some areas of Trust sites are now designated for the use of e-cigs. Verbal update noted

- Quality Improvement Strategy – Implementation Plan presented by Director of Business Improvement and Transformation. This focussed on the roll-out, communication and implementation of the Quality Improvement Strategy.

- Report on Autism Commission Service presented by Director of Business Improvement and Transformation. This was a clear summary of the contracts and service specifications that the Trust currently has in respect of Autism Spectrum Disorder (ASD). Good practice elsewhere was discussed, in particular Northamptonshire.

- Policy Review: Verbal update on Waiting List Team Approach (review of policy as ratified by TMT (Trust Management Team) written paper circulated outside of the meeting.

- Forward Plan and draft agenda for September meeting

Assurance/Lack of Assurance Obtained

- Significant assurance from the Quarterly Risk Assurance Escalation Report that this process is in place

- Limited assurance around the Patient Safety report due to the late closure of actions, but clear recognition of the progress

- Significant assurance around the Health and Safety Report

- Significant assurance around the action plan for ligature risk reduction, with oversight from the Health & Safety Committee

- Significant assurance that we have process to escalate relevant points with our commissioners

- Significant assurance with regards to the activity since April 2018 around Accessibly Information Standards

- Assurance re physical healthcare strategy to be considered when a written report is submitted

- Limited assurance re Safety Planning due to compliance rates of completed forms

- Limited assurance re Recovery Enablement Strategy due to the impact of changes in commissioned structures for service user and carer input

- Significant assurance with the Quality Improvement Strategy Implementation Plan

Key risks identified

- Discussed the emerging theme of a perceived lack of engagement from the Trust from Children's services colleagues
- Concerns around the data in the dashboard around the overdue Serious Incidents and actions. This has been escalated to Board for information and has also been flagged with ELT. (Evidence of improvement in this performance is in the SI report which includes a later time period)

Decisions made

- Agreed to the review of the sustainability of the adult assessment only ASD service
- For the Director of Business Improvement and Transformation to work with commissioners to progress an ASD service provision within the Trust and
- Supported the aims of the newly formed ASD Group to establish a Trust position in respect of Autistic Spectrum Disorder
- The Committee agreed to await a response from Mark Powell as to the additional resource required to speed up the closure of Serious Incident (SI) reporting before escalating this issue to the Board.

Escalations to Board or other committee

- To re-escalate the issue of incomplete Serious Incident actions to Board
- Decision required by the Board for the Trust's own case study examples to be used within the Raising Concerns and Whistleblowing training programme

Committee Chair: Dr Julia Tabreham	**Deputy Executive Lead: Darryl Thompson, Deputy Director of Nursing & Quality Governance**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 September 2018

Report from the Council of Governors Meeting
Held on Tuesday 3 July 2018

The Council of Governors met on Tuesday 3 July 2018 at the Ashbourne Centre, Kingsway, Derby. The meeting was attended by 21 governors.

Questions Received from Members of the Public
Two questions had been received from members of the public. Richard Wright, Non-Executive Director and Chair of Finance & Performance Committee responded to a question regarding the Trust's financial performance and over-achievement of the control total by £663,000. Caroline Maley, Trust Chair responded to a question on concerns regarding the use of IAPT therapists in job centres. In responding to each question, clarity was provided and responses were reported in full in the public minutes of the meeting. A copy of the response was also provided to the individuals who raised the questions.

Annual Accounts 2017/18
Claire Wright, Deputy Chief Executive & Director of Finance presented a summary on the financial performance of the Trust during 2017/18. Overall, the Trust's performance has exceeded plan by £663,000 with additional incentive funding received to be used to fund capital projects to benefit staff and patients.

External Auditor Opinion On The Annual Report And Accounts 2017/18
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 & Risk Committee gave an update on the work he had undertaken and been involved with since appointment to the Trust in December 2017, highlighting how he holds Executive Directors to account through the course of his role.

Integrated Performance Report Summary
Caroline Maley presented the Integrated Performance Report to provide the governors with an overview of performance as at the end of May 2018. Each of the Non-Executive Director Board Committee Chair reported on how the report had been used to hold Executive Directors to account in their respective Board Committees for areas with regards to workforce, finance, operational delivery and quality performance.

Escalation Items to the Council of Governors
Three items were escalated to the Council of Governors from the Governance Committee. Amanda Rawlings, Director of People & Organisational Effectiveness, responded to a question relating to the recently established People Services Team. Ifti Majid responded to two questions regarding crisis information on the Trust website and a request for assurance on how the voice of mental health is being heard and addressed within Joined Up Care Derbyshire. In responding to each question, clarity was provided and are reported in full in the public minutes of the meeting. A copy of the responses was tabled for each governor.

Staff Engagement Update
Richard Wright, Non-Executive Director, presented the update on behalf of Margaret Gildea. The Council of Governors noted the Trust's position in relation to the staff feedback received over the past six months, including the NHS Staff Survey and Pulse Check results, where key themes have been identified and the suggestions in terms of the local engagement pilot

across services. They took assurance from the next steps outlined in the report and noted the ongoing internal communications programme for staff engagement.

Membership Of The Governors' Nominations & Remuneration Committee
The Council of Governors approved a process to seek expressions of interest from staff and appointed governors for membership of this Committee.

Governance Committee Report
Gillian Hough, Chair of the Governance Committee presented a report of the meeting held on 12 June 2018 and encouraged governors to consider the upcoming roles of Chair and Deputy Chair of the Governance Committee.

Staff Governor Job Description
The Council of Governors approved a staff governor job description, which provides clarification on the role of the staff governor.

CQC Feedback
Ifti Majid, Chief Executive, summarised the activities that had taken place to date as part of the CQC inspection.

2018-19 Board Annual Forward Plan

Exec Lead	Item	1 May 18	5 Jun 18	3 Jul 18	4 Sep 18	2 Oct 18	6 Nov 18	4 Dec 18	5 Feb 19	5 Mar 19
		23 Apr	25 May	25 Jun	24 Aug	24 Sep	29 Oct	26 Nov	28 Jan	26 Feb
SH	Declaration of Interests	X	X	X	X	X	X	X	X	X
CM	Minutes/Matters arising/Action Matrix	X	X	X	X	X	X	X	X	X
CG	Actions and learnings from patient stories	X				X		X		X
CM	Board Forward Plan (for information)	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
STRATEGIC PLANNING AND CORPORATE GOVERNANCE										
CM	Chair's Update	X	X	X	X	X	X	X	X	X
IM	Chief Executive's Update	X	X	X	X	X	X	X	X	X
MP/CW	NHSI Annual Plan - timing to be confirmed						X			
JS	Data Security and Protection - annual declaration									A
AR	Staff Survey Results and Action Plan									X
AR	Equality Delivery System2 (EDS2) & Workforce Race Equality Standard (WRES) Submission	A			X				X Benchmarking report	
AR	Pulse Check Results and Staff Survey Plan				X					
SH	Corporate Governance Framework						A			
SH	Trust Sealings	X				X				
SH	Annual Review of Register of Interests	A								
SH	Board Assurance Framework Update	X			X			X		
SH	Raising Concerns (whistleblowing) and Freedom to Speak Up Guardian Report			X					X	
SH	Committee Assurance Summaries (following every meeting) - Audit & Risk Committee - Finance & Performance - Confidential - Mental Health Act Committee - Quality Committee - Safeguarding Committee - People & Culture Committee	X	X	X	X	X	X	X	X	X

Exec Lead	Item	1 May 18	5 Jun 18	3 Jul 18	4 Sep 18	2 Oct 18	6 Nov 18	4 Dec 18	5 Feb 19	5 Mar 19
SH	Fit and Proper Person Declaration	X								X
MP	Emergency Planning Report (EPPR)						A			
SH	Board Effectiveness Survey									X
SH	Report from Council of Governors Meeting (for information)		X		X	X		X	X	
SH	Review of Policy for Engagement between the Board & COG									A
SH	Board Development Programme									X
GH	Business Plan 2017-18 Monitoring					X				X
GH	Measuring the Trust Strategy	X								
SH	Well Led Recommendations - update report on Phase 3 Deloitte recommendations to be received at the November 2018 Board meeting						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
QUALITY GOVERNANCE										
CG	Quality Report (Incorporates Strategy and assurance aspects of Quality management) Quarterly publication of specified information on death in Jan/Mar/JulOct/Feb/Apr			X	X	X	X	X	X	x
CG/JS	Safeguarding Children & Adults at Risk Annual Report				A					
CG	Control of Infection Report			A						
JS	Annual report on Re-validation of Doctors including NHSE Returnon Medical Appraisals sign off by Trust Chair			A						
CG	Annual Review of Recovery Outcomes						A			
CG	Annual Looked After Children Report					A				

GLOSSARY OF NHS AND DHCT TERMS	
NHS Term / Abbreviation	**Terms in Full**
A	
A&E	Accident & Emergency
ACCT	Assessment, Care in Custody & Teamwork
ACE	Adverse Childhood Experiences
ACP	Accountable Care Partnership
ACS	Accountable Care System (now known as ICS)
ADHD	Attention Deficit Hyperactivity Disorder
AfC	Agenda for Change
AHP	Allied Health Professional
ALB	Arms-length body
AMHP	Approved Mental Health Professional
ASD	Autism Spectrum Disorder
ASM	Area Service Manager
B	
BAF	Board Assurance Framework
BMA	British Medical Association
BAME	Black, Asian & Minority Ethnic group
C	
CAMHS	Child and Adolescent Mental Health Services
CASSH	Care & Support Specialised Housing
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CCT	Community Care Team
CDMI	Clinical Digital Maturity Index
CEO	Chief Executive Officer
CGA	Comprehensive Geriatric Assessment
CIP	Cost Improvement Programme
CMDG	Contract Management Delivery Group
CMHT	Community Mental Health Team
CNST	Clinical Negligence Scheme for Trusts
COAT	Clinical Operational Assurance Team
COF	Commissioning Outcomes Framework
COG	Council of Governors
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPR	Child Protection Register
CQC	Care Quality Commission
CQUIN	Commissioning for Quality Innovation
CRB	Criminal Records Bureau
CRG	Clinical Reference Group
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CTO	Community Treatment Order
CTR	Care and Treatment Review

GLOSSARY OF NHS AND DHCT TERMS	
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
DTOC	Delayed Transfer of Care
DVA	Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action)
DWP	Department for Work and Pensions
E	
ECT	Enhanced Care Team
ECW	Enhanced Care Ward
ED	Emergency Department
EDS2	Equality Delivery System 2
EHIC	European Health Insurance Card
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising & Reprocessing Therapy
EMR	Electronic Medical Record
EPR	Electronic Patient Record
ERIC	Estates Return Information Collection
ESR	Electronic Staff Record
EWTD	European Working Time Directive
F	
FBC	Full Business Case
FOI	Freedom of Information
FFT	Friends and Family Test
FSR	Full Service Record
FT	Foundation Trust
FTN	Foundation Trust Network
F&P	Finance and Performance
5YFV	Five year forward view
G	
GDPR	General Data Protection Regulation
GGI	Good Governance Institute
GMC	General Medical Council
GP	General Practitioner
GPFV	General Practice Forward View
H	
HEE	Health Education England

GLOSSARY OF NHS AND DHCT TERMS	
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 Disablities
LHP	Local Health Plan
LHWB	Local Health and Wellbeing Board
LOS	Length of Stay
M	
MARS	Mutually Agreed Resignation Scheme
MAU	Medical Assessment Unit
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.
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 DHCT TERMS	
NHS Term / Abbreviation	**Terms in Full**
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard
MHRT	Mental Health Review Tribunal
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
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PHE	Public Health England
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PLIC	Patient Level Information Costs
PMLD	Profound and Multiple Disability
PPT	Partnership and Pathway Team
PREM	Patient Reported Experience Measure
PROMS	Patient Reported Outcome Measure
Q	
QAG	Quality Assurance Group
QC	Quality Committee
QIPP	Quality, Innovation, Productivity Programme
R	
RAID	Rapid Assessment, Interface and Discharge
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
RTT	Referral to Treatment
S	
SAAF	Safeguarding Adults Assurance Framework
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services

GLOSSARY OF NHS AND DHCT TERMS	
NHS Term / Abbreviation	**Terms in Full**
SEND	Special Educational Needs and Disabilities
SI	Serious Incidents
SLA	Service Level Agreement
SLR	Service Line Reporting
SOC	Strategic Options Case
SOF	Single Operating Framework
SPOA	Single Point of Access
SPOE	Single Point of Entry
SPOR	Single Point of Referral
STEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Partnership
S(U)I	Serious (Untoward) Incident
T	
TARN	Trauma Audit and Research Network
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TMT	Trust Management Team
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
TMAC	Trust Medical Advisory committee
W	
WTE	Whole Time Equivalent