NHS
Derbyshire Healthcare
NHS Foundation Trust

Meeting of the Board of Directors

1 March 2017

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NHS Foundation Trust

NOTICE OF BOARD MEETING - WEDNESDAY 1 MARCH 2017
TO COMMENCE AT 1.00 PM IN CONFERENCE ROOMS A&B, FIRST FLOOR,
RESEARCH & DEVELOPMENT CENTRE, KINGSWAY, DERBY DE22 3LZ

	TIME	AGENDA	ENC	LED BY
1.	1:00	Chair's welcome, opening remarks and apologies for absence	**-**	Caroline Maley
2.	1:05	Service Receiver Story	**-**	Carolyn Green
3.	1:30	Declarations of Interest	**A**	Caroline Maley
4.	1:30	Minutes of Board of Directors meeting held on 1 February 2017	**B**	Caroline Maley
5.	1:35	Matters arising – Actions Matrix	**C**	Caroline Maley
6.	1:40	Acting Chair's Update - Voice of the Service User Community/Third Sector Discussion	**-**	Caroline Maley Mark Powell
7.	2:00	Acting Chief Executive's Update	**D**	Ifti Majid
OPERATIONAL PERFORMANCE, QUALITY AND STRATEGY				
8.	2:10	Integrated Performance and Activity Report	**E**	Mark Powell Claire Wright Amanda Rawlings Carolyn Green
9.	2:25	Position Statement on Quality	**F**	Carolyn Green
10.	2:35	Board Committee Assurance Summaries and Escalations: Quality Committee 9 February, People & Culture Committee 21 February, *(Safeguarding Committee 24 February to follow)*	**G**	Committee Chairs
3:45 B R E A K				
11.	3:00	Deep Dive - Neighbourhoods	**H**	Mark Powell
GOVERNANCE				
12.	3:20	Governance Improvement Action Plan Update	**I**	Sam Harrison
CLOSING MATTERS				
13.	3:30	Any Other Business	**-**	Caroline Maley
14.	3:35	2017/18 Board Forward Plan	**J**	Caroline Maley
15.	3:45	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	**-**	Caroline Maley

Questions that are applicable to the agenda, and at the Chairman'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.turner2@derbyshcft.nhs.uk

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 1.00 pm on 26 April 2017
in Conference Rooms A & B, Centre for Research and Development, Kingsway, Derby DE22 3LZ
Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.
Participation in meetings is at the Chairman's discretion.

Declaration of Interests Register 2016-17

NAME	INTEREST DISCLOSED	TYPE
Margaret Gildea Non-Executive Director	Director, Organisation Change Solutions Limited Non-Executive Director, Derwent Living	(a, b)
Ifti Majid **Acting Chief Executive**	Board Member, North East Midlands Leadership Academy Board	(a)
Caroline Maley Acting Trust Chair	Director – C D Maley Ltd Trustee – Vocaleyes Ltd.	(a) (a, d)
Barry Mellor Non-Executive Director	Non-Executive Director, Rotherham NHS Foundation Trust Trustee, Rotherham Hospital Charity Mrs Mellor is a befriender with Age UK	(a, d)
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	(a, d)
Dr John Sykes Medical Director	Independent Deprivation of Liberty mental Health Assessor undertaking assessments on patients at the request of Derbyshire County Council via Medical Director's secretary	(b)
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 Board member, RESTORE (supporting older offenders in the criminal justice system) Lay Member - National Institute for Health and Care Excellence, Guideline Development Group, National Collaborating Centre for Mental Health of Adults in the Criminal Justice System Julia Tabreham is assisting NICE (National Institute for Health and Care Excellence) to write training programmes for people providing lay advice to its Guideline Development Groups Julia Tabreham has also been asked by the Department of Health to lead on the Parliamentary and Health Service Ombudsman's contribution to establishing NHS complaints advocacy support in Ireland	(a, d)
Lynn Wilmott-Shepherd Acting Director of Strategic Development	Director of Commissioning at Erewash CCG	(a)
Richard Wright Non-Executive Director	Director, Sheffield Chamber of Commerce Chair, The Sheffield College Multi Academy Trust Chair Sheffield University Technical College Member of Advisory Board of Sheffield National Centre for Sport and Exercise Medicine	(a)

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 share holdings in organisations likely or possibly seeking to do business with the NHS.
(d) A position of authority in a charity or voluntary organisation in the field of health and social care.
(e) Any connection with a voluntary or other organisation contracting for NHS services.

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

Wednesday 1 February 2017

MEETING HELD IN PUBLIC

Commenced: 1pm Closed: 4:25pm

PRESENT:	Caroline Maley	Acting Trust Chair
	Margaret Gildea	Senior Independent Director
	Dr Julia Tabreham	Deputy Trust Chair and Non-Executive Director
	Maura Teager	Non-Executive Director
	Dr Anne Wright	Non-Executive Director
	Richard Wright	Non-Executive Director
	Ifti Majid	Acting Chief Executive
	Claire Wright	Executive Director of Finance
	Carolyn Green	Executive Director of Nursing & Patient Experience
	Mark Powell	Acting Chief Operating Officer
	Amanda Rawlings	Director of People & Organisational Effectiveness
	Samantha Harrison	Director of Corporate Affairs & Trust Secretary
Until Item DHCFT/2017/026	Lynn Wilmott-Shepherd	Interim Director of Strategic Development
IN ATTENDANCE:	Anna Shaw	Deputy Director of Communications & Involvement
	Sue Turner	Board Secretary (Minutes)
	Jan Nicholson	Paediatric Occupational Therapist, OC Lead Children's Therapies
For Item DHCFT/2017/018	Kerry Grady	Occupational Therapist
For Item DHCFT/2017/029	Tracey Holtom	Acting General Manager for Campus Services
For Item DHCFT/2017/029	Lisa Stone	Area Service Manager Urgent and Planned Care Division
For Item DHCFT/2017/029	Pete Emery	Senior Nurse, Urgent and Planned Care Division
For Item DHCFT/2017/029	Carole Clay	Senior Nurse, Urgent and Planned Care Division
For Item DHCFT/2017/029	Bob Gardner	Nurse Consultant Psychiatric Liaison, Acute and Community Care Division
For Item DHCFT/2017/029	Keith Walters	Honorary Research Fellow (Self-Harm/Suicide Prevention) & Director of Centre for Self-Harm and Suicide prevention
APOLOGIES:	Dr John Sykes	Executive Medical Director
VISITORS:	John Morrissey	Lead Governor, Public Governor, Amber Valley South
	Mark McKeown	Derbyshire Mental Health Alliance
	Melissa Castledine	Derbyshire Mental Health Alliance

DHCFT 2017/017	**ACTING CHAIR'S WELCOME, OPENING REMARKS AND APOLOGIES** Caroline Maley opened the meeting and welcomed everyone. Apologies were noted from John Sykes. Carolyn Green introduced Jan Nicholson who she had invited to shadow her at the meeting.
DHCFT 2017/018	**SERVICE RECEIVER STORY** Carolyn Green introduced Jan Nicholson and Kerry Grady from the Children's

	Occupational Therapy team who described the difficulties they were experiencing in co-ordinating appropriate provision of powered wheelchair for a young boy who has cerebral palsy. They also told of the support they are providing for his family. The Board heard how in 2015 this boy had been referred for a powered wheelchair which would give him early mobility skills. Since 2015 he had grown and long term provision of a wheel chair had been applied for. This resulted in a powered wheelchair being delivered to his school. Although this wheelchair did not meet his postural needs the boy still managed to use it. However, the school was concerned about the safety aspect of the wheelchair being used on school premises and carried out a risk assessment. This resulted in the wheelchair being taken away from the child. The Board heard how the Occupational Therapy team provides much support to families and how they train children to use wheelchairs safely. Kerry explained that she was supporting the family in trying to get the wheelchair returned to the boy as his family are not able to solve this for themselves particularly as the mother does not have enough language skills or feel empowered to be able to deal with the situation. She had also made a complaint on the family's behalf through PALS (Patient Advice and Liaison Service) but had not yet received a response. The Board understood that demands for wheelchair provision far exceed the waiting lists. The fact that a wheelchair had been made available to this little boy and it was then taken away from him was a point of concern and Amanda Rawlings undertook to take this up with the Operational Director who leads the wheelchair provision. The Board agreed to revisit this story to learn how this case has moved forward. The Board thanked Jan and Kerry for bringing this matter to the Board's attention and for their efforts in trying to find a resolution for this young child and his family. **RESOLVED: The Board of Directors noted the effort made by the Occupational Therapy Team and thanked them for the support they were providing for the family.**
DHCFT 2017/019	**DECLARATIONS OF INTEREST** The Declaration of Interests register was noted.
DHCFT 2017/020	**MINUTES OF THE MEETING DATED 11 JANUARY 2017** The minutes of the previous meeting, held on 11 January were agreed and accepted subject to the attendance list being amended to show Barry Mellor present at the meeting.
DHCFT 2017/021	**MATTERS ARISING AND ACTIONS MATRIX** The Board agreed to close all completed actions. Updates were provided by members of the Board and were noted directly on the actions matrix.
DHCFT 2017/022	**ACTING CHAIR'S VERBAL REPORT** Caroline Maley reported that during the last three weeks she had mainly focussed on developing her role as the Acting Trust Chair. She had held a good introductory meeting with the CQC (Care Quality Commission) and feels confident the Trust will move forward with its ongoing challenges. An effective performance review meeting was also held with NHS Improvement (NHSI). A lot of questions were raised regarding finance and NHSI was pleased with the good progress the Trust is making with the Governance Improvement Action Plan (GIAP). Caroline Maley held a meeting with Lead Governor John Morrissey and she also intends

	to meet individually with other governors including Gillian Hough, Chair of the Governance Committee. She also reported that the Governors had held a Nominations and Remunerations Committee meeting where much discussion was held about the work governors propose to carry out within their constituencies. Caroline Maley had also met with Prem Singh and Tracy Allen, the Chair and Chief Executive of DCHS to discuss the plans for collaboration between our two organisations. During the next few weeks Caroline Maley plans to meet more staff and asked the Board to let her know of any members of staff who wish to meet her. She feels that although there are a lot of challenges to overcome it is clear there are a lot of staff in the Trust carrying out some extremely good work. **RESOLVED: The Board of Directors noted the Interim Chairman's verbal report.**
DHCFT 2017/023	**ACTING CHIEF EXECUTIVE'S REPORT** Ifti Majid, Acting Chief Executive, provided the Board of Directors with feedback on changes within the national health and social care sector as well as providing an update on developments occurring within our local Derbyshire health and social care community. The report also updated the Board on feedback from external stakeholders such as our commissioners and feedback from the Trust's staff. Ifti Majid was pleased to see that the Suicide Prevention briefing was on the agenda of today's meeting and commended the strategy that had been produced by this team. He also drew attention to Public Health England's new services that are focussing on the impact of alcohol on public health and how effective alcohol control policies have been. With regard to local matters, Ifti Majid reported that he went to the Health and Wellbeing Board (HWB) in January and made a presentation on mental health which focussed on challenges the Trust is currently facing. He was pleased with the support received from the Chair of the HWB and with the outcome that a sub-group of the HWB will help support the Trust with its local services. Ifti Majid drew attention to the informal weekly email he has recently started to send to all staff each Friday called The Weekend Note. He has been pleased with the response this has received and feels that this initiative has proved to be an effective way of engaging with staff. Mark Powell asked if any themes were emerging from responses from staff. It would seem these are mainly concerned with capacity and staff feeling they could do more if they have more time within their daily routine. A lot of the feedback showed that staff are concerned about the same issues as the Board and it was thought that this shows a good connection throughout the Trust. Ifti Majid reminded the Board that a Board Development Session will soon take place on diversity and equality although this will now be held in April rather than March. He asked that Board members in the meantime take a special interest when visiting different teams within the organisation to learn more about particular issues these REGARDs groups (Race, Economic disadvantage, Gender, Age Religion or belief, Disability and Sexual Orientation) have within our services. Julia Tabreham remarked that she looked forward to exploring this more and asked that the other Non-Executive Directors make an effort to focus on these issues when carrying out quality visits. **RESOLVED: The Board of Directors noted the Acting Chief Executive's update.**
DHCFT 2017/024	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT (IPR)** Mark Powell, Acting Chief Operating Officer, opened discussions on the integrated overview of performance in workforce, finance, operational delivery and quality performance as at the end of December 2016.

The theme this month was ongoing staffing and activity pressures. This was underpinned by the difficulty in achieving 100% Registered Nurse fill rates for night shifts on our inpatient wards. Although mitigated by extra Nursing Assistant cover this continues to be a concern and is being closely monitored. Under-occupancy on Wards 1 and 2 allowed temporary consolidations into one ward and this is seen as a very positive improvement and resulted in improved KPIs. The report provided assurance as to the Trust's quality perspective and ability to deliver CQC compliance. Although the report showed that early intervention in psychosis referrals to treatment target was not met, these records have since been corrected and Mark Powell assured the Board that future performance will not be affected by this and that January's rates are on track and above target.

Mark Powell pointed out that the new Delayed Transfer of Care (DTOC) target has been set very low by NHS England. This is 0.8% and will be very difficult to be achieved and he is working with the Regulators to see if this can be reanalysed. Mark Powell was also concerned about the performance target for outpatient letters and was pleased to point out that these are now definitely back on track for January.

Mark Powell and Carolyn Green provided the Board with an overview of matters discussed during NHS England's risk review meeting on 12 hour trolley breaches relating to mental health held earlier that day. Over December and January bed occupancy was high and it was sometimes difficult to adequately place individual patients and Mark Powell and Carolyn Green are working with Derby Royal Hospital on setting protocols to improve the care for mental health patients. They informed the Board that the Trust has fully engaged with and supported acute Trusts to ensure these patients were cared for until a bed was found for them. NHS England acknowledged that the Trust has worked positively on all levels. It is clear that more community investment is required to allow the Trust to achieve improved bed stocks so that patients can be looked after in a more managed way and a position statement is being written to show how the Trust managed the 12 hour trolley status. The Board thanked Mark Powell and Carolyn Green for summarising the outcome of the meeting they attended with NHS England. The Board recognised that trolley breaches resulted in poor patient experience and is not acceptable. It was noted that there will be ongoing discussions with commissioners regarding non provision of services such as PICU (Psychiatric Intensive Care Unit) CAMHS Tier 4 services in Derbyshire.

In considering the financial performance, Claire Wright responded to the impact of agency staff on the Trust's overall Use of Resources rating. She explained that to avoid triggering the override, the Trust would need to spend £360k less than forecast (ie to spend less than 50% above ceiling by the end of March). This would result in the overall use of resource rating of the Trust as 2 and not 3. Since last month there has been a favourable development that meant the previously unmet CIP gap has improved and in terms of this financial year, Claire Wright felt confident that the Trust will reach the required control total.

Carolyn Green highlighted that quality performance had continued to focus on addressing the issues arising from the Trust's recent Care Quality Commission (CQC) inspection report. She was pleased to report that a number of the Trust's Committees had received assurance on CQC plans. Although significant improvement has been made in management supervision, more headway is required for further improvement in clinical supervision in order to meet our own required standards. Maura Teager queried whether there was a reason for a rise in patients being secluded and it was thought that this was due to the fact that some very seriously ill and high risk patients were being cared for currently and the recent changes in the way incidents of seclusion have been recorded.

Amanda Rawlings addressed the people performance section of the report. She was pleased to report that agency usage had reduced slightly as had the vacancy rate. The People & Culture Committee was continuing to focus on recruitment and would look at

	improved models to work on. **RESOLVED: The Board of Directors considered the Integrated Performance Report and obtained a good level of assurance on current performance across the areas presented.**
DHCFT 2017/025	**<u>POSITION STATEMENT ON QUALITY</u>** Carolyn Green presented the statement to provide the Board of Directors with an update on the organisation's continuing work to improve the quality of services provided in line with the Trust's Strategy, Quality Strategy and Framework and strategic objectives. This month the report set out: • Learning, Candour and Accountability • Quality Leadership Teams and commencement of the Trust Management Team meeting • Quality visits and feedback from the January review forum • CQC action planning from the June comprehensive inspection visit and the Joint area local SEND inspection in Derbyshire The report covered learning, candour and accountability which was received by the Quality Committee in January. Particular attention was drawn to the joint inspection by the Care Quality Commission and Ofsted into areas for young people and children with special needs (SEND) and the letter that set out the results of the inspection. It was noted that this would be led by the Trust's Safeguarding Committee. Carolyn Green pointed out that the Quality Committee is working closely with the Quality Leadership Teams (QLTs). However, one team is working well and the other has yet to develop its effectiveness. John Sykes and Carolyn Green proposed take to the People and Culture Committee a detailed improvement plan on how to support this QLT and next month's Quality Position Statement will provide the Board with assurance as to how this will be addressed. Julia Tabreham drew the Board's attention to the GIAP action relating to the QLT team's achievement of actions. She was concerned that it was taking time for this process to embed and she proposed to meet with Carolyn Green outside of the meeting to discuss how this could be completed within the required timeframe. In response to Julia Tabreham's concern, Mark Powell took the opportunity to talk about the newly set up Trust Management Team (TMT). He explained that although it will take time for this meeting to evolve and fulfil its governance role it will focus on clinical priorities linked to operational aspects. He was working with Carolyn Green and John Sykes through TMT so that this can manifest itself with the QLT to help the team achieve accountability for its actions. The Board thanked Carolyn Green for a very informative position statement and agreed that a high level of assurance had been obtained from its content. **RESOLVED: The Board of Directors** **1. Received and noted the Quality Position Statement** **2. Gained assurance and information on the content of this very information position statement.**
DHCFT 2017/026	**<u>BOARD ASSURANCE SUMMARIES & ESCALATIONS</u>** Assurance summaries were received from the Audit & Risk Committee held on 17 January, Quality Committee 12 January and People & Culture Committee on 18 January.

	Audit & Risk Committee: No escalations were made to the Board from this Committee. Two Board Assurance Framework risks were reviewed and both were downgraded from high risk to moderate. **People & Culture Committee:** The People Plan and Workforce Plan and results of Staff Survey were the main topics covered during the meeting and a very inspiring story was heard from the Audrey House team on how they managed the move from Vernon Street to the Kingsway site which was an excellent example of management and patient care. **Quality Committee:** No escalations were made to the Board from this Committee. A lot of the issues discussed at the Quality Committee were contained in the Quality Position statement. The Committee Chair's only concern was delivery of embeddedness of the QLT GIAP recommendation outlined in item DHCFT 2017/025 above. Lynn Wilmott-Shepherd left the meeting at this point. **RESOLVED: The Board of Directors received the Board Committee Assurance Summaries and Escalations.**
DHCFT 2017/027	**EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) STRATEGY 2017-2020** This document set out the Trust's strategy for EPRR for the next three years. The purpose of the Strategy is to ensure the continual development of Derbyshire Healthcare Foundation NHS Trust's resilience and response to a significant/major incident and/or a severe disruption to business continuity and was brought to the Board for final approval. Julia Tabreham wished it to be recorded that Mark Powell and his team have achieved an enormous task in producing an extremely professional EPRR strategy. The Board noted that the strategy set out the EPRR framework for the organisation and obtained assurance that compliance will be regularly monitored by the Quality Committee and the Board duly approved the EPRR Strategy. It was noted that the EPRR annual report will be received each year by the Board and compliance will continue to be noted through the assurance summaries received by the Quality Committee. **ACTION: EPRR annual report to be captured in the 2017/18 Board forward plan.** **RESOLVED: The Board of Directors approved the EPRR Strategy.**
DHCFT 2017/028	**GOVERNANCE IMPROVEMENT ACTION PLAN (GIAP)** Sam Harrison presented the GIAP report which provided Board members with an update on progress on the delivery of the GIAP. The report reaffirmed the status and performance against all 53 core areas of the GIAP and outlined the approval pipeline for recommendations and completion of the blue approval forms. Sam Harrison highlighted one blue form for review by the Board which relates to a recommendation that has gone through Quality Committee. The Board reviewed the off track recommendations and these are summarised as follows: ***RR1 - Implement proposals to improve succession planning at Board level including ensuring that Governors are adequately engaged in this process. Alongside this, develop processes for succession planning for Senior Leader positions:*** The timeline for delivery has been revised and the Remuneration and Appointments Committee have agreed that RR1 would return to the April meeting for

close off and decided that this recommendation has moved from 'off track' to 'some issues' due to the reprioritisation of agreed timelines.

CQC2 - The Trust should continue to proactively recruit staff to fill operational vacancies: Evidence of this recommendation will be taken to the February meeting of the People & Culture Committee for sign-off.

ClinG1 - Refresh the role of Quality Leadership Teams to increase their effectiveness as core quality governance forums: Julia Tabreham asked that the evidence to be received by the Quality Committee from the QLTs over four months should be corrected to three months in the GIAP.

ClinG3 - Increase the effectiveness of the Quality Committee by ensuring clear alignment of the committee with the quality strategy and associated objectives, and ensuring a clear focus on seeking assurance: The Board noted that following discussion at January Quality Committee and subsequent Executive Director Lead meeting it was agreed that a blue form be prepared for the February meeting of the Quality Committee.

WOD7 - The Trust should monitor the adherence to the grievance, disciplinary, whistle-blowing policies and the current backlog of cases concluded: This was discussed at the People & Culture Committee and a blue form will be brought to the Committee at the February meeting for sign off.

The Board reviewed the Blue completion form for recommendation ***ClinG2 - the Trust would benefit from a robust and thorough policy review programme*** and was satisfied that this recommendation was now complete. Progress reports have been provided to the Quality Committee in June 2016 and October 2016 with respect to progress against the policy review programme as a whole. Deloitte reviewed progress on this recommendation as part of their phase 1 report and the December Audit & Risk Committee addressed the gap in reporting identified as part of this review (section 2.4). It was agreed at the December Quality Committee that this recommendation has been completed and a blue form could be prepared and submitted in January 2017.

Sam Harrison drew attention to the pipeline of blue forms that would be coming to the Board over forthcoming months and made the point that some of the forms could be presented at the extraordinary Board meeting to be held between the eight week period between next two Board meetings scheduled to take place on 1 March and 276 April.

Mark Powell considered that the approval pipeline was very helpful and asked if there were any significant risks against delivering to the approval pipeline. Sam Harrison responded that the Quality Committee had one recommendation that would continue to be monitored closely and the Committee will continue to monitor that progress is being made. She made the Board aware that we are now entering phase 2 of the GIAP when Deloitte will consider how the recommendations have been embedded and carried out during 'business as usual'. Deloitte will work with the Trust until the end of March to assess the impact of the GIAP on our activities. Sam Harrison reported that management consultants Deloitte have been commissioned to undertake Phase 2 of their external assurance work. Their work will focus on how the GIAP recommendations and actions have been completed, evidenced and embedded within the organisation.

RESOLVED: The Board of Directors:

1) Noted the progress made against addressing GIAP recommendations
2) Discussed the areas rated as 'off track' and 'some issues' and sought assurance where necessary on the mitigation provided
3) Formally approved the 1 blue form as presented and confirmed that this is provided assurance of completion, namely:

- **ClinG2**

	4) Noted the GIAP recommendations approval pipeline and its role in supporting effective oversight of progress
DHCFT 2017/029	**DEEP DIVE INTO OLDER PEOPLE INPATIENTS** Tracey Holtom, Carole Clay, Lisa Stone and Pete Emery joined the meeting to present a deep dive into the older people's pathway which focussed on improvements made to the service since the CQC visit in June in areas relating to security, compliance with the Mental Capacity Act and discharge planning. **Security:** The Board was assured by the robust plans taken to uphold the care of patients and their valuables and was pleased to note that this was now an area of high priority. **Mental Capacity Act:** When the CQC visit took place in June concern was raised that not enough detail was being recorded with regard to the Mental Capacity Act. This has since been addressed and assessments have significantly improved. The team now have a clinical compliance lead who will continue to lead on this work to ensure continued compliance. Maura Teager was aware of the pressures associated with staff capacity and the stress felt on the wards, and asked how the team could be confident of sustaining compliance. Pete Emery responded that it was clear that in the past the team was not fully complying with the Mental Capacity Act. Significant record keeping improvements in the PARIS system have been made and the team feel far more confident recording Mental Capacity Act activity. **Discharge planning:** Since the merger of the two wards on London Road, discharge planning has improved. The Board heard how the team had enhanced the system for discharge planning and that this has significantly improved patient experience. The team were able to help staff from other service areas with discharge planning which allowed them to upskill themselves. The team was commended by the Board for this initiative. The Board was pleased to hear that verbal feedback from the recent unannounced visit from the CQC was extremely positive and this was taken as further assurance of the improvements that have been put in place. The Board also heard how e-rostering management was a successful piece of work undertaken by the team and this should be extended across the organisation. Mark Powell added that he was grateful for the support and motivation the team provided for other staff groups and this was a testament to the way this team operates. Ifti Majid felt there was great leadership shown in the way the team has overcome the challenges raised by the CQC. The Board felt inspired by way the team supported each other and staff from other service areas. **RESOLVED: The Board of Directors obtained assurance from the work carried out by the Older People's service team which resulted in improved patient experience.**
DHCFT 2017/030	**SUICIDE PREVENTION BRIEFING** In the absence of John Sykes, Keith Waters and Bob Gardner from the Suicide Prevention team attended the meeting and provided the Board with a briefing on suicide prevention. The Board noted the Suicide Prevention Strategy that was produced in 2016 and was aware that all clinical staff had been trained in suicide awareness. However, it was noted that suicide rates in mental health services have risen and it was understood that this is because more people are in now contact with mental health services. There has also been a national increase in suicide rates and this this is thought to be due to the state of the nation's economy. The Board discussed why figures are higher in the north of the county and established that although this has been discussed with clinical teams and

	public health forums, the Crisis Team are aware of various reasons and figures are consistent with other trusts but no conclusion has been reached as to why the north of the county is more affected. The Board also discussed how eradicating suicide is unrealistic. The strategy identifies important outcomes and its key message is that we all have a part to play; suicide prevention is everyone's business. The actions and objectives of the strategy mean that all front line clinical staff will be trained by September 2017 and will receive the nationally validated suicide awareness and response training. All staff will receive supervision in line with the Trust's Supervision Policy 2016. All staff will be supported to cope with thorough post incident debrief/support. All clinical staff will have the opportunity to discuss complex cases within a multi-disciplinary team environment. The Board noted that nationally more people are accessing mental health services. This was seen as a positive aspect as it means that the stigma associated with mental illness is relaxing. Julia Tabreham was very impressed with the work undertaken by Keith Waters and Bob Gardner but was concerned about how people have access to the media and 'suicide culture'. She was also worried about the impact that suicide has on the family and was pleased that one of the strategic priorities of the strategy was to support the media in delivering sensitive approaches to suicide and suicidal behaviour. Keith Waters and Bob Gardner asked for the Board's support to ensure that staff continue to receive suicide awareness response training and asked that the Board also take part in the training. The Board heard how the Communications Team is working with the Suicide Prevention Team to get the key message across the Trust and that a Suicide Prevention Day is being held in September. This was a very successful event last year and the Board committed to being involved in this year's event. The Board thanked Keith Waters and Bob Gardner for providing their briefing and fully supported the Suicide Prevention team's work. **RESOLVED: The Board of Directors:** **1) Noted the approach taken to suicide prevention** **2) Noted the progress being made with suicide prevention training**
DHCFT 2017/031	**<u>BOARD ASSURANCE FRAMEWORK (BAF) UPDATE ISSUE 4</u>** This report meets the requirement for Boards to produce an Assurance Framework and detailed the fourth issue of the BAF for 2016/17. Sam Harrison highlighted the activity of the BAF since it was last reviewed by the Board and gave an overview of the movement of key risks as outlined in the report. She was pleased to report that risks 3a and 3b were recently reviewed by the Audit & Risk Committee and were downgraded from being high risk to medium. The Board agreed to two new risks being added to the BAF as follows: • 1d) The Trust does not fully comply with the statutory requirements of the Mental Health Act (MHA) Code of Practice and the Mental Capacity Act (MCA) which has resulted in a 'requires improvement' action from the CQC and impacts on person centred care. • 1e) Lack of compliance with the Civil Contingencies Act as a category 2 responder. Risk identified through 2016/17 EPRR Assurance Process The Board also agreed to the removal of risk 3c) There is a risk that turnover of the Board members could adversely affect delivery of the organisational strategy due to loss of specialist organisational knowledge, capacity and stability. This risk was reviewed by the Board in December 2016 when it was determined that the risk had been mitigated with recent appointments and so could be removed from the BAF. This was agreed to

	be removed at December Board and the Board noted its removal from the BAF following the December Board decision. Sam Harrison drew attention to the deep dive of risks scheduled for the remainder of the year and confirmed that these were currently on track. She also reminded the Board that a Board Development Session was due to take place on the BAF on 8 February which will enable the Board to look at how the BAF has been managed for this year and to understand how it will be addressed for 2017/18. The Board felt assured that the BAF had been robustly challenged by the Audit & Risk Committee and that the Board will continue to receive the BAF four times during the year, in line with NHS Improvement governance guidance. **RESOLVED: The Board of Directors approved this fourth issue of the BAF for 2016/17, and agreed to two new risks being added to the BAF and the removal of one risk.**
DHCFT 2017/032	**REPORT FROM COUNCIL OF GOVERNORS MEETING HELD ON 19 JANUARY 2017** Sam Harrison presented the report which provided a summary of issues discussed for noting by the Board. The Board was pleased to note from the report that Carole Riley has agreed to temporarily take on the role of Deputy Lead Governor. The Active in Mind Presentation made to governors was seen as a positive initiative. This organisation will work with the Trust to enable and encourage all who are suffering from mental health problems or anguish as well as their carers and supporters and will help them to enjoy physical activities and nature in order to improve their physical and mental wellbeing. Sam Harrison also made the Board aware of the results of the recent elections held this week when six governors were appointed. This leaves one vacancy in North East Derbyshire. The Board congratulated the new governors who were elected and the existing governors who were re-elected. **RESOLVED: The Board of Directors noted the summary report from the Council of Governors**
DHCFT 2017/033	**ANY OTHER BUSINESS** No items were discussed.
DHCFT 2017/034	**2016/17 BOARD FORWARD PLAN** The forward plan will be reviewed and carried forward to next year. Sam Harrison pointed out that the Board Effectiveness Survey will be carried out during February and reported back to the following Board Development Session for discussion. **RESOLVED: The Board of Directors noted the forward plan for 2016/17.**
DHCFT 2017/035	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK OR GIAP** The Board noted the strong direction of travel achieved with the GIAP and that no issues arose from the meeting that should be included in the BAF that were not already included.
DHCFT 2017/036	**MEETING EFFECTIVENESS** The Board agreed that the meeting had been effective and very good reports had been

	received. The issues raised in the patient story would be reported back to the next meeting in March to learn how this case has moved forward. A way of working a half hour break between the confidential and public sessions would be considered.

The next meeting of the Board held in Public Session will take place at 1pm on Wednesday, 1 March February 2017.

The location is Conference Rooms A and B
Research and Development Centre, Kingsway, Derby DE22 3LZ

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - MARCH 2017			Enc C
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
11.1.17	**DHCFT 2016/007**	Integrated Performance Report	Mark Powell	Mark Powell will circulate a draft of changes made to the IPR to Board members for comment in advance of April, this will include KPIs taken from the single oversight framework.	26.4.2016	IPR to be submitted to April Board meeting to include KPIs taken from the single oversight framework.	Yellow
11.1.17	**DHCFT 2016/010**	GIAP Update	Amanda Rawlings Sam Harrison	Monitoring and reporting to form part of forward planning for the People and Culture Committee and will be incorporated into the Committee's annual work plan for 2017/18	1.3.2017	Monitoring and reporting of GIAP is captured in People & Culture Committee's forward plan. Amanda Rawlings will also incorporate the GIAP into the terms of reference where relevant ready for them to be reviewed at March People & Culture Committee meeting.	Amber
1.2.17	**DHCFT 2016/027**	Emergency Preparedness, Resilience & Response (EPPR) Strategy 2017-2020	Sam Harrison	EPRR annual report to be captured in the 2017/18 Board forward plan	1.3.2017	EPRR annual report incorporated in forward plan for 2017/18 - Sue check month with Sam	Green

Resolved	**GREEN**	1	33.3%
Action Ongoing/Update Required	**AMBER**	1	33.3%
Action Overdue	**RED**	0	0.0%
Agenda item for future meeting	**YELLOW**	2	33.3%
		4	100%

Derbyshire Healthcare NHS Foundation Trust
Report to Public Board of Directors 1 March 2017

Acting Chief Executives 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. The Secretary of State has announced plans for new regulations that will make it a legal requirement for all Trusts to recover the costs upfront and in full for any non-urgent or immediately necessary care to be given to 'overseas visitors and migrants'. These changes will come into effect from April 2017. As a Trust we provide care and treatment on rare occasions to the patient groups detailed in the proposed revised legislation.

2. The Policing and Crime Bill has received Royal Assent meaning it now becomes an Act of Parliament. The Act has significant and positive implications for mental health with measures including:

   - Stopping those under 18 from being detained in a police station and restricting such detention for adults by reforming police powers under sections 135 and 136 of the Mental Health Act 1983
   - An extended definition of places that can be used as places of safety (encouraging innovation through the use of alternative providers such as voluntary sector groups and enabling suitable places to be used on an ad hoc basis on a contingency basis)
   - Extending section 136 powers to anywhere other than a domestic dwelling
   - Enabling mental health assessments under section 135 to take place in the person's own home rather than having to remove them
   - Reducing the detention time from 72 hours to 24 hours – with provision for an extension of time on clinical grounds alone
   - New powers of search for safety purposes in homes or places of safety under s135 and 136

   The mental health provisions are currently on course to come into effect from May and guidance will be published in due course to support this. It will be for us as local health and policing partners to work together, I think through the Crisis Concordat meetings to identify wider implications for how to implement the changes. We must consider awareness amongst our practitioners, provision of places of safety and resourcing when rolling out the changes.

3. On 15 February I received a letter from Claire Murdoch, Bruce Keogh and Mathew Swindells from NHS England (NHSE) with respect to the operational planning and contracting round 2017/19 and the assurance of the mental health investment standard, mental health in STPs and the delivery of national commitments for mental health. NHSE are seeking assurance that:

    - The two-year mental health investment reported in commissioner financial plans is accurate and sufficient to facilitate the delivery of the mental health implementation plan in the local health economy
    - This investment will meet the planning guidance mental health 'must do's' and deliver the 5 year forward view for mental health commitments
    - The additional funding for children and young people mental health services, included in CCG (Clinical Commissioning Group) baseline allocations, is used for the purpose for which it was intended.

    To ensure that NHSE has confidence that the first two points above will be delivered they have amended the finance planning template and updated the finance FAQs. The amended finance template and additional guidance have been designed to facilitate triangulation with providers and to improve commissioner data quality on mental health spend. This template will form part of the consolidated finance return on 27 February. On point three the health select committee and the CQC (Care Quality Commission) are doing deep dives into Children and Young People's Services in 2017/18. Importantly NHSE are also asking for a jointly signed letter from CCGs and their main NHS mental health provider confirming that their mental health finance returns are an accurate reflection of health economy investment in mental health and ensure a joint commitment to meeting national expectations set out in the Five Year Forward View. Finally, it is clear NHSE look to 2017/18 as a key year for delivery of the Mental Health Five Year Forward View, and they are putting in place regional deep dive meetings to assess delivery plans for the next two years with a specific focus on mental health investment plans, the 2017/18 delivery plan and the vision for mental health set out in the STP (Sustainability Transformation Plan).

    It is my belief that the details set out in the letter are a real indication of the commitment from NHSE to truly ensure that the five year forward view for people with mental health problems is transparently supported and provides real leverage to local providers to ensure CCGs are held accountable to local people for their commissioning decisions relating to mental health funding and services. As we continue with our contracting discussions we will be asking local CCGs about their response to the requirements detailed in the NHSE letter.

Local Context

4. On 9 February the system held the first formal system management executive meeting after the contracting process was completed on 23 December 2016. We heard feedback from the national meeting of STP responsible officers with Simon Stevens. From this it was clear that STPs are likely to remain as a currency of engagement between NHSE, NHS Improvement (NHSI) and local systems. They are to receive increased devolved powers from those two regulators and are expected in time to become an entity of local governance with an appointed leader who will have a level of

authority to make decisions on behalf of the system. We need to fully understand how this vision will be actioned to enable us to get clarity on the impact within our system locally. In addition local leaders spent some time understanding commitment to the Derbyshire system from all organisations, an analysis of what happened to system working during the contracting round and what actions need to be taken to prevent 'sovereign organisation first' behaviour derailing the delivery of system agreed outcomes.

5. The Erewash MCP Vanguard has received support for the next year from the NHSI Vanguard team. This funding is enabling the development of initiatives to support integrated care delivery under two work stream areas: Community and Personal Resilience and Primary Care Development. The Community and Personal Resilience programme has worked with the local community in Erewash to develop initiatives focussed around:

    - Strengthening the voluntary sector
    - Community Development Forum
    - Community Wellbeing Link workers
    - TimeSwap Erewash
    - Person Centred Planning
    - Alcohol and women over 45
    - Move More Erewash
    - Brilliant Erewash – primary school initiative

    These initiatives are already having an impact on people who use our services, for example the person centred planning lead has attended Kedleston Unit and other Wards on the Kingsway site to discuss and support our drive towards improving person centred planning.

Within our Trust

6. Myself and Mark Powell attended a meeting with South and City Early Interventions Team at St Andrew's House, thanks to the team for their hospitality, openness and willingness to adopt a solution focussed approach. Key things from the meeting for me were associated with the need for clear two way communication to team level to ensure Board messages and approaches arrive at teams. I was also struck by the teams willingness to develop solutions to issues and our need as a Trust to ensure Teams have the right amount of autonomy to make decisions locally, hopefully this will be supported by the new accountability framework.

7. During February we had re-visits from the CQC to our learning Disabilities services to review actions associated with our warning notice and CQC action plan. Little feedback was received on the day and I understand that feedback will be added to previous visits in January to give the CQC a more complete picture of our current compliance levels.

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

(Board) 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 is being reported into the Board

Consultation

- The report has not been to any other group or committee

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

Equality Delivery System

- There are no issues raised in this paper that would have a negative impact on any regards groups

Recommendations

The Board of Directors is requested to note the contents of the Acting Chief Executive's Update Report

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

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 1 March 2017

Integrated Performance Report Month 10

Purpose of Report

This paper provides Trust Board with an integrated overview of performance as at the end of December 2016. The focus of the report is on workforce, finance, operational delivery and quality performance.

Recommendations

The Board of Directors is requested to consider the content of the paper and consider their level of assurance on current performance across the areas presented.

Executive Summary

The Trust continued to perform well against many of its key indicators during December. This Executive Summary provides an overview of the some of the key issues during the month, assurance in a number of challenged areas and a forward view of some future risks and/or issues Board members need to be aware of.

The key theme for month 10 continues to be one of ongoing staffing and activity pressure in many of the Trust's services. This is highlighted by the difficulty in achieving 100% Registered Nurse fill rates for day and night shifts on our inpatient wards. Although mitigated by extra Nursing Assistant cover this continues to be a concern which is being closely monitored. During January there continued to be patients placed Out of Area (OOA) because the Trust had limited beds available at times.

Activity pressures on both Radbourne and Hartington Units are highlighted by very high bed occupancy across all wards. As a result of this, the Deputy Director of Operations and Campus General Manager have reviewed staffing levels in order to determine if there is a need to instigate emergency measures in response to reduced staffing levels. They have reviewed bed occupancy and for certain periods there are high levels of patient leave so although staffing continues to be an ongoing concern the number of patients on wards reduces the risks. Occupancy levels are of more concern on the Hartington Unit as they are operating routinely on higher bed numbers with same staffing levels as the Radbourne Unit. An ongoing review of staffing against bed occupancy will continue in order to risk assess and determine if further emergency action is required

Further activity pressure as a result of demand being greater than capacity available is highlighted in the Board deep dive on Neighbourhoods which will be discussed later in the agenda.

Quality Performance

During the month quality performance focus has remained on addressing the issues arising from the Trust's recent Care Quality Commission (CQC) inspection report. Clinical and operational teams, led by the Director of Nursing and Patient Experience have been working on the existing action plan. In addition there have been additional data requests for additional service visits to the Kedleston unit, Older Adults wards in the South, Learning Disability and additional queries for Children's services. We do envisage further unannounced visits in addition to those we have received in January 2017, and are maintaining focus on improvement.

The use of CQC portals 1 and 2 action tracker has continued to provide an integrated approach to managing competing priorities and there continues to be extensive activity across all service lines to focus on environmental, clinical, policy and organisational governance priorities. A number of the Trust's committees received assurance on CQC plans.

Some of the key areas of sustained focus have been on:

- Maintaining the increase in Fire warden training compliance which is now at 78%.

- Safeguarding children's training at Level 3 which is now reported at 76% for Level 3 training at three yearly, and just shy of the predicted at 85% + at 82.57% for the annual yearly refresher. This demonstrates significant in year improvement in staff training levels. Specific detailed analysis and assurance has been supplied to the February safeguarding committee. Medical staff continue to be an outlier and despite, exception reporting and specific requests for training, the progress towards improvement remains slow and is of concern. Anticipated in previous reports. Training will continue to be delivered, and performance managed, overseen by the Trust Management Team.

- Mental capacity assessments, both completion rates and the quality of this clinical decision making and record keeping have continued to improve. Further analysis of the impact of the Mental Capacity training, both for mental health services and the children's services is required. This should be over seen by the Mental Health act committee with an exception report on the new version training, current compliance levels and the new mental capacity training for Children's services based upon System one and its impact.

- Ensuring that supervision and appraisals are recorded has been a significant focus and a slight improvement is noted. This continues to improve in Neighbourhoods and Children's services and in some areas is still challenging which impacts upon our Trust wide overall position with the Deputy Director of Operations taking oversight of the mitigation plan. Significant improvement has been made in management supervision and further improvement in clinical supervision is still required in campus settings.

- Reports on the capacity of teams such as Care co-ordination in mental health community teams has been reviewed and pressure on the teams remains significant and plans to mitigate this have not currently been established with our commissioners. Sessions with the community teams to explore the pressure, discussion re clinical practice changes to mitigate this are being progressed jointly between Operations and Nursing and Quality.

- There continues to be significant challenge around compliant investigations completed within the 40 working days timeframe. The recruitment of the 2 posts to lead on serious incident investigations is underway, increased review and performance monitoring through the TMT is in place to continue to improve this situation.

- There has been a reduction in episodes of physical restraint and use of seclusion within this month

The new indicators which have been added this month include number of deaths, and complaint investigations by the Parliamentary Ombudsman.

There continues to be challenge around the plans to move towards full implementation of the safety plan model. Training for staff to be able to use the model is reported now at 93%. However the reported use of the model remains very low. The anticipated date to cease use of the existing system, FACE, is April 2017. This is led by the Medical Director and the Patient safety plan implementation group that report to the Quality committee on their progress.

Operational Performance

Overall performance remains relatively stable, with all of the new activity based Single Oversight Framework indicators being achieved.

There are a number of areas where performance remains variable, with further detail provided in the main body of the report.

Key areas of note are as follows;

Performance for outpatient letters has been reviewed by the General Manager. Sickness and annual leave have continued to impact on capacity, resulting in performance being just below 90%. At the time of writing this report February's performance was above 90%.

The number of outpatient appointments cancelled by the Trust continues to be high. The main reasons continue to be sickness absence /no consultant, both of which relate to short episodes of sickness from a small number of Doctors.

Financial Performance

The year to date, and forecast score, from the Use of Resources (UoR) metrics is unchanged from last month: our overall UoR is a 3. Four of the five metrics are strong at 2, 1, 1 and 1, but the fifth metric, agency spend against ceiling, remains at 4, and that triggers an override that restricts the overall rating to a 3.

When considering the impact of agency on the Trust overall Use of Resources rating: to avoid triggering the override, the Trust would need to spend £629k less than forecast (i.e. to spend less than 50% above ceiling by the end of March). If that were the case, the overall use of resource rating of the Trust would be 2 not 3.

In surplus terms, the Trust remains ahead of plan cumulatively for the year to date, with a trajectory to return to planned control total by year end due to the aggregate impact of changes in the run rates of costs and income at year end.

In forecasting the achievement of the control total surplus, the Board are aware that it still assumes the mitigation of some significant risks, the potential for backdated pay which is not yet fully quantified, ongoing pressures in agency costs and other emerging costs.

Early planning continues for cost improvement action required to reach 2017/18 control total financial plan. Whilst early plans exist for some of the Trust CIP of £3.85m (at our risk) the Commissioner-driven QIPP disinvestment of £3.05m (at commissioner risk) is not yet agreed.

People Performance

In January we continue to see slight movement in a number of our people metrics. Compulsory training compliance has stabilised at 86.21%, below our internal 90% target but is above our main contract non CQUIN target of 85%. There has been a slight improvement in appraisal completion to 74.60%.

Staff attendance remains a significant challenge to the trust at 6.47% against a target of 5.04% which is very high against comparable trusts. Annual sickness absence rates are beginning to stabilise following a two year period of increase, but remain high. The People and Culture Committee reviewed this at its meeting in February.

As a result in the issues associated with workforce supply, close monitoring of agency usage continues along with recent actions taken to reduce agency usage. Our vacancy rate has reduced slightly in the month due to increased recruitment and there is an ongoing focus on clinical vacancies which is supported by a detailed action plan which was presented at the People and Culture Committee. The action plan covers how we plan to tackle each vacancy and includes campaigns and open days across the UK, incentives where necessary and introducing overseas recruitment for hard to fill posts. Our recruitment process continues to improve with the recent changes to the approval process and the introduction in March 2017 of a new e-Recruitment system (TRAC) which will enable managers and candidates to utilise a streamlined, interactive and responsive process, which will reduce or eliminate paperwork and unnecessary delays.

Strategic considerations

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

Board Assurances

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

As an integrated performance report the content of 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 papers and aspects of detailed content supporting the overview presented are regularly provided to, Finance and Performance Committee, People and Culture Committee and Quality Committee.

Governance or Legal issues

The integrated nature of this report is in response to the Deloitte Well Led Review and specifically recommendation R 22: *The Board needs to introduce an integrated performance report which encompasses key operational, quality, workforce and finance metrics*

Information supplied in this paper is consistent with returns to the Regulator. This report has replaced the previous operational and financial reports reported to Trust Board.

Equality Delivery System

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.

Report presented by:	**Mark Powell, Acting Chief Operating Officer** **Claire Wright, Director of Finance** **Amanda Rawlings, Director of People and Organisational Effectiveness** **Carolyn Green, Director of Nursing and Patient Experience**
Report prepared by:	**Peter Charlton, General Manager, Information Management** **Rachel Leyland, Deputy Director of Finance** **Liam Carrier, Workforce Systems & Information Manager** **Rachel Kempster, Risk and Assurance Manager** **Peter Henson, Performance Manager**

Highlights

- Surplus better than plan YTD. Forecast to achieve plan at year end.
- Cash better than plan at the end of January

Challenges

- CIP forecast not to deliver to full target
- Containment of agency expenditure which is currently triggering an override on the new Use of Resources Rating
- Mitigations of Financial risks during 16/17

Highlights

- Breastfeeding coverage targets have been addressed

Challenges

- A review of the waiting list for IAPT services has caused the rate of recovery to reduce.

Highlights

- Compulsory training compliance remains high and is above the 85% main contract commissioning for quality and innovation (CQUIN) target.

Challenges

- Monthly and annual sickness absence rates remain high.
- Budgeted Fte vacancies remain high but are decreasing.
- Appraisal compliance rates remain low but compliance is increasing.

Highlights

- New indicators for deaths, serious incidents, and complaint investigations by the Parliamentary Ombudsman have been added this month
- Seclusion episodes and incidents for Q3 have decreased compared to previous quarter
- Incidents of physical restraint overall and prone restraint specifically, have continued to decrease
- Incidents of physical assault have decreased
- No of concerns has fallen
- CTO rights forms received by the MHA office has improved
- % of staff recorded as compliant with clinical and management supervision has increased

Challenges

- Incidents of reported as moderate to catastrophic harm has increased, although no specific trends identified
- No of inpatient falls has increased slightly from 19 in Dec 16 to 27 in Jan 17
- % of complaint investigations completed on time is low and falling
- No of actions from serious incidents and complaints has increased

FINANCIAL OVERVIEW – JANUARY 2017

Category	Sub-set	Metric	Period	Actual	Rating	Trend	Key Points
Governance	Use of Resources (UoR) Metric	Overall Use of Resources Metric	YTD	3	A	→	As at the end of January the Use of Resources Rating is 3 and is also forecast to be a 3 at the end of the year, due to triggering an override on the agency metric.
			Forecast	3	A	→	
		Capital Service Cover	YTD	2	Y	→	
			Forecast	2	Y	→	
		Liquidity	YTD	1	G	→	
			Forecast	1	G	→	
		Income and Expenditure Margin	YTD	1	G	→	
			Forecast	1	G	→	
		Income and Expenditure variance to plan	YTD	1	G	→	
			Forecast	1	G	→	
		Agency variance to ceiling	YTD	4	R	→	We have been segmented in segment 3.
			Forecast	4	R	→	
	Single Oversight Framework	NHS I Segment	YTD	3	n/a	n/a	

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
I&E and profitability	Income and Expenditure	Control Total position £'000	In-Month	248	5	R	↓	The Control Total shows the position including the Sustainability Transformation Fund (STF) and the Underlying Income and Expenditure position excludes the STF. Surplus is better than plan in the month and due to changes in the run rate is forecast to achieve plan at the end of the financial year. The Normalised Income and Expenditure shows the financial performance adjusting for any non-recurrent costs or benefits that will not continue.
			YTD	2,006	2,815	G	↗	
			Forecast	2,531	2,531	G	→	
		Underlying Income and Expenditure position £'000	In-Month	179	-64	R	↓	
			YTD	1,315	2,124	G	↓	
			Forecast	1,701	1,701	G	→	
		Normalised Income and Expenditure position £'000	In-Month	179	-17	R	↓	
			YTD	1,315	1,979	G	↓	
			Forecast	1,701	1,657	R	↓	
	Profitability	Profitability - EBITDA £'000	In-Month	851	592	R	↓	
			YTD	8,075	8,665	G	↑	
			Forecast	9,806	9,701	R	→	
		Profitability - EBITDA %	In-Month	7.4%	5.2%	R	↓	
			YTD	7.0%	7.7%	G	↘	
			Forecast	7.1%	7.2%	G	→	
Liquidity	Cash	Cash £m	YTD	12.719	15.748	G	↑	Cash is currently above plan but is forecast to be below plan at year end due to expected large payments as contracts discussions are resolved. Capital is slightly behind plan YTD but is forecast to fully spend by the end of the financial year.
			Forecast	13.153	12.711	R	→	
	Net Current Assets	Net Current Assets £m	YTD	6.616	8.872	G	↑	
			Forecast	7.570	6.505	R	→	
	Capex	Capital expenditure £m	YTD	2.766	1.910	R	↑	
			Forecast	3.450	3.450	G	→	
Efficiency	CIP	CIP achievement £m	In-Month	0.358	0.195	R	↗	CIP is currently behind plan and is forecast not to deliver the full plan at the end of the financial year. This is compensated for by other cost avoidance and underspends in the overall position.
			YTD	3.583	1.909	R	↓	
			Forecast	4.300	2.299	R	→	
			Recurrent	4.300	1.645	R	→	

Key:

Period
In-Month = Current Month
YTD = Year to Date
Forecast = Year end out-turn

Plan
In-month or Year end Trust plan

Achieving plan
Not achieving plan

Trend comparing current month against previous month actual/YTD/Forecast

OPERATIONAL OVERVIEW – JANUARY 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	NHSI	CPA 7 Day Follow-up (M)	Month	95.00%	95.24%	G	→	All NHSi metrics are all compliant except "Priority Metrics" which is a new indicator and does not become a measured target until the next financial year. For each metric we have indicated if it is monitored by NHSi Quarterly (Q) or Monthly (M).
			Quarter	95.00%	95.95%	G	→	
		Data completeness - Identifiers (M)	Month	95.00%	99.49%	G	→	
			Quarter	95.00%	99.49%	G	→	
		Data completeness - Priority Metrics (M)	Month	85.00%	70.38%	R	→	
			Quarter	85.00%	69.98%	R	→	
		Crisis Gatekeeping (Q)	Month	95.00%	98.59%	G	→	
			Quarter	95.00%	98.78%	G	↑	
		IAPT RTT within 18 weeks (Q)	Month	95.00%	99.70%	G	→	
			Quarter	95.00%	99.61%	G	→	
		IAPT RTT within 6 weeks (Q)	Month	75.00%	90.80%	G	↑	
			Quarter	75.00%	90.71%	G	↑	
		Early Intervention in Psychosis RTT Within 14 Days - Complete (Q)	Month	50.00%	96.30%	G	↑	
			Quarter	50.00%	97.06%	G	↑	
		Early Intervention in Psychosis RTT Within 14 Days - Incomplete (Q)	Month	50.00%	85.71%	G	↑	
			Quarter	50.00%	84.38%	G	↑	
		Patients Open to Trust In Employment (M)	Month	N/A	8.93%		→	
			Quarter	N/A	8.86%		→	
		Patients Open to Trust In Settled Accommodation (M)	Month	N/A	59.54%		→	
			Quarter	N/A	59.04%		↑	
		Under 16 Admissions To Adult Inpatient Facilities (M)	Month	0	0	G	→	
			Quarter	0	0	G	→	
		IAPT People Completing Treatment Who Move To Recovery (Q)	Month	50.00%	53.33%	G	→	
			Quarter	50.00%	52.82%	G	→	
		Physical Health - Cardio-Metabolic - Inpatient (Q)	Month	N/A				
			Quarter	N/A				
		Physical Health - Cardio-Metabolic - EI (Q)	Month	N/A				
			Quarter	N/A				
		Physical Health - Cardio-Metabolic - on CPA (Community) (Q)	Month	N/A				
			Quarter	N/A				

Key:

Period Month Current Month

Quarter Current Quarter

Achieving target

Not achieving target

Trend compared to previous month/quarter

OPERATIONAL OVERVIEW – JANUARY 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Locally Agreed	CPA Settled Accommodation	Month	90.00%	96.78%	G	→	An improvement plan has been defined to address Clustering.
			Quarter	90.00%	96.78%	G	→	
		CPA Employment Status	Month	90.00%	97.25%	G	→	
			Quarter	90.00%	97.25%	G	→	
		Data completeness - Identifiers	Month	99.00%	99.49%	G	→	
			Quarter	99.00%	99.49%	G	→	
		Data completeness - Outcomes	Month	90.00%	93.96%	G	→	
			Quarter	90.00%	93.96%	G	→	
		Patients Clustered not Breaching Today	Month	80.00%	77.46%	R	→	
			Quarter	80.00%	77.48%	R	→	
		Patients Clustered regardless of review dates	Month	96.00%	94.15%	R	→	
			Quarter	96.00%	94.10%	R	→	
		7 Day Follow-up - all inpatients	Month	95.00%	96.80%	G	↑	
			Quarter	95.00%	97.33%	G	↑	
		Ethnicity coding	Month	90.00%	90.30%	G	↓	
			Quarter	90.00%	90.30%	G	↓	
		NHS Number	Month	99.00%	99.99%	G	→	
			Quarter	99.00%	99.99%	G	→	
		CPA Review in last 12 Months (on CPA > 12 Months)	Month	95.00%	95.06%	G	→	
			Quarter	95.00%	95.06%	G	→	
		Community Care Data - Activity Information Completeness	Month	50.00%	93.48%	G	→	
			Quarter	50.00%	93.45%	G	→	
		Community Care Data - RTT Information Completeness	Month	50.00%	92.31%	G	→	
			Quarter	50.00%	92.31%	G	→	
		Community Care Data - Referral Information Completeness	Month	50.00%	72.40%	G	↓	
			Quarter	50.00%	72.32%	G	↓	
		Early Interventions New Caseloads	Month	95.00%	133.90%	G	↓	
			Quarter	95.00%	133.90%	G	↓	
		Clostridium Difficile Incidents	Month	7	0	G	→	
			Quarter	7	0	G	→	
		18 Week RTT Greater Than 52 weeks	Month	0	0	G	→	
			Quarter	0	0	G	→	

OPERATIONAL OVERVIEW – JANUARY 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Schedule 6	Consultant Outpatient Trust Cancellations	Month	5.00%	6.15%	R	↑	Information is now available to identify the specific reason cancelations occur.
			Quarter	5.00%	5.84%	R	→	
		Consultant Outpatient DNAs	Month	15.00%	16.50%	R	↓	
			Quarter	15.00%	16.81%	R	↓	
		Under 18 admissions to Adult inpatients	Month	0	0	G	→	
			Quarter	0	0	G	→	The 10 day typing target has been breached primarily due to 2 consultants leaving the Trust.
		Outpatient letters sent in 10 working days	Month	90.00%	88.37%	R	↑	
			Quarter	90.00%	88.44%	R	↑	
		Outpatient letters sent in 15 working days	Month	95.00%	96.73%	G	↑	
			Quarter	95.00%	96.67%	G	↑	
		Inpatient 28 day readmissions	Month	10.00%	2.24%	G	↑	
			Quarter	10.00%	1.89%	G	↑	
		MRSA - Blood stream infection	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Mixed Sex accommodation breaches	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Discharge Fax sent in 2 working days	Month	98.00%	99.16%	G	→	
			Quarter	98.00%	99.30%	G	→	
		Delayed Transfers of Care	Month	0.80%	1.17%	R	→	Trust Target has been set by the NHS at 0.8% which is below the rate currently being achieved.
			Quarter	0.80%	1.12%	R	→	
		18 Week RTT Less Than 18 Weeks - Incomplete	Month	92.00%	94.87%	G	↑	
			Quarter	92.00%	94.69%	G	↑	

OPERATIONAL OVERVIEW – JANUARY 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Fixed Submitted Returns	18 weeks RTT greater than 52 weeks	Month	0	0	G	→	Compliant with Fixed Targets
			Quarter	0	0	G	→	
		18 Week RTT incomplete	Month	92.00%	94.87%	G	↑	
			Quarter	92.00%	94.87%	G	→	
		Mixed Sex accommodation breaches	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Completion of IAPT Data Outcomes	Month	90.00%	95.31%	G	↓	
			Quarter	90.00%	95.31%	G	→	
		Ethnicity coding	Month	90.00%	91.84%	G	↑	
			Quarter	90.00%	91.84%	G	→	
		NHS Number	Month	99.00%	99.99%	G	→	
			Quarter	99.00%	99.99%	G	→	
Other Dashboards	Health Visiting	% 10-14 Day Breastfeeding coverage	Month	98.00%	98.57%	G	→	Compliant with Health Visiting Targets
			Quarter	98.00%	98.57%	G	→	
		% 6-8 Week Breastfeeding coverage	Month	98.00%	99.62%	G	→	
			Quarter	98.00%	99.62%	G	→	
	IAPT	Recovery Rates	Month	50.00%	53.43%	G	→	Reliable & Recovery Rates have been impacted by a review of the IAPT waiting lists
			Quarter	50.00%	53.43%	G	→	
		Reliable & Recovery Rates	Month	65.00%	64.70%	R	→	
			Quarter	65.00%	64.70%	R	↓	
	Safer Staffing	Inpatient Safer Staffing Fill Rates	Month	90.00%	104.3%	G	↓	Detailed ward level information shows specific variances
			Quarter	90.00%	104.3%	G	↓	

WORKFORCE OVERVIEW – JANUARY 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance		Trend	Key Points
Workforce Dashboard	NHSI Key Performance Indicator (KPI)	**Turnover** (annual)	**Jan-17**	10%	**11.37%**	↗	G	⇩	Annual turnover remains within the Trust target parameters and is below the regional Mental Health & Learning Disability average of 12.65% (as at June 2016 latest available data). The monthly sickness absence rate is 0.08% lower compared to the previous month, however it is 0.18% higher than in the same period last year (January 2016). The annual sickness absence rate is running at 5.57% (as at 31st December 2016 latest available data). The regional average annual sickness absence rate for Mental Health & Learning Disability Trusts is 5.14% (as at October 2016 latest available data). Anxiety/stress/depression/other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 25.61% of all sickness absence, followed by at cold, cough, flu - influenza at 15.05% and Surgery at 13.42%. Budgeted Fte vacancy rates have decreased by 0.57% compared to the previous month. The number of employees who have received an appraisal within the last 12 months has increased by 0.32% to 74.60%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £1.608m of which £976k related to Medical staff. Compulsory training compliance remains static this month at 86.21% and remains above the 85% main contract non CQUIN.
			Dec-16		11.28%		G		
		Sickness Absence (monthly)	**Jan-17**	5.04%	**6.47%**	↘	R	⇨	
			Dec-16		6.55%		R		
		Vacancies (including 10% funded fte flexibility / cover)	**Jan-17**	10%	**14.35%**	↘	A	⇩	
			Dec-16		14.92%		A		
		Vacancies (actual against target)	**Jan-17**	0%	**4.35%**	↘	A	⇩	
			Dec-16		4.92%		A		
		Appraisals (all staff - number of employees who have received an appraisal in the previous 12 months)	**Jan-17**	90%	**74.60%**	↗	R	⇧	
			Dec-16		74.28%		R		
		Appraisals (medical staff only - number of employees who have received an appraisal in the previous 12 months)	**Jan-17**	90%	**82.41%**	↗	A	⇩	
			Dec-16		80.19%		A		
		Qualified Nurses (to total nurses, midwives, health visitors and healthcare assistants)	**Jan-17**	65%	**69.24%**	↗	G	⇧	
			Dec-16		69.05%		G		
		Agency Usage (£ year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Jan-17**	£0	**£1.608m**	↗	R	⇧	
			Dec-16		£1.392m		R		
		Agency Usage (% year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Jan-17**	0%	**63.67%**	↗	R	⇧	
			Dec-16		61.20%		R		
	Other KPI	**Compulsory Training** (staff in-date)	**Jan-17**	90%	**86.21%**	→	A	⇩	
			Dec-16		86.21%		A		

Key:

Period Current month and previous month

Plan Trust target

↗ Variance to previous month

Achieving target/within target parameters

Approaching target/approaching target parameters

Not achieving target/outside target parameters

Trend based on previous 4 months

Turnover parameters (8% to 12%)

Vacancy parameters (10% to 20%)

QUALITY OVERVIEW – JANUARY 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Quality	Safe	No of incidents of moderate to catastrophic actual harm	Month	24	39			Plan: average last fin yr (month). No specific increase in trends when analysed by team or incident category
			Quarter	73	91			Plan: average last fin yr (Qtr). Actual: Q3 data
		No of deaths of patients who have died within 12 months of their last contact with DHcFT	Month	170	189			New data item. Trend to commence from next month. Plan: average last fin yr (month) . Note: Not all deaths for Jan 17 will have been reported.
			Quarter	511	547			New data item. Trend to commence from next quarter. Plan: average last fin yr (Qtr). Actual: Q3 data
		No of serious incidents reported to the CCG	Month	6	6			New data item: Plan - average last fin yr (month)
			Quarter	18	16			New data item: Plan - average last fin yr (Qtr). Actual: Q3 data
		No of episodes of patients held in seclusion	Month	6	8			
			Quarter	35	23			Plan: average last fin yr (Qtr). Actual: Q3 data
		No of incidents involving patients held in seclusion	Month	20	10			
			Quarter	61	32			Plan: average last fin yr (Qtr). Actual: Q3 data
		No of incidents involving physical restraint	Month	55	38			
			Quarter	165	113			Plan: average last fin yr (Qtr). Actual: Q3 data
		No of incidents involving prone restraint	Month	10	9			Month plan based on average from 1/7/16 when prone restraint collected on Datix as defined field.
			Quarter	29	28			Qtr plan based on average for Q2/Q3. Actual Q3 data
		No of incidents of physical assault - patient on patient	Month	15	11			
			Quarter	44	34			Actual: Q3 data.
		No of incidents of physical assault - patient on staff	Month	20	11			
			Quarter	61	34			Actual: Q3 data
		No of falls on in-patient wards	Month	38	27			
			Quarter	113	72			Actual: Q3 data
		No of incidents of absconsion	Month	43	35			
			Quarter	130	87			Actual: Q3 data
		No of patients with a clinical risk plan (FACE or Safety Plan)	Month	100%	79.39%			
			Quarter	100%	79.56%			
		Of above, no of patients with a Safety Plan	Month	90%	1.64%			Safety Plan to replace FACE from 1/4/2017
			Quarter	90%	2.41%			
		% of staff compliant with Level 3 Safeguarding Children training	Month	95%	76.15%			
			Quarter	95%	NA			Qtr comparison not available
		% of staff compliant with Think Family training	Month	95%	79.08%			
			Quarter	95%	NA			Qtr comparison not available
		% of staff compliant with Clinical Safety Planning eLearning	Month	95%	93.54%			
			Quarter	95%	NA			Qtr comparison not available
		% of staff compliant with Fire Warden training	Month	90%	78.0%			Estimated compliance provided for Jan 17
			Quarter	90%	NA			Qtr comparison not available
		No of people with LD or Autism admitted without a CTR (Care & Treatment Review)	Month	0	2			
			Quarter	0	7			

QUALITY OVERVIEW – JANUARY 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Quality	Caring	No of complaints opened for investigation	Month	9	8			
			Quarter	26	26			Actual: Q3 data
		No of concerns received	Month	18	18			
			Quarter	53	109			
		No of compliments received	Month	72	49			
			Quarter	217	313			
		No of investigations by the Parliamentary Ombudsman	2015/16	5	1			
			2016/17	5	7			Note: Ombudsman active review of cases increasing nationally. Not all refer to complaints raised during 2016/17
		% of complaints upheld (full or in part) by the Parliamentary Ombudsman	2015/16	2	0			
			2016/17	2	2			Note: Figures to date. 1 no further action. 4 still ongoing.
		% of responded to (orange) complaint investigations completed within 40 working days, opened after 01/04/2016	Year	100%	24%			108 (orange) complaints. 47 not responded to within 40 working days. 35 ongoing
			Year	100%	0%			5 (red) complaints. 3 not responded to within 60 working days. 2 ongoing.
		No of incidents requiring Duty of Candour	Month	2	0			These figures will fluctuate based on the outcome of investigations.
			Quarter	8	1		NA	
	Effective	% of in-patients with a recorded capacity assessment	Month	100%	87.84%			
			Quarter	100%	87.60%			
		% of patients who have had their care plan reviewed and have been on CPA > 12months	Month	90%	94.16%			
			Quarter	90%	95.66%			
		No of seclusion forms not received by MHA Office	Month	0	7			
			Quarter	0	6			Actual: Q3 data
		% of CTO rights forms received by MHA Office	Month	100%	95%			
			Quarter	NA	NA	NA	NA	
		% of in patient older adults rights forms received by MHA Office	Month	100%	95.20%			
			Quarter	100%	100%			
	Responsive	% of staff uptake of Flu Jabs	Month	45%	38.4%			Data to end of 30/11/16
			Year	45%	22.7%			Relates to 2015.16 compaign
		% of policies in date	Month	95%	96.6%			
			Quarter	NA	NA	NA	NA	
	Well Led	% of staff who have received Clinical Supervision, within defined timescales	Month	90%	42.71%			
			Quarter	90%	NA	NA	NA	
		% of staff who have received Management Supervision, within defined timescales	Month	90%	61.7%			
			Quarter	90%	NA	NA	NA	
		No of outstanding actions following serious Incident investigations	Month	0	40			As of 9/2/17 this number had reduced to 29.
			Quarter	0	27		NA	
		No of outstanding actions following complaint investigations	Month	0	63			
			Quarter	0	NA	NA	NA	
		No of outstanding actions following CQC comprehensive review report	Month		120			Figure as at 28/01/2017

Financial Section

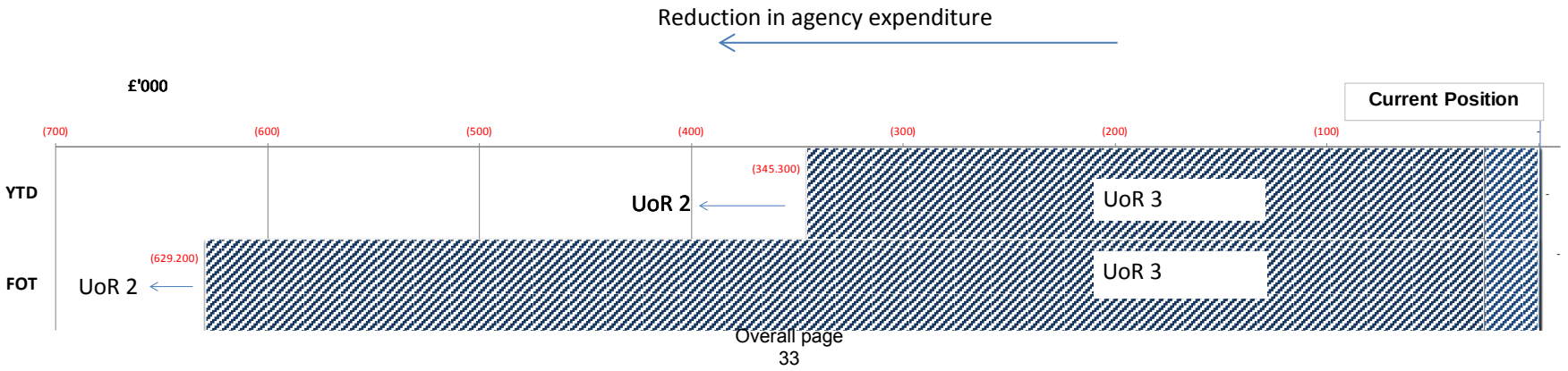
Governance – Use of Resources (UoR) Rating

The Use of Resources rating at the end of January is a 3 which is due to triggering the override rule as the agency metric is a 4. The agency expenditure is forecast to continue to be in excess of 50% above the ceiling and therefore continuing to trigger a 4 generating a UoR rating of 3 at the end of the financial year.

	YTD @ Quarter 1		YTD @ Quarter 2		YTD @Quarter 3		YTD @ Quarter 4	
	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual
Capital Service Capacity rating	3	2	2	2	2	2	2	2
Liquidity rating	2	1	1	1	1	1	1	1
I&E Margin rating	2	1	1	1	1	1	1	1
Distance from Financial Plan	1	1	1	1	1	1	1	1
Agency distance from Cap	1	4	1	4	1	4	1	4
UoR	2	2	1	2	1	2	1	2
4 on any metric	No Trigger	Trigger	No Trigger	Trigger	No Trigger	Trigger	No Trigger	Trigger
UoR	2	3	1	3	1	3	1	3

To note some of the metrics including the overall rating does not have a plan set by NHS Improvement, so the plan figures are based on an internal calculation.

As four of the metrics are in a healthy position and it is the agency metric that is driving the lower rating and the trigger, this is the area of focus from a headroom perspective, which is shown in the chart below. YTD if agency expenditure had been £0.3m less we would have not triggered an override and remained at an overall rating of 2. From a forecast perspective we would need to reduce expenditure by £0.6m in the next two months in order avoid triggering an override and achieve an overall rating of a 2.



Income and Expenditure

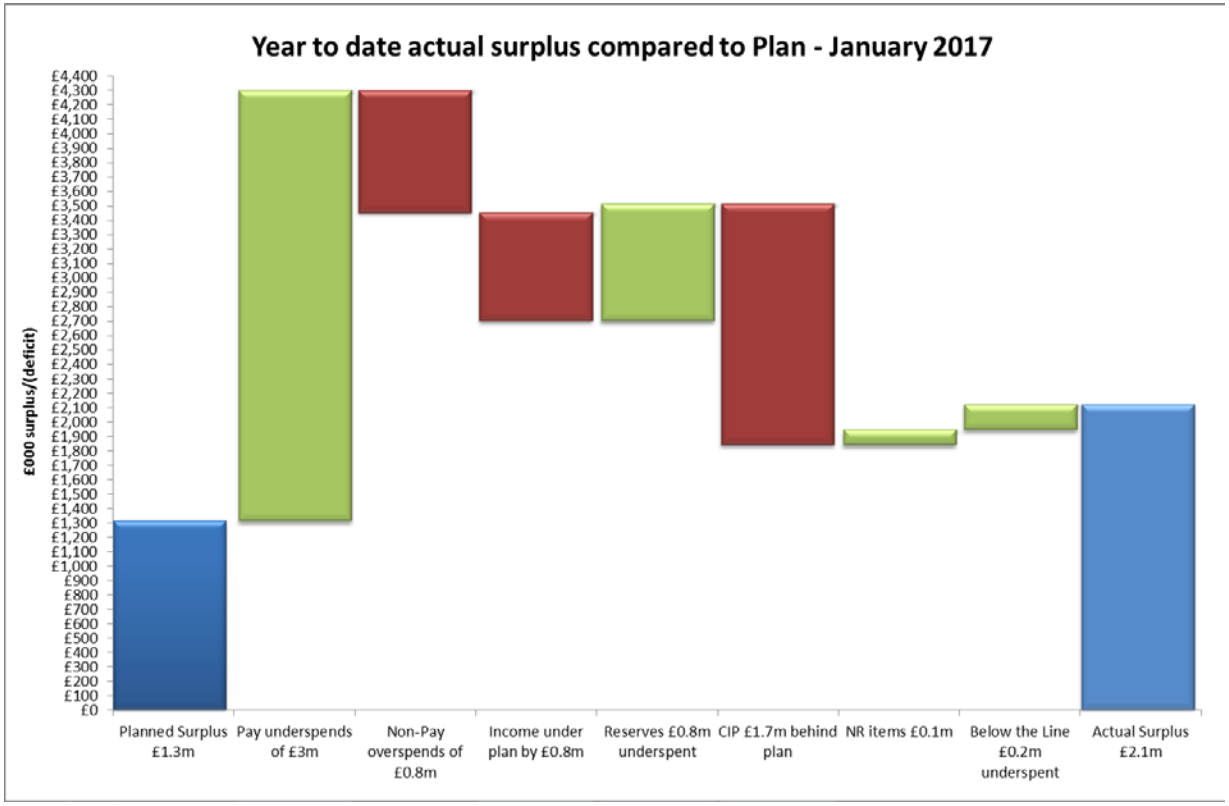
Statement of Comprehensive Income — January 2017

	Current Month			Year to Date			Forecast		
	Plan	Actual	Variance Fav (+) / Adv (-)	Plan	Actual	Variance Fav (+) / Adv (-)	Plan	Actual	Variance Fav (+) / Adv (-)
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical Income	10,580	10,336	(243)	105,417	103,143	(2,274)	126,576	123,997	(2,579)
Non Clinical Income	918	947	29	9,183	8,666	(517)	11,020	10,350	(670)
Employee Expenses	(8,422)	(7,929)	494	(84,648)	(80,259)	4,389	(101,492)	(96,887)	4,605
Non Pay	(2,225)	(2,763)	(538)	(21,877)	(22,885)	(1,008)	(26,298)	(27,759)	(1,461)
EBITDA	**851**	**592**	**(259)**	**8,075**	**8,665**	**589**	**9,806**	**9,701**	**(104)**
Depreciation	(295)	(279)	16	(2,945)	(2,737)	208	(3,534)	(3,456)	78
Impairment	0	(2)	(2)	0	(38)	(38)	(300)	(300)	0
Profit (loss) on asset disposals	0	0	0	0	0	0	0	0	0
Interest/Financing	(175)	(175)	0	(1,790)	(1,766)	24	(2,141)	(2,102)	39
Dividend	(133)	(133)	(0)	(1,333)	(1,346)	(13)	(1,600)	(1,613)	(13)
Net Surplus / (Deficit)	**248**	**3**	**(245)**	**2,006**	**2,778**	**771**	**2,231**	**2,231**	**0**
Technical adjustment - Impairment	0	-2	(2)	0	(38)	(38)	(300)	(300)	0
Control Total Surplus / (Deficit)	**248**	**5**	**(243)**	**2,006**	**2,815**	**809**	**2,531**	**2,531**	**0**
Technical adjustment - STF Allocation	69	69	0	692	692	0	830	830	0
Underlying Net Surplus / (Deficit)	**179**	**-64**	**(243)**	**1,315**	**2,124**	**809**	**1,701**	**1,701**	**0**

Due to the timing differences between the submission of the annual plan and the conclusion of contract negotiations a set of income and expenditure assumptions were included in the plan that are not in the actual or forecast position. Therefore there will be variances across Income, pay and non-pay but mostly with nil effect overall.

The Statement of Comprehensive Income shows both the control total of £2.5m which includes the Sustainability Transformation Fund (STF) and the underlying surplus / (deficit) against the underlying plan with the STF excluded.

Clinical Income is £0.2m less than plan in month and is forecast to be £2.6m less than plan by the end of the year of which a significant proportion is due to differences in planning assumptions with offsetting expenditure reductions. There is however forecast underperformances on activity related income.
Non Clinical income is less than plan in the month by £29k and has a forecast outturn of £0.6m behind plan. £0.4m of this relates to a miscellaneous income target with no income forecast against it.
Pay expenditure is £0.5m less than the plan in the month and the year end forecast position is £4.6m more favourable than plan which is due to planning assumptions (with offsetting income reductions) but also vacancies and recruitment.
Non Pay is overspent in the month by £0.5m and has a forecast outturn of £1.5m worse than plan which mainly relates to Drugs and PICU expenditure.



Summary of key points for YTD variances

Overall favourable variance to plan year to date which is driven by the following:

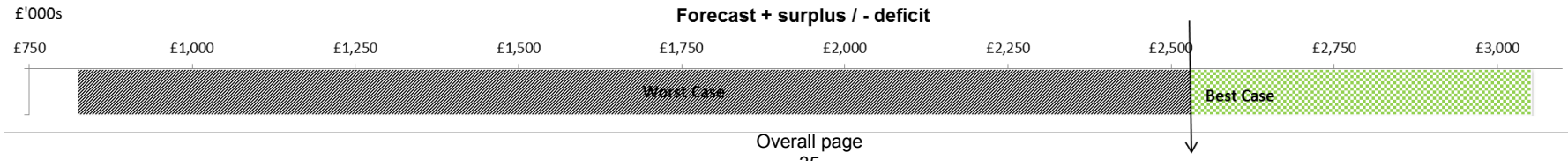
- Pay budget is significantly underspent which is mainly driven by vacancies across the Trust. Some of this also relates to planning assumptions which are different to final contract negotiations (which is offset by corresponding income reductions).
- Non pay overspends related to Drugs and PICU placements.
- Income is behind plan mainly due to activity related services.
- Reserves are underspent due to actual expenditure phased differently to the original plan.
- This is helping to offset the CIP which is behind plan year to date by £1.7m.

Forecast Range

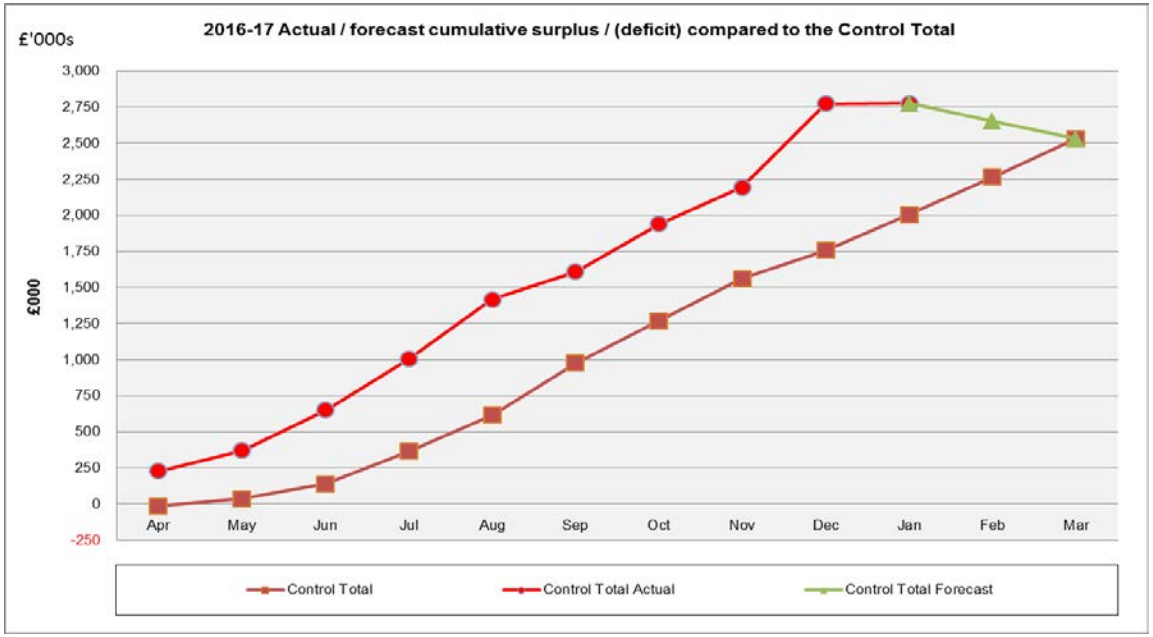
Best Case	Likely Case	Worst Case
£3.0m surplus	£2.5m surplus	£0.8m surplus

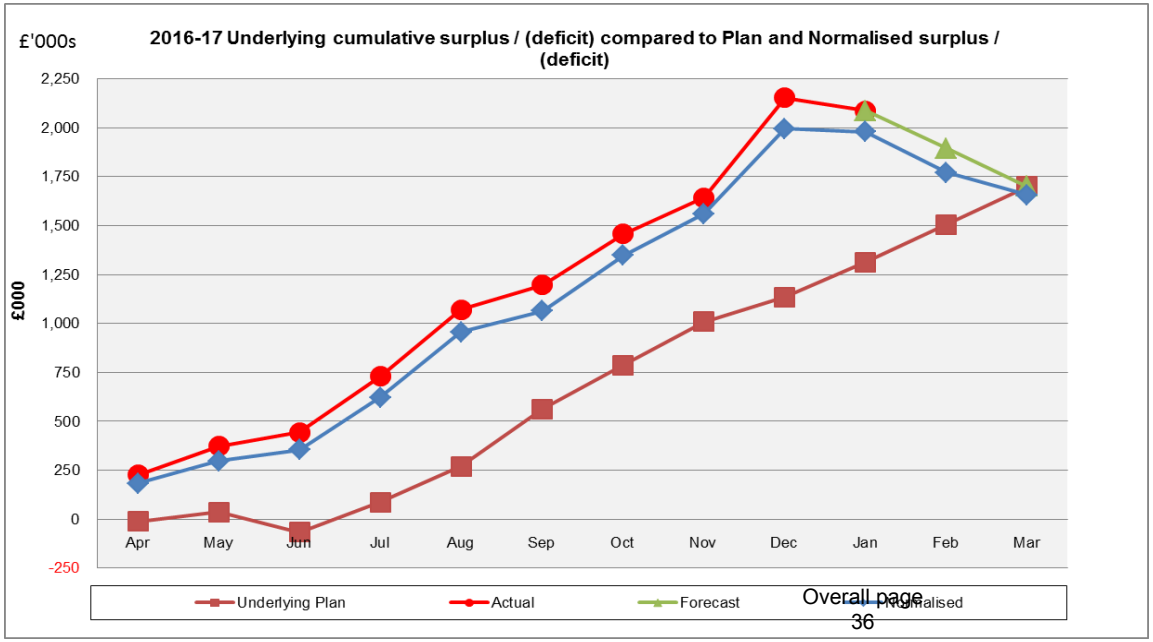
Forecast range

The main variables in the forecast range are: STF income loss (2 months), agency expenditure, AfC backlog claims, PICU, IAPT, CPC income and other unexpected non-pay costs.



Normalised Income and Expenditure position





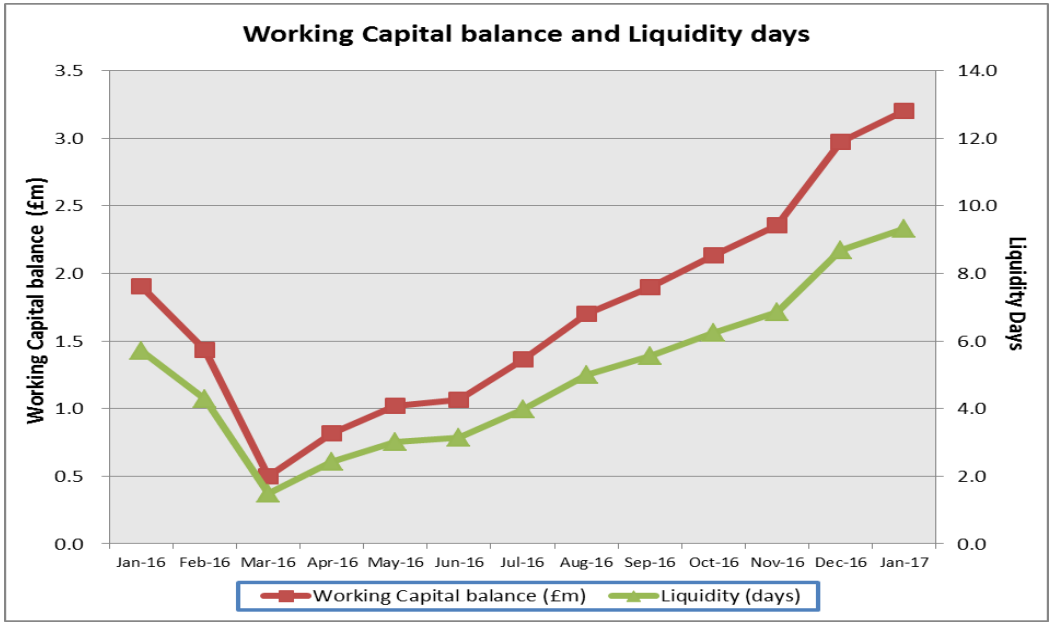
The first graph shows the actual and forecast cumulative surplus against the control total (including the Sustainability Transformation Fund (STF). The surplus is forecast to remain ahead of plan until the latter part of the financial year when it will reduce back down to the planned control total.

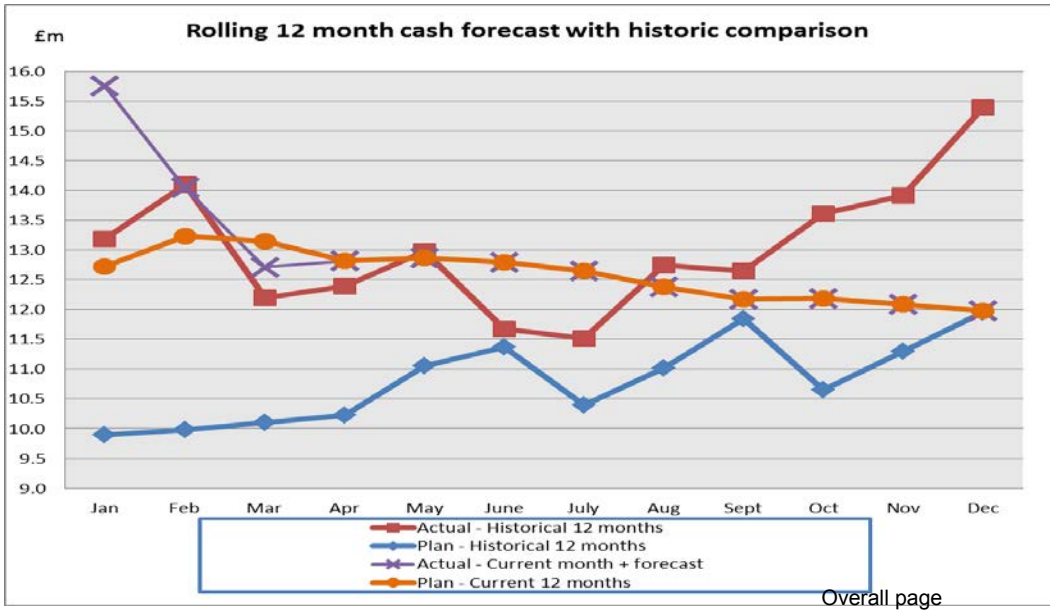
The second graph shows the underlying actual and forecast surplus against the underlying plan excluding the STF.

This graph also shows the normalised financial position. This is referring to the position removing any one off non-recurrent items of cost or income that is not part of the business as usual.

There is some additional non-recurrent income in the year to date and forecast position along with additional non-recurrent costs related to Governance Improvement Action Plan and CQC action plan for additional resources. In the normalised position these have been removed.

Liquidity





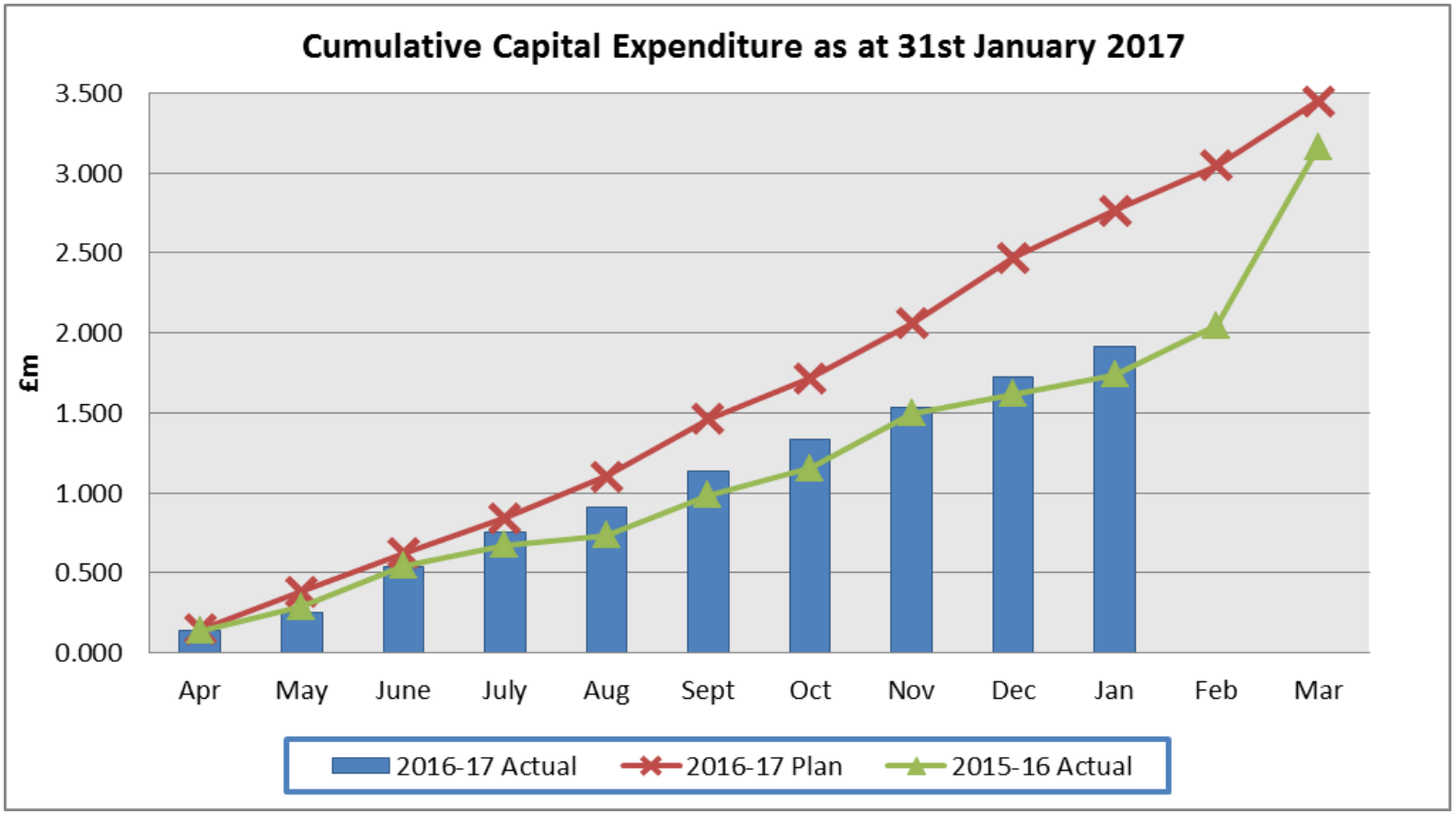
The first graph shows the working capital balance for the last 12 months (net current assets less net current liabilities adjusted for assets held for sale and inventories) and how many days of operating expenses that balance provides.

During last financial year working capital continued to improve due to improved cash levels. The downward trend at the end of last financial year is reflective of the reduction in cash due to year end transactions. January continues to show a further improvement up to 9.32 days which still gives a rating of 1 (the best) on that metric (-7days drops to a rating of 2).

The Trust Board is reminded that sector benchmarking information recently provided by external auditors illustrates that the peer average continues to be around +24 days, therefore our liquidity must remain a strategic priority for us to continue to improve and protect.

Cash is currently at £15.7m which was £3.2m better than the plan at the end of January. This is mainly driven by the Income and Expenditure surplus and capital being slightly behind plan.

Capital Expenditure

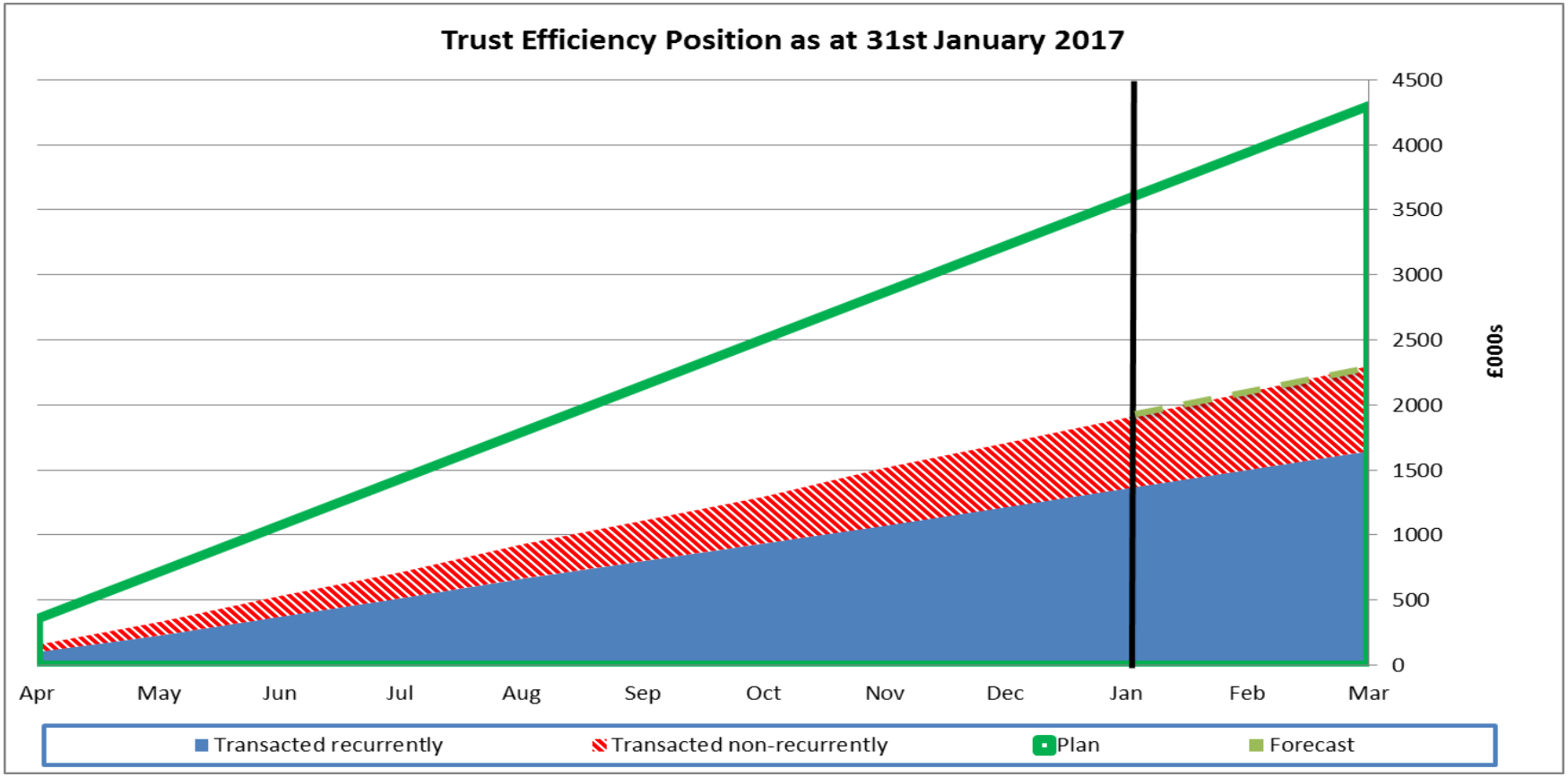


Capital Expenditure is £856k behind plan year to date but is forecast to spend to the plan of £3.45m by year end.

The 2016/17 schemes are regularly reviewed by Capital Action Team (CAT) including the reprioritisation to fund any new schemes. Some reprioritisation of schemes has already taken place to date this year in order to fund more urgent schemes. Capital Action Team members are overseeing the delivery of CQC-related capital requirements related to environment.

Efficiency

Cost Improvement Programme (CIP)



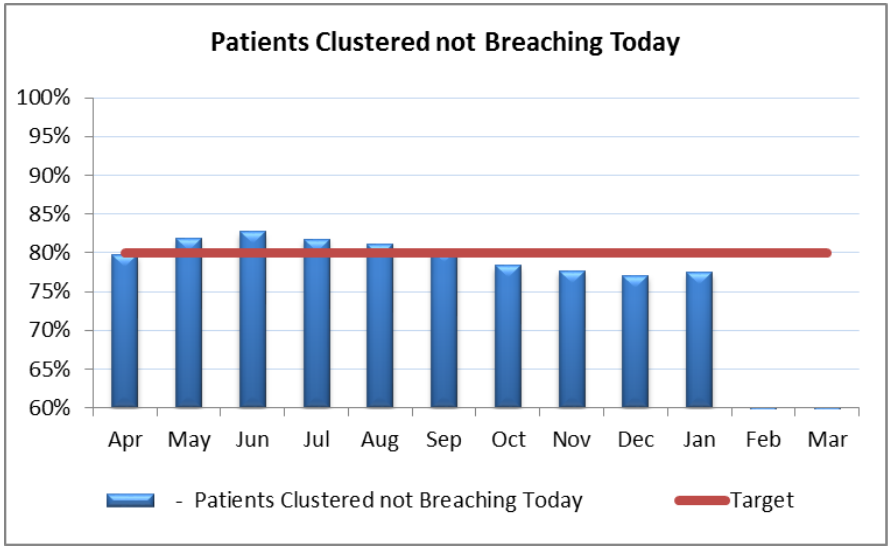
At the end of January there was a shortfall against the year to date plan of £1.674m. The full year amount of savings identified at the end of January reporting is £2.3m leaving a gap of £2.0m.

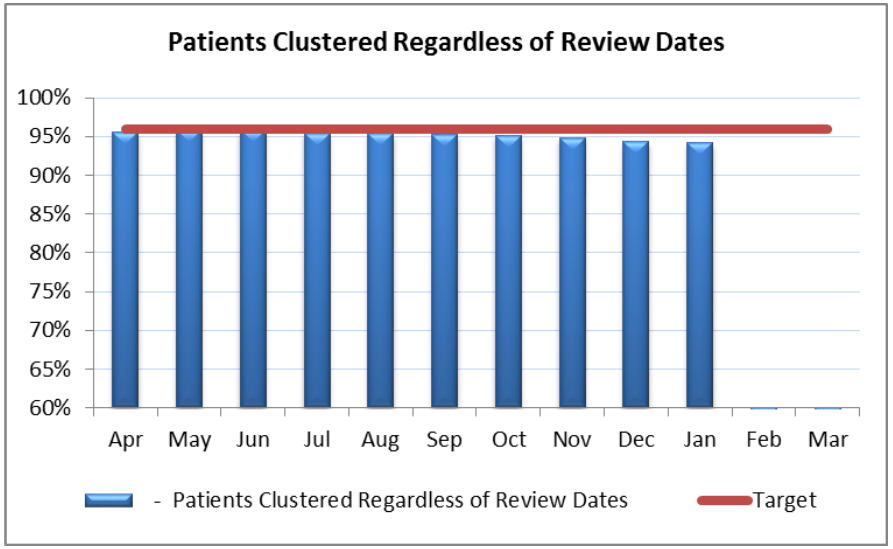
The forecast assumes no further CIP will be achieved by the end of the financial year leaving unfound CIP at £2.0m. This underachievement is compensated for by cost avoidance and other underspends in the overall position.

Programme Assurance Board continues to performance-monitor CIP delivery which is reported to Finance and Performance Committee who have delegated authority from Trust Board for oversight of CIP delivery.

Operational Section

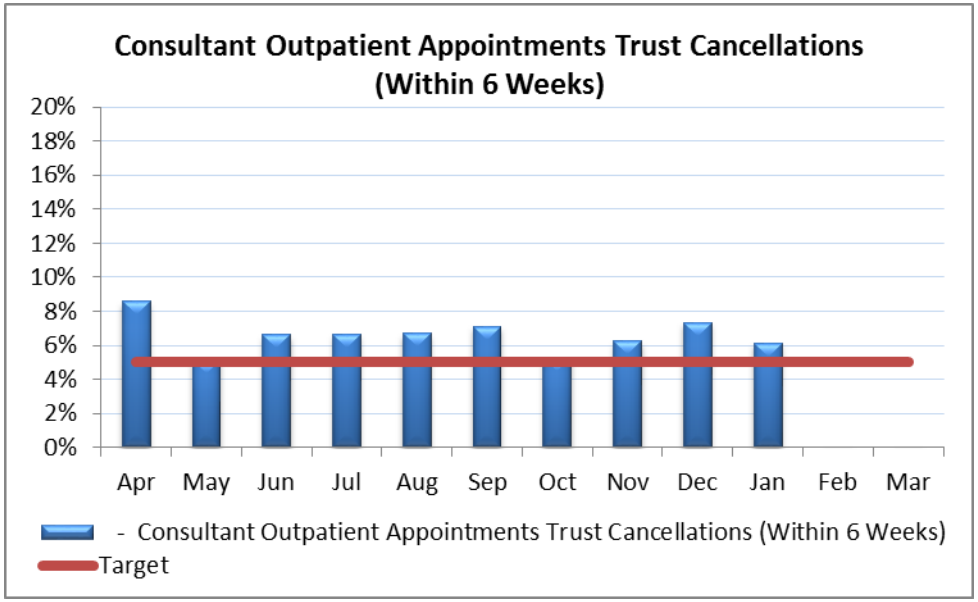
Clustering





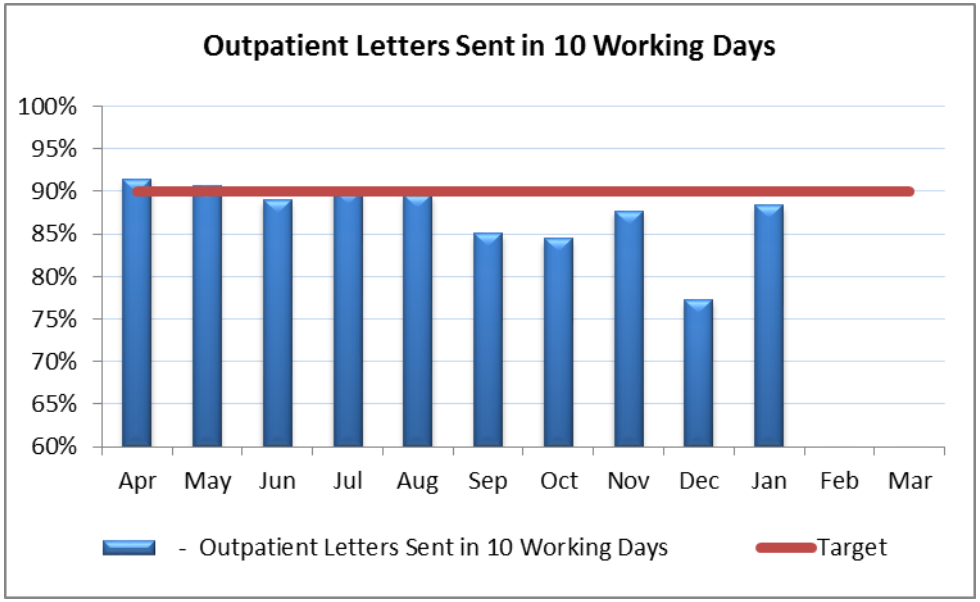
An action plan has been implemented. We should be able to start evaluating the impact of the actions as each is completed over the next few months.

Consultant Outpatient Appointments Trust Cancellations (within 6 weeks)



- The vast majority of cancellations were unavoidable. The main reasons for cancellations were consultant sickness absence, appointments being rescheduled to meet 18 week referral to treatment requirements, or because there was no consultant.

Outpatient Letters Sent in 10 Working Days

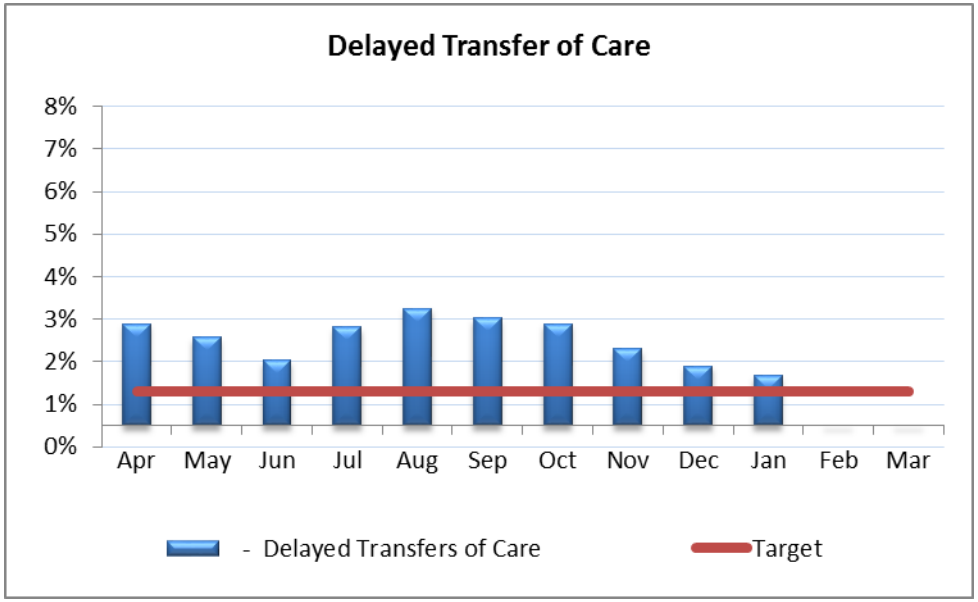


- Two Consultants left the Trust late Jan/early Feb (which meant we needed to clear all their typing before their last day to enable signature). A consultant left 27th January (51 letters typed immediately upon upload during her last week); A consultant left on 3rd February (67 letters typed immediately upon upload during his last week).
- There was a delay in some of the new cohort of junior doctors gaining access to both DictateIT and the correct Teams on Paris. The delay appears to have resulted from communication issues and annual leave of key individuals.
- Capacity was reduced in the support office, with the equivalent of 1.8 wte absent for the entire month. This was as a result of retirements, a bereavement and a full time member of staff successfully gaining a permanent role in another team.

Actions:

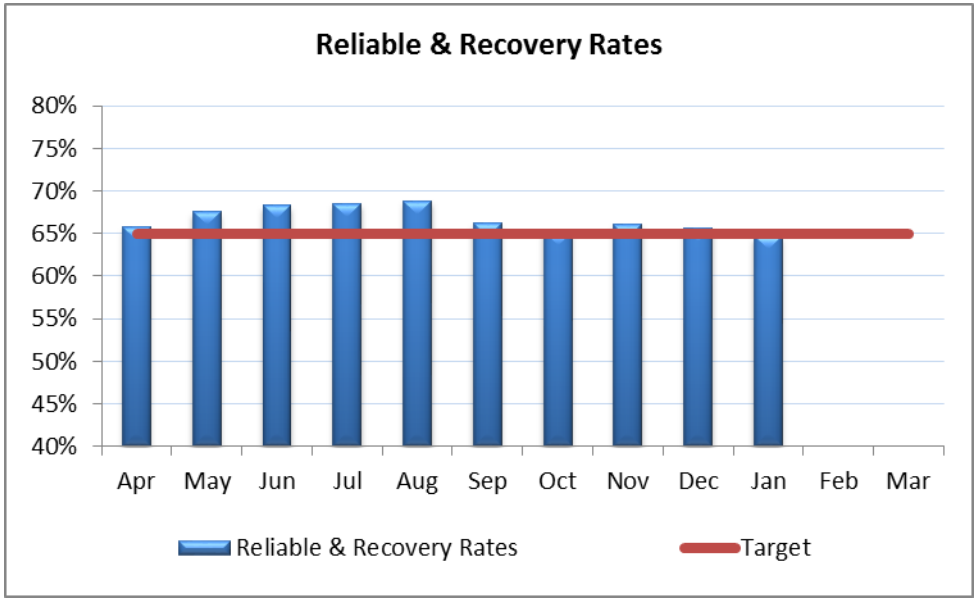
- The Professional Head of Admin and Secretarial Services to address the communication gaps ahead of the next rotation in August.
- Proactive audit continues and alerts are sent to all Medics found to have uploaded late or delayed jobs.

Delayed Transfers of Care



There are currently 4 delayed transfers of care: 2 patients are awaiting public funding and 2 patients are awaiting residential home placements by social services.

IAPT Reliable & Recovery Rates



We have been following through on several initiatives to try to ratify our wait lists and reduce them wherever possible. One of our initiatives is to follow up a first appointment with a second contact within 4 weeks to address a letter of concern about wait times. We have been doing this and these are then seen by the system as treatments. When we then contact people on our wait list to see if they are happy to continue waiting, if people are discharged at that point they have an impact on the recovery rate.

We have conducted wait list ratification in Erewash, Derby City and South Derbyshire where there have been the largest numbers waiting to get a clear number of people who are still waiting for treatment. Unfortunately these initiatives have a short term concentrated impact on recovery rates as can be seen in January, and they may have a similar impact in February whilst this process is completed.

WARD STAFFING

Ward name		Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Occupancy % Rate	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
AUDREY HOUSE RESIDENTIAL REHABILITATION	80.65%	139.6%	73.2%	138.7%	61.3%	Yes	Again we continue to run on 2qualified at nights unless moved to another area which will be back filled by unqualified staff. We currently have only have 4 full time NA staff and 1 part time NA staff. Our qualified ratio is now higher to come in line with trust procedure in attempting to work to 2 qualified per shift.
CHILD BEARING INPATIENT	87.63%	62.7%	105.4%	96.8%	183.9%	Yes	The current fill rate tolerance for registered nurses on days was broken due to covering vacancy and care staff on nights due to long term sickness.
CTC RESIDENTIAL REHABILITATION	82.19%	109.2%	90.9%	106.5%	95.2%	No	
ENHANCED CARE WARD	100.00%	84.0%	112.5%	66.1%	182.3%	Yes	ECW is carrying 3.8 RN vacancies and have further interviews planned for 20/02 we continue to maintain having a trust RN on every shift. We have also had 2 band 6 nurses of sick for the majority of January. We have now recruited into 4 of our NA vacancies and will have them in post as soon as pre employment checks are completed. We have 2 NAs on long term sick. We continue to attempt to use a group of bank staff familiar with the ward and our patients.
HARTINGTON UNIT - MORTON WARD ADULT	98.39%	123.4%	154.7%	53.2%	232.3%	Yes	We continue to carry some band 3 and band 5 vacancies - some if these are recruited into and the new starters are awaiting start dates. Also we have increased observations on the ward which requires higher staffing levels. Finally we are in the process of going"live" with the electronic patient records and this has also led to an increase in staffing levels.

WARD STAFFING

Ward name		Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Occupancy % Rate	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
HARTINGTON UNIT - PLEASLEY WARD ADULT	99.68%	126.8%	81.6%	36.8%	167.7%	Yes	The ward currently has one HCA removed from duty and through January was carrying a 0.6 B3 vacancy. Due to the last staff up lift the ward carries reduced HCA's on it's staffing complement. These factors have resulted in a higher ratio of Registered staff to HCA's on days. Due to sickness and training commitments it has been difficult to ensure two registered staff on every night shift, this has been further complicated by having two registered staff who are still completing Preceptorship. The ward has had to rely on bank HCA cover on nights resulting in the higher ratio of HCA's to Registered staff on nights. In the coming weeks it is expected that two full time HCA's will be returning to duty and the registered under preceptor will have completed allowing a more equitable ratio of staff on both days and nights.
HARTINGTON UNIT - TANSLEY WARD ADULT	98.52%	88.5%	127.0%	56.8%	174.2%	Yes	Deficits in Registered Nurse duties have been filled by predominantly Bank HCA duties to enable overall staffing figures of 5/5/3 the reasons for the skills deficits are detailed below: Vacancies: currently 4.4 wte Band 5 posts, 1 x wte recruited into from October 17 after the candidate qualifies, 1 x wte held for the development of the MOT role (Medicines Optimisation Technician) to support the registered nurses in the safety and governance of medicines which is just about to go out to advert and 2 x wte unfilled. Absences: 1 wte Band 5 removed from the Ward pending investigation, due to be interviewed this month, 0.6 x wte Band 5 on maternity leave due to return within the next 4 weeks, 0.6 x wte Band 5 on long term sick. 1 x wte Band 6 on long term sick, in addition a number of Band 5 staff have reported short term sickness over the last 4 weeks due to usual winter conditions. All sickness reported and in the process of being managed. This means that only around 75% of the budgeted wte at Band 5 is available for duty before taking into account short term sickness, training or annual leave in addition only 50% of wte Band 6 is available for duty on day duty to cover Lead Nurse and Bleep duties or clinical shifts. All registered staff are doing extra shifts where they can to keep a safe skill mix and staffing ratio we expect as sickness reduces and staff return from maternity leave the skill mix will once again improve.

WARD STAFFING

Ward name		Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Occupancy % Rate	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
KEDLESTON LOW SECURE UNIT	62.10%	89.0%	99.2%	100.0%	100.0%	Yes	We have been carrying several Registered Nurse vacancies which may contribute to us not having 2RN's on each ward per shift. We are always aiming for 3 across both wards in the day and use support from bleep holder etc and leadership team where necessary.
KINGSWAY CUBLEY COURT - FEMALE	58.06%	113.3%	91.8%	66.1%	115.1%	Yes	he reasons for breaking the night qualified safe staffing rules are: 1 RN vacancy, Annual leave, Maternity leave, 2 RN on Block Training.
KINGSWAY CUBLEY COURT - MALE	72.58%	81.1%	134.0%	77.4%	194.6%	Yes	We have 2 new RNs who started 30th Jan and 1st Feb this will improve February's fill rate of RN's. We also had some unplanned sickness in January due to the time of year bugs etc
LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP	85.28%	99.3%	79.0%	90.3%	117.0%	Yes	There were variations in the care staff ratio up to the 17/1/17 Prior to this the patient numbers were low on wards 1 & 2 Care staff and Registered nurses were redeployed to other wards to cover sickness and vacancies after the 17/1/17 the establishment numbers have been increased to reflect the increased risk as ward 1 is a stand alone unit There are also shifts when Temporary Staffing Dept. have not filled outstanding shifts for short term sickness
LONDON ROAD COMMUNITY HOSPITAL - WARD 2 OP	33.47%	116.7%	73.2%	100.0%	106.7%	Yes	Ward 2 was combined with Ward 1 16/2/2017
RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT	103.23%	75.4%	172.6%	54.8%	148.4%	Yes	Tolerance rates have been broken due to significant Band 5 Registered Nurse Vacancies, unable to fulfil the required 2 Band 5 Registered Nurse on nights shifts, these shifts and day shifts are being filled by Unqualified staff.
RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT	104.35%	91.3%	132.4%	69.4%	251.6%	Yes	Ward 34 have had increased level of engagements and continue to carry RN vacancies which has increased the use of bank nursing assisitants.
RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT	107.10%	80.4%	152.3%	72.6%	140.3%	Yes	We continue to run with vacancies for Band 5 nurses that we are unable to fill despite ongoing recruitment.
RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT	100.32%	80.0%	116.2%	51.6%	135.5%	Yes	During January we have had 2 members of staff on long term sick, a daily escort to RDH and ECt escorts twice per week , therefore the staff return is correct

Workforce Section

WORKFORCE DASHBOARD

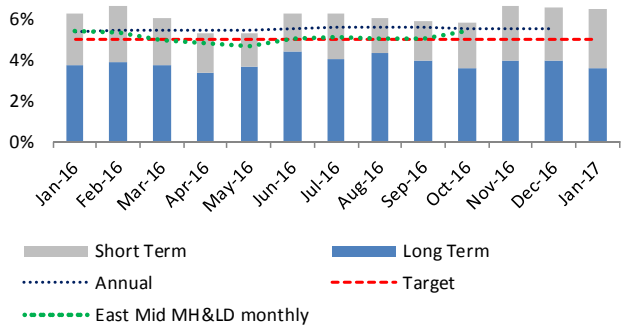
Wellbeing

Sickness Absence

(Monthly)

Nov-16	Dec-16	Jan-17
6.65%	6.55%	**6.47%**

Target 5.04%



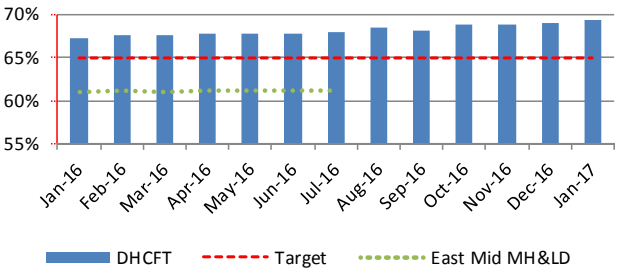
The monthly sickness absence rate is 0.08% lower compared to the previous month, however it is 0.18% higher than in the same period last year. The Trust annual sickness absence rate is running at 5.57% (as at Dec 2016 latest available data). Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 25.61% of all sickness absence, followed by at cold, cough, flu - influenza at 15.05% and Surgery at 13.42%. Compared to the previous month short term sickness absence has increased by 0.28% (notable increase in cold, cough, flu) and long term sickness absence has decreased by 0.36% (notable decrease in surgery).

Qualified Nurses

(To total nurses, midwives, health visitors and healthcare assistants)

Nov-16	Dec-16	Jan-17
68.86%	69.05%	**69.24%**

Target 65%



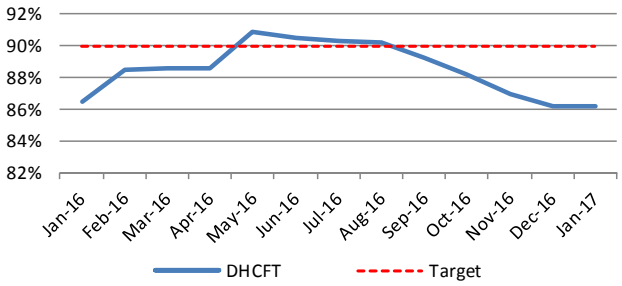
Contracted staff in post qualified nurses to total nurses, midwives, health visitors and healthcare assistants is running at 69.24%. Vacancy rates can impact on this measure. The average for East Midlands Mental Health & Learning Disability Trusts is 61.19%. Health Visitors represent 5.08% of the Trust total and are not included in the Qualified Nurses calculation. Healthcare Assistants and Nursing Support staff represent 25.68% of the total.

Compulsory Training

(Staff in-date)

Nov-16	Dec-16	Jan-17
86.94%	86.21%	**86.21%**

Target 90%

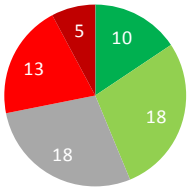


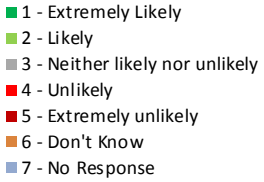
Compulsory training compliance continues to remain high running at 86.21%, retaining the same level of compliance compared to the previous month. Compared to the same period last year compliance rates are 0.07% higher. Compulsory training compliance remains above the 85% main contract commissioning for quality and innovation (CQUIN) target.

Motivation

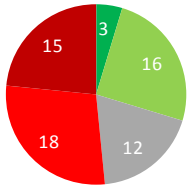
Staff FFT Q2 2016/17 (In-Patient campus focus; 64 responses, 10.08% response rate) & Staff Survey 2015

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





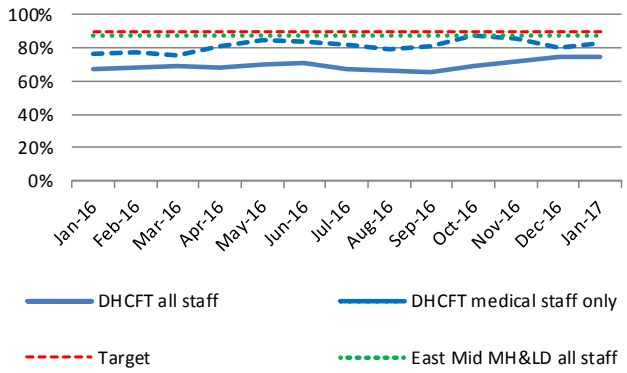
How likely are you to recommend this organisation to friends and family as a place to work.



	2014	**2015**	National Average
Overall staff engagement	3.75	**3.73**	3.81

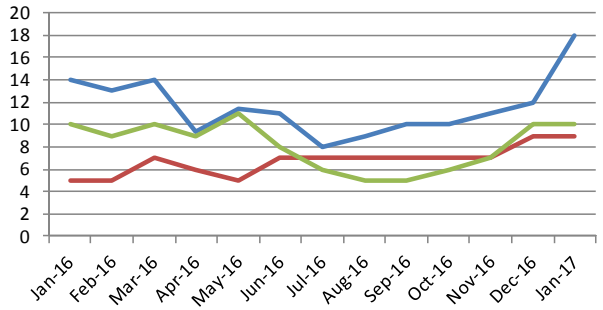
Appraisals	Nov-16	Dec-16	**Jan-17**
(All staff)	72.24%	74.28%	**74.60%**

Target 90%

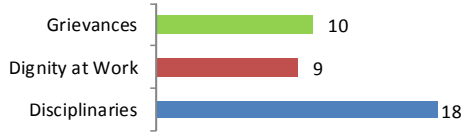


The number of employees who have received an appraisal within the last 12 months has increased by 0.32% during January 2017 to 74.60%. Compared to the same period last year, compliance rates are 6.73% higher. Medical staff appraisal compliance rates are running at 82.41%. According to the 2015 staff survey results, the national average for Mental Health & Learning Disability Trusts is 91%. Local benchmarking data for a range of Trusts in the East Midlands shows an average completion rate of 82.86%.

Grievances/Dignity at Work/Disciplinaries as at 31/01/17



There continues to be 10 grievance cases lodged at the formal stage. No new grievances have been lodged and the outcome of 2 cases should be known before the next period. No new Dignity at Work cases have been identified and it is anticipated that up to 4 cases may be resolved before the next period. 6 new Disciplinary cases have occurred in the period making 18 in total with the possibility of 1 being resolved before the next period.

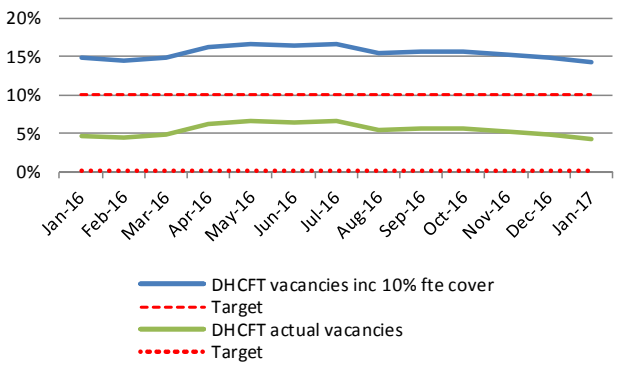


WORKFORCE DASHBOARD

Attendance

Vacancy

(Budgeted full time equivalent)	Nov-16	Dec-16	Jan-17
Including 10% funded fte flexibility/cover	15.22%	14.92%	**14.35%**
Actual against target	5.22%	4.92%	**4.35%**

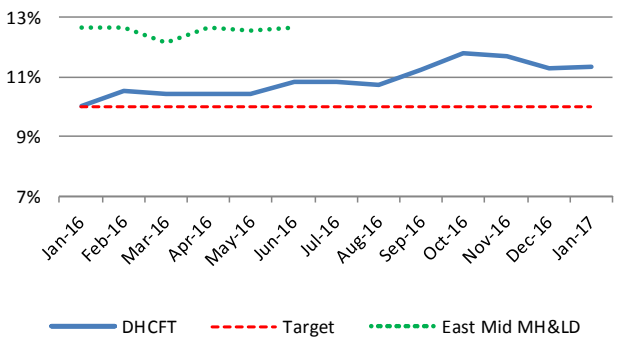


Target 10%/0%

The Trust target for contracted staff in post is 90% which allows 10% funded full time equivalent surplus for flexibility including sickness and annual leave cover in In-Patient areas. The budgeted fte vacancy rate has decreased by 0.57%. April 2016 included additional full time equivalent investment for 2016/17. New recruitment activity during January 2017 was for 82 posts. 78% were for qualified nursing, 9% admin, 9% allied health professionals, 2% additional clinical services, 1% Medical and 1% estates-ancillary.

Turnover

(Annual)	Nov-16	Dec-16	Jan-17
	11.71%	11.28%	**11.37%**

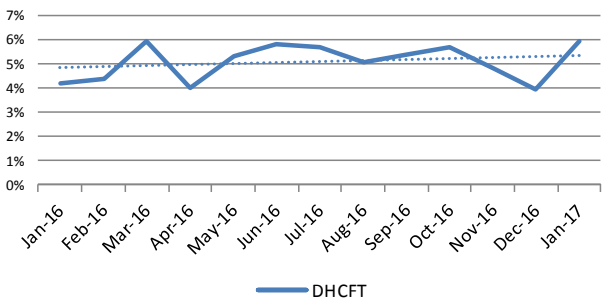


Target 10%

Annual turnover remains within Trust target parameters at 11.37% and remains below the average for East Midlands Mental Health & Learning Disability Trusts. The average number of employees leaving over the last 12 months has increased slightly to 23.08. During January 2017 18 employees left the Trust which included 2 retirements. A key factor still remains for the increase in recent turnover rates, which is a reduction in overall contracted staff in post caused by unfilled vacancies.

Agency Usage

(Spend)	Nov-16	Dec-16	Jan-17
	4.79%	3.91%	**5.91%**



Total agency spend in January was 5.91% (6.32% including medical locums). Of total agency and locum spend for all staff groups, Qualified Nursing represented 1.1%, Medical 3.6% and other agency usage 1.2%. Agency Qualified Nursing spend against total Qualified Nursing spend in January was 19.8%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £1.608m of which £976k related to Medical staff.

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 1 March 2017

Quality Position Statement

Purpose of Report

The purpose of this report is to provide the Trust Board of Directors with an update on our continuing work to improve the quality of services we provide in line with our Trust Strategy, Quality Strategy and Framework and our strategic objectives.

Executive Summary

This position statement sets out:

1. Safety planning update
2. Update around Quality Leadership teams and the governance structure around them
3. Neighbourhoods event feedback
4. Quality visits update
5. CQC action planning from the June comprehensive inspection visit and recent contact with the CQC
6. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) Safety Scorecard, specifically the effectiveness of our 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	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

Strategic considerations

To give an insight into our Quality management and focus our reporting to the key areas as key lines of enquiry and questioning by the Care Quality Commission as our Quality regulator and to provide assurance level information on our services and their performance.

(Board) Assurances

Compliance with the key areas covered by the Care Quality Commission key lines of enquiry and emerging clinical strategy and how this will influence the quality team in developing practice.

Consultation

This paper has not been previously presented but does reference information available to the Quality Leadership Teams and quality governance structures

Governance or Legal issues

Evidence of our compliance with the Health and Social Care Act 2008 (Regulation activities) Regulations 2014 Part 3 and Care Quality Commission (Registration) Regulations 2009 (Part 4)

Children and Families Act 2014

Equality Delivery System

Any impact or potential impact on equality is considered as a key part of all our quality work.

Recommendations

The Board of Directors is requested to:

1) Receive this quality position statement
2) Gain assurance, be advised on quality leadership strategy and engagement and information on its content and seek clarity or challenge on any aspect of the report

Report prepared by: **Darryl Thompson**
Deputy Director of Nursing & Quality Governance

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

QUALITY POSITION STATEMENT

1. SAFE SERVICES

1.1 Safety Planning

The FACE risk assessment tool is being decommissioned at the end of March, so the Safety Planning tool will be the place for staff to record risk assessment and risk management. This is being used already in some areas, but there are concerns from other key service areas about the appropriateness of the tool to their relevant areas. We are keen to capture these concerns, together with ideas from staff for improvement and to change our culture and practice in personalised safety planning. In partnership with communications, we are developing different ways of making it as easy as possible for staff to feed these back, and these will be in place before 1 April. This decision has been made in partnership with medical, clinical and operational colleagues. Throughout, we are keen to maintain the partnership approach to risk management that Safety Planning brings.

2. WELL LED

2.1 Quality Leadership

The Quality Leadership Teams continue to evolve, and are now incorporating operational issues with wider attendance from an integrated group. We recognise that these groups will require on-going attention to support their development. It is clear that both Campus and Neighbourhood areas are under intense pressure and this is not assisting the growth of these specific clinical reference groups. The Associate clinical director does recognise the need to understand quality governance and develop quality improvement that connects with the voice of the clinical team and is working to enhance communication as these specific groups continue to evolve.

Action: There is clear commitment from the Director of Nursing & Patient Experience and the Medical Director to attend these meetings or offer alternative support in any manner and support their continued development.

2.2 Trust Management Team & Senior Assurance Support meeting

The Trust Management Team meeting and the Senior Assurance Support Meeting are becoming more established, the next stage being more of a shared ownership of their respective agendas.

3. RESPONSIVE

3.1 Investigation Facilitators- responsiveness of complaints and serious incidents

We are interviewing for these two posts on Friday 24th March, significant interest has been received which hope to contribute to timeliness and consistency of serious incidents and complaint reports, together with some capacity for clinical staff who are currently undertaking these to relieve some of the pressure.

3.2 Neighbourhood Teams

Within the Neighbourhood teams, the Service Managers and Service Line Managers met with Kath Lane (Deputy Director of Operations), Claire Biernacki (General Manager) and Darryl Thompson (Deputy Director of Nursing & Quality Governance) on 9 February. There was clear and open discussion, together with a positive attitude to working together to move this forward. We discussed

in particular the current waiting lists for a Care Co-ordinator within the Neighbourhood teams, the impact of this on other parts of the service, recruitment and retention, and the potential 'creep' of tolerance within teams around issues such as criteria for being offered care under the Care Programme Approach, Service Managers having a caseload, and consistency between the teams as to threshold for acceptance of people referred. As an initial plan, Claire Biernacki is leading on a piece of work to gain greater clarity around waiting list size to keep a current and accurate picture of those on the waiting list in all teams, what other support those on the waiting list might be accessing. Future meetings are planned with the managers to support them in moving forward with this, within their commissioned resources. This is further explored in the deep dive for community services in today's clinical deep dive.

4. EFFECTIVE

4.1 Quality visits

The reviewed technical guidance and briefing on Quality Visits is now complete and has been distributed to those who are conducting Quality Visits. There are 76 areas to visit, 21 of these are booked, we are awaiting confirmation from three more teams, and the rest are to be arranged over the coming months. Each visit is led by an executive director. The key theme for this year is the continuation of the key lines of enquiry; in addition staff to show case Family inclusive practice or the Triangle of Care for clinical services and inclusivity for non-clinical areas.

4.2 Care Quality Commission Comprehensive Inspection

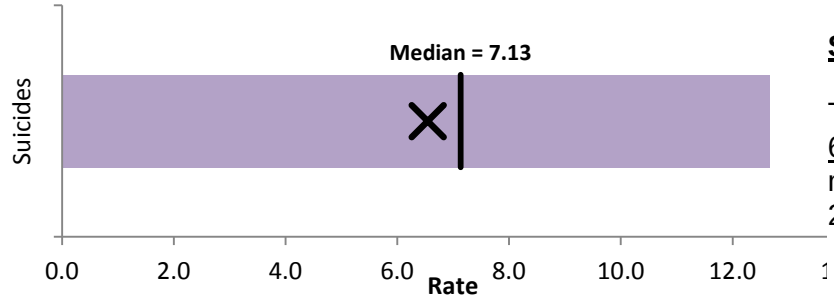
The CQC full inspection report was published on 29 September 2016. We continue to work on our action plan. Eight data requests arrived for children's services on 8 February, all of which were completed within expected time frames. We have now submitted all the data updates that were requested on 25th January, all showing improvement and/or appropriate action plans. There was an announced case note inspection of colleagues in the Community Team for Learning Disabilities, based at St Andrew's House and the Council House in Derby on 13th February. The teams were able to show their approach to supporting capacious decision making, ensuring an adherence to the spirit of the Mental Capacity Act, not just the process. Recording of capacity is still in development for these teams, however, and we expect feedback to also reflect that. Of note, this visit has not as yet triggered any more visits. Colleagues in Substance Misuse services continue to prepare for their expected visit, which would be expected in 2017.

Each lead for CQC outstanding actions has been offered 1-1 support and many have accepted this. Progress is reviewed monthly and reported to the Quality Committee.

4.3 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) Safety Scorecard

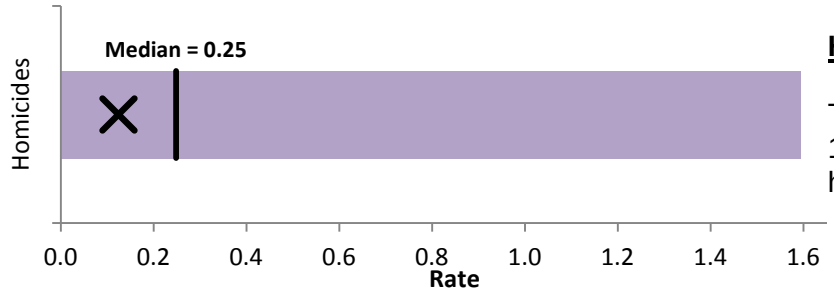
The chart below is the NCISH Safety Scorecard for your trust, accompanied by an information sheet for you to consider.

The NCISH Safety Scorecard has been developed in response to the request from our commissioners, the Healthcare Quality Improvement Partnership (HQIP), for benchmarking data to support quality improvement.



Suicide rate

The suicide rate in your Trust was 6.5 (per 10,000 people under mental health care) between 2012-14.



Homicide rate

The homicide rate was 0.1 (per 10,000 people under mental health care) between 2012-14.

Trust Scorecard: Derbyshire Healthcare NHS Foundation Trust

The figures give the range of results for mental health providers across England, based on the most recent available figures: 2012-2014 for suicides, homicides and sudden unexplained deaths (SUD), 2015-16 for people on the Care Programme Approach (CPA), 31 October 2015 – 31 October 2016 for non-medical staff turnover and 2012-16 for trust questionnaire response rates. 'X' marks the position of your trust. Rates have been rounded to the nearest 1 decimal place and percentages to whole percentage numbers.

Additional scrutiny of the sudden unexplained deaths (SUD) is being explored before being released into the public domain, to confirm the number of patients this relates too. The Trust has historically been above average in this area, and in this scorecard the same data set continues. Further analysis of this issue and what it means for practice and learning will be led by the SIRI and mortality group and reported to the Quality committee.

Report prepared by: **Darryl Thompson**
Deputy Director of Nursing & Quality Governance

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

Board Committee Summary Report to Trust Board
Quality Committee - meeting held on 9 February 2017

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Minutes and Actions matrix	Agreed and ratified	Significant assurance	See minutes for full actions		
CQC Action Plan	Significant improvement and pace assurance on progress and the pipeline Reviewed with review and challenge. CQC Mental Health Act visit to Tansley Ward	Significant assurance No assurance in actions outside of the Trust control in commissioning intentions. Limited assurance on sustained performance	Risks to delivery – CQC actions not in the control of DHCFT. Despite confirmation at the Quality summit of formal support in these areas and formal letters of intent of investment in CQC required actions. Commissioning intentions- 136/ Community staffing and psychological therapy/ SALT in Learning disability are completely absent Lack of clinical operational diligence and delivery in key areas of practice on this ward. History of highly inconsistent practice and lack of consistent practice	Significant risks to delivery due to CCG QUIPP proposals of 3 million + worth of removal of service Significant risks to delivery due to failure of commissioners to invest in CQC regulatory issues Action operations team, to develop actions that mitigate this risk, in the operational delivery arm	Escalation to Board, Significant risk to delivery on no assurance in CQC actions outside of the Trust control in commissioning intentions.
Quality Dashboard	Significant improvement Detailed discussion on the information included and actions already in place,	Significant assurance overall with positive upward trajectory Limited assurance on	Clinical and management performance of supervision Complaints completion and	Additional weekly monitoring by COO remains in place. New investment in	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
	demonstrating progress.	complaints completions timescales	performance	complaints response time improvement model in process of recruitment. Timescales for completions confirmed	
Governor feedback on Quality indicators	Deferred to next meeting				
Service recipient and Carer feedback	The lived experience and the impact of errors in appointment letters feedback Medicines incidents and yellow alert form to be issued Carers travel allowance- national travel Discussion re carers training in physical healthcare and what assurance do we have that we hold a record of training giving to parents and carers in Child Health, substance misuse and Learning Disability services	Family and care experience	Confirmation of individual investigation Explorations of risks through physical healthcare committee, and section to be included in the next report on child health/ naloxone in substance misuse/ physical healthcare in LD.	Escalation to DHCFT Patient experience to confirm follow up on complaint Pharmacy follow up on medicines incident Exploration with carers groups – travel assistance / and how accessible this is Assess and mitigate possible Trust exposure and monitoring	
Community Paediatrics	Position paper Although substantial	Significant improvement but remains as limited	Responsiveness and waiting times.	Remains red rated risk/ revised mitigation plan	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
	improvement. Children and families are waiting to access a Paediatrician	assurance. due to the sheer volume of referrals		following recent successful recruitment. NED (JT or AW) children's service visit to gain service assurance on the process and practice/ is triangulated.	
Community mental health model	Feedback to Quality Committee 16 February regarding mitigations for current waits for mental health care coordination in neighbourhood services	Limited assurance. due to the sheer volume of referrals and patients with significant mental health need	Responsiveness and waiting times.	Significant risks to delivery due to failure of commissioners to invest in community mental health services. Partial settlement in 2016, with intention to invest in 2017. Was not provided in 2017	Escalation to Board, Significant risk to delivery, emerging potential patient safety issues without mitigation plan. Staff stress and significant pressure
Serious incident monthly report	Detailed review of incidents and themes No immediate cluster or concerns Review checks against 3-monthly moving averages in order to identify any trends was provided.	Significant assurance	Close monitoring of serious incidents and death rate The committee reviewed the possibility of a predictive pipeline for actions / with a trend	Additional actions agreed to include detailed CQC paper in the February QPS for the public.	
Transition to adult services	Verbal report on progress	Limited assurance, until formal plan emerges. But positive feedback on work to date and progress	Responsiveness and waiting times. Effective transition	Scheduled on forward plan. Note CQUIN and priorities are to be a quality priority	
Clinical practice – seclusion and	Written report	Limited assurance, until formal plan is fully	Continual revisions and assurance/ repetitive	Mental Health Act committee to lead this	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
segregation	Small amendment to Change a date and moving of one summary statement to top line for prominence	embedded (Tansley feedback)	compliance checks until fully sustained.	work, transfer of actions	
Person centre care implementation plan	Written report Positive research work Positive service user involvement, co-production and training Positive clinical outcome measures to measure effectiveness Positive links to patient safety plans	Limited assurance, until formal plan is fully embedded	Pace and roll out of training to fully embed person centred care	Moving into full implementation	
Dementia board report	Written repost Descriptive Clinical risks explored and risks to delivery Impact of commissioner intentions	Significant assurance	Feedback given on style and format of report, which is descriptive. More targeted focus on strategy and performance against strategy in a summary report rather than descriptive evidence	Future reports to be amended	
Consideration of BAF risks	Clinical risks and BAF risks representative of known risks No new known risks Discussion re future BAF and draft proposal to be presented to the March	Significant Assurance received on the identified risk areas and plans	As discussed risks are being added around disinvestment from commissioners and the potential for increased risk to patient safety as a result of the contract settlement round.	Revisions to the BAF/ BAF closing and new BAF to be designed	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
	2017 meeting				
Clinical audit	Written report Improvement in pace and working relationships with QLT Triangulation of feedback from QLT previously and in 2017. Audit leads to only summarise key learning and recommendation key actions, with advice to QLT on action, Decision, training, and Changes to policy and standards. human factors and prioritisation only	Significant assurance	Feedback from QLT on two occasions on audits. Full reports from audits may be having a negative impact on QLT effectiveness reconsider model of presentation and summary format	Report received and progress was noted Requested actions to change working style requested. Action John Sykes	
Emergency preparedness Resilience and response	Gap in assurance. Risk based issue / so prioritised for Quality committee Reduced performance, due to capacity issues. Significant team investment and predicted trajectory to move form no assurance to significant assurance	Upward trajectory to reach Significant assurance, following independent assessment findings	Significant work in development and in delivery phase	Monthly reporting to Trust management team. Reference to Health and safety in work plan to confirm Exception to Quality committee if rating achieved.	
Pharmacy and medicines management	High quality report with performance, trend and trajectory with precise	Significant assurance	Confirmation of link and feedback to community pharmacy on 77 and 17% of DHCFT incidents not relating to	Further performance management on sustained performance in medicines safety report by	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
report	recommendations		Trust practice. Significant assurance on system and process of identifying errors on entry or admission to the service	acting COO.	
Governance Improvement Action plan	Reviewed the content of the update and received assurance. a 'blue form' was produced, scrutinised and was singed off as an action in the February meeting.	Significant assurance. Improved performance	Delivery of QLT effectiveness and improvement for one QLT. Significant risk to delivery	Further performance management on sustained performance by directors to improve this situation	
Neighbourhood and Campus QLT	Summary report provided Report endorsed by Medical Director Challenge by NED, positive to represent views Challenge by NED, on content and issues. Concern by chair on structure, model, clarity on role and priorities Concerns re performance on sub groups Clinicians attendance Feedback from ACD and Chair on medical staffing and views	Limited to no assurance	Delivery of QLT effectiveness and improvement for one QLT. Value of senior clinicians of clinical governance Balance of engagement but the need to progress a QLT that is effective in monitoring the Quality of care and making positive and proactive decisions.	Further development work with the QLT Support, coaching and direction, was requirement of well led. Medical Director to attend and feedback. Escalation to CEO as significant concerns Structural chart to explain governance and exploration of engagement with Psychiatry	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
	Lack of medical consultant body engagement or prioritisation				
Childrens and Central services	Richard Morrow confirmed the QLT has met as planned. The SMT and QLT for Children's have combined into one meeting structure effective 31 January.	Significant assurance	No issues to escalate from the QLT	Formal report received.	
Risk escalation report	Received and accepted	Significant assurance	Clear identification Early feedback on internal audit emerging findings	Formal report received	
Minutes of Drugs and therapeutic	Received and accepted	Significant assurance	None positive attendance and discussion re Equality risk assessment training by the D&T leadership team	Review TOR on reporting of minutes	
Any other business	None				

Board Committee Summary Report to Trust Board
People & Culture Committee
21 February 2017

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Welcome and Apologies Minutes of People & Culture Committee held 18 January 2017	Minutes approved	N/A	None	None	None
Actions Matrix and Matters Arising	Job Planning policy – Full update on job planning to PCC in March 2017 Review of induction process back to PCC in April 2017 Leadership Development Strategy May 17 Follow up on the Staff Engagement Action Plan March 2017		None	None	N/A
Staff Story	Positive staff experience of accessing staff support services		None	None	N/A
Strategic Workforce Report	Gender Equalities timetable National position of staff absence	Significant assurance	None	None	N/A

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	People Plan reporting process including a monthly deep dive				
GIAP Trajectory/Closure and Review the blue forms for recommendations PC2, PC3, PC4, PC5, WOD1, WOD3, WOD4, WOD7, WOD8 and CQC2	PC2 to be revisited again in March 2017 with a document that pulls together all the activity that we have on staff engagement PC3 approved. The online forum to made accessible to the Exec team PC4 – Approved PC5 – Approved WOD1/WOD7 – Approved WOD3 – Approved WOD4 – Approved WOD8 – Approved CQC2 - Approved	Full assurance was taken on all but the PC2	None	None	PC3 – Approved PC4 – Approved PC5 – Approved WOD1/WOD7 – Approved WOD3 – Approved WOD4 – Approved WOD8 – Approved CQC2 – Approved To be signed off at Trust Board
Staff Survey Results and Action Plan	4 key themes discussed with the committee, March to receive the detailed engagement plan	Limited assurance on the results with more work to take place on the action plan	Time frame to make impact Staff awareness of focus areas	PCC to receive an engagement plan in March 2017	
Culture Change	Paper followed up on the	Paper was put on hold	Tool kit to be utilised but		

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Programme Action Plan	board paper received in December. Agreed to proceed with the staff engagement approach and revisit the culture plan in due course		will be considered in the work with culture work stream with DCHS		
Recruitment Review and Action Plan Update	Action to look at every opportunity speed up the clearances. 73 in process. Process improvements on track. Update on medical recruitment plan – overseas trip planned for later in March	Paper received limited assurance	Workforce supply is on the BAF	Increase the focus on speeding up clearances	Board to receive and have a discussion on the workforce plan
Position statement on Nursing vacancies	Deep dive paper on recruitment issues and solutions	Paper received limited assurance	Workforce supply is on the BAF	Workforce plan to identify strategic options for future workforce supply	Board to receive and have a discussion on the workforce plan
People Performance Report	Sickness rates in top 5 teams	Paper received limited assurance	Workforce supply is on the BAF	Workforce plan to identify strategic options for future workforce supply	Board to receive and have a discussion on the workforce plan
Update Report on Apprenticeship Levy	Update on progress, mapping to standards and frameworks complete. Demand will outstrip the levy.	Significant assurance on the progress that has been made	None	None	N/A

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	Wider discussion should be had at board about				
Deep Dive of BAF Risk 1b Equality	Assurance taken on the BAF deep dive and the risk sitting at moderate	Significant assurance received	None	None	N/A
Staff Attendance Management	Deep dive into short and long term sickness	Limited assurance	None	Further work to be undertaken to reduce staff absence	N/A
Occupational Therapy Strategy (Mental Health & Wellbeing)	Progress against the strategy 87 OT's across the trust 8 new preceptors Rotation opportunities North and South of county AHP student facilitator in post	Significant assurance	None	Integrate the work into the workforce plan	N/AS
Any Other Business	None	None	None	None	N/A
Forward Plan					
Items escalated to the Board or other Committees Identified Risks Meeting effectiveness	Workforce plan – future supply and funding needs focused board time and discussion	None	None	None	Workforce plan – future supply and funding needs focused board time and discussion

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
FOR INFORMATION					
Minutes of JNCC held on 30 November 2016					N/A
Notes from Mindful Health & Wellbeing Group 16 January 2017					N/A
Equalities Forum held on 25 January 2017					N/A

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 1 March 2017

Community Mental Health Team Capacity and Risk Mitigation

Purpose of Report

This paper provides Trust Board with an in depth review of the growing pressures faced by the community teams, the risks being carried and any mitigation against these risks.

Executive Summary

- There are multiple challenges to the capacity of community teams to deliver safe, timely, effective and good quality patient care and levels of risk are high and increasing
- There is a significant resource gap and no indication that this can be closed in the near future
- Caseloads are well above national guidelines, waits for service are lengthy and growing
- Demand for service is increasing
- Recruitment and retention issues, although marginally improved over recent weeks are likely to remain a long term problem
- There is evidence that our thresholds for access to service are becoming higher, this is a risk and will increasingly impact other key Trust services
- Achieving KPIs is becoming increasingly difficult, and there is a high risk that this will become the norm
- Services in areas of highest pressure, are varying from Trust practice policy in delivering some service, particularly in maintaining some cohorts on Care Programme Approach (CPA), this represents a high risk
- Retraction of services in social care and the voluntary sector increase demand and stifles flow
- Services are innovating but outcomes are not all promising
- The drive to a more recovery focussed strategic approach is going forward but requires support
- Other options to improve the situation have risks associated

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

Board Assurances

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

Consultation

Aspects of this paper have been presented to the Trust Management Team and Executive Leadership Team.

Governance or Legal issues

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:
Regulation 17 – *"To meet this regulation; providers must have effective governance, including assurance and auditing systems or processes. These must assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service. The systems and processes must also assess, monitor and mitigate any risks relating the health, safety and welfare of people using services and others."*
Regulation 18 – *"To meet the regulation, providers must provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times and the other regulatory requirements set out in this part of the above regulations."*

Health and Safety at Work etc. Act 1974

Equality Delivery System

DHCFT has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. We have thought about how the issues dealt with in this paper might affect protected groups. We believe the paper will not have any adverse impact upon these groups and that DHCFT has fulfilled its duty under the Act.

Recommendations

The Board of Directors is requested to:

1) Consider the content of this paper
2) Write to the commissioners to formally acknowledge the level of risk within the community

Report presented by: **Claire Biernacki, General Manager**
Julia Lowes, Area Service Manager

Report prepared by: **Kathryn Lane, Deputy Director of Operations**
Claire Biernacki, General Manager
Peter Henson, Performance Manager

Derbyshire Healthcare
NHS Foundation Trust

Community Mental Health Team Capacity & Risk Mitigation

March 2017

Table of Contents

Derbyshire Healthcare
NHS Foundation Trust

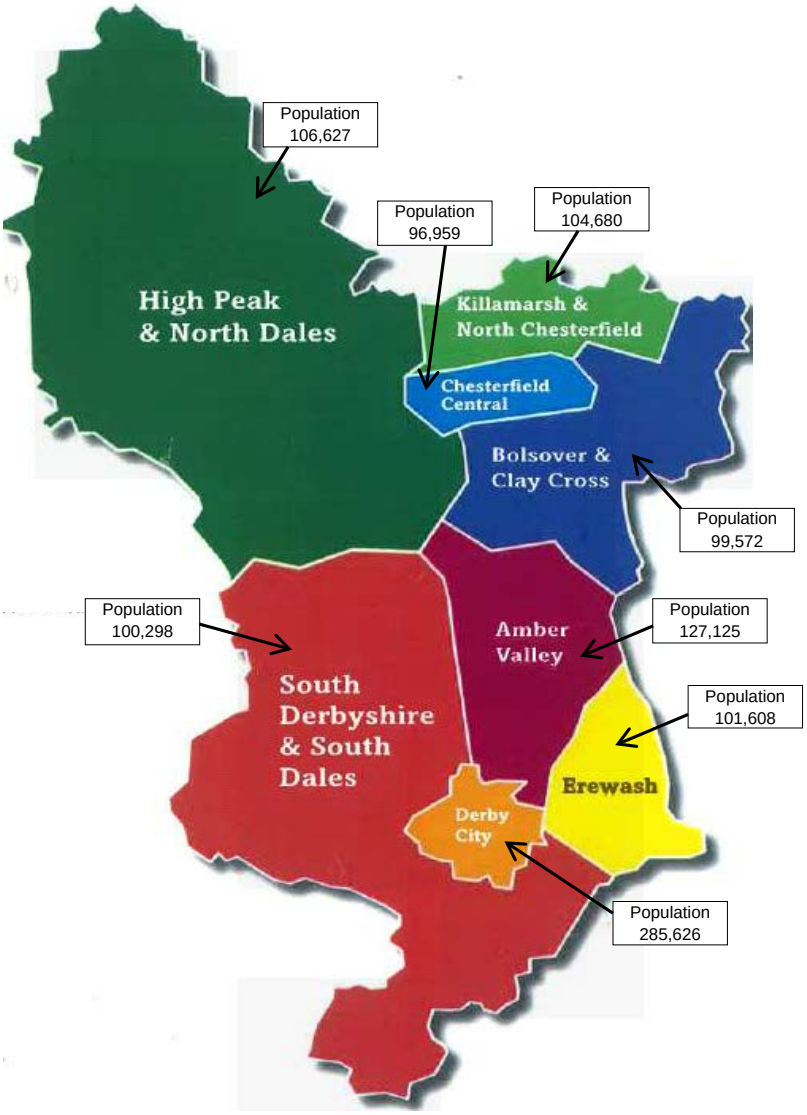
Community Mental Health Team Capacity & Risk Mitigation

1. Introduction

The purpose of this report is to provide the Trust Board with an in-depth analysis of the pressures being experienced by the community mental health teams, the current risks and options for mitigation.

2. Current state

Since 1st April 2016 community mental health services have been provided by teams in the following areas, serving adults and older adults, and termed Neighbourhoods



2.1 National guidance for Community Teams

Previous guidance published by the Department of Health on safe team and care coordinator caseload sizes is as follows:

"The following guidance for caseload sizes and team constitution are calculated on a model of a single team for a defined population.

- *Each team to have a maximum caseload between 300–350 patients but may be considerably less. Otherwise information exchange becomes unwieldy eroding clinical capacity.*
- *Full time care co-ordinators to have a maximum caseload of 35 and part-time staff to have their caseload reduced pro-rata."*

Dept. Health (2002) *Mental Health Policy Implementation Guide - Community Mental Health Teams*

2.2 Caseload

(a) Caseload per Team

In 5 of the 8 teams within the neighbourhood teams the caseload is greater than the maximum recommended by the Dept. Health, by up to as much as 65%. This picture is complicated owing to the move to Neighbourhoods and the ongoing work of caseload adjustment between Neighbourhoods, however even once adjustment has been undertaken, overall the total caseload per team is 18% above the maximum recommended.

Excessive caseloads mean that information exchange will be having a significant negative impact on clinical capacity. However this is not the only consequence of carrying excessive caseloads.

Neighbourhood and Team	Total Patients with open Episode (Dec 16)	Number of Sub Teams	PIG Guidance Max Team Caseload	Actual versus PIG caseload
Derby City Community	1732	3	350	65%
Total Derby City	**1732**	**3**	**350**	**65%**
Bolsover & Clay Cross - Community	495	2	350	-29%
Chesterfield Central - Community	898	2	350	28%
High Peak and North Dales - Community	791	2	350	13%
Killamarsh & North Chesterfield - Community	577	2	350	-18%
Total North Derbyshire	**2761**	**8**	**350**	**-1%**
Amber Valley - Community	1011	2	350	44%
Erewash - Community	683	2	350	-2%
South Derbys & South Dales - Community	826	2	350	18%
Total South Derbyshire	**2520**	**6**	**350**	**20%**

(b) Caseload per Care Coordinator

In all 3 of the neighbourhood areas, and in all but one team within the neighbourhoods, caseload per care coordinator exceeds the maximum 35 recommended by the Dept. Health.

Caseload per whole time equivalent care coordinator ranges from 34.7 in South Derbyshire and South Dales to 65.8 in Chesterfield.

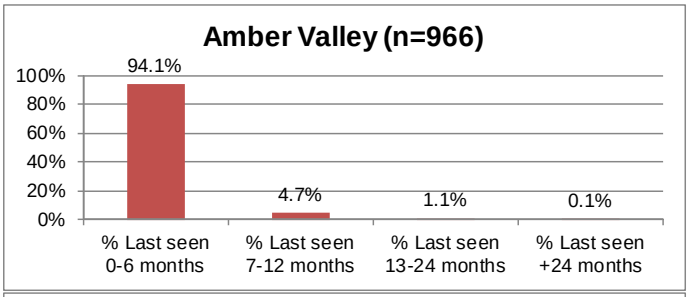
The average care coordinator caseload size across Derbyshire is 48.9 per wte.

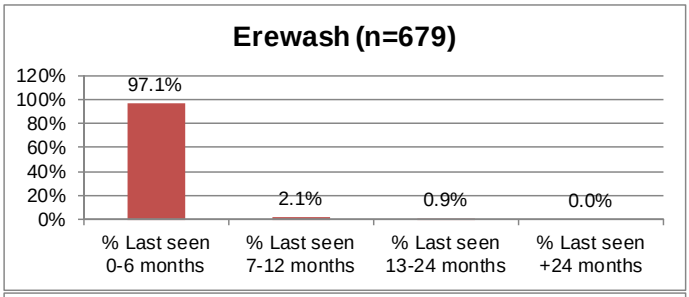
Overall caseload size is too large, however where there is gross variation this reflects teams attempts to manage the demand for service in different ways. In teams where some workers are carrying caseloads of 65 these caseloads are managed through clinics rather than lengthier face to face visits or appointments. Contacts in this way are frequently less time intensive and significantly some of this work is managed outside the boundaries of what we would accept as the Trust usual approach to implementation of Care Programme Approach procedures.

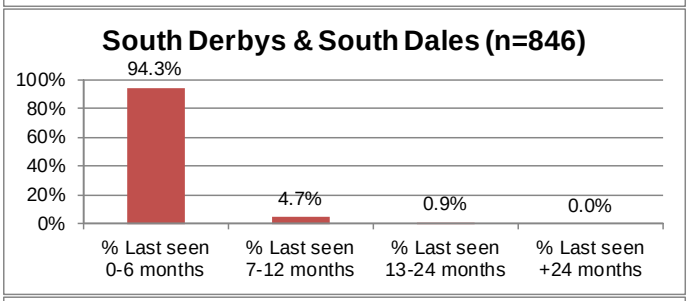
Large caseloads impact on clinical capacity to provide effective, efficient and good quality treatment, they also impact on the stress levels of workers and we have had seen that reflected in sickness levels, staff survey feedback and our turnover rates.

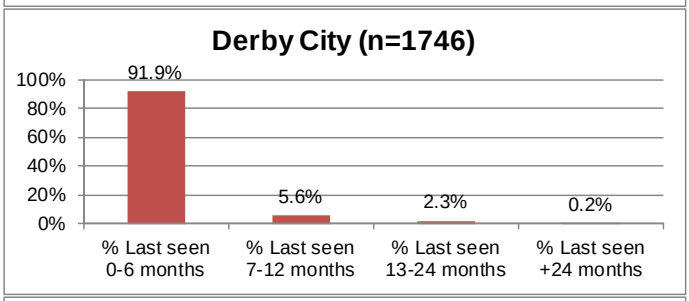
(C) Caseload by frequency of contact

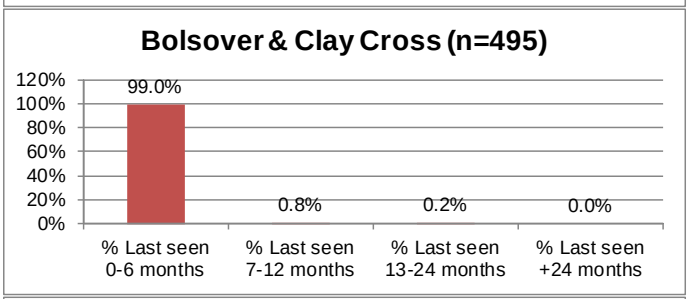
Pressure in certain teams is being managed through seeing patients less frequently. This may be having a negative impact on cluster reviews.

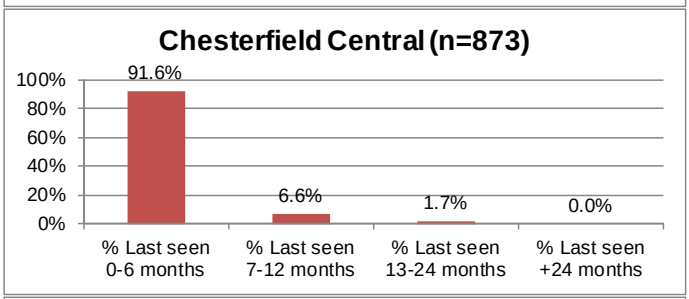


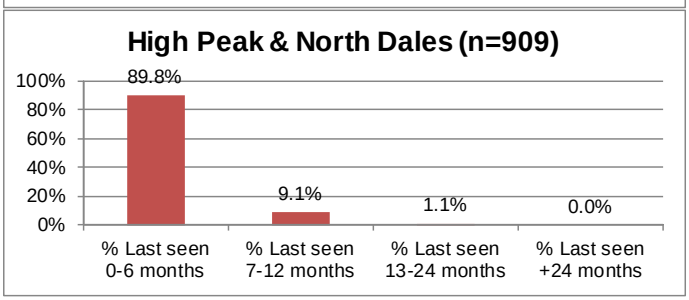


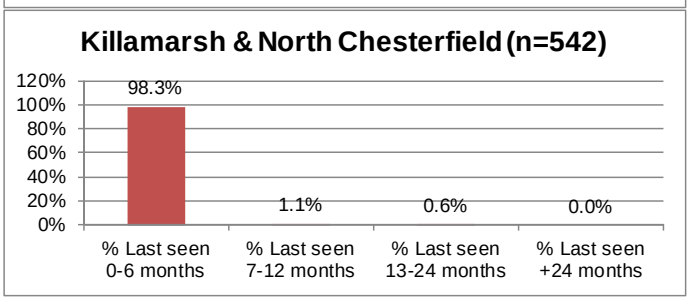








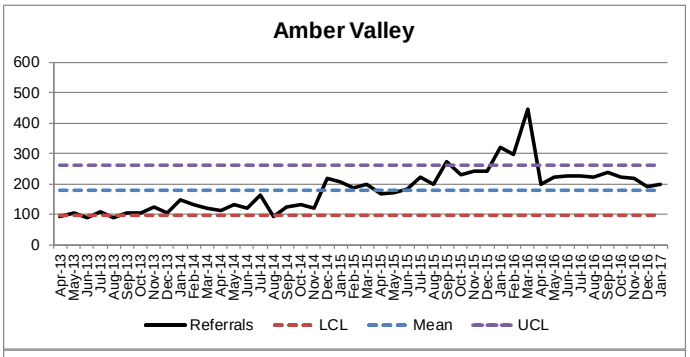


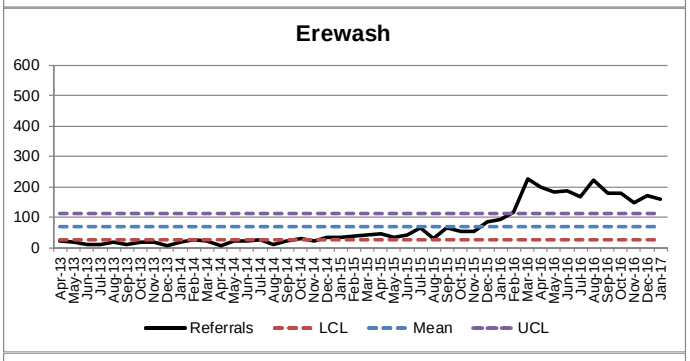


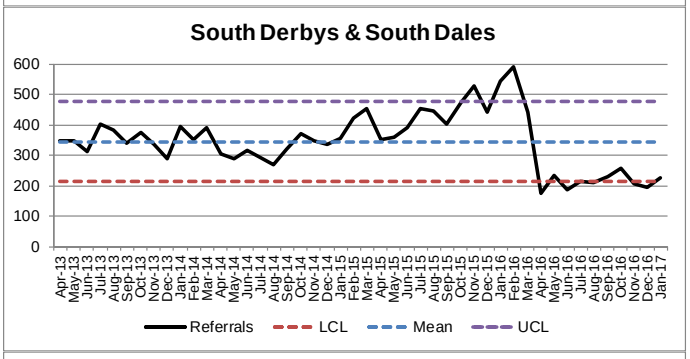
(d) Referrals and discharges over time

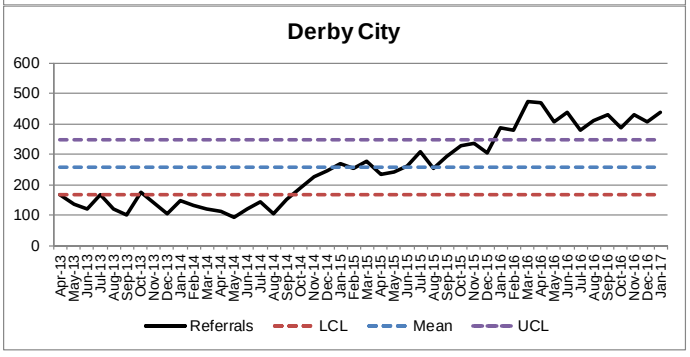
The changes apparent in March 2016 reflect the time CMHT moved to Neighbourhoods and the adjustment around populations, however the trend in all but one area is for an increase in rates of referral. Overall there has been a 16% increase in the rate of referral in 2016/17.

REFERRALS









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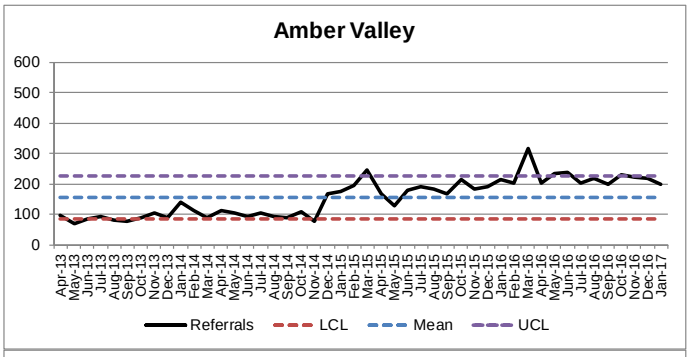

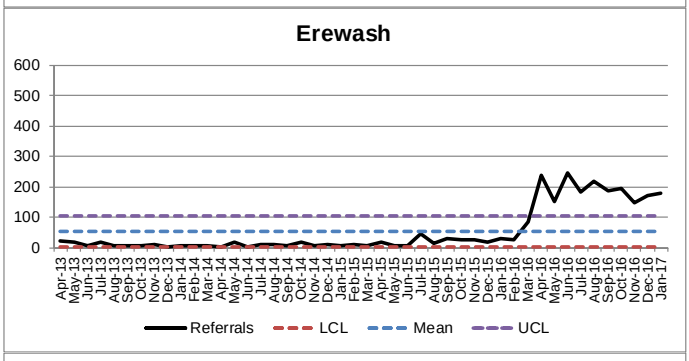

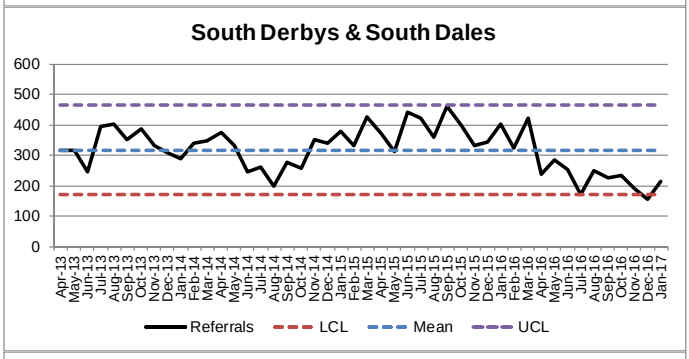

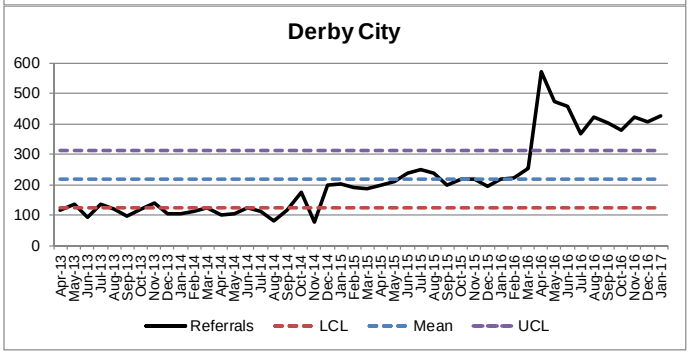

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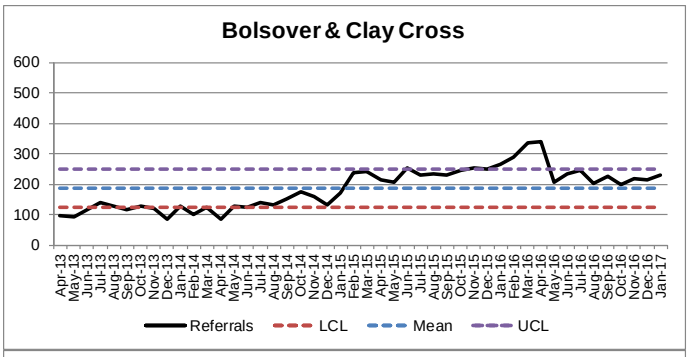

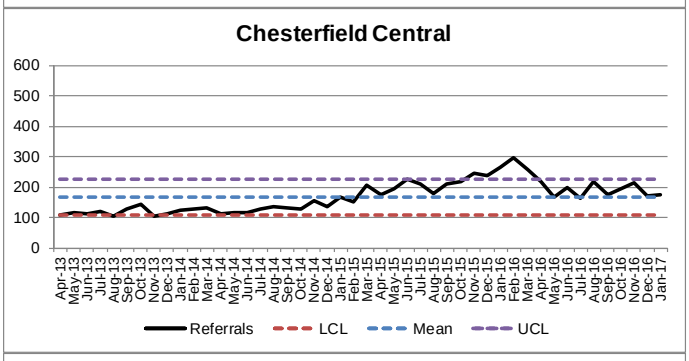

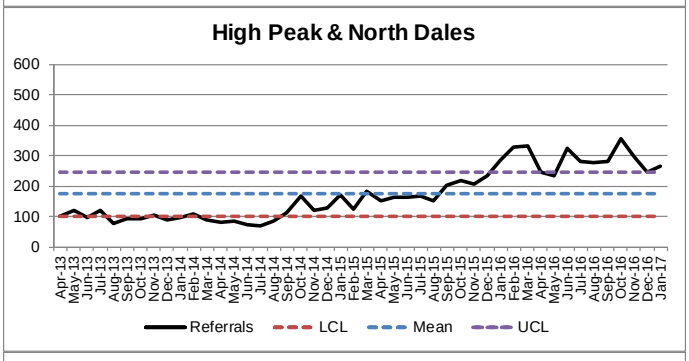

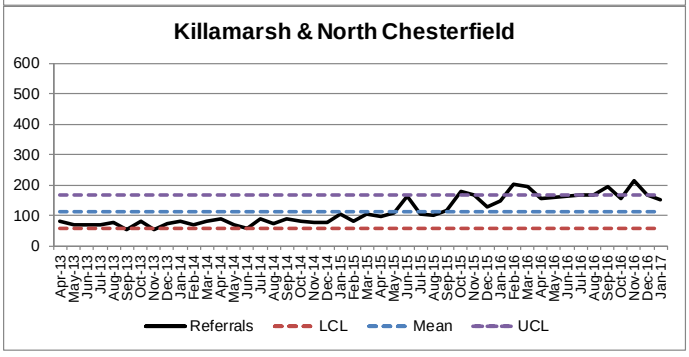

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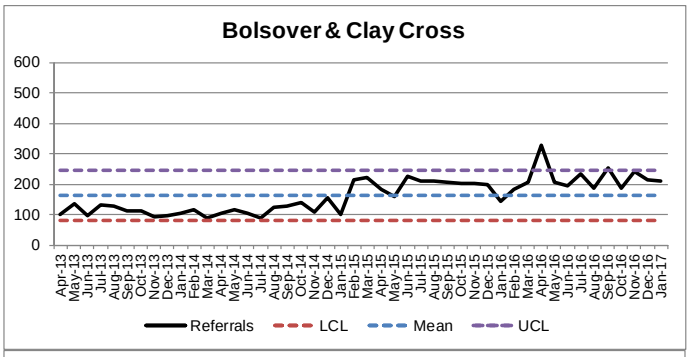
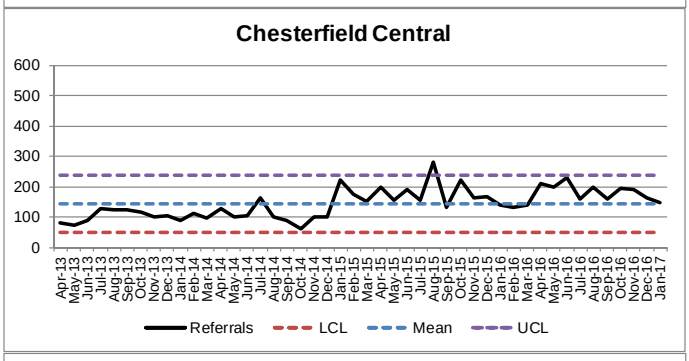
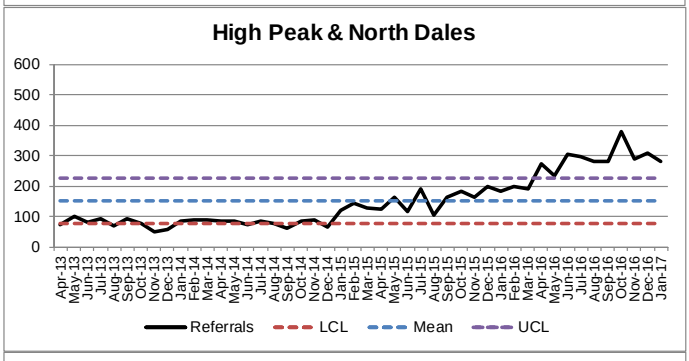
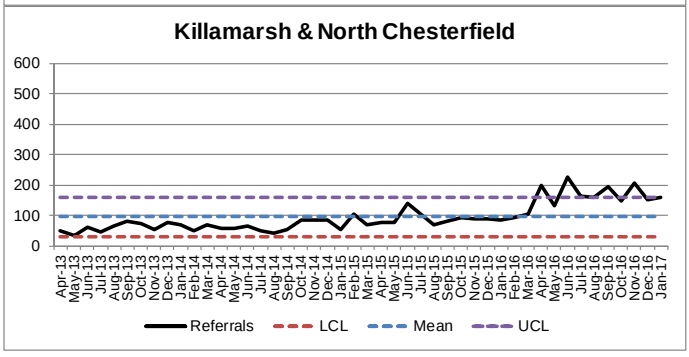








2.3 Care coordinator shortfall

Papers have been prepared for commissioners who are aware of the gap in resource to deliver appropriate levels of care coordination. This has been acknowledged by commissioners but it has been stated that there is no additional resource to close that gap. In 2015/16 commissioners did fund a quarter of the deficit identified at that time, however the rise in rates of referral and other pressures meant that this additional resource had limited impact.

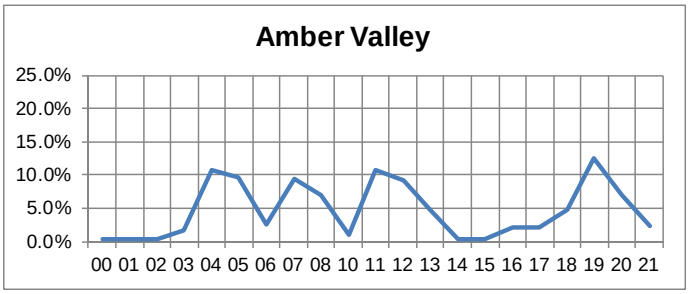
This is important as we currently have a significant number of new referrals to the team who have been assessed as requiring services and are now awaiting allocation of a care coordinator:

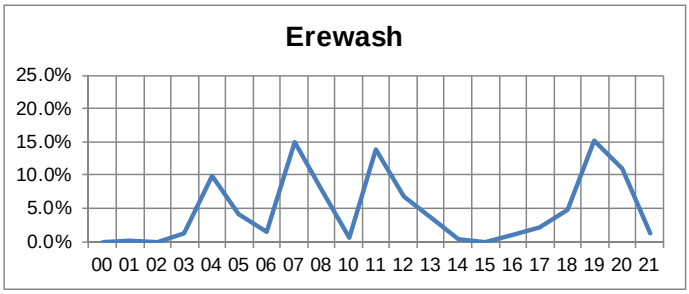
Neighbourhood Team	Waiting list for care coordination		
	Dec-16	Feb-17	Change
Derby City Community	152	134	-12%
Bolsover & Clay Cross - Community	11	37	236%
Chesterfield Central - Community	40	47	18%
High Peak and North Dales - Community	87	83	-5%
Killamarsh & North Chesterfield - Community	22	27	23%
Amber Valley - Community	50	95	90%
Erewash - Community	70	61	-13%
South Derbys & South Dales - Community	42	55	31%

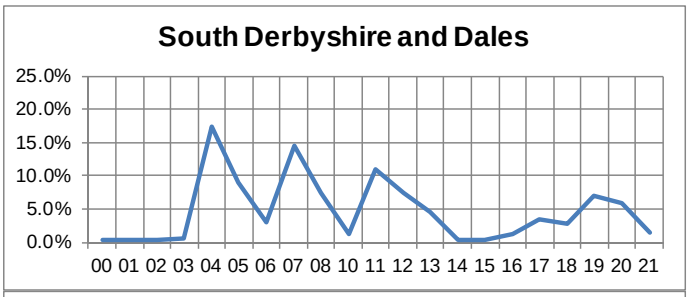
Care Coordinator Funded Posts Deficit

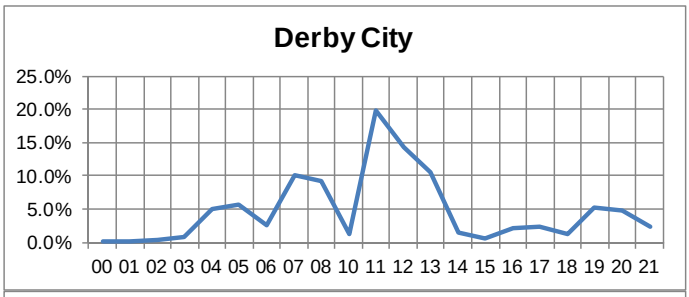
Neighbourhood	Team	Total Funded wte CCs in post	Total Funded CC wte vacancies	Total funded CC wte - in post plus vacancy	Total Patients with open Episode	Waiting list	Caseload per wte	wte required for max 35 caseload	wte deficit
Derby City	Derby City - Community Adult	24.8	4.4	29.2					
	Derby City - Community Older Adult	8.64	1.4	10.04					
	Derby City Community	**33.44**	**5.8**	**39.24**	**1732**	**152**	**48.01**	**53.83**	**14.59**
	Total Derby City	**33.44**	**5.8**	**39.24**	**1732**	**152**	**48.01**	**53.83**	**14.59**
North Derbyshire	Bolsover & Clay Cross - Community Adult	6.6	1	7.6					
	Bolsover & Clay Cross - Community Older Adult	4.16	0.6	4.76					
	Bolsover & Clay Cross - Community	**10.76**	**1.6**	**12.36**	**495**	**11**	**40.94**	**14.46**	**2.1**
	Chesterfield Central - Community Adult	9.9	0	9.9					
	Chesterfield Central - Community Older Adult	3.36	1	4.36					
	Chesterfield Central - Community	**13.26**	**1**	**14.26**	**898**	**40**	**65.78**	**26.8**	**12.54**
	High Peak & North Dales - Community Adult	7.43	0	7.4					
	High Peak & North Dales - Community Older Adult	6.4	0	6.4					
	High Peak and North Dales - Community	**13.83**	**0**	**13.8**	**791**	**87**	**63.49**	**25.09**	**11.26**
	Killamarsh & North Chesterfield - Community Adult	8.6	1.8	10.4					
	Killamarsh & North Chesterfield - Community Older Adult	3.05	2.8	5.85					
	Killamarsh & North Chesterfield - Community	**11.65**	**4.6**	**16.25**	**577**	**22**	**36.86**	**17.11**	**0.86**
	Total North Derbyshire	**49.5**	**7.2**	**56.7**	**2761**	**160**	**51.52**	**83.46**	**26.76**
South Derbyshire	Amber Valley - Community Adult	7.8	0.4	8.2					
	Amber Valley - Community Older Adult	9.12	1	10.12					
	Amber Valley - Community	**16.92**	**1.4**	**18.32**	**1011**	**50**	**57.91**	**30.31**	**11.99**
	Erewash - Community Adult	4	1	5					
	Erewash - Community Older Adult	8.8	0	8.8					
	Erewash - Community	**12.8**	**1**	**13.8**	**683**	**70**	**54.57**	**21.51**	**7.71**
	South Derbys & South Dales - Community Adult	12.58	4.78	17.36					
	South Derbys & South Dales - Community Older Adult	7.61	0	7.61					
	South Derbys & South Dales - Community	**20.19**	**4.78**	**24.97**	**826**	**42**	**34.76**	**24.8**	**-0.17**
	Total South Derbyshire	**49.91**	**7.18**	**57.09**	**2520**	**162**	**46.98**	**76.63**	**19.54**
								TOTAL CC WTE DEFICIT:	**60.89**

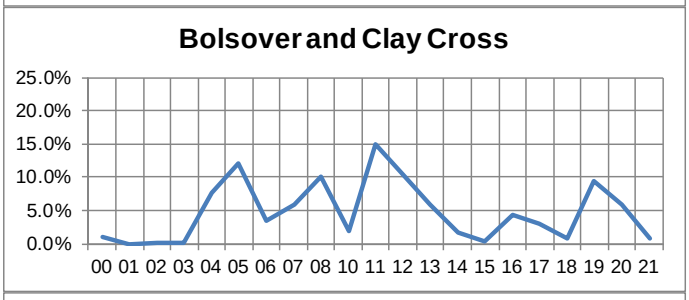
2.4 Cluster profiles

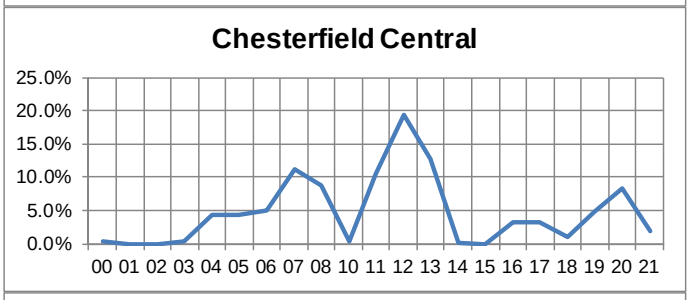


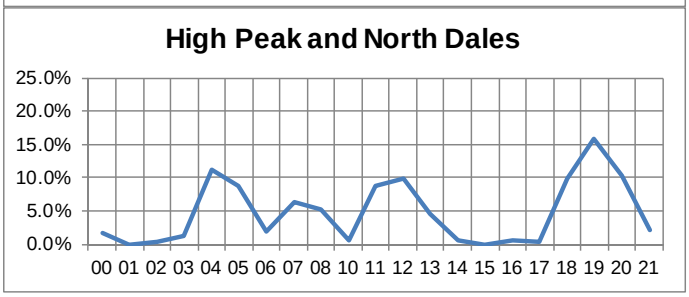


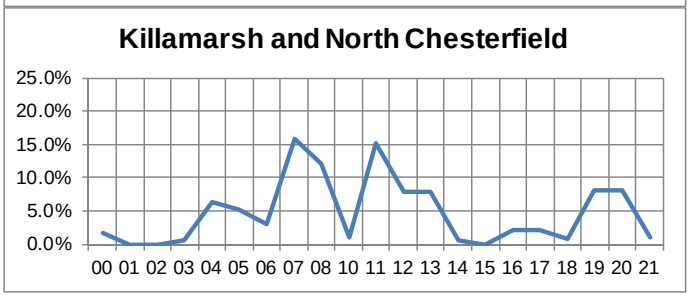












Cluster definitions:

0 variance cluster service users who do not fit other clusters	12 ongoing recurrent psychosis (high disability)
1 common mental health problems (low severity)	13 ongoing recurrent psychosis (high symptoms & disability)
2 common mental health problems (low severity with greater need)	14 psychotic crisis
3 non-psychotic (moderate severity)	15 severe psychotic depression
4 non-psychotic (severe)	16 dual diagnosis
5 non-psychotic (very severe)	17 psychosis and affective disorder-difficult to engage
6 non-psychotic disorders of over-valued ideas	18 cognitive impairment (low need)
7 enduring non-psychotic disorders (high disability)	19 cognitive impairment or dementia complicated (moderate need)
8 non-psychotic chaotic and challenging disorders	20 cognitive impairment or dementia complicated (high need)
10 first episode psychosis	21 cognitive impairment or dementia complicated (high physical or engagement)
11 ongoing recurrent psychosis (low symptoms)	

2.5 CPA thresholds

We have considered the premise whether the caseloads are too high because there are “too many patients on CPA”. Analysis of the position over time indicates that the percentage of people on CPA is less than half what is was 2 years ago, while the number of mental health patients open to the Trust has increased by 15% over the same period. This suggests a picture of elevating thresholds for CPA.

When compared with the national picture, from the latest published Mental Health Services Data Set (October 2016), the number of people on CPA in the Trust was 13.8% of the total people in contact with services. This ranks us below the national average for England of 15.9%. This suggests that our thresholds may already be higher than the national average.

The increase in demand for service has led to teams moving away from managing some cohorts through the Trusts CPA policy and procedures. For example, in some teams people on depot medication who meet the threshold for CPA but who have been stable for a period of time and are effectively managed with reduced frequency of contact do not have the usual level of CPA documentation to demonstrate their care and treatment.

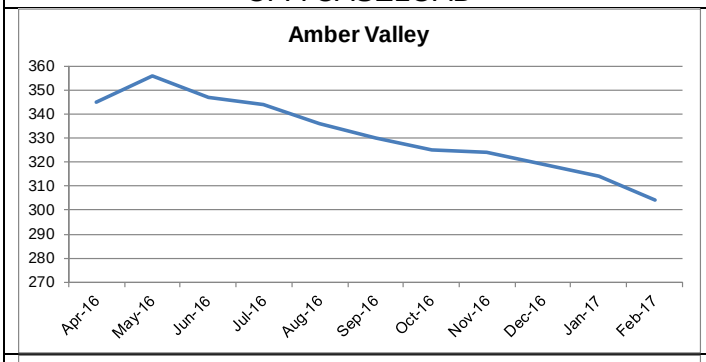
There is also a tension, clinically, around managing people on the recovery pathway within the strictures of CPA.

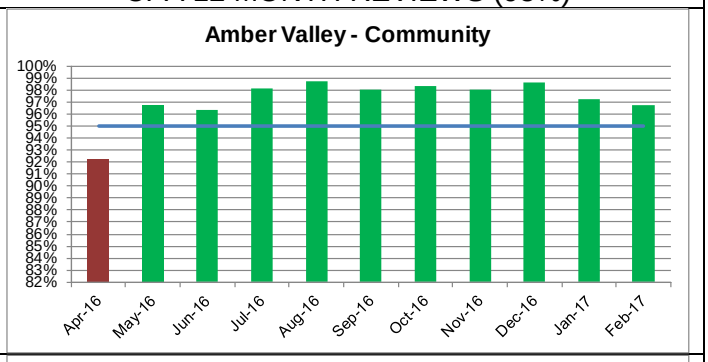
PRIMARY_LEVEL_DESCRIPTION	MHS01 - People in contact with services at the end of the Reporting Period	MHS02 - People on CPA at the end of the Reporting Period	% of caseload on CPA
CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	9235	3750	40.6%
GREATER MANCHESTER WEST MENTAL HEALTH NHS FOUNDATION TRUST	12260	4895	39.9%
HUMBER NHS FOUNDATION TRUST	7325	2565	35.0%
BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	9630	3230	33.5%
OXFORD HEALTH NHS FOUNDATION TRUST	11800	3955	33.5%
MANCHESTER MENTAL HEALTH AND SOCIAL CARE TRUST	9870	3295	33.4%
AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	19155	6195	32.3%
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	22325	6315	28.3%
TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	35315	8995	25.5%
SOMERSET PARTNERSHIP NHS FOUNDATION TRUST	8650	2140	24.7%
DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST	6330	1565	24.7%
5 BOROUGHS PARTNERSHIP NHS FOUNDATION TRUST	16070	3940	24.5%
NORTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	13320	3230	24.2%
SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST	14155	3340	23.6%
CAMDEN AND ISLINGTON NHS FOUNDATION TRUST	10225	2375	23.2%
SOUTH STAFFORDSHIRE AND SHROPSHIRE HEALTHCARE NHS FOUNDATION TRUST	23255	5360	23.0%
DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	12100	2635	21.8%
BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	15985	3380	21.1%
SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	13520	2625	19.4%
NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	21585	4025	18.6%
ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST	12690	2225	17.5%
CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	10230	1750	17.1%
NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	17565	2995	17.1%
KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	27005	4540	16.8%
SHEFFIELD HEALTH & SOCIAL CARE NHS FOUNDATION TRUST	7750	1270	16.4%
NORTH EAST LONDON NHS FOUNDATION TRUST	19070	3125	16.4%
England	**1033459**	**164800**	**15.9%**
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	29925	4760	15.9%
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	27395	4185	15.3%
WEST LONDON MENTAL HEALTH NHS TRUST	19655	2970	15.1%
MERSEY CARE NHS FOUNDATION TRUST	22445	3375	15.0%
HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	16720	2485	14.9%
LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	16580	2400	14.5%
COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	19690	2750	14.0%
EAST LONDON NHS FOUNDATION TRUST	34180	4745	13.9%
DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	**21005**	**2900**	**13.8%**
WORCESTERSHIRE HEALTH AND CARE NHS TRUST	7050	905	12.8%
NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	18490	2330	12.6%
CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	38355	4650	12.1%
2GETHER NHS FOUNDATION TRUST	12510	1505	12.0%
LIVEWELL SOUTHWEST	6080	720	11.8%
SOUTHERN HEALTH NHS FOUNDATION TRUST	19385	2230	11.5%
SOLENT NHS TRUST	6145	685	11.1%
SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST	26155	2735	10.5%
PENNINE CARE NHS FOUNDATION TRUST	35200	3230	9.2%
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	24395	1935	7.9%
BIRMINGHAM CHILDREN'S HOSPITAL NHS FOUNDATION TRUST	5490	435	7.9%
LEICESTERSHIRE PARTNERSHIP NHS TRUST	20965	1580	7.5%
LANCASHIRE CARE NHS FOUNDATION TRUST	57790	4105	7.1%
LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	17000	1130	6.6%
SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	54390	3330	6.1%
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	2755	75	2.7%

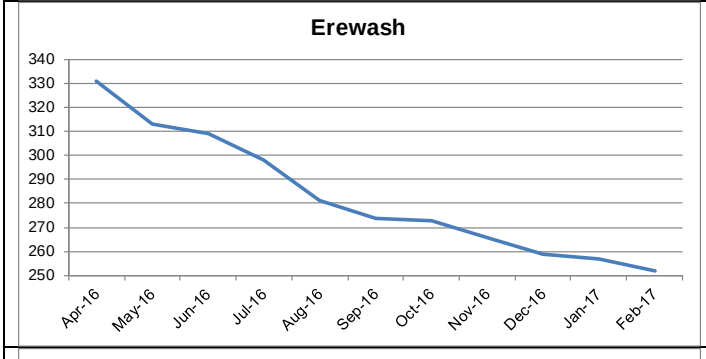
Data source:
http://www.content.digital.nhs.uk/searchcatalogue?productid=24285&topics=0%2fMental+health&sort=Relevance&size=10&page=1#top

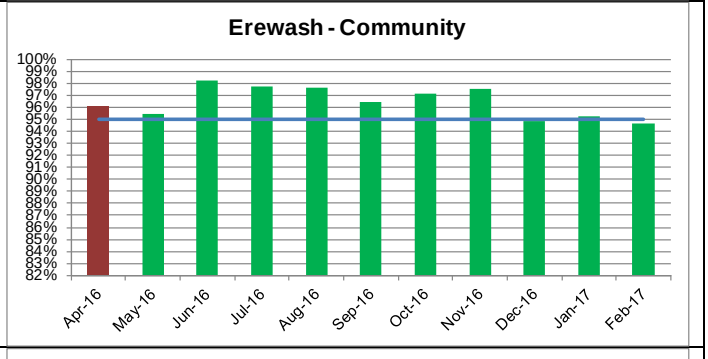
CPA caseload versus CPA reviews over time

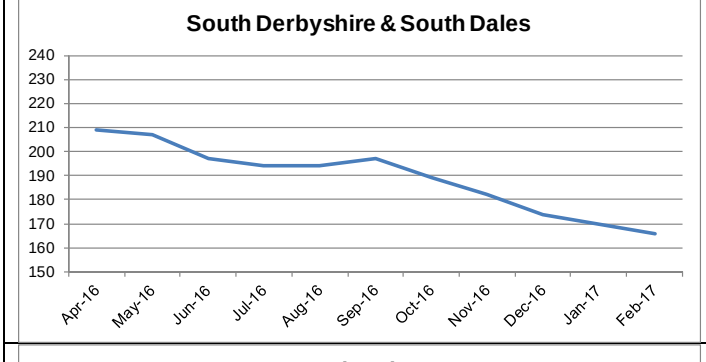
CPA CASELOAD	CPA 12 MONTH REVIEWS (95%)

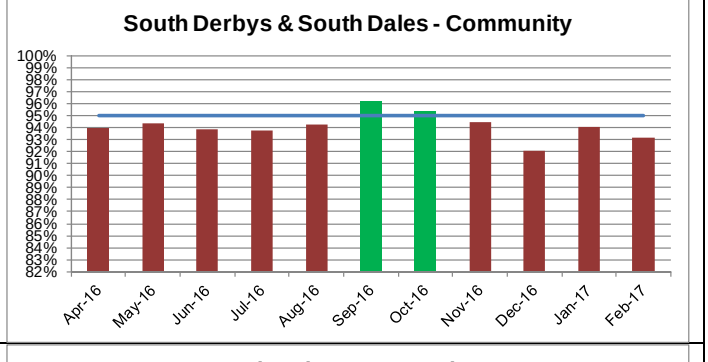


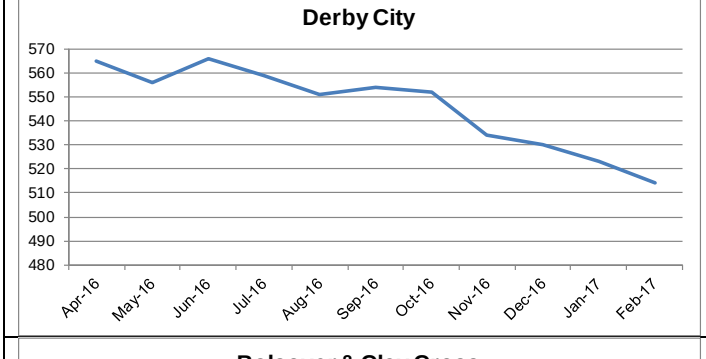


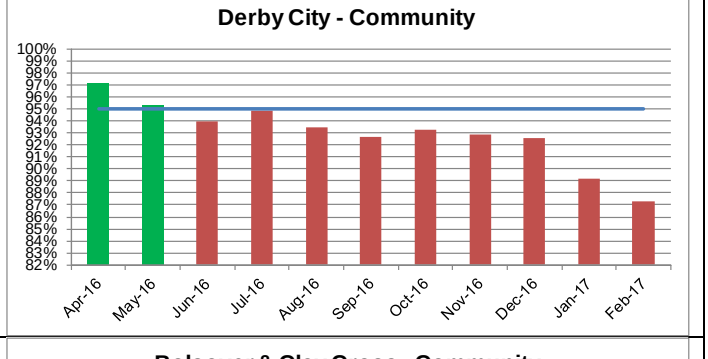


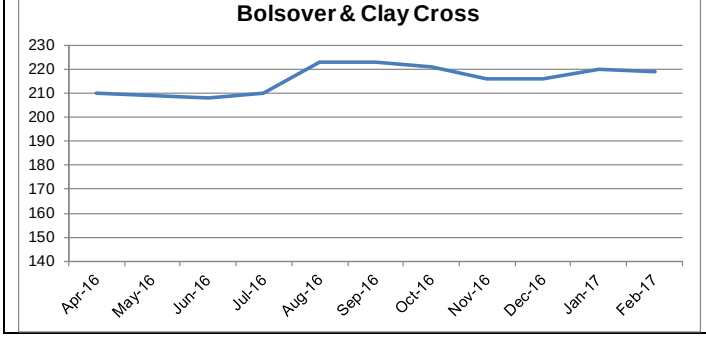


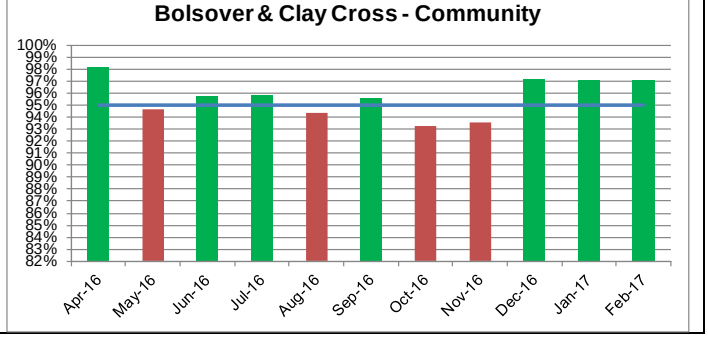




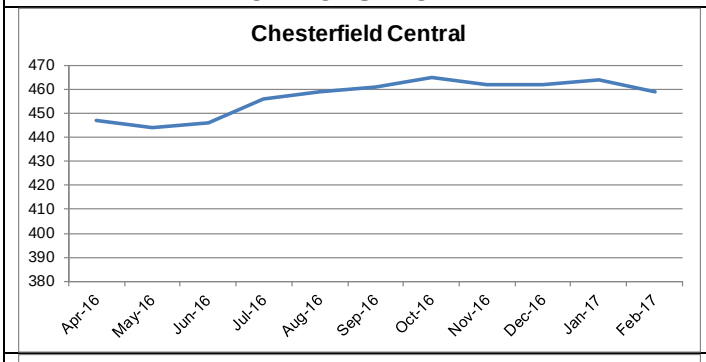


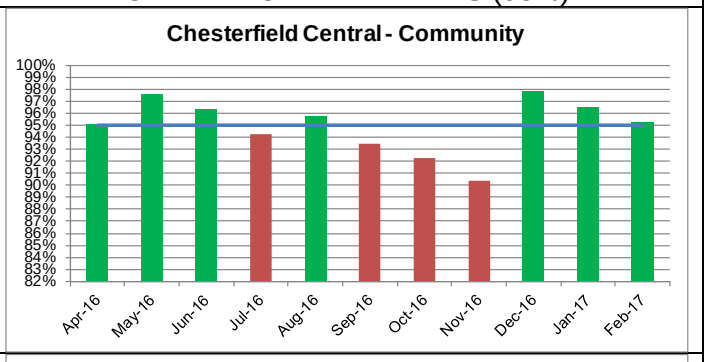


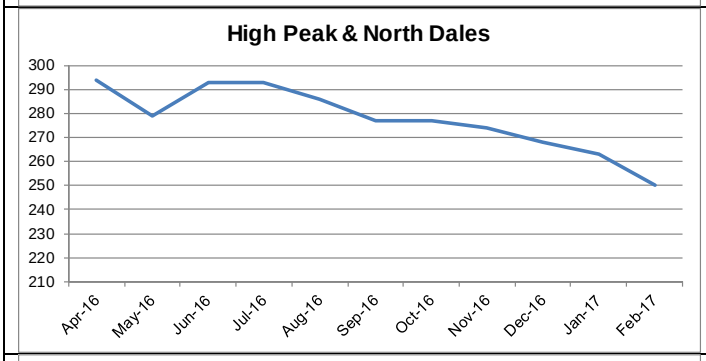


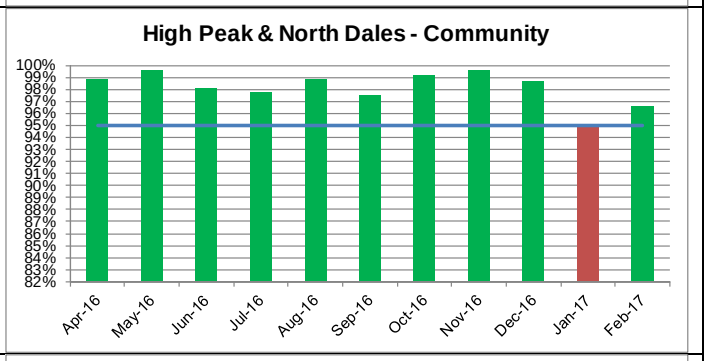


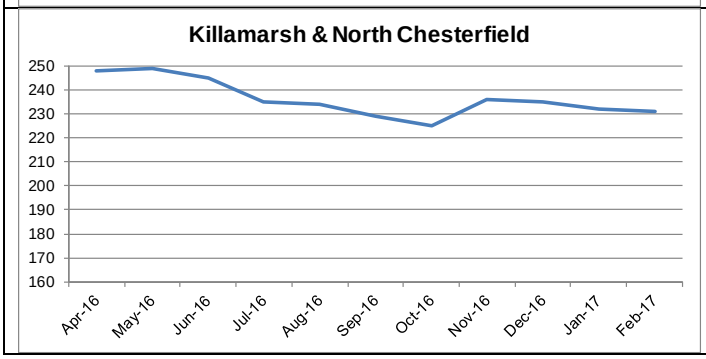
CPA CASELOAD	CPA 12 MONTH REVIEWS (95%)

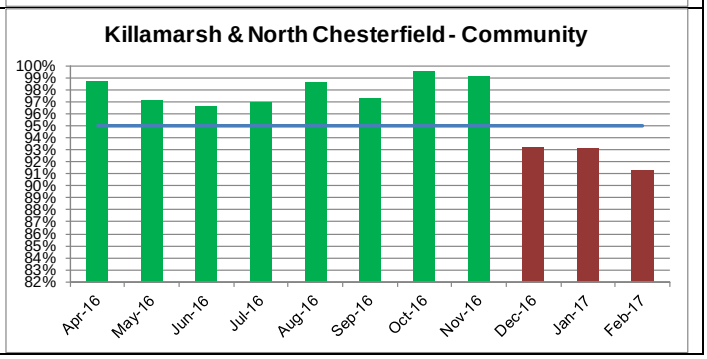












2.6 Human factors

Although there has been some improvement in sickness levels they remain high in many areas, with the most common reason for sickness absence being anxiety, stress, depression or other psychiatric illness.

TOP TEN ABSENCE REASONS (Working Days Lost)

Absence Reason	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17
S10 Anxiety/ stress/ depression/ other psychiatric illnesses	121	106	99	117	102	137	118	210	219	164	210	225	152
Surgery	38	71	82	35	34	58	91	48	34	37	71	96	86
S17 Benign and malignant tumours, cancers	40	43	69	63	65	66	44	64	61	50	40	30	18
S13 Cold, Cough, Flu - Influenza	71	55	54	69	30	37	20	7	24	39	44	48	98
S25 Gastrointestinal problems	30	17	31	8	33	29	16	24	42	24	43	51	39
S12 Other musculoskeletal problems	18	13	33	20	7	36	38	42	38	26	19	31	51
S11 Back Problems	5	14	13	19	12	8	11	0	19	21	60	32	51
Not Assigned	27	20	23	22	21	28	40	22	22	16	7	0	0
S98 Other known causes - not elsewhere classified	3	19	44	24	38	33	26	2	15	0	0	1	0
S28 Injury, fracture	29	18	3	0	7	24	33	19	29	13	23	22	8

SICKNESS (%)

Department	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17
Neighbourhood	**6.19**	**6.77**	**7.77**	**7.25**	**5.87**	**7.54**	**7.12**	**7.08**	**8.20**	**6.36**	**8.41**	**8.34**	**7.72**
City Neighbourhood	**5.61**	**10.67**	**10.06**	**8.39**	**5.80**	**7.24**	**7.09**	**4.26**	**6.96**	**5.48**	**5.49**	**9.00**	**7.21**
383 Dementia Rapid Response (OSER) (G61736)	5.19	19.32	20.71	9.73	7.77	6.54	9.95	6.62	11.30	2.89	0.00	7.65	7.16
383 County South Older People Day Hospital 'DH' (OSER) (G61877)	9.76	0.00	0.70	12.27	0.00	0.00	0.00	0.00	0.00	1.58	2.51	1.46	0.00
383 Dovedale Older People Day Hospital 'DH' (OSER) (G61876)	0.45	6.05	5.75	2.80	0.00	3.59	0.90	2.71	0.00	10.12	0.00	0.00	5.57
383 Resource Ctr Outpatient (OSER) (G61105)	4.52	0.00	0.00	0.00	0.00	11.67	0.00	0.00	0.00	10.54	12.44	1.51	3.01
383 Derby City Neighbourhood - Team A (OSER) (G64008)	8.98	11.66	11.64	3.72	0.00	2.21	9.61	5.15	4.04	3.78	4.62	6.18	4.05
383 Derby City Neighbourhood - Team B (OSER) (G64008)	2.20	0.74	0.89	6.50	1.60	4.26	0.63	2.71	4.75	6.79	5.61	7.55	6.88
383 Derby City Neighbourhood - Team C (OSER) (G64008)	6.76	19.09	15.41	15.34	16.73	18.97	13.90	5.61	12.43	6.56	9.91	12.18	7.72
383 Medics Neighbourhood City (OSER) (G64012)	2.82	3.02	0.00	7.29	11.29	2.92	0.00	0.00	13.12	7.65	23.73	68.89	48.99
383 St James House Administration (OSER) (G61001)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	12.87
County North Neighbourhood	**6.65**	**7.45**	**7.08**	**6.99**	**6.77**	**7.76**	**7.78**	**7.00**	**6.78**	**5.20**	**7.02**	**6.02**	**9.00**
383 Bolsover+CC Neighbourhood - Medics (OSER) (G64007)	0.00	0.00	0.00	6.22	12.04	0.00	0.00	0.00	18.67	0.00	0.00	0.00	0.00
383 Bolsover+CC Neighbourhood - Team A (OSER) (G64007)	3.08	1.89	6.17	4.38	2.88	10.37	15.64	9.63	4.03	5.42	0.91	4.74	3.07
383 Bolsover+CC Neighbourhood - Team B (OSER) (G64007)	7.66	13.04	12.49	16.93	19.62	10.73	1.48	5.41	14.63	15.86	18.21	11.69	8.88
383 Cfd Central Locality - Adult (OSER) (G61341)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.26	0.00
383 CfldCentral Neighbourhood - Medics (OSER) (G64004)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
383 CfldCentral Neighbourhood - Team A (OSER) (G64004)	11.22	14.54	15.93	12.45	9.33	9.24	10.63	8.90	9.23	4.14	1.87	9.78	8.90
383 CfldCentral Neighbourhood - Team B (OSER) (G64004)	0.43	4.12	3.54	1.84	0.91	0.00	4.11	1.13	0.00	1.56	3.39	1.06	2.41
383 HP+NthDales Neighbourhood - Medics (OSER) (G64006)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
383 HP+NthDales Neighbourhood - Team A (OSER) (G64006)	9.97	8.14	11.33	9.39	8.94	16.82	10.76	9.03	3.83	2.11	4.57	4.39	3.50
383 HP+NthDales Neighbourhood - Team B (OSER) (G64006)	7.64	4.47	4.97	4.44	4.90	10.29	8.62	9.03	6.89	3.41	7.91	8.81	16.44
383 KillNthCfld Neighbourhood - Medics (OSER) (G64005)	0.00	0.00	20.07	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
383 KillNthCfld Neighbourhood - Team A (OSER) (G64005)	16.84	19.64	12.66	12.66	2.77	8.12	16.07	17.61	15.56	1.76	3.64	2.19	2.93
383 KillNthCfld Neighbourhood - Team B (OSER) (G64005)	5.64	4.01	1.42	3.62	5.02	5.25	7.81	3.79	2.81	4.41	9.74	5.34	13.75
383 MAS North (OSER) (G61885)	10.35	11.90	1.88	6.16	6.45	2.30	12.26	22.28	25.94	9.25	2.03	2.11	3.96
383 Medics Neighbourhood Nth (OSER) (G64011)	0.00	0.00	0.00	0.00	3.44	0.00	0.00	0.00	0.00	10.67	5.11	4.02	32.17
County South Neighbourhood	**5.94**	**2.48**	**6.86**	**6.75**	**5.23**	**7.95**	**6.65**	**10.70**	**13.02**	**10.33**	**14.08**	**11.99**	**8.52**
383 Amber Valley Neighbourhood - Medics (OSER) (G64001)	0.00	0.00	10.04	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
383 Amber Valley Neighbourhood - Team A (OSER) (G64001)	2.12	1.47	3.08	3.59	4.95	4.24	4.57	6.00	13.00	3.81	7.19	11.30	9.26
383 Amber Valley Neighbourhood - Team B (OSER) (G64001)	6.98	5.20	10.33	9.57	4.52	8.97	9.41	13.03	13.46	6.56	16.06	17.26	19.73
383 Erewash Neighbourhood - Medics (OSER) (G64002)	18.06	0.00	0.00	0.00	0.00	118.22	126.45	138.49	136.89	0.00	0.00	0.00	0.00
383 Erewash Neighbourhood - Team A (OSER) (G64002)	13.20	1.43	2.01	0.69	0.00	4.53	6.40	8.43	7.66	12.58	15.67	11.29	8.71
383 Erewash Neighbourhood - Team B (OSER) (G64002)	4.52	3.80	4.77	4.34	11.28	11.40	0.00	0.00	2.80	4.66	7.85	8.29	5.39
383 MAS South (OSER) (G61883)	8.91	1.01	20.70	12.64	3.71	3.28	10.40	15.59	16.11	4.95	5.68	4.40	3.57
383 Medics Neighbourhood Sth (OSER) (G64010)	0.00	0.00	0.00	3.80	3.93	4.06	0.00	35.34	0.00	15.77	8.52	0.00	1.34
383 Sth DD Neighbourhood - Medics (OSER) (G64003)	0.00	0.00	12.04	0.00	0.00	0.00	22.58	0.00	62.22	0.00	0.00	0.00	0.00
383 Sth DD Neighbourhood - Team A (OSER) (G64003)	3.12	3.29	6.15	9.18	4.11	4.27	6.54	16.29	7.72	7.96	15.87	3.20	1.60
383 Sth DD Neighbourhood - Team B (OSER) (G64003)	7.07	1.76	12.74	8.85	8.99	13.20	6.75	7.09	20.57	24.41	31.11	26.99	14.00
383 Trust Wide Discharge Liaison Team OP (OSER) (G61828)	0.00	0.00	0.00	29.31	0.00	0.00	0.00	31.70	34.48	35.04	6.90	23.36	0.00
Neighbourhood (L4)	**6.95**	**5.23**	**6.19**	**6.25**	**4.07**	**6.06**	**5.80**	**4.55**	**2.42**	**0.85**	**5.13**	**3.54**	**0.68**
383 Psychology Neighbourhood (OSER) (G64009)	6.95	5.23	6.19	6.25	4.07	6.06	5.80	4.55	2.42	0.85	5.13	3.54	0.68

KPI Compliance

When services are under pressure, compliance with key performance targets such as supervision, individual appraisal and training requirements are all affected. This is not because these are not regarded as important, but is a side effect of trying to keep the patient at the centre of everything we do when caseloads are too large to manage effectively within funded capacity. The CQC report has also impacted teams' morale and added demand to their workload. This has created further tension as much of the improvement required has translated into increased documentation as we seek to deliver assurance on services we provide.

SUPERVISION

Neighbourhood	Team	Staff	Managerial	Clinical
City Neighbourhood	City Early Intervention Medical	1	0%	0%
	County South Older People Day Hospital DH	6	100%	80%
	Dementia Rapid Response	27	89%	50%
	Derby City Early Intervention	11	0%	36%
	Derby City Neighbourhood	1	100%	0%
	Derby City Neighbourhood - Team A	25	96%	41%
	Derby City Neighbourhood - Team B	33	58%	42%
	Derby City Neighbourhood - Team C	20	55%	24%
	Dovedale Older People Day Hospital DH	7	86%	67%
	Medics Neighbourhood City	12	33%	0%
	Resource Ctr Outpatient	4	100%	N/A
	St James House Administration	1	0%	N/A
	Trust Wide Discharge Liaison Team OP	4	75%	33%
	Total	**152**	**67%**	**39%**
County North Neighbourhood	Bolsover+CC Neighbourhood - Team A	12	92%	91%
	Bolsover+CC Neighbourhood - Team B	20	80%	88%
	Cfd Central Locality - Adult	1	100%	0%
	CfldCentral Neighbourhood - Team A	13	92%	82%

Neighbourhood	Team	Staff	Managerial	Clinical
	CfldCentral Neighbourhood - Team B	30	37%	41%
	County N Early Int Medical	1	0%	0%
	County North Early Intervention	15	93%	93%
	Hartington Unit Older People Memory Clinic	2	100%	100%
	HP+NthDales Neighbourhood - Team A	14	79%	69%
	HP+NthDales Neighbourhood - Team B	26	46%	55%
	KillNthCfld Neighbourhood - Team A	8	88%	100%
	KillNthCfld Neighbourhood - Team B	22	73%	56%
	MAS North	4	100%	50%
	Medics Neighbourhood Nth	15	20%	27%
	Total	**183**	**66%**	**65%**
County South Neighbourhood	Amber Valley Neighbourhood - Team A	20	95%	83%
	Amber Valley Neighbourhood - Team B	19	37%	29%
	County South Adult Locality	1	100%	N/A
	County South Early Intervention	11	18%	27%
	Early Intervention Clinical Specialist	4	25%	25%
	Erewash Neighbourhood - Team A	18	78%	81%
	Erewash Neighbourhood - Team B	16	56%	36%
	MAS Erewash	2	100%	100%
	MAS South	8	88%	100%
	Medics Neighbourhood Sth	10	70%	10%
	Sth DD Neighbourhood - Team A	17	94%	93%
	Sth DD Neighbourhood - Team B	14	79%	23%
	Total	**140**	**69%**	**54%**
Neighbourhood (L4)	Psychology Neighbourhood	36	69%	71%
	Total	**36**	**69%**	**71%**
Total		**511**	**67%**	**54%**

APPRAISALS

Neighbourhood and team	in date	overdue	total	In date %
City Neighbourhood	**98**	**55**	**153**	**64%**
City Early Intervention Medical	1		1	100%
County South Older People Day Hospital DH	6		6	100%
Dementia Rapid Response	13	14	27	48%
Derby City Early Intervention	8	3	11	73%
Derby City Neighbourhood		1	1	0%
Derby City Neighbourhood - Team A	21	5	26	81%
Derby City Neighbourhood - Team B	21	12	33	64%
Derby City Neighbourhood - Team C	10	10	20	50%
Dovedale Older People Day Hospital DH	7		7	100%
Medics Neighbourhood City	9	3	12	75%
Resource Ctr Outpatient	2	2	4	50%
St James House Administration		1	1	0%
Trust Wide Discharge Liaison Team OP		4	4	0%
County North Neighbourhood	**141**	**46**	**187**	**75%**
Bolsover+CC Neighbourhood - Team A	9	2	11	82%
Bolsover+CC Neighbourhood - Team B	17	3	20	85%
Cfd Central Locality - Adult	1		1	100%
Cfld Central Neighbourhood - Team A	12	1	13	92%
Cfld Central Neighbourhood - Team B	17	13	30	57%
County N Early Int Medical		1	1	0%
County North Early Intervention	13	2	15	87%
Hartington Unit Older People Memory Clinic	2		2	100%
HP+Nth Dales Neighbourhood - Team A	13	2	15	87%
HP+Nth Dales Neighbourhood - Team B	20	7	27	74%
Kill Nth Cfld Neighbourhood - Team A	8		8	100%
Kill Nth Cfld Neighbourhood - Team B	13	10	23	57%
MAS North	3	2	5	60%
Medics Neighbourhood Nth	13	3	16	81%
County South Neighbourhood	**116**	**27**	**143**	**81%**
Amber Valley Neighbourhood - Team A	19		19	100%
Amber Valley Neighbourhood - Team B	16	2	18	89%
County South Adult Locality	1		1	100%
County South Early Intervention	8	3	11	73%
Early Intervention Clinical Specialist	1	3	4	25%
Erewash Neighbourhood - Team A	17	1	18	94%
Erewash Neighbourhood - Team B	15	2	17	88%
MAS Erewash	2	1	3	67%
MAS South	6	4	10	60%
Medics Neighbourhood Sth	9	1	10	90%
Sth DD Neighbourhood - Team A	16	1	17	94%
Sth DD Neighbourhood - Team B	6	9	15	40%
Neighbourhood (L4)	**22**	**17**	**39**	**56%**
Psychology Neighbourhood	22	17	39	56%

Neighbourhood and team	in date	overdue	total	In date %
Total	**377**	**145**	**522**	**72%**

TRAINING

Training	Doesn't meet	Meets	Total	Meets %
383|LOCAL|C Counter Fraud and Corruption in the NHS (3 yearly) eLearning|	42	469	511	92%
383|LOCAL|C Equality & Diversity Level 1 (3 yearly) All Staff|	99	412	511	81%
383|LOCAL|C Fire Safety (annual) All Staff|	94	417	511	82%
383|LOCAL|C Health & Safety Awareness (3 Yearly) All Staff|	57	455	512	89%
383|LOCAL|C Information Governance (annual) All Staff|	78	433	511	85%
383|LOCAL|C Moving & Handling & Basic Back Level 1 (3 yearly)|	63	448	511	88%
383|LOCAL|C Promoting Safer & Therapeutic Services Clinical Staff (3 yearly)|	88	359	447	80%
383|LOCAL|C Promoting Safer & Therapeutic Services Non-Clinical Staff (3 yearly)|	9	55	64	86%
383|LOCAL|C Safeguarding Adults Level 1 (Non Clinical staff) (3 Yearly)|	9	55	64	86%
383|LOCAL|C Safeguarding Adults Level 1+2 (All Clinical Staff) (2 yearly)|	99	347	446	78%
383|LOCAL|C Safeguarding Children Level 1 (3 yearly)|	6	59	65	91%
383|LOCAL|C Safeguarding Children Level 1 (once only)|	16	431	447	96%
383|LOCAL|H Clinical Risk Management (e-learning) (3 yearly)|	9	2	11	18%
383|LOCAL|H Meds Mgmt - Patient Safety - Medicines eLearning (once only)|	1		1	0%
383|LOCAL|H Meds Mgmt - Use of the BNF eLearning (once only)|	5		5	0%
383|LOCAL|H Moving & Handling Level 2 - People (2 yearly) Community|	7	2	9	22%
383|LOCAL|P Equality & Diversity Level 2 (REGARDS) (Once)|	10	5	15	33%
383|LOCAL|P Mentor Sign Off (Once Only) Registered Nurses|		37	37	100%
383|LOCAL|P Preceptorship (Once) Newly qualified registered nurses & AHP's|	3	2	5	40%
383|LOCAL|R Awareness of Falls Prevention & Management (2 yearly)|	80	228	308	74%
383|LOCAL|R Care Certificate (Once Only)|	38	1	39	3%
383|LOCAL|R Clinical / Practice Supervision (Once) Registered professional staff|	66	242	308	79%
383|LOCAL|R Clinical Safety Planning Part 1 (Once only)|	20	389	409	95%
383|LOCAL|R CPA Level 1 (3 Yearly)|	97	316	413	77%
383|LOCAL|R CPA & Care Co-ordinator Level 2 (Once) All CPNs|	110	175	285	61%
383|LOCAL|R Deprivation of Liberty Standards (Once)|	31	322	353	91%
383|LOCAL|R Dual Diagnosis Level 1 (Once)|	176	269	445	60%
383|LOCAL|R Dual Diagnosis Level 2 (Once)|	78	241	319	76%
383|LOCAL|R Fire Warden (3 Yearly)|	28	30	58	52%
383|LOCAL|R First Aid at Work Certificate (3 Yearly)|	1	5	6	83%
383|LOCAL|R Food Hygiene Awareness Update (Annual)|	20	8	28	29%
383|LOCAL|R Food Hygiene Certificate (3 Yearly)|	17		17	0%
383|LOCAL|R General Risk Assessor Training (3 Yearly)|	25	11	36	31%
383|LOCAL|R Health Record Keeping (Once)|	108	396	504	79%
383|LOCAL|R HoNOS (Health of the Nation Outcome Score) (Once Only)|	163	158	321	49%
383|LOCAL|R Incident & Risk Management Awareness for Managers (3 Yearly)|	1		1	0%
383|LOCAL|R Infection Control (2 Yearly) All clinical|	91	356	447	80%
383|LOCAL|R Investigating Incidents, Complaints, Claims & Report Writing (Once only)|	3	33	36	92%
383|LOCAL|R Managing People - Appraisals (3 yearly)|	12	11	23	48%
383|LOCAL|R Managing People - Capability (3 yearly)|	13	10	23	43%
383|LOCAL|R Managing People - Disciplinary (3 yearly)|	13	10	23	43%
383|LOCAL|R Managing People - Grievance and Dignity (3 yearly)|	13	10	23	43%
383|LOCAL|R Managing People - Health and Attendance (3 yearly)|	13	10	23	43%
383|LOCAL|R Managing People - Recruitment & Selection (3 yearly)|	13	10	23	43%
383|LOCAL|R Medic - Approved Clinician (5 Yearly)|	6	29	35	83%
383|LOCAL|R Medic - Clinical Supervision (once only)|	5	11	16	69%
383|LOCAL|R Medic - Clinical Supervision Refresher (online or face to face) (3 yearly)|	9	8	17	47%
383|LOCAL|R Medic - Educational Supervision (once only)|	7	9	16	56%
383|LOCAL|R Medic - Educational Supervision Refresher (online or face to face) (3 yearly)|	10	7	17	41%
383|LOCAL|R Medic - Section 12 Approval (5 Yearly)|	6	29	35	83%
383|LOCAL|R Meds Mgmt - Administration & Documentation eLearning (once only)|	9		9	0%
383|LOCAL|R Meds Mgmt - Basic Calculations eLearning (once only)|	8	1	9	11%
383|LOCAL|R Meds Mgmt - Medicines Code & Medication Policy Awareness eLearning (once only)|	19	7	26	27%
383|LOCAL|R Meds Mgmt - Prescribing Medicines eLearning (once only)|	2		2	0%
383|LOCAL|R Meds Mgmt - Use of Medication in the Management of Violence & Aggression v5 (3 yearly)|	2	1	3	33%
383|LOCAL|R Mental Capacity Act (Once)|	36	353	389	91%
383|LOCAL|R Mental Health Act 2007 (Once)|	66	287	353	81%
383|LOCAL|R Mentor (Annual) All Registered Nurses|	69	177	246	72%
383|LOCAL|R Mentor Triennial Review (3 yearly)|	112	101	213	47%
383|LOCAL|R Moving & Handling Level 2 - MEDICAL EXEMPTION (See individual risk assessment) 1 Year|		1	1	100%
383|LOCAL|R Moving & Handling Level 2 - People (2 yearly)|	92	239	331	72%
383|LOCAL|R Nutrition (2 Yearly)|		1	1	100%
383|LOCAL|R Observation Practice Booklet (Once)|	5	6	11	55%
383|LOCAL|R Positive & Safe - Breakaway - (Annual)|	1		1	0%
383|LOCAL|R Positive & Safe - Control & Restraint - inc PSTS (Annual)|	4		4	0%

Training	Doesn't meet	Meets	Total	Meets %
383|LOCAL|R Positive & Safe - PROACT SCIPr-UK - PACE (LD) - inc PSTS (annual)|	2		2	0%
383|LOCAL|R Positive & Safe - PROACT SCIPr-UK - TACTICS (Older) inc PSTS (Annual)|	7	8	15	53%
383|LOCAL|R Resuscitation - Basic Life Support & AED (annual)|	2	6	8	75%
383|LOCAL|R Resuscitation - Basic Life Support (annual)|	91	258	349	74%
383|LOCAL|R Resuscitation - Basic Life Support Paediatric (annual)|	3		3	0%
383|LOCAL|R Resuscitation - Immediate Life Support - ILS - (annual)|	26	23	49	47%
383|LOCAL|R Safeguarding - Adults Level 3 (2 Yearly)|	11	8	19	42%
383|LOCAL|R Safeguarding - Children Level 2 (3 yearly)|	17	50	67	75%
383|LOCAL|R Safeguarding - Children Level 2 (once only)|	36	387	423	91%
383|LOCAL|R Safeguarding - Children Level 3 (3 yearly)|	92	343	435	79%
383|LOCAL|R Safeguarding - Children Level 3 (annual)|	3	1	4	25%
383|LOCAL|R Safeguarding - PREVENT Awareness L1 Training (3 yearly)|	61	58	119	49%
383|LOCAL|R Safeguarding - PREVENT WRAP L3 Training (3 yearly)|	166	227	393	58%
383|LOCAL|R Safeguarding - Think Family (Once Only)|	83	355	438	81%
383|LOCAL|R Staff Recruitment Training (3 Yearly) - All Recruiters|	18	25	43	58%
383|LOCAL|R Suicide Awareness and Response (Parts 1 & 2) Training - CwP (once only)|	168	222	390	**57%**
383|LOCAL|R Trust Induction (once only)|	3	45	48	94%
383|LOCAL|R Waste Management (Annual)|	215	154	369	42%
Total	**3397**	**10666**	**14063**	**76%**

2.7 Recruitment

The recruitment situation is not as acute as within the inpatient areas but even with additional resource recruitment has been slow in some areas. Posts have required multiple advertising and Band 5 posts have been particularly difficult to recruit to, a reflection of lower numbers training and high demand across the East Midlands and beyond.

As part of the Neighbourhood development a skill mix was introduced to deliver uniform ratio of Band 5 to Band 6s across all areas. There is recognition that matching skill set to patient need is important and that Band 5 skill set is important within the Neighbourhood teams, however the lack of availability of Band 5 nurses has led to translation of Band 5 resource into Band 6 in order to support recruitment. This is not a trend we would wish to perpetrate but it is acknowledged that this may happen if the training numbers retract further, which given the loss of the bursary seems likely.

Converting a Band 5 post to a Band 6 reduces overall capacity but reduces the need for agency and improves capacity in the short term.

The risk remains that moving resources to higher grades of pay and higher skilled workers will impact the medium to long term finances of the Trust and mean that highly skilled workers will be undertaking work that could be done by lower grades of staff.

2.8 National shortage of nurses and mental health nurses

Nationally there is a shortage of mental health nurses. Between 2010 and 2015 the number of qualified nurses working in psychiatry dropped by 10.8% (data source: http://www.theguardian.com/society/2016/jan/25/number-of-mental-health-nurses-falls-10).

According to a report by the Institute for Employment Studies (2016) commissioned by the Migration Advisory Committee, which cites the ageing workforce, poor planning by government and the risks from Brexit as key problems:

- Nationally, a 17% cut in nurse training places between 2009 and 2013 has resulted in a shortfall of at least 20,000 nurses, meaning 1 in 10 nurse posts in England are unfilled.
- 29% of nurses are aged over 50, meaning the shortage of nurses could be massively increased through retirements.
- 13% of nurses come from overseas.

- Nurses could be put off by the prospect of Brexit which, together with the other factors, means the recruitment of extra nurses from the rest of the world will "not be sufficient" to plug the gap in the workforce.

(Data source: http://www.employment-studies.co.uk/resource/labour-market-nurses-uk-and-its-relationship-demand-and-supply-international-nurses-nhs)

3. Externally generated pressures

3.1 Cuts to social care budgets

Austerity measures in both councils have led to the raising of thresholds for social care mental health input, increasing pressure on our community services. There has been significant retraction of voluntary sector services which have traditionally supported transition out of our services which has had a negative impact on flow through services. Additional pressure comes from holding cases that would previously have passed to social care for ongoing management and support but where the thresholds or waits for that service are higher than was previously the case and statutory obligation (apart from human response) leaves the case requiring ongoing input from our services

3.2 Cuts to healthcare budgets

Healthcare budgets across the NHS have been required to demonstrate efficiencies in service to deliver cost improvement. In line with this the Trust has been subject to annual cost improvement programmes which have been successful over a period of years, however whilst the aim has always been to protect front line services over time there has inevitably been an impact.

3.3 The STP and Commissioning

The STP for Enhanced Neighbourhood Services is ambitious in describing pathways of care to deliver good quality mental health services. The plan identifies new ways of working with Primary Care to secure better management of care early in the trajectory of a person's illness. The plan also identifies Neighbourhood embedded community forensic services and the Personality Disorder Pathway. However it now seems very unlikely that there will be additional resource to support these ways of working and attempts to respond within existing Neighbourhood resource are proving either ineffective or to add to the volume of work and increased waits for service.

4. Internally generated pressures

4.1 Additional record keeping

The Trust has a tradition of producing new forms. These are created for sound reasons but become another part of the care package, further impacting on the finite capacity of the care coordinator. Two recent examples are the "*Recovering Quality of Life*" outcome measure that was introduced in February 2017 and must be completed at each cluster review and the "*Smoke free Trust*" information provision and recording requirement which went live in January 2017. We also launched the Safety Plan in Neighbourhood services in October with a go live date of April 1st, although this is accepted as a move towards improved patient participation in risk management and care it is also demanding in terms of time to complete. At the time of writing there are 318 approved clinical forms on the intranet.

4.2 Additional training

The essential training requirements have increased over time with no accompanying ability to generate capacity in individuals work day to accommodate this. If we listen to our staff in Neighbourhoods they want more training, they are keen to complete the essential and would like specific training in areas that could support their confidence and skills in delivering good care, however we are compromised on capacity to release staff and cost of some training.

5. Future pressures

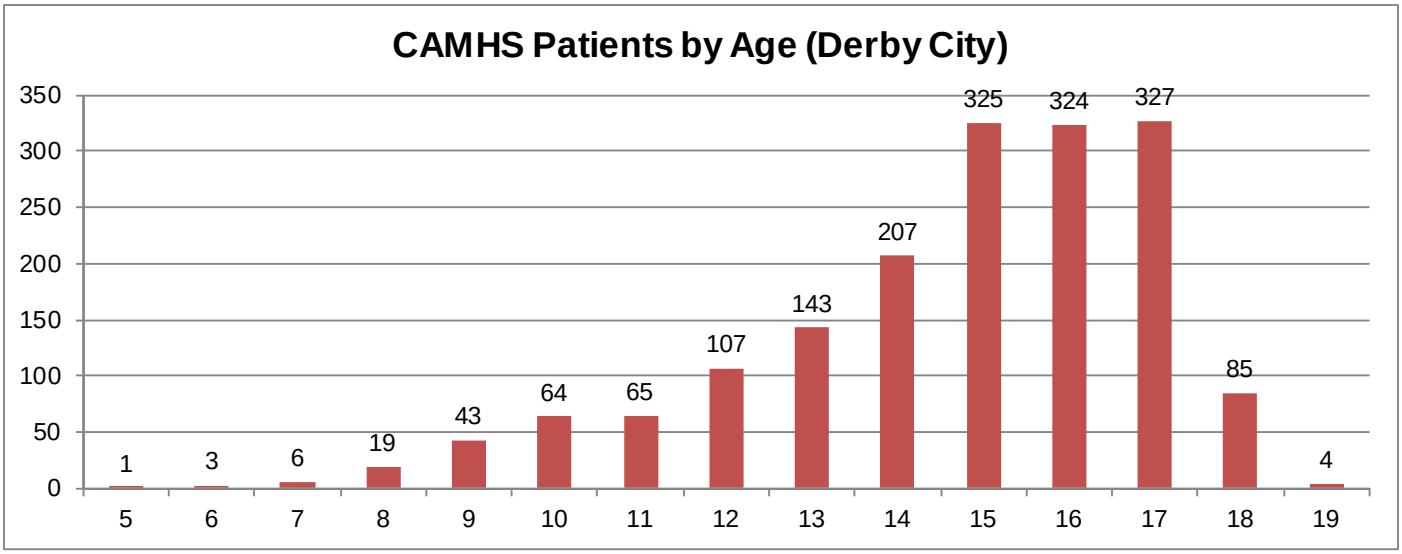
5.1 Referrals from other services

(a) Waiting list for care coordination

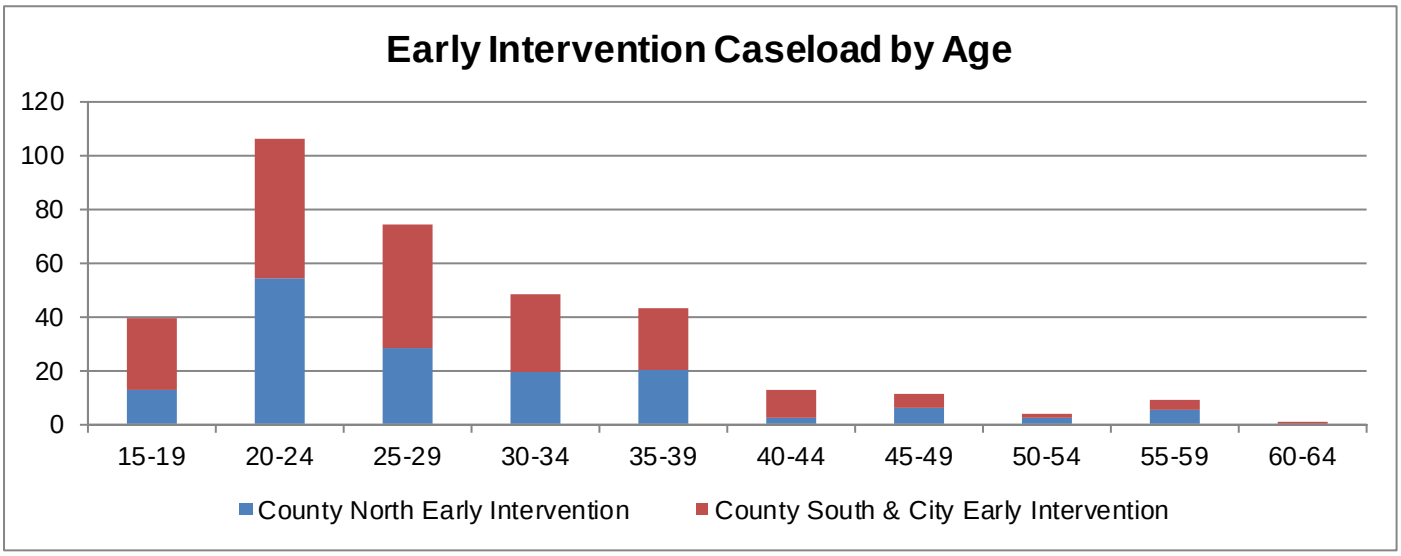
We are likely to continue to see an increase in the number of people who have been assessed as requiring services and are now awaiting allocation of a care coordinator:

(b) Transition from CAMHS to adult services

The data below relates to Derby City. It is likely that a significant number of these patients will require mental health services in adulthood.



There will be similar transition requirements from early intervention services to community mental health services.



(C) Increasing mental illness prevalence in the population served over time

The prevalence of people with mental illness in Derby and Derbyshire is predicted to increase over time by as much as 13%, predominantly in people aged 65 or over.

	PREVALENCE				CHANGE OVER TIME		
Team	**2015**	**2020**	**2025**	**2030**	**2020**	**2025**	**2030**
Amber Valley	**22939**	**23525**	**24113**	**24909**	**3%**	**5%**	**9%**
18-64							
antisocial personality disorder	256	255	251	248	0%	-2%	-3%
borderline personality disorder	333	333	329	325	0%	-1%	-2%
common mental disorder	11891	11893	11732	11603	0%	-1%	-2%
early onset dementia	35	37	39	37	6%	11%	6%
psychotic disorder	296	296	292	288	0%	-1%	-3%
two or more psychiatric disorders	5309	5303	5231	5173	0%	-1%	-3%
65+							
dementia	1805	2083	2517	3049	15%	39%	69%
depression	2297	2524	2799	3151	10%	22%	37%
severe depression	717	801	923	1035	12%	29%	44%
Bolsover	**14156**	**14479**	**14798**	**15143**	**2%**	**5%**	**7%**
18-64							
antisocial personality disorder	163	163	162	161	0%	-1%	-1%
borderline personality disorder	210	210	209	205	0%	0%	-2%
common mental disorder	7503	7522	7470	7347	0%	0%	-2%
early onset dementia	20	22	23	22	10%	15%	10%
psychotic disorder	186	187	186	183	1%	0%	-2%
two or more psychiatric disorders	3355	3363	3341	3290	0%	0%	-2%
65+							
dementia	1006	1140	1337	1617	13%	33%	61%
depression	1302	1423	1563	1747	9%	20%	34%
severe depression	411	449	507	571	9%	23%	39%
Chesterfield	**19277**	**19550**	**19882**	**20138**	**1%**	**3%**	**4%**
18-64							
antisocial personality disorder	218	216	211	206	-1%	-3%	-6%
borderline personality disorder	282	280	275	270	-1%	-2%	-4%
common mental disorder	10081	10004	9837	9632	-1%	-2%	-4%
early onset dementia	28	30	30	29	7%	7%	4%
psychotic disorder	251	249	245	239	-1%	-2%	-5%
two or more psychiatric disorders	4502	4466	4388	4294	-1%	-3%	-5%
65+							
dementia	1491	1676	1997	2277	12%	34%	53%
depression	1841	1996	2183	2399	8%	19%	30%
severe depression	583	633	716	792	9%	23%	36%
Derby	**46197**	**47712**	**49106**	**50685**	**3%**	**6%**	**10%**
18-64							
antisocial personality disorder	553	569	578	585	3%	5%	6%
borderline personality disorder	706	722	730	737	2%	3%	4%
common mental disorder	25286	25849	26174	26418	2%	4%	4%
early onset dementia	58	63	66	64	9%	14%	10%
psychotic disorder	628	642	650	656	2%	4%	4%
two or more psychiatric disorders	11322	11586	11742	11856	2%	4%	5%
65+							

	PREVALENCE				CHANGE OVER TIME		
Team	**2015**	**2020**	**2025**	**2030**	**2020**	**2025**	**2030**
dementia	2988	3356	3752	4293	12%	26%	44%
depression	3532	3728	4074	4583	6%	15%	30%
severe depression	1124	1197	1340	1493	6%	19%	33%
Erewash	**21031**	**21635**	**22302**	**22915**	**3%**	**6%**	**9%**
18-64							
antisocial personality disorder	238	238	240	238	0%	1%	0%
borderline personality disorder	311	312	312	310	0%	0%	0%
common mental disorder	11100	11133	11158	11061	0%	1%	0%
early onset dementia	30	32	34	32	7%	13%	7%
psychotic disorder	276	277	277	275	0%	0%	0%
two or more psychiatric disorders	4950	4964	4978	4935	0%	1%	0%
65+							
dementia	1560	1849	2179	2550	19%	40%	63%
depression	1945	2145	2352	2645	10%	21%	36%
severe depression	621	685	772	869	10%	24%	40%
High Peak & North Dales	**24026**	**24445**	**25035**	**25599**	**2%**	**4%**	**7%**
18-64							
antisocial personality disorder	272	269	263	257	-1%	-3%	-6%
borderline personality disorder	351	347	340	332	-1%	-3%	-5%
common mental disorder	12541	12386	12164	11861	-1%	-3%	-5%
early onset dementia	40	42	42	40	4%	5%	0%
psychotic disorder	312	308	303	295	-1%	-3%	-5%
two or more psychiatric disorders	5603	5535	5434	5301	-1%	-3%	-5%
65+							
dementia	1816	2095	2570	3097	15%	42%	71%
depression	2353	2633	2956	3331	12%	26%	42%
severe depression	741	833	965	1087	12%	30%	47%
North East Derbyshire	**18412**	**18833**	**19224**	**19588**	**2%**	**4%**	**6%**
18-64							
antisocial personality disorder	201	199	195	191	-1%	-3%	-5%
borderline personality disorder	260	258	253	248	-1%	-3%	-5%
common mental disorder	9308	9211	9050	8850	-1%	-3%	-5%
early onset dementia	29	30	30	29	3%	3%	0%
psychotic disorder	231	229	225	220	-1%	-3%	-5%
two or more psychiatric disorders	4156	4113	4041	3954	-1%	-3%	-5%
65+							
dementia	1543	1853	2185	2574	20%	42%	67%
depression	2047	2237	2444	2649	9%	19%	29%
severe depression	637	703	801	873	10%	26%	37%
South Derbyshire & South Dales	**24368**	**25422**	**26643**	**27635**	**4%**	**9%**	**13%**
18-64							
antisocial personality disorder	279	283	287	285	1%	3%	2%
borderline personality disorder	361	366	370	368	1%	3%	2%
common mental disorder	12875	13062	13239	13149	1%	3%	2%
early onset dementia	38	41	44	43	7%	16%	13%
psychotic disorder	321	325	330	327	1%	3%	2%
two or more psychiatric disorders	5754	5837	5916	5877	1%	3%	2%
65+							
dementia	1737	2080	2543	3116	20%	46%	79%
depression	2288	2614	2956	3371	14%	29%	47%
severe depression	718	817	960	1101	14%	34%	53%
Grand Total	**190406**	**195601**	**201103**	**206611**	**3%**	**6%**	**9%**

(data sources: www.pansi.org.uk and www.poppi.org.uk)

5.2 Out of area placements

In Financial year 2017/18 the Trust will be responsible for funding out of area acute placements and has been allocated a budget by the commissioners of less than a third of what has been spent this financial year on adult acute out of area placements. Reducing out of area placement requires the freeing up of bed capacity within the Trust, which in turn relies upon more intense treatment in the community. There is currently no funded capacity to provide that additional intense support and it is likely that this will lead to increased pressure in Neighbourhood services

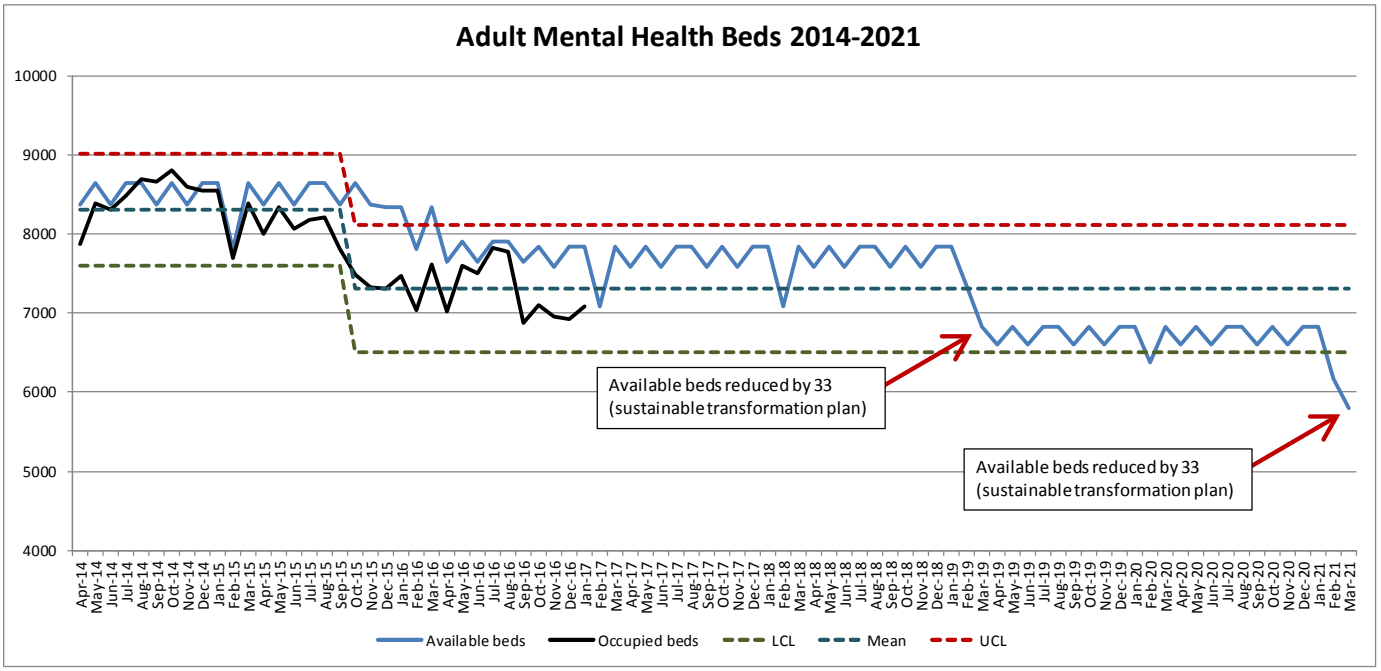
5.3 North Consultation and STP bed reduction proposal

Although currently only a proposal, if the STP bed reduction proposal comes to fruition it is likely to have a significant impact on community services.

Year	Proposed reduction	Potential impact
2017/18	20 dementia beds (North Derbyshire)	Increase to caseloads in the northern community teams of Dementia patients with increased acuity
2018/19	33 adult mental health beds	Increase to caseloads in all community teams of patients with increased acuity
2020/21	33 adult mental health beds	Increase to caseloads in all community teams of patients with increased acuity

(Date source re proposed reductions: http://www.southernderbyshireccg.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=4225)

The North dementia bed reduction proposal may not have a detrimental impact on community team capacity of the proposed DRRT for North materialises, however that transition may have implications for our team staff retention and recruitment.



Adult acute bed occupancy reduced in September 2015. Since then occupancy of anything between 6504 and 8105 bed days per month is normal, with an average of 7305 occupied bed days per month.

If nothing changes, and if the proposed bed reduction is implemented in March 2019, it is likely to mean there will not be enough beds at least 50% of the time. This is likely to have a significant impact on the community teams.

5.4 Ongoing cost reduction requirements (CIP)

The Trust has been given a further significant CIP target for 2017/18. In Neighbourhood services savings have been identified but, currently, fall far short of that which is required to be delivered. Added to this commissioners are currently indicating that the savings identified in one area may actually be to commissioner rather than Trust benefit.

6. Risks and Mitigation Overview

The risks identified have been developing at varying rates across community mental health teams over a period of two years and the teams and management team have been working hard to respond to challenges and mitigate associated risks. However the issues have become more widespread and started to have more serious impact, and associated increased levels of risk during this financial year.

DHCFT is unlikely to be the only Trust in such a position, however under-investment over a period of years may mean we are reaching critical levels of risk sooner.

The actions being taken and those planned will help but in the face of the challenges outlined are unlikely to actively reduce the risk to manageable levels and Neighbourhood services are keen for the Board to know that despite significant and sustained effort, risks will continue.

Risk 1 Managing Caseloads in Different Ways

The way we are managing some cohorts in some areas means that we are moving away from CPA. CPA is one of the ways the Trust reflects the cohort of people with serious mental illness, those with highest need and complexity. CPA is also one of the ways we demonstrate how effectively we manage people in this cohort. It is also national guidance.

The introduction of clinic working for specific cohorts has led to caseloads as high as 65 being carried by individual workers. This is most often seen in depot clinics or Clozaril clinics. Service users held in this way represent a level of need and history of risk which would indicate they meet criteria for CPA, however because working within the current demands of our CPA policy and procedures is time intensive, the current situation is that the patients either aren’t managed through the policy or the targets for CPA review aren’t met.

It is also the case that adherence to CPA where we are trying to manage people on a recovery pathway, is counterintuitive and clinicians are questioning how we can move away from CPA as we move people with long standing mental ill-health towards caring for themselves.

Mitigation

There are two options for improvement in this situation, and it may be that we need to adopt both:

Firstly we review and issue much clearer guidance to workers on how to use CPA, with significantly reduced record keeping and adherence to formal multi-disciplinary meetings.

Secondly we consider that certain cohorts which previously we would have managed under CPA will no longer be managed in this way.

The neighbourhood management team have started and are currently reviewing the CPA policy and procedure and specifically how we apply the policy. There is a concern that although some of the strictures of CPA were removed some years ago, and a measure of individual interpretation of

the application of the process was encouraged, this has not happened and CPA is still interpreted as requiring significant record keeping and formal meeting structure. There is an element of culture change required, but not only in team members also in how the organisation recognises this adaptation, particularly where serious incidents are reviewed.

The aim is for the Trust to be able to demonstrate the number of complex, high risk and high need people using services and to also demonstrate safety and effectiveness in care and treatment. However what is clear currently is that the demand in this area far outstrips our ability to do so.

Risk 2

Management of waiting lists

The waiting lists, in terms of length of wait and numbers waiting is at the highest it has ever been. The waits for care coordination are perceived as critical because the cohort are the highest level of need and complexity, however people are also waiting for initial assessment and for allocation of a worker to undertake treatment (non-care coordination cases) The policy to enable people to wait well, and in a supported manner is difficult to operationalise as a result of other pressures within teams. For example the role of duty has previously undertaken phone contacts to support clinical contact but this is no longer possible in most areas as duty is a role undertaken as part of other usual duties, and the worker often responds to urgent requests for support whilst in the role. Therefore there is a risk that people aren't supported well clinically whilst waiting.

Mitigation

The head of nursing for neighbourhoods is undertaking work with a group of service managers to review the Management of Waiting Times Across Neighbourhoods Policy and Procedure to ensure the procedures are achievable and offer as much clinical support as is possible.
This will include the drafting of a leaflet about waist which will reinforce the need to contact services if an individual's situation changes, and to share this information with someone who may be able to support the individual, for example family and friends. There is work ongoing to try to introduce more capacity into teams which is discussed throughout the document, however the current waiting times are a high risk.

Risk 3 Recruitment and retention

Neighbourhood services are having difficulty recruiting staff in some areas and to some skill sets. There has been a shift in skill mix which isn't desirable but is currently unavoidable. Retention is an issue, people have more flexibility to move and we have a large cohort of older nurses retiring within the next three years.

Mitigation

The Trust has stepped up efforts to recruit new staff and retain existing staff over the past year. This has paid dividends across community services, however there is no doubt that rigorous approaches from multiple areas are required to continue this work which will only get harder given the predicted climate. In recognition of the need to recruit and retain high calibre of staff in all fields, particularly AHPs, medics and nursing, there is continued effort to enable swift and effective recruitment procedures which draw on appropriate talent pools and ensure that resources are deployed in the most appropriate way.

Once implemented in March 2017, e-Recruitment, using TRAC system, will enable managers and potential employees to utilise a streamlined, interactive and responsive process, which would reduce or eliminate paperwork and unnecessary delays.

The future positioning of our Trust is also partly dependent on our ability to attract and recruit from a wider talent pool, more so when recruiting to 'hard-to-fill' clinical vacancies/posts. Hence, our recent achievement of Tier 2 Sponsorship Licence through the UK Visas & Immigration (UKVI) in December 2016 will facilitate the Trust's ability to recruit from an international/worldwide pool of talent.

In addition, since December 2016, 'hard-to-recruit' vacancies are being advertised on social media platforms - LinkedIn and Facebook.

Alternative skill mix:

Suggestions have been made relating to the recruitment of social workers and we currently employ two social workers through the agency, however we do not have a clear support structure for newly qualified social workers. The staff we have through agency are more experienced, but our governance in relation to social work posts requires review if we are to accept newly qualified staff.

Post qualification requirements have changed and we are not in a position to respond to these requirements. Investment in training for existing social work staff would be required in order for them to be able to support newly qualified staff and access to specific post qualification training would be required for newly qualified workforce. This would involve workforce strategy development and investment in time and finance.

Risk 4 Achieving KPI

Neighbourhood services have increasing difficulty meeting key targets. Targets for CPA review, clustering and time from referral to treatment have all suffered due to the competing challenges. Supervision, IPR and training compliance are also threatened and meeting these targets is proving impossible in most areas. This situation is likely to get worse over time.

Mitigation

The systems in place to alert the whole management line to issues with target compliance is well established and embedded in neighbourhood services. To date this has been largely effective, however increasingly this system demands that a clinician prioritise these activities over patient facing activity and this is a compromise that clinicians find most difficult.

Managers and clinicians express awareness of the importance of demonstrating good patient care and how target compliance reflects this, however there is increasingly no facility within the team workload to ensure targets can be met.

In some areas staff have identified mitigation. For example in the City and in Chesterfield staff have raised inability to park as a time thief and the management team have worked hard to support prioritising parking as part of a solution to improve time management. However given the multiple challenges, time that could be saved through provision of adequate parking is not necessarily the answer to this particular risk.

Risk 5 The retraction of social care and voluntary sector services

A significant element of care and treatment in community services is based on managing people on a pathway that leads to self-care. Much of this work is predicated on the availability, across communities of supportive services for people to use as they progress towards better health. The cuts to social care budgets have led not only to retraction of their service but retraction, or more

often loss, of voluntary sector provider options. The raising of thresholds for social care has also been an outcome of cut backs and this continues to impact demand and caseload flow in our services.

Mitigation

The senior management team in neighbourhoods is linked in with commissioners, social services and newly commissioned voluntary sector services to work on the pathways of care and how we can create a cross community multi-agency response for people with mental health needs. Each neighbourhood is working on their recovery focussed strategy and this is supported through the management and clinical lead line. This work represents some of the best opportunities we have to improve quality and flow of service. As mentioned above some work around CPA and how it fits with this is required and this has been commenced.

Risk 6 The impact on other Trust Services

As pressures has built in neighbourhood services there has been an active approach to prioritising cases referred from within the Trust, for example CRHTT, Campus and CAMHs. This has adversely impacted the waiting lists externally however it is recognised that flow within the mental health systems is vital. As all the pressures have grown, the waits even within Trust services have been felt and this is leading to longer waits for key services into neighbourhoods.

There has been some impact on IAPT services where the problem is two-fold and IAPT managers describe difficulty getting people into neighbourhood services, inappropriate referrals from neighbourhood services (above threshold) and referrals from external services because neighbourhood waits are too long. Information we have indicates these pressures will grow significantly over the next 12 months.

Mitigation

Neighbourhood managers at every level work with managers in other Trust services to ensure prioritisation of cases and to enable shared understanding of risks, both to service users and to systems.

7 Exploring Options to Improve Capacity and Work on Demand

There has been work ongoing in neighbourhood services to try and impact demand by creating capacity. This work of itself demands time and adds to the overall pressures of workload. However there is an understanding that continuing to do things the way we always have is creating an untenable situation. That said although there are some (not as many as people think) examples of different ways of working that could help the majority when further investigated have been created using new resources or infrastructure not available to us. This section describes some of the actions we are investigating and some of the outcomes or issues with these areas of investigation.

7.1 Links with Outpatients and Psychological Therapy Service Development

Work is being undertaken to review clinical variation in outpatients and to review the provision of psychological therapies. The emerging models tend to rely upon the specialist supervising a nurse to take on a role in providing service currently provided by the specialist. Whilst this is an efficient approach there is insufficient capacity to support these developments. A higher level of specialist supervision may assist with other patient flow issue but that is a different issue.

7.2 Outpatients

Patient flow within outpatient services is a different but associated issue. If there was more capacity within outpatients the role of care coordination could be less onerous. Kathryn Lane and Dr Paul Rowlands suggested the RAIN model (“rapid access in need”). This has not been fully agreed across the Consultant body and requires primary care support, which can be variable. The model relies on referrals back into services being rapidly picked up, given current pressures and size of waiting lists there is a significant piece of work and movement to be achieved before this offer can be reliably secured.

However if this could be implemented to a greater degree it may allow for a similar model to be in operation between outpatients and care coordinators to enhance the flow of patients enabling rapid access back to a care coordinator.
Some consultants currently aware of waits for care coordination may be reluctant to agree discharge from a nurse’s caseload. This is a difficult issue and relates to threshold management. Existing pressure on referral to treatment which relates to outpatients also increases pressures on nurse assessment capacity.

7.3 Resource Management

Review of Nurse Assessment is being undertaken. Options being appraised include:

- Lengthening the wait for assessment in order to allocate patients waiting for care coordination. Waits for assessment in some areas are already high. Some areas are still operating a pathfinder type model in an attempt to ring-fence workload. There is staff resistance to working differently in these areas associated with concern that it will impact the waits further down the line.
- Reducing number of assessments by triaging a greater number of referrals back to the GP without face to face assessment. This should be an option but potentially increases clinical risk and is an irritant to GPs.
- Introducing more flexibility into the assessment model currently widely used, this could reduce face to face and record keeping time

7.4 Raise thresholds for patient access at assessment and allocation of care coordination

All Neighbourhood teams share a common operational policy. There is clinical variation in application and there is likely to be some clinical variance with regard to thresholds but this is hard to quantify. There is no doubt that teams that have seen most demand increase have moved the most – depot clinic models, ways of working with people with dementia for example.

An option would be to work up criteria for raised thresholds. This is a complex task and would inherently raise clinical risk, but in a managed way.

This would require a working group and full clinical and commissioner consultation.

However we have to acknowledge that any improved capacity generated by change in threshold for Neighbourhood services is likely to automatically impact on demand for our other services, indeed the increased wait times for Neighbourhood teams service has already seen an impact on IAPT and CAMHs, as indicated below, and this would worsen:

- Increase inappropriate referral to IAPT
- Increase the gap in service between IAPT provision and secondary care
- Increase referral to Crisis
- Reduce capacity to accept referrals from CAMHs
- Reduced capacity to accept EIS referrals
- GP relationship
- Pressure within outpatients service
- Patient complaints

7.5 Increased integration with Primary Care

Small pilot work in this area with working age individuals has not proved to deliver the same benefits as older adult linking. This has delivered more work and inappropriate referrals to the Neighbourhoods and adversely impacted capacity. In older adult care the link workers were invited to specific meetings about the complex shared cohort and the meeting offers opportunity to engage about clinical and operational issues. However this isn't the case in Adult care and GPs have thus far used pilots established as a short cut to service, with scant regard to the agreed parameters of the pilot. This isn't a criticism of the GPs but rather a reflection of the intense pressure they are also under. The growing consensus in neighbourhood services is that more interface at the point of referral within primary care would be beneficial but requires new resource.

7.6 Increased recovery-focused solutions

This work is ongoing within Neighbourhoods and offers the most realistic opportunity to improve service user experience, whilst assisting with flow and capacity. Although the voluntary sector are under increasing threat we are seeking to actively engage with and work in partnership with this sector to propel a shared strategy for recovery focussed work. There are issues we need to work on in respect of CPA, as previously identified and access to more training materials and courses would be beneficial. There is a lot of work to be done in this area but if well supported we could see multiple benefits.

7.7 Increased use of Peer Support

This work is more established in some areas than others and is small scale. However the benefits in outcomes for service users means that we would strive to enable more peer support within services, and embedded particularly within the recovery strategy

7.8 Increased nurse clinic models

This work is in place across Neighbourhoods, there is potential for some growth which will be explored. However as we have seen working in this way means individuals have to sustain caseloads of double the recommended size, in order to do this the level of record keeping has to be to a minimum, there is likely to be a risk/benefit calculation requirement and we would seek to share this risk with commissioners and for it to be explicit. We also need to consider the impact on individuals' health, and the fact that such large caseloads mean that at any one time the risk of someone on caseload going into crisis or having increased level of need requiring quick response is also doubled, there is no ability to build any associated flexibility into the workers workload.

8. Conclusion

The pressures within community mental health services are significant and growing. This report highlights the main risks, in how we manage caseload and demand, how we recruit and retain staff, how we achieve our key targets and how we manage in the face of a retracting community care environment and how we control these pressures from impacting other key Trust services.

The truth of the situation is that neighbourhood services can deliver some mitigation, but can't resolve these risks and the trajectory of demand indicates that the situation could quite quickly become very threatening from multiple perspectives, including patient safety, staff well-being and the Trust's reputation and financial standing.

The neighbourhood management team seek to make the board aware of the nature and depth of these issues and seek support in applying mitigation detailed and working on other potential solutions.

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 1 March 2017

Governance Improvement Action Plan (GIAP)

Purpose of Report
As described in the GIAP Governance and Delivery framework, the Board has overall responsibility for ensuring that the GIAP is delivered.

Therefore, the purpose of this paper is as follows:

1. To provide Board members with an update on progress on the delivery of the GIAP, including the identification of tasks and recommendations that are off track.

2. To receive assurances on delivery and risk mitigation from Board Committees and Lead Directors.

3. To enable Board members to constructively challenge each other to establish whether sufficient evidence has been provided for completed actions.

4. To decide whether tasks and recommendations can be closed and archived.

Executive Summary

This paper provides the Board with an update on the progress of delivering the GIAP.

The governance of each core area is as follows:

Core	Committee	Lead Director
Core 1 - HR and associated Functions	People and Culture	Interim Director of People and Organisational Effectiveness
Core 2 - People and Culture	People and Culture	Interim Director of People and Organisational Effectiveness
Core 3 - Clinical Governance	Quality	Director of Nursing and Patient Experience
Core 4 - Corporate Governance	Audit & Risk	Director of Corporate Affairs
Core 5 - Council of Governors	Council of Governors	Director of Corporate Affairs
Core 6 - Roles and Responsibilities of Board Members	Remuneration and Appointments	Director of Corporate Affairs
Core 7 - HR and OD	People and Culture	Interim Director of People and Organisational Effectiveness
Core 8 - Raising concerns at work	People and Culture	Director of Corporate Affairs
Core 9 - Fit and Proper	Remuneration and Appointments	Director of Corporate Affairs
Core 10 - CQC	People and Culture	Interim Director of People and Organisational Effectiveness
Core 11 - NHS improvement undertakings	Board of Directors	Director of Corporate Affairs

The summary table below provides Board members with an overview of performance against all 53 recommendations, set against each respective core area.

Core	Number of Recommendations	Off Track	Some Issues	On Track	Completed
Core 1 - HR and Associated Functions	5	0	0	2	3
Core 2 - People and Culture	6	0	0	1	5
Core 3 - Clinical Governance	3	0	1	0	2
Core 4 - Corporate Governance	13	0	0	8	5
Core 5 - Council of Governors	3	0	0	0	3
Core 6 - Roles and Responsibilities of Board Members	5	0	1	3	1
Core 7 - HR and OD	8	0	0	3	5
Core 8 - Raising concerns at work	1	0	0	1	0
Core 9 - Fit and Proper	1	0	0	0	1
Core 10 - CQC	2	0	0	0	2
Core 11 - NHS improvement undertakings	6	0	0	3	3
Total	53	0	2	21	30

There are 10 blue forms to present to the Board in March.

GIAP Recommendations Approval Pipeline, January – May 2017

As reported to the February Board meeting, a pipeline of planned completion of blue action forms for all GIAP recommendations has been developed. This report is presented monthly to ELT to ensure oversight of progress and escalation and management of any issues arising. The approval pipeline as at 23.02.17 is attached for information.

There is one recommendation which is deferred for one month which relates to ‘Raising Concerns at work’ Core 8, which has been reviewed by the Director of People and Organisational Effectiveness and the Director of Corporate Affairs. It was agreed that further evidence and assurance was required for completion of actions relating to this recommendation. The blue form is now on track for discussion at People and Culture Committee in March 2017.

The body of the report provides detail on areas that are currently rated as ‘off track’ or ‘some issues’.

Strategic considerations

Delivery of the GIAP links directly to NHS Improvement’s enforcement action and associated licence undertakings

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	

Board Assurances
This paper should be considered in relation to key risks contained in the Board Assurance Framework namely:

3a: There is a risk that the NHSI enforcement actions and CQC requirement notice, coupled with adverse media attention may lead to significant loss of public confidence in our services and in the trust of staff as a place to work
3b: Risk of a fundamental loss of confidence by staff in the leadership of the organisation at all levels

Consultation
Core areas have been discussed at respective Board Committees.

Governance or Legal Issues
This paper links directly to NHSI enforcement action and associated licence Undertakings.

Equality Delivery System
Delivery of elements of the GIAP is likely to have a positive impact on outcomes for certain REGARDS groups.

Recommendations

The Board of Directors is asked to:

1) Note the progress made against addressing GIAP recommendations
2) Discuss the areas rated as 'some issues', seeking assurance where necessary on the mitigation provided
3) Formally approve the 10 blue forms as presented and confirm that this is provides assurance of completion, namely:
   - **PC3**
   - **PC4**
   - **PC5**
   - **ClinG3**
   - **WOD1**
   - **WOD3**
   - **WOD4**
   - **WOD7**
   - **WOD8**
   - **CQC2**
4) To note the GIAP recommendations approval pipeline and its role in supporting effective oversight of progress
5) Agree at the end of the Public Board meeting whether any further changes are

required to the GIAP following presentation of papers, outcomes of item specific discussions and/or other assurances provided throughout the meeting

Report presented by: **Kelly Sims (CQC and Governance Coordinator)**

Report prepared by: **Samantha Harrison (Director of Corporate Affairs and Trust Secretary)**

1. Introduction

The Board summary table provides Board members with an overview of performance against all 53 recommendations, set against each respective core area.

Detailed below are updates against Core areas where there have been notable decisions made with respect to actions required to confirm completion of recommendations and scheduled dates identified for these to be brought to respective Committees and the Trust Board:

Core 2 – People and Culture
It was agreed at the February meeting of the People and Culture Committee that recommendations PC3, PC4 and PC5 were complete. The blue forms were duly signed off.

It was agreed that PC2 was near completion but the blue form submission should be deferred until the March 2017 People and Culture Committee.

Core 3 – Clinical Governance
Following discussion at the Quality Committee, held in February, the blue form was approved for ClinG3. Progress on actions to complete recommendation ClinG1 have been formally escalated by the Committee Chair.

Core 7 – HR and OD
It was agreed at the February meeting of the People and Culture Committee that recommendations WOD1, WOD3, WOD4, WOD7 and WOD8 were complete. The blue forms were duly signed off.

Core 8 – Raising Concerns at Work
It was agreed at the January meeting of the People and Culture Committee that recommendation RC1 would be reviewed by the Director of People and Organisational Effectiveness and the Director of Corporate Affairs. It was agreed that further evidence and assurance was required for completion of actions relating to this recommendation. The blue form is now on track for discussion at People and Culture Committee in March 2017.

It was agreed at the February meeting of the People and Culture Committee that recommendation CQC2 complete. The blue form was duly signed off.

2. Red Rated 'Off Track' recommendations

None to report.

3. Amber rated 'some issues' rated recommendations

There are 2 recommendations rated as Amber as detailed below (3 last month):

Core Area	Recommendation	Action(s)	Mitigation
Core 3 - Clinical Governance	ClinG1 - Refresh the role of Quality Leadership Teams to increase their effectiveness as core quality governance forums	1) Agree and implement a QLT forward plan process to ensure all required papers are received at each meeting 2) Develop and implement a standard escalation template to be used by QLTs 3) For a 6 month period DoN and MD to attend QLTs to provide coaching and oversight of meeting effectiveness	QC agreed that in order to progress this recommendation to completion it would need to see evidence of escalation templates, minutes of meetings, work plans linked to the Quality Committee forward plan, attendance embedded on the minutes and risk register. QLT leads will need to attend QC on a rotational monthly basis but detailed QLT updates from each Team will be provided monthly. When the Committee has received all this information from each QLT consistently on a monthly basis for three months the Committee indicated they would be prepared to sign off this recommendation. Reviewed at December Quality Committee – confirmed that this remains 'some issues' pending evidence to be received over further months. Position confirmed to remain as 'some issues' at January meeting. Risk to completion of this action escalated by Quality Committee Chair in January 2017. Action plan to ensure progress back on track to be developed.
Core 6 - Roles and Responsibilities of Board Members	RR1 - Implement proposals to improve succession planning at Board level, including ensuring that Governors are adequately engaged in this process. Alongside this, develop processes for succession planning for Senior Leader positions	Develop and approve Board level, key divisional and corporate leaders succession plan	A mitigation plan was agreed at October's Remuneration & Appointments Committee, with succession planning process being led by Amanda Rawlings and Ifti Majid. Further development of the succession plan was discussed at the November and December Remuneration and Appointments Committee and proposed to be deferred until the new year due to priorities of other work areas. The status was reported and noted at the January Board meeting and agreed following recommendation of the

Core Area	Recommendation	Action(s)	Mitigation
			remuneration and appointment committee held in February that the status of this action be amended to 'Some Issues' reflecting the reprioritised timeline of April 2017.

GIAP Recommendations: Approval Pipeline January - May 2017

Pipeline as at 23.02.17

Core	Total	Off Track	Some Issues	On track	Com-plete	Update	Programme for Blue Forms to Board				
							Jan	Feb	Mar	Apr	May
Core 1 - HR and associated Functions Director of People and Organisational Effectiveness	5	0	0	2	3	Forms approved by Board in Jan. PCC Jan agreed: **HR3** – to PCC in March **HR4** – to PCC in March	HR1 HR2 HR5			HR3 HR4	
Core 2 - People and Culture Lead - Director of People and Organisational Effectiveness	6	0	0	1	5	PCC Jan agreed: **PC2 -** to PCC in Feb **PC3 -** to PCC in Feb **PC4** - to PCC in Feb **PC5 -** to PCC in Feb (following review by SH and AR)	PC1 PC6		PC3 PC4 PC5	*PC2*	
Core 3 - Clinical Governance Lead - Director of Nursing	3	0	1	0	2	**ClinG1:** Jan QC reviewed timescale to April for QC assurance on evidence **ClinG2** **ClinG3:** Update to Feb QC on actions, including potential effectiveness survey for members, feedback from observation and clear link to strategy		*ClinG2*	*ClinG3*		*ClinG1*
Core 4 - Corporate Governance Lead – Director of Corporate Affairs	13	0	0	8	5	Forms approved by Board in Jan (5) Jan A&R agreed: **CorpG1** – to Mar A&R **CorpG3** – to Mar A&R **CorpG4** – to Mar A&R **CorpG5** – to Mar A&R **CorpG6** – to Mar A&R **CorpG7** – to Mar A&R **CorpG8** – to Mar A&R **CorpG11** – to Mar A&R	CorpG2 CorpG10 CorpG12 CorpG13 Corp G9			CorpG1 CorpG3 CorpG4 CorpG5 CorpG6 CorpG7 CorpG8 CorpG11	
Core 5 - Council of Governors Lead – Director of Corporate Affairs	3	0	0	0	3	All areas Complete (signed off December 2016)					
Core 6 - Roles and Responsibilities of Board Members Lead – Director of Corporate Affairs	5	0	1	3	1	**RR1 –** to Apr RAC **RR2 –** to *Apr* RAC **RR3 –** to *Apr* RAC **RR4 –** March RAC **RR5** – to *Apr* RAC				RR4	RR1 *RR2* *RR3* *RR5*
Core 7 - HR and OD Lead - Director of People and Organisational Effectiveness	8	0	0	3	5	Jan PCC agreed: **WOD1** - to Feb PCC **WOD2** - to Mar PCC **WOD3 -** to Feb PCC **WOD4** - to Feb PCC **WOD5 -** to April PCC **WOD6** - to Mar PCC **WOD7** - to Feb PCC **WOD8** - to Feb PCC			WOD1 WOD3 WOD4 WOD7 WOD8	WOD2 WOD6	WOD5
Core 8 - Raising concerns at work Lead - Director of People and	1	0	0	1	0	To Feb PCC - to confirm how completion/ embeddedness to be				*RC1*	

Core	Total	Off Track	Some Issues	On track	Com-plete	Update	Programme for Blue Forms to Board				
							Jan	Feb	Mar	Apr	May
Organisational Effectiveness						defined (and become business as usual)					
Core 9 - Fit and Proper Lead – Director of Corporate Affairs	1	0	0	0	1	Complete. Approved by Board in November 2016.					
Core 10 – CQC Lead – Acting Chief Operating Officer	2	0	0	0	2	Jan Board approved CQC1. CQC 2 to be reviewed by Feb PCC	CQC 1		CQC2		
Core 11 - NHS improvement undertakings Lead - Chief Executive/Director of Corporate Affairs	6	0	0	3	3	Assurance and embeddedness is dependent on removal of enforcement undertakings and external assurance (e.g. Deloitte review)					M1 M2 M3 M4 M5 M6
Total	**53**	**0**	**2**	**21**	**30**	Approved prior Jan: **4**	**11**	**1**	**10**	**15**	**12**

At the February meeting of the People and Culture Committee it was agreed that PC2 was near completion but the blue form submission should be deferred until the March 2017 People and Culture Committee when further evidence and assurance will be presented.

Recommendation PC3: Supplement the current mechanisms to engage with staff through the inclusion of more informal activities across both clinical and corporate areas. Develop clearer reporting of information and trends from these activities in order to triangulate with other information, for example, through the CEO report and Quality Position Statement	**Current BRAG Rating**	**Recommended BRAG Rating**
	Completed	**Assurance Received**

Detail

The CEO Report to Board has been enhanced to include more detail about staff engagement. This summarises feedback from staff and provides evidence of where action has been taken in response to this feedback.

May 2016 P&CC received an internal communications plan which was then further developed in line with the Engagement Plan and supported by setting up the Engagement Group.

At June P&CC a revised report was presented which outlined the Comms approach to recording feedback. The Engagement Group provided feedback to July's P&CC on how the feedback would be used. A paper detailing how feedback would be monitored was presented to July P&CC. The system identifies common themes and priority areas which will be monitored by the Engagement Group and reported to the P&CC on a quarterly basis.

A summary of engagement activity was presented to the Board Development session in September 2016. This included team meetings, attendance at Band 7 Development sessions Kingsway Campus; Medical Staff meetings and individual interviews with staff and Managers. Information from these meetings in 2016 is stored on Sharepoint (a platform for storing data) and collated into themes, which have been presented to the P&CC, and highlights were presented to the Board in September 2016 at a development session.

The Engagement Group is in place and meets monthly. Examples of staff engagement plans being implemented include the staff survey and the 'Spotlight on our Leaders' events. A quarterly pulse check incorporating the staff Friends and Family questions starts end of February 2017, administered by Picker. This will enable us to continuously monitor improvement in staff engagement. This plan was presented to the P&CC in January 2017. The results of the pulse check will be presented to the People and Culture Committee in April 2017. This links to the Engagement Strategy which presented an engagement proposal to work through teams using a 'Pioneer' role. Volunteers from teams will work on action plans for the staff survey.

Evidence

2.23 a, b CEO report – Example September 2016 (with Listen, Learn, Lead appendix)

2.24 Internal communications plan on staff engagement – May P&CC

2.25 June's PCC report – Comms approach to providing feedback

2.26 Evidence from Engagement Group, presented to July's P&CC, on recording feedback

2.27 Engagement activity presentation to Board Development session Sept 2016

2.4 Engagement Group Terms of Reference May 2016

2.28 Engagement Group minutes

2.29 Spotlight on our Leaders example programme, November 2016 2.22 January 2017 report to P&CC on pulse check proposals 2.19 December 2016 Board Paper Engagement and Culture Plan 2.20 January 2017 People and Culture Committee staff survey results report 2.21 February 2017 Board staff survey results report – Confidential session			
On-going Monitoring Arrangement Engagement Group monthly meeting People and Culture Committee: Bi-monthly reporting			
Executive Director Responsible	Director of People and Organisational Effectiveness	**Responsible Assurance Committee**	People and Culture Committee

Recommendation PC4: Prioritise the development of the People Strategy and ensure the agenda and focus of the newly formed People and Culture Committee is clearly aligned the Trust's overall strategy	**Current BRAG Rating**	**Recommended BRAG Rating**
	Completed	**Assurance Received**

Detail

A draft People Strategy framework and plan was presented to P&CC on 20.4.16. The Committee acknowledged progress and discussed the draft documents, agreeing that the content was good, but that the People Plan (implementation) was not complete. A further revision was taken in June 2016 and the Committee requested a revised plan to be developed which would provide clarity on ownership of actions, clearly defined KPIs, timescales and deliverables and was finally approved at the P&CC in July 2016.

The Revised People Plan was submitted to the January 2017 P&CC meeting and approved. This captures actions and priorities for 2017 P&CC agenda.

Evidence

2.30 Cover sheets used for P&CC/Board Committees – Including requirement to identify the link to Trust strategic objectives

2.3 People Plan, February P&CC

2.1 Sample agenda, February P&CC

2.31 Minutes from January P&CC confirming approval of People Plan

On-going Monitoring Arrangements
P&CC to receive People Plan progress reports by featured segments at each meeting – Standing item as outlined on Forward Plan.

Quarterly update on progress on full People Plan to P&CC.

Executive Director Responsible	Director of People and Organisational Effectiveness	**Responsible Assurance Committee**	People and Culture Committee

Recommendation	Current BRAG Rating	Recommended BRAG Rating
ClinG3 - Increase the effectiveness of the Quality Committee by ensuring clear alignment of the committee with the quality strategy and associated objectives, and ensuring a clear focus on seeking assurance	**Completed**	**Assurance Received**

Detail

The terms of reference of the Committee were reviewed and agreed in May 2016 and further reviewed in December 2016. These revised terms of reference aim to outline the remit of the Committee to seek assurance on delivery of the Quality Strategy. All terms of reference were reviewed collectively by the Audit and Risk Committee to ensure alignment and coordination.

The Quality Committee previously agreed that the action matrix requires richer narrative when capturing actions and accountabilities and this was reviewed in January's Committee meeting. It was agreed that this has been achieved.

A Board Development Session was held in July focussing on Board Committee effectiveness and including holding to account for completion of actions. Actions are now clearly articulated, with a named lead, agreed timeframe and updates provided. These are RAG rated and analysed prior to each meeting to provide percentage of actions completed (green), set for forward agendas (yellow), ongoing (orange) or overdue (red). Progress against actions are reviewed at each meeting and scrutinised to ensure that evidence is provided on appropriate progress.

A forward work plan has been developed to cover all areas of the Quality Committee terms of reference and is reviewed at each Committee meeting.

The Committee agenda has been reviewed and from July 2016 has been structured according to CQC domains and covers topics to support the delivery of the quality strategy and is cross referenced against quality priorities. The link to organisational strategic objectives is outlined on the cover sheet which accompanies all papers (strategic prompt added from December 2016).

A review of the Committee, including considering effectiveness, was undertaken at the end of March 2016 and presented to the Committee and also the Audit and Risk Committee, along with all other Board Committee year end reports for 2015/16. A report of the business of the Committee for 2016/17 is being developed and will be brought to the March meeting. This will review the Committee's effectiveness against all areas of the terms of reference.

A peer observation exercise was carried out for the Committee in January 2017. Feedback has been given to the Executive Lead and will be shared with the Committee Chair and actions arising will be agreed by the Committee for implementation.

Evidence			
3.1 Quality Committee Terms of Reference 3.2 Quality Committee agenda 3.3 Quality sub-group Terms of Reference 3.5 Quality Committee Forward Plan 3.6 Quality Committee 2015/16 Annual review 3.7 Feedback from peer Observation January 2017			
On-going Monitoring Arrangements • Annual review of terms of reference (due March 2017 and annually on workplan) • Forward plan for the Committee (agenda item April 2017) • Annual review of the Committee (to the Committee in March and Audit and Risk Committee in April 2017) • Implementation of actions arising from peer observation (for agreement and discussion at March 2017 Committee)			
Executive Director Responsible	Director of Nursing	**Responsible Assurance Committee**	Quality Committee

Recommendation WOD1: **DR34** - Define and agree a process to regularly monitor the consistent application of HR policies and procedures for the full range of Employee Relations cases **CQC1** - The trust must ensure HR policies and procedures are followed and monitored for all staff	**Current BRAG Rating** **Complete**	**Recommended BRAG Rating** **Assurance Received**

Detail

DR34

The Director of Workforce, OD and Culture met with internal audit during the week commencing 09.05.16. It was suggested that Internal Audit should review the Disciplinary and Health Attendance policies. Policy audit reviews were completed by our internal auditors, PWC; actions were identified and undertaken – detail of these can be seen in the PWC audit paper.

In January 2017 the People and Culture Committee agreed that the PWC audit actions paper produced by the Principal Workforce and OD Manager (Garry Southall) provided assurance that this action is now complete. The paper detailed all actions, mitigations, progress to date and forward planning.

The employment relations paper, also produced by Garry Southall, was submitted to the January People and Culture Committee. The Committee agreed that this also provided sufficient evidence of completion of actions WOD1 and WOD7 – the 'points to consider' section of the paper provides assurance that this action can now be signed off.

CQC1

A series of management development programme sessions have been implemented from November 2016 to train staff on implementation and adherence to HR policies and procedures.

The Managing People Policy training took place from 14 November 2016 to 30 January 2017 with enough places for all of the relevant managers including contingencies where people were unable to attend for operational reasons. The programme consisted of six sessions covering the following policies and process:

- Health and attendance
- Employee Improvement (capability)
- Grievance and Dignity at Work
- Recruitment and selection
- Discipline
- Appraisal (process)

It was agreed at the January People and Culture Committee meeting that a blue form should be completed and submitted to the February 2017 Committee meeting.

Evidence

7.1 ER cases report to P&CC, January 2017

7.2 Disciplinary and grievance PWC audit actions paper, November 2016

7.6 PWC audit, as presented to the Audit & Risk Committee
2.31 Minutes of the January 2017 P&CC meeting
7.7 Management development programme sessions – Agendas of sessions and attendance sheets
On-going Monitoring Arrangements **DR34** In order to monitor and ensure adherence to the ER Policies and Procedures the ER Case Tracker is the subject of a two weekly review meeting between Principal Workforce & OD Managers and the Director of People & Organisational Effectiveness. This meeting identifies any pinch points and discusses ways of taking complex cases forward. There is also regular review meeting between Principal Workforce & OD Managers and staff side colleagues. The meeting with Staff Side is paramount in ensuring policies are followed as Staff Side are often privy to information around this, therefore this acts as a monitoring process from both sides. A Principal Workforce & OD Manager attends ELT on a monthly basis to provide an overview of current and new cases and resolved cases. At the meeting any complex, overrunning cases and non-compliance are escalated upwards to the relevant Director. HR&OD will continue to work with Staff Side to review all employee related policies, and information will inform the review of grievance, dignity at work and disciplinary policies. **CQC1** In January 2017 work commenced with IT on a project to improve the mechanism for reporting Employee Relations cases. This system will be an enhancement on the current ER Tracker and will track the process of each stage in all ER cases. There will be access not only for Workforce & OD staff but also restricted access to track each stage of their relevant investigations. They will also be able to populate their investigations also. Therefore at any one time information on what stage the case is at, any complexities and whether process is being followed will be known. A Workforce & OD Working Group is set up to ensure the system covers everything that is necessary and it is anticipated that this will be complete by end of April 2017. At the end of each month a progress report will be produced and where timescales in accordance with the policy haven't been met; the manager be reminded than an exception report will need to be included. Another internal audit will be undertaken to review the benefits and adherence to policies towards the end of 2017.

Executive Director Responsible	Director of People and Organisational Effectiveness	**Responsible Assurance Committee**	People & Culture Committee

Recommendation WOD4: As part of its review programme, the Trust may wish to consider a mandatory programme for line managers in order to embed the revised policies and procedures	**Current BRAG Rating** **Completed**	**Recommended BRAG Rating** **Assurance Received**

Detail

The post of Management Trainer was appointed to on 01.08.16.

The training programme started in November 2016.

Staffside had input on the comprehensive programme.

The Managing People Policy Training took place from 14 November to 30 January 2017 with enough places for all of the relevant managers including contingencies where people were unable to attend for operational reasons. The programme consisted of six sessions covering the following policies and process:

- Health and attendance
- Employee Improvement (capability)
- Grievance and dignity at Work
- Recruitment and selection
- Discipline
- Appraisal (process).

Staff-side were involved in the design process providing many of the scenario case studies and essential inputs into the challenges, traps and pitfalls section of the workshops and the job aids (provided for each policy).

The requirement has been placed in the relevant managers' training passports and compliance monitored centrally by the training manager and as part of line management.

All sessions had registers and these are captured on the training monitoring system. Evaluation forms have also been submitted and are recorded on the training monitoring system.

The responses in the evaluation forms was very positive.

Mop-up sessions are also being provided during February and March 2017 for those people who were unable to attend sessions between November 2016 and January 2017.

At January 2017 P&CC the Committee agreed the preparation of a blue completion form to present evidence of assurance to the Committee so that they may assess completion of this recommendation.

Evidence

7.5 a, b Managing People Policy training posters

Training report on programme uptake

On-going Monitoring Arrangements

P&CC updates on leadership training roll out.

Leadership development strategy coming to P&CC in May 2017 will capture progress and next steps plan.

Non-compliance will be dealt with additional training or through the capability process.

Internal audit – potential for programme 2017/18.

Executive Director Responsible	Director of People and Organisational Effectiveness	**Responsible Assurance Committee**	People and Culture Committee

Recommendation WOD7: The trust should monitor the adherence to the grievance, disciplinary, whistle-blowing policies and the current backlog of cases concluded	**Current BRAG Rating** **Complete**	**Recommended BRAG Rating** **Assurance Received**

Detail

The Director of Workforce, OD and Culture met with internal audit during the week commencing 09.05.16. It was suggested that Internal Audit should review the Disciplinary and Health Attendance policies. Policy audit reviews were completed by our internal auditors, PWC; actions were identified and undertaken – details of these can be seen in the PWC audit paper.

In January 2017 the People and Culture Committee agreed that the PWC audit actions paper produced by the Principal Workforce and OD Manager (Garry Southall) provided assurance that this action is now complete. The paper detailed all actions, mitigations, progress to date and forward planning.

The employment relations paper, also produced by Garry Southall, was submitted to the January People and Culture Committee. The Committee agreed that this also provided sufficient evidence of completion of actions WOD1 and WOD7 – the 'points to consider' section of the paper provides assurance that this action can now be signed off.

A series of management development programme sessions have been implemented from November 2016 to train staff on implementation and adherence to HR policies and procedures.

A report on activity against the Trust Raising Concerns (whistleblowing policy has been presented to the Audit and Risk committee May 2016 and December 2016 and is scheduled for reporting on a six monthly basis.

It was agreed at the January People and Culture Committee meeting that a blue form should be completed and submitted to the February Committee meeting.

Evidence
7.6 PWC audit, as presented to the Audit & Risk Committee
7.1 ER cases report to P&CC, January 2017
7.2 Disciplinary and grievance PWC audit actions paper, November 2016
2.31 Minutes of the January 2017 P&CC meeting
7.7 Management development programme sessions – agendas of sessions
7.12 Update on Raising Concerns to Audit and Risk Committee, May 2016
7.13 Update on Raising Concerns to Audit and Risk Committee, December 2016

On-going Monitoring Arrangements

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A Principal Workforce & OD Manager attends ELT on a monthly basis to provide an overview of current and new cases and resolved cases. At the meeting any complex, overrunning cases and non-compliance are escalated upwards to the relevant Director.

HR&OD will continue to work with Staff Side to review all employee related policies, and information will inform the review of grievance, dignity at work and disciplinary policies.

In January 2017 work commenced with IT on a project to improve the mechanism for reporting Employee Relations cases. This system will be an enhancement on the current ER Tracker and will track the process of each stage in all ER cases. There will be access not only for Workforce & OD staff but also restricted access to track each stage of their relevant investigations. They will also be able to populate their investigations also. Therefore at any one time information on what stage the case is at, any complexities and whether process is being followed will be known. A Workforce & OD Working Group is set up to ensure the system covers everything that is necessary and it is anticipated that this will be complete by end of April 2017. At the end of each month a progress report will be produced and where timescales in accordance with the policy haven't been met; the manager be reminded than an exception report will need to be included. Another internal audit will be undertaken to review the benefits and adherence to policies will be undertaken towards the end of 2017.

Executive Director Responsible	Director of People and Organisational Effectiveness/ Director of Corporate Affairs	**Responsible Assurance Committee**	People & Culture Committee

Recommendation WOD8: The trust should continue to make improvements in staff engagement and communication	**Current BRAG Rating**	**Recommended BRAG Rating**
	Complete	**Assurance Received**

Detail

The approach and direction, as outlined in the Engagement & Culture Plan was presented to the Board in December 2016; this was discussed and agreed at the Board and People and Culture Committee. The engagement group meets monthly.

At January 2017 P&CC the Committee agreed the preparation of a blue completion form to present evidence and assurance to the Committee so that they could assess that this action is complete.

A number of improvements have been made, and continue to be made, to staff communication. The Acting Chief Executive now sends a weekly message to all staff, which he personally writes, outlining his work during the preceding week; this has given staff a greater insight into the work of the executive team and has resulted in many staff responding and engaging with the Acting Chief Executive.

A Trust Management Team meeting now takes place once every two weeks to bring together clinical and operational leadership from across the Trust. The group has made a commitment to cascade information and key messages down through service lines.

A Trust staff app has been introduced, which staff can download on their personal smartphones to read latest news, access the e-rostering system and find useful contact numbers (such as for the Workforce team or the 24-hour employee assistance programme). 450 staff have downloaded the app, which particularly aims to support staff without regular access to a computer during working hours.

The Trust's monthly corporate video message to staff, the 'team talk', has been revised and is now in the form of an interview, with a staff representative putting questions to a director. This provides a new outlet for staff at all levels to challenge the executive team and encourage dialogue about issues that matter to them.

In a staff survey in the summer of 2016, 71% of respondents said that Trust-wide communications were either 'good' or 'very good'. We are continuing to refine the corporate communications channels and approach to ensure this figure continues to increase.

The corporate Communications team also manages the ongoing staff recognition scheme, the DEED scheme, which has continued to grow in popularity since its launch in 2015. The scheme had its most successful period to date in January and February 2017 with 43 nominations submitted by staff (and a small number of members of the public) for individual employees and Trust teams who had delivered excellence in their roles. This reflects staff's growing willingness to praise colleagues who demonstrate the Trust values, while feedback from individuals who have been nominated suggests that they feel very positively about this recognition.

We will continuously improve staff engagement energy and well-being increasing the positive pulse check year on year. A new quarterly pulse check starts end of February 2017 NHS Staff survey action plans are being developed through teams. These will be overseen by the Engagement Group and will feed directly into the People and Culture Committee.

A new quarterly pulse check will start in February 2017, administered by Picker.

Evidence

7.10 December 2016 Board Paper Engagement and Culture Plan

2.20 January 2017 People and Culture Committee staff survey results report

2.21 February 2017 Board Staff survey results report – Confidential Board

2.35 Weekly email by CEO – Example January 2017

2.4 Engagement Group Terms of Reference May 2016

2.28 Engagement Group sample minutes

7.11 Engagement Group meeting schedule February 2017

On-going Monitoring Arrangements

People and Culture Committee bi-monthly reporting on progress with Engagement Plan.

Engagement group monthly meetings.

We will continuously improve staff engagement energy and well-being increasing the positive pulse check year on year. A new quarterly pulse check starts at the end of February 2017 and the findings will be reported quarterly from April 2017 to People and Culture Committee meeting.

NHS Staff survey action plans are being developed through teams. Once in place they will also be monitored through the Trust Management Team meeting.

Executive Director Responsible	Director of People and Organisational Effectiveness	**Responsible Assurance Committee**	People and Culture Committee

Recommendation CQC2: The trust should continue to proactively recruit staff to fill operational vacancies	**Current BRAG Rating**	**Recommended BRAG Rating**
	Complete	**Assurance Received**

Detail

In April 2016 P&CC received an operational recruitment plan paper from the Director of Operations. The Committee were assured that the actions identified in the plan were the right ones, but requested a clear improvement trajectory and sought further assurance that there was enough capacity within the Trust to be able to deliver the plan. Confirmation was sent to Committee members to confirm that HR had the capacity to deliver the plan in the timeframes suggested.

May P&CC received an updated recruitment plan. The Committee were assured by the paper and the suggested trajectory. A paper was presented to the September P&CC. The Committee was not assured that the actions were having the intended outcome given ongoing recruitment issues and they requested a reviewed action plan for October's P&CC.

In September a new Director of People and Organisational Effectiveness and the new Acting Chief Operating Officer was appointed and received approval at the October Board for additional investment into resources to focus on temporary and permanent staffing and these individuals have been in post for three months. Detailed and focussed activity and plans are in place for UK and overseas recruitment and a weekly meeting is in place to track progress. Delivery plans have been prepared for medical recruitment, nursing and other professionals.

Finance and operations teams review vacancies monthly within budget meetings and as part of review of financial forecasting agree a proactive approach to recruitment.

The recruitment process has been reviewed and improved to improve the speed and effectiveness and this has been communicated to all leaders and followed up with training.

Evidence

10.2 May P&CC recruitment plan
10.3 Monthly Board report on workforce
10.4 Monthly update on recruitment to P&CC
10.5 Medical recruitment plan – Jan P&CC

On-going Monitoring Arrangements

- Monthly board reporting in the performance report
- Monthly updates to P&CC
- Trajectory monitoring of vacancy fill and retention rates

Executive Director Responsible	Acting Chief Operating Officer/ Director of People and Organisational Effectiveness	**Responsible Assurance Committee**	People and Culture Committee

2017-18 Board Annual Forward Plan

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	26 Apr 17	24 May 17	28 Jun 17	26 Jul 17	27 Sep 17	1 Nov 17	29 Nov 17	27 Jan 18	28 Feb 18	28 Mar 18
		Deadline for papers	**17 Apr**	**15 May**	**29 Jun**	**18 Jul**	**18 Sep**	**30 Oct**	**20 Nov**	**22 Jan**	**19 Feb**	**19 Mar**
CM	Apologies given		X	X	X	X	X	X	X	X	X	X
SH	Declaration of Interests	FT Constitution	X	X	X	X	X	X	X	X	X	X
CM	Minutes/Matters arising/Action Matrix	FT Constitution	X	X	X	X	X	X	X	X	X	X
CG	Actions and learnings from patient stories.		X	X	X	X	X	X	X	X	X	X
CM	Board Forward Plan	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X
CM	Board review of effectiveness of the meeting	Statutory Outcome 3	X	X	X	X	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE												
CM	Chair's report	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X
IM	Chief Executive's report	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X
MP/ CW	APR NHSI Annual Plan submissions and governance statements, including financial plan and budgets (subject to change for NHSI deadlines each year) *Confidential*	FT Constitution/NHSI Risk Assurance Framework (RAF)	X									X
CW	NHSI Compliance Return (Public) (subject to change (incorporated into Integrated Performance Report)	NHSI Single Operating Framework		X	X				X	X		X
JS	Information Governance Updates	Strategic Outcome 1 Strategic Outcome 3 Information Gov toolkit	X					X				
AR	Staff Survey Results and Action Plan	Strategic Outcome 3 and 4	X									
SH	Review SOs, SFIs, SoD	FT Constitution Standing Orders				X						
SH	Trust Sealings	FT Constitution Standing Orders		X								
SH	Annual Review of Register of Interests	FT Constitution Annual Reporting Manual	X									
SH	Board Assurance Framework Update	Licence Condition FT4	X				X		X		X	

2017-18 Board Annual Forward Plan

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	26 Apr 17	24 May 17	28 Jun 17	26 Jul 17	27 Sep 17	1 Nov 17	29 Nov 17	27 Jan 18	28 Feb 18	28 Mar 18
SH	Raising Concerns (whistleblowing)	Strategic Outcome 1 Public Interest Disclosure Act			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	Strategic Outcome 3	X	X	X	X	X	X	X	X	X	X
SH	Governance Improvement Action Plan	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X
SH	Fit and Proper Person Declaration	Licence Condition FT4		X								X
MP	Emergency Planning Report (EPPR)								X			
SH	Board Effectiveness Survey											X
SH	Report from Council of Governors Meeting		X				X	X		X	X	
SH	Review of Policy for Engagement between the Board & COG								X			
SH	Board Development Programme										X	
LWS	Measuring the Trust Strategy		X									
OPERATIONAL PERFORMANCE												
CG, CW, AR, MP	Integrated performance and activity report to include Finance, Workforce, performance and Quality Dashboard	Licence Condition FT 4 Strategic outcome 1 Strategic Outcome 3	X	X	X	X	X	X	X	X	X	X
QUALITY GOVERNANCE												
CG	Position Statement on Quality (Incorporates Strategy and assurance aspects of Quality management) Includes Annual Review of Recovery Outcomes in October and Annual Looked After Children Report in December	Strategic Outcome 1 CQC and Monitor	X	X	X	X	X	X	X	X	X	X

2017-18 Board Annual Forward Plan

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	26 Apr 17	24 May 17	28 Jun 17	26 Jul 17	27 Sep 17	1 Nov 17	29 Nov 17	27 Jan 18	28 Feb 18	28 Mar 18
CG/JS	Safeguarding Children Annual Report	Children Act Mental Health Standard Contract							X			
CG/JS	Safeguarding Adults Annual Report	CQC Mental Health Standard Contract								X		
CG	Control of Infection Report	Health Act Hygiene Code		X								
CG/JS	Integrated Clinical Governance Annual Report including MHA/Governance/Complaints and Compliments/SIRIs/Patient Safety/NHS Protect (LSMS) and Emergency Preparedness/H&S (including H&S and Fire Compliance and Associated Training)	CQC and H&S Act							X			
CG	Annual Community Patient Survey	Clinical Practice CQC							X			
JS	Re-validation of Doctors	Strategic Outcome 3			X							
CG	Annual Review of Recovery Outcomes *							X				
CG	Annual Looked After Children Report *									X		

* Incorporated in Quality Position Statement